STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Whiting	23 Schoolhouse Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44833

Based on observation, interview and review of facility documentation, it was determined the facility failed to maintain a comfortable and homelike environment for resident rooms on 3 of 3 nursing units of the facility observed (1 East, 2 East, and 2 West). The evidence of this deficient practice includes:

1.) On 03/18/2024 from 9:33 AM to 11:41 AM, during the initial tour of the 2 [NAME] nursing unit, the surveyor made the following observations:

The vinyl wall covering in resident room [ROOM NUMBER] behind bed B was partially removed and pulled away falling off the wall.

room [ROOM NUMBER] the plastic/vinyl wall bumper behind bed A was broken with pointed edges.

The bath tub in room [ROOM NUMBER] contained brown and grey stains and the overflow plate was covered with a white crusty material.

The wall behind bed A in room [ROOM NUMBER] had an approximately 12 inch by 4 inch area with gouges missing paint and revealing the bare drywall.

room [ROOM NUMBER] had four holes approximately one inch in diameter in the wall directly under the ceiling and to the right of the bathroom door.

room [ROOM NUMBER] bathroom door was missing a door knob with a hole where the door knob would be placed and had the paint removed along the edge of the door by the door knob opening, the call bell control panel was hanging down off of the mounting bracket on the wall exposing the wires in the wall, and the wall behind bed A was damaged with two large holes approximately four to five inches wide and peeled wallpaper.

On 3/25/2024 at 12:35 PM, the surveyor, in the presence of the survey team, interviewed the Director of Maintenance (DOM), who stated that environmental concerns fall under the maintenance department's responsibility. He included that maintenance department is notified of reeded repairs through an electronic work order program utilized by the facility. The DOM was presented with photos of the above observations, and he acknowledged the need for repairs.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF PROVIDER OR SUPPLIER Aristacare at Whiting		STREET ADDRESS, CITY, STATE, ZIP CODE 23 Schoolhouse Road Whiting, NJ 08759	

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F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of the facility's undated Maintenance Service policy included but was not limited to: maintenance service shall be provided to all areas of the building, grounds, and equipment. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The following functions are performed by maintenance, but are not limited to: .b. maintaining the building in good repair and free from hazards .g. maintaining the paging system in good working order

NJAC 8:39-4.1(a)

43936

Complaint # NJ152908, NJ156248, NJ152672

2.) On 03/18/2024 at 10:29 AM during the initial tour of the facility, Surveyor # 2 observed resident room [ROOM NUMBER]. At that time, there was no trash bag in the garbage can.

On the same date at 11:24 AM during the initial tour of the facility, Surveyor # 2 observed room [ROOM NUMBER]. At that time, Surveyor # 2 observed stains on the privacy curtain that was located between the beds in the room.

On 03/20/2024 at 1:29 PM, Surveyor # 2 observed room [ROOM NUMBER]. At that time, Surveyor # 2 observed the dresser in the room. The front of the bottom drawer was detached and left leaning against the side of the dresser. In addition, Surveyor # 2 observed the floor base board was missing behind the bed and in the corner near the bathroom door. The unfinished dry wall was exposed.

On 03/25/2024 at 12:30 PM, during an interview with Surveyor # 2, the Director of Maintenance confirmed that if a dresser or bed was broken it would be maintenance's responsibility to fix it. The Director of Maintenance said he was unaware of the broken dresser and missing floor base board in room [ROOM NUMBER]. He concluded by saying he will have his staff repair it immediately.

On 03/25/2024 at 12:44 PM during an interview with Surveyor # 2, the Director of Housekeeping said that resident rooms are cleaned every day. He further said that privacy curtains are changed once a month or as needed. Lastly, he confirmed that his staff are to put a new trash bag in a garbage can when they empty it.

A review of the facility provided document titled, Work Order #4648 revealed a note, REPAIRED DRESSER DRAWER with a completed status of 03/26 at 12:58 PM. The document confirmed the repair was completed after the surveyor brought the observations to the attention of the Director of Maintenance.

A review of the undated facility provided document titled, Maintenance Service revealed under, Policy Interpretation and Implementation that, 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.

48964

On 03/19/2024 at 11:20 AM Surveyor #3 observed Resident #71 in his/her room and noted seven missing floor tiles in front of the sink. Resident #71 stated the tiles were missing forever and it bothers him/her as the wheelchair gets stuck and hard to propel with the difference in the floors.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Whiting	23 Schoolhouse Road Whiting, NJ 08759

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/21/2024 at 10:34 AM Surveryor #3 noted seven floor tiles remain missing in Resident #71's room in front of the sink On 03/25/2024 09:49 AM Surveyor #3 noted seven missing floor tiles in Resident #71's room in front of sink. On 03/25/24 at 12:30 PM Surveyor #3 interviewed the maintenance director, who stated when the staff sees something, they put it in TELS, (TELS is a building management platform designed for Senior Living with integrated Asset Management, Life Safety, and Maintenance solutions), and then it comes to him. He stated that he was not aware of anything needing attention in room [ROOM NUMBER]. He also stated there was nothing in TELS regarding this room. He further stated that the tiles should not be pulled up like that. On 03/27/24 at 10:12 AM Surveyor #3 reviewed facility provided work order #4651 indicates work order was created on 03/26/24 at 12:53pm. A review of the undated facility provided document titled, Maintenance Service revealed under, Policy Interpretation and Implementation that, 2. b. Maintaining the building in good repair and free from hazards. N.J.A.C. 8:39-4.1(a)11, 31.4(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40744 Based on observation, interview, and record review it was determined that the facility failed to notify the resident and/or resident representative in writing of the reason for transfer or discharge to the hospital for 3 of 3 residents reviewed for hospitalization Residents #43, #129, and #230. This deficient practice was evidenced by the following: 1.) On 03/20/24 the surveyor reviewed the Electronic Medical Record (EMR) which indicated Resident #129 was admitted to the facility for short term rehabilitation. Further review showed there was a Discharge/Return Anticipated Minimum Data Set (MDS), an assessment tool completed on 12/22/23 following a transfer to the hospital for right shoulder pain. Review of the Admission Record indicated Resident #129 had medical diagnoses which included but were not limited to the following: acute respiratory failure, kidney disease, and anxiety. The surveyor reviewed the most recent MDS which revealed the resident had a Brief Interview of Mental Status of 3, meaning the resident had severe cognitive impairment. On 03/20/24 at 12:58 PM, review of the progress notes showed that on 12/21/23 at 9:00 PM Resident #129 was found in the room on the floor. The resident complained of right shoulder pain at that time. The resident's physician and family were notified via telephone and shoulder x-rays were ordered. Further review of the progress notes showed that on 12/22/23 at 09:00 AM, the resident complained of pain to right shoulder, right arm and right wrist. Resident #129 was sent to the hospital on 12/22/23 following the complaints of pain. On 03/25/24 at 01:01 PM, the surveyor interviewed the Director of Social Work (DSW) regarding notification of hospitalization in writing to the resident and/or resident representative and ombudsman. The DSW stated, The last receptionist would send the hospitalization to the Ombudsman's office in bulk at the end of the month. The DSW could not locate the confirmation of the faxes. The surveyor asked about the notification to the resident and/or resident representative in writing. The DSW stated, The receptionist was supposed to do both resident representative and ombudsman, but she wasn't doing that. The receptionist is now going to be sending it to the resident representative. On 03/27/24 at 11:53 AM, the surveyor reviewed the policy titled Preparing a Resident for Transfer or Discharge, an undated policy. The policy statement revealed that the facility shall prepare a resident for a transfer or a discharge. Number three of the policy indicated that the receptionist would send out an email notice of the discharge. The policy did not indicate who received the email notice. 44833 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF PROVIDER OR SUPPLIER: Aristacare at Whiting		STREET ADDRESS, CITY, STATE, ZIP CODE: 23 Schoolhouse Road Whiting, NJ 08759	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) On 03/25/2024 the surveyor reviewed Resident #43's EMR. Review of the Admission Record indicated Resident #43 was admitted to the facility with diagnosis which included but were not limited to essential hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD, a chronic lung disease), and heart disease. Further review indicated Discharge/Return anticipated MDS for 4/12/23 following transfer to the hospital for tachycardia (rapid heart rate) and another dated 12/10/23 after being found unresponsive in bed. The surveyor reviewed the most recent MDS which revealed the resident had a Brief Interview of Mental Status of 15 out of 15 indicating intact cognition. Review of the progress notes showed that on 4/12/23 at 12:56 PM, the resident was admitted to the hospital with severe sepsis shock (infection in the blood stream), and another progress note dated 12/10/23 at 10:46 PM, which indicated the resident was admitted to the hospital with hypotension (low blood pressure). 48964 3.) On 03/21/2024, the surveyor reviewed Resident #230's EMR. Review of the progress notes indicated that Resident #230 was admitted to the facility for short term rehabilitation following a hospitalization which included abdominal surgery for an ileostomy (the lower small intestine is brought through the abdominal wall via a surgical opening). The notes further indicated that on the day of planned discharge, bright red blood was noted in the ileostomy bag. Resident #230's physician was notified, and the resident was transferred to the emergency room for evaluation and admitted for ileostomy dysfunction. Review of the admission MDS, dated [DATE], indicated a BIMS of 15, indicating intact cognition. Further review showed there was a Discharge/Return Anticipated MDS completed on 01/18/2024 following the transfer to the hospital. On 03/25/24 at 01:01 PM, the surveyor interviewed the Director of Social Work (DSW) regarding notification of hospitalization in writing to the resident and/or resident representative and ombudsman. The DSW stated, The last receptionist would send the hospitalization to the Ombudsman's office in bulk at the end of the month. The DSW could not locate the confirmation of the faxes. The surveyor asked about the notification to the resident and/or resident representative in writing. The DSW stated, The receptionist was supposed to do both resident representative and ombudsman, but she wasn't doing that. The receptionist is now going to be sending it to the resident representative. On 03/27/24 at 11:53 AM, the surveyor reviewed the policy titled Preparing a Resident for Transfer or Discharge, an undated policy. The policy statement revealed that the facility shall prepare a resident for a transfer or a discharge. Number three of the policy indicated that the receptionist would send out an email notice of the discharge. The policy did not indicate who received the email notice. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-9.6 (e)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Whiting	23 Schoolhouse Road Whiting, NJ 08759

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48964 Based on interviews, review of medical records, and other facility documentation, it was determined that the facility failed to electronically transmit the Minimum Data Set (MDS, an assessment tool), within 14 days of completing the resident's assessment. This deficient practice was identified for 1 of 1 unsampled resident, (Resident # 95) reviewed in the Resident Assessment Task for MDS record over 120 days old. On 03/20/2024 the surveyor reviewed the MDS history in the electronic medical record which revealed: Resident #95 was discharged on [DATE]. Resident #95's discharge MDS was completed on 12/27/2023. The history indicates that Resident #95's discharge MDS was transmitted on 03/18/2024. On 03/21/2024, the surveyor interviewed the MDS Coordinator (MDSC), who stated that the discharge MDS on Resident #95 should've been completed within 14 days of discharge and transmitted within one week after completion. She also stated, it's late and the MDSs are usually transmitted once they're completed, this one got missed. Review of facility provided policy MDS Submission Timeframes included: The following submission timeframe for MDS records will be observed by this facility: Discharge - final completion date + 14 days According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2023, page 2-17, discharge return-not anticipated must be completed no later than the discharge date + 14 calendar days with the transmission date no later than MDS completion date +14 days. On 03/27/2024, the surveyor interviewed the Director of Nursing who provided a QAPI and stated that the QAPI was done the day the surveyor brought the issue to their attention. NJAC 8:39-11.2 (e) 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315309	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Whiting	23 Schoolhouse Road Whiting, NJ 08759

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48964 Based on interview and record review it was determined the facility failed to conduct a new Preadmission Screening and Resident Review (PASRR) level 1 assessment after a resident was newly diagnosed with a mental illness. This deficient practice was identified in 1 of 3 residents reviewed for PASRRs (Resident #71) and was evidenced by the following: On 03/19/2024 the surveyor reviewed Resident #71's Electronic Medical Record (EMR) which included review of the PASARR level 1 completed on 08/09/2022 which was negative and marked no for any diagnoses of mental illness. Review of the Admission Minimum Data Set (MDS), an assessment tool, dated 07/06/2022, indicated a Brief Interview of Mental Status (BIMS) score of 15/15, indicating intact cognition and review of section I did not include any psychiatric diagnoses. A review of the Quarterly MDS dated [DATE], indicated bipolar disorder and psychotic disorder noted in Section I. A review of the Quarterly MDS dated [DATE], indicated bipolar disorder and psychotic disorder noted in Section I. A review of Resident #71's care plans revealed a focus of I have expressed to my therapist that I am angry, frustrated experiencing psychotic delusions that a nurse was trying to hurt him/her over the weekend with a goal of I will have a decrease on psychotic delusions thru next review date and a focus of I have a diagnosis of Bipolar with use of psychotropic medication. No additional PASRR including the diagnoses of bipolar disorder and psychotic disorder was located. On 03/19/24 the surveyor interviewed the Director of Social Service (DSS) who stated that the level 1 PASSR was not redone with the new diagnosis. On 03/25/24 the surveyor reviewed the facility provided policy pertaining to PASRR which does not address a resident with a new psychological diagnosis after admission. On 03/25/24 at 01:29 PM the surveyor interviewed the DSS who stated prior to surveyor inquiry, it was not in their policy to redo the PASRR upon new diagnosis. On 03/27/24 at 10:48 AM the surveyor interviewed the Director of Nursing who stated that after surveyor inquiry an updated PASRR as completed for Resident #71 and the DSS did an audit of the entire building. NJAC 8:39.5.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40744 Based on observations, interview, and review of facility documentation it was determined that the facility failed to 1. Obtain physician orders for a resident's discharge home, 2. follow physicians' orders during medication observation and 3. follow physician orders by obtaining an air mattress for a resident at risk for pressure ulcers. This deficient practice was identified for 3 of 29 residents reviewed (Resident #61, #96 and #128) and was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter. Nursing Board The Nurse Practice Act for the State of New Jersey states; The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. 1.On 03/20/24 at 10:15 AM, the surveyor reviewed Resident #128 Minimum Data Set (MDS) list, an assessment tool. The MDS list revealed that Resident #128 was admitted to the facility on [DATE] and a Discharge/Return Not Anticipated MDS was completed on 02/27/24. Review of the Admission Record indicated that Resident #128 had medical diagnoses which included but were not limited to heart disease, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), pacemaker (artificial device to stimulate the heart muscle), and anxiety. Review of the most recent MDS, a discharge assessment tool revealed the resident had a Brief Interview of Mental Status of 15, meaning the resident was cognitively intact. On 03/20/24 at 10:31 AM, the surveyor reviewed the progress notes which showed the following physician note written on 02/26/24: The resident is seen and examined at the bedside for a full assessment, evaluation of current chronic medical conditions, and for medical clearance prior to a planned discharge as requested by the Social Worker and the disciplinary team. Another note written on 02/26/24 by the social worker showed the following: Note Text: Resident is discharging 02/26/24 at 2 PM. Resident going home with a friend, who will provide transportation. On 03/20/24 at 10:36 AM, the surveyor reviewed the progress notes which showed the following note documented on 02/27/24: Discharge instructions reviewed with resident. Medication list explained, resident voiced understanding. Folder with medication list and discharge summary placed in black computer bag. At 01:30pm the resident was picked up by son. Transferred to car via wheelchair with all personal belongings. No acute distress noted at the time of discharge. On 03/20/24 at 10:46 AM, the surveyor reviewed the care plan which showed the following focus: plan of care will be resident centered around the goal of returning to the community after completion of short-term rehabilitation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/21/24 at 10:08 AM, the surveyor reviewed documentation provided by the facility which included progress notes, physician orders, and the physician discharge summary. The discharge instructions included medications and follow up instructions and were signed by the resident at the time of discharge. The surveyor could not locate a physician's order for discharge after review of the physician orders. On 03/25/24 at 1:11 PM, the surveyor interviewed the Director of Nursing (DON) regarding residents being discharged home. The surveyor asked what a resident would need to be discharged home. The DON stated that residents should have a discharge order, medications should be arranged, and discharge instructions reviewed with the resident or resident representative. The surveyor asked about the need for a discharge order for Resident #128 and the DON responded, Definitely should have a physician order for discharge, we started in-servicing making sure the discharge orders are in the chart. A review of the policy titled, Preparing a Resident for Transfer or Discharge, an undated policy. The policy statement was that the facility shall prepare a resident for a transfer or discharge. Under the section policy interpretation and implementation, the policy did not include obtaining a physician order as part of the policy. 44833 2. On 03/21/2024 at 9:14 AM, during medication administration observations, the surveyor observed Registered Nurse (RN) #1 administer medication to Resident #61. Along with other ordered medications, RN #1 administered one drop of artificial tears solution 0.2-0.2-1% (eye drops) into the resident's left eye and one drop into the resident's right eye. At 9:16 AM, the surveyor, along with RN #1, reviewed the physician's order (PO) for artificial tears in the electronic medical record (EMR). At this time RN #1 confirmed the PO indicated for one drop to be administered in the right eye, and not both eyes. RN #1 at this time acknowledged that medications should be administered as ordered. A review of Resident #61's Admission Record indicated the resident was admitted to the facility and had diagnosis which included but was not limited to: blepharitis (inflammation of the eyelid which affects the eyelashes or tear production) of the right lower eye lid. A review of the physician Order Summary Report (POS) indicated an active order with start date of 12/20/23 for artificial tears ophthalmic solution 0.2-0.2-1% instill one (1) drop in right eye two times a day related to unspecified blepharitis right lower eye lid. A second order was initiated dated 3/21/24 for artificial tears ophthalmic solution 0.2-0.2-1% instill one (1) drop in both eyes two times a day related to unspecified blepharitis right lower eye lid after surveyor's observation and inquiry. A review of the resident's care plan indicated a care focus initiated 9/29/23 for glaucoma with a goal to maintain optimal quality of life within limitation imposed by visual function. A review of the February and March 2024 Medication Administration Record (MAR) indicated artificial tears were administered and signed by the nursing staff twice daily. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/24 at 1:15 PM, the surveyor interviewed the DON who stated nurses should follow physician's orders when administering medication. She acknowledged it was not appropriate for RN #1 to administer the eye drops into both eyes if the order called for administration in the right eye. 3. On 3/18/24 at 10:21 AM, during the initial tour of the facility, the surveyor observed Resident #96 in their room, laying in their bed. The resident was laying on a mattress that did not have an air or pressure regulating device and was observed to be a standard mattress with no pressure reducing device. The resident informed the surveyor that they have a wound from lying in bed. On 3/20/24 the surveyor reviewed Resident #96's EMR. Review of the Admission Record indicated the resident was admitted to the facility and had diagnosis which included but was not limited to pressure ulcer of the sacral region (bed sore at the portion of the spine between lower back and tailbone). A review of the most recent Quarterly MDS dated [DATE] indicated the resident had a Brief Interview of Mental Status score of 15 out of 15 indicating intact cognition. A review of the physician Order Summary Report (POS) indicated an active order with start date 2/26/24 for an air mattress to be checked for function and placement every shift. A review of the resident's care plan revealed a care focus area for required use of an air mattress due to pressure ulcer with revision date 5/30/23 with interventions including to visually inspect the air mattress for over inflation or deflation each time when entering the room. Further review of the care plan indicated a focus area for pressure ulcer to sacrum with revision date 9/10/23 and intervention including air mattress check function and placement every shift. A review of the February and March 2024 Treatment Administration Record (TAR) revealed air mattress placement and function checks were conducted and signed as completed by the nursing staff every shift as ordered. On 3/21/24 at 8:36 AM, the surveyor observed Resident #96 in bed with a standard mattress and no pressure reducing device. On 3/25/24 at 10:50 AM, the surveyor observed Resident #96 in bed with a standard mattress and no pressure reducing device. At 10:53 AM, the surveyor asked RN #1 to identify the type of mattress being used for the resident. RN #1 along with the surveyor entered the resident's room at which point RN #1 acknowledged the mattress being used was not an air mattress or pressure reducing device as ordered. RN #1 further stated she was going to notify the appropriate department to bring an air mattress for the resident's bed. At 10:56 AM, the resident informed the surveyor that they think they should have one (air mattress) and that they never refused the use of one. At 10:58 AM, RN #1 informed the surveyor the resident should have an air mattress because it was ordered, and she was not sure why the resident did not have one. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Whiting	23 Schoolhouse Road Whiting, NJ 08759

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/24 at 11:02 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated the resident should have an air mattress as ordered, and it was not really being checked by the nursing staff as ordered. On 3/25/24 at 11:08 AM, the Assistant Director of Nursing (ADON) notified the surveyor that an air mattress was being brought to the resident's room by the housekeeping/maintenance department. Review of the facility's undated Administering Medications policy included but was not limited to: medications must be administered in accordance with the orders, including any required time frame. NJAC 8:39-11.2 (a) (b)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 43936 Based on interview, review of Nursing Staffing Report sheets and facility provided documents, it was determined that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 5 of 51 days reviewed under the Sufficient and Competent Nurse Staffing Task. The deficient practice was evidenced by the following: A review of the Nurse Staffing Reports completed by the facility for the weeks of 07/10/2022 through 07/16/2022, 01/08/2023 through 01/14/2023, 03/10/2024 through 03/16/2024 revealed the facility had no RN coverage for all shifts on 07/16/2022, 01/08/2023, 01/14/2023, 03/10/2024, and 03/16/2024. A review of the facility provided schedules for those dates did not reveal any RN coverage. Additionally, facility provided schedules for 07/17/2022 and 03/17/2024. 07/17/2022 did not reveal any RN coverage. The schedule for 03/17/2024 revealed the Director of Nursing was present in the facility however the resident census on that day was 136. On 03/26/2024 at 1:40 PM during an interview with the surveyor, the Director of Nursing said they have Registered Nurses at times but sometimes they leave for various reasons. A review of the undated facility policy titled, Staffing revealed under 'Policy Interpretation and Implementation that, 1. This facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the deliver of resident care services. NJAC 8:39-25.2(h)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44833 49707 Based on observation, interview, and record review, it was determined that the facility failed to ensure the accountability of the narcotic shift count logs were completed in accordance with facility policy. The deficient practice was identified on 2 of 4 medication carts reviewed (1 East Low side cart and 2 [NAME] High side cart) during the Medication Storage Task. The deficient practice was evidenced by the following: On 03/19/2024 at 10:05 AM during an interview with the surveyor, Licensed Practical Nurse (LPN) # 4 said that narcotic shift count logs are to be completed by two nurses (the incoming and outgoing nurses) at the same time once they confirm an accurate count of the narcotics (opium, opium derivatives, and their semi-synthetic substitutes) in the medication cart. She also confirmed that shift count logs should not be missing any documentation or signatures. Further, she said that the inventory sheet should be filled out when she prepares to administer a narcotic. At that time, the surveyor, in the presence of LPN 4, reviewed the 1 East low side medication cart Narcotic Bingo Card Log which revealed the following: On 3/10/24 the 3-11 shift section revealed that positive, negative, and End Shift total sections were blank. On 3/13/24 the 11-7 shift section revealed that positive and negative sections were blank. On 03/19/2024 at 10:33 AM during an interview with the surveyor, LPN # 2 stated that the narcotics shift log should be counted and signed by the incoming and outgoing nurses together. At that time, LPN # 2 stated, I forgot to sign it in this morning. At that time, the surveyor in the presence of the LPN # 2, reviewed the 2 [NAME] High side medication cart's CONTROLLED DRUGS CARD COUNT document which revealed the following: On 03/04/2024, in the 7A-3P Shift section, the positive and negative count section was blank. On 03/05/2024, in the 7A-3P Shift section, the positive and negative count section was blank. On 03/06/2024, in the 3P-11P SHIFT section, the Nurse on (11-7) [3-11] section was blank. On 03/07/2024, in the 7A-3P SHIFT section, the Nurse off (11-7) section was blank. On 03/11/2024, in the 7A-3P Shift section, the positive and negative count section was blank. On 03/19/2024, in the 7A-3P SHIFT section, the Nurse On (7-3) section was blank. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/19/2024 at 11:14 AM during an interview with the surveyor, LPN # 6 said all nurses assigned to carts are responsible for the organization and maintenance of the medication cart. She further stated that narcotic shift to shift count logs are to be completed by two nurses (the incoming and outgoing nurses) at the same time once they confirm an accurate count of the narcotics in the cart. She also confirmed that logs should not be missing any documentation, signatures. On 03/19/2024 at 1:33 PM during an interview with the surveyor, the Director of Nursing (DON) said controlled substance shift to shift logs are to be completed with two nurses at the change of shift. The DON said this occurs after they both complete a count of the controlled substance in the medication cart to show they [narcotics] are accounted for. She confirmed that the purpose is for accountability of the controlled medications. A review of the facility's undated policy titled; Controlled Substances revealed that nursing staff will count controlled drugs at the end of each shift. The nurse coming on duty and nurse going off duty will make the count together. They will document and report any discrepancies to the Director of Nursing services. NJAC 8:39-29.3(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40744 Based on observation, interview, and record review, it was determined that the facility failed to ensure required monthly visits by the Consultant Pharmacist (CP) for the months of November 2023, December 2023, and January 2024. This irregularity was identified for 3 of 3 residents reviewed for CP review, Residents #63, #83, and #27. This deficient practice was evidenced by the following: 1.) On 03/21/24 at 11:37 AM, the surveyor reviewed the CP progress notes. During review it was identified that the CP reviewed Resident #63 medications January 2023 through October 2023 every month. There was no available documentation for November 2023, December 2023, or January 2024. A review of the Admission Record for Resident #63 indicated the resident had medical diagnoses which included but were not limited to hypertension (high blood pressure), anxiety disorder, and intellectual disabilities. Review of the annual Minimum Data Set (MDS), an assessment tool dated 01/20/24 revealed the resident had a Brief Interview of Mental Status of 3, meaning the resident had severe cognitive impairment. On 03/26/24 at 10:05 AM, the surveyor interviewed the Director of Nursing (DON) regarding the CP. The DON told the surveyor, The consultant pharmacist stopped coming. The surveyor asked what process was put in place for the three months the facility did not have a CP. The DON replied, We did medication pass with nurses and looked at the new admissions medications. The DON told the surveyor the facility at that time was in the process of getting a new Consulting Pharmacist. On 03/26/24 at 12:30 PM, the surveyor requested documentation supporting the facility securing a new CP following the October CP reviews. No information was provided. On 03/28/24 at 12:31 PM, the surveyor reviewed the policy titled, Pharmacy Consultant Policy and Procedure, an undated policy. Under number five of the policy, it indicated that the Consultant Pharmacist is responsible to provide drug regimen review reports to the Administrator, DON, and to the Nurse Managers monthly. 48964 2.) On 03/21/2024 at 09:49 AM the surveyor reviewed the CP progress notes. During review it was identified that the CP reviewed Resident #83's medication from April 2023 through October 2023 every month. There was no available documentation for November 2023, December 2023, or January 2024. On 03/21/2024 at 09:49 AM the surveyor reviewed the progress notes for Resident #83 which indicated the resident had medical diagnoses that included but were not limited to history of deep vein thrombosis (blood clot), sacral stage 4 ulcer (wound on backside), and quadriplegia (paralysis). Review of quarterly MDS dated [DATE] revealed a Brief Interview of Mental Status of 15, indicating intact cognition. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 03/26/24 at 10:05 AM, the surveyor interviewed the Director of Nursing (DON) regarding the CP. The DON told the surveyor, The consultant pharmacist stopped coming. The surveyor asked what process was put in place for the three months the facility did not have a CP. The DON replied, We did medication pass with nurses and looked at the new admissions medications. Review of facility provided, undated policy titled, Pharmacy Consultant Policy and Procedure, number five of the policy indicatd, the Consultant Pharmacist is responsible to provide drug regimen review reports to the Administrator, DON, and to the Nurse Managers monthly. N.J.A.C. 8:39-29.3(a)1 49707 3.) A review of the CP progress notes revealed Resident #27's medications were reviewed August 2023 through October 2023 every month. There was no available documentation for November 2023, December 2023, or January 2024. A review of the Admission Record for Resident #27 indicated that, the resident had medical diagnoses which included but were not limited to essential hypertension (high blood pressure), anxiety disorder, bipolar disorder (a disorder associated with episodes of mood swings) disabilities, type 2 diabetes mellitus, and major depressive disorder. A review of the annual Minimum Data Set (MDS), an assessment tool dated 10/18/23 revealed the resident had a Brief Interview of Mental Status score of 15/15, meaning the resident had no cognitive impairment. On 03/26/24 at 10:05 AM, during an interview with the surveyor, the DON stated, The consultant pharmacist stopped coming. The surveyor asked what process was put in place for the three months when the facility did not have a CP. The DON replied, We did medication pass with nurses and looked at the new admissions medications. The DON said the facility at that time, was in the process of getting a new Consulting Pharmacist. A review of the undated facility-provided policy titled, Pharmacy Consultant Policy and Procedure, number five of the policy indicated, the Consultant Pharmacist is responsible to provide drug regimen review reports to the Administrator, DON, and to the Nurse Managers monthly. N.J.A.C. 8:39-29.3(a)1

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49707 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to accurately label multidose medications to facilitate the consideration of precautions and safe administration. The deficient practice was observed for 1 of 4 medication carts (2 [NAME] High Side) reviewed under the Medication and Storage Task. The deficient practice was evidenced by the following: On 03/19/2024 at 10:33 AM, the surveyor in the presence of Licensed Practical Nurse (LPN) # 2 observed the 2 [NAME] High Side medication cart. At that time, the surveyor observed the following: 1 opened Artificial Tear bottle. The bottle was not dated when it was opened. 1 opened Spiriva (treats asthma and chronic obstructive pulmonary disease) handheld inhaler. The inhaler was not dated when it was opened. 3 opened Lantaprost 0.005% ophthalmic solution eye drops. The bottles were not dated when they were opened. 1 opened Dorzolamide hydrochloride and Timolol maleate ophthalmic solution eye drops. The bottle was not dated when they were opened. At this time, during an interview with the surveyor, LPN # 2 stated, The eye drops, and inhaler should have been dated and initialed once opened. On 03/19/2024 at 1:34 PM, during an interview with the surveyor, the Director of Nursing (DON) stated, . Inhalers when open should be dated on the packaging and the medication itself, this includes insulin and eye drops. The DON confirmed that opened medications should be dated. A review of the facility's undated policy titled, Labeling of Medication Containers revealed that, labels for each single unit dose package shall include all necessary information, such as: The name and strength of the drug, the lot or control number, the dated drug dispensed, the expiration date, when applicable dating of medications should be dated with the open date. 44833 2. On 3/21/24 at 12:16 PM, the surveyor observed LPN2 during medication administration for Resident #381. LPN2 gathered the prescribed medication for Resident #381 which included drawing six (6) units of Humulin R 100 units/milliliter (U/mL) insulin into a syringe from a multi-dose insulin vial. She then placed the insulin vial on top of the medication cart, which was situated in the hallway, outside of the resident's room, and proceeded to enter the room to administer the insulin injection, leaving the insulin vial unsecured on top of the locked medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:20 PM, LPN2 returned to the medication cart, at which point the surveyor interviewed the LPN. The LPN stated she should have put the insulin in the drawer so no one can grab it. On 3/25/24 at 9:16 AM, the surveyor interviewed the DON who confirmed that nurses administering medication should not leave medication on top of the cart unsecured. The DON confirmed that LPN2 should not have left the insulin vial on top of the medication cart. Review of the facility's undated Administering Medications policy included but was not limited to, during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. N.J.A.C. 8:39-29.4

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48964 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 03/18/2024 from 9:18 AM to 9:45 AM, the surveyor, accompanied by the Food Service Director (FSD), toured the kitchen and observed the following: In the walk-in freezer, the surveyor observed a spinach quiche, two packages identified by the FSD as pulled pork, and a pie with no labels or dates. The FSD stated that there should be a use by label if out of the package. He further stated that the above referenced items were not correct. A review of facility provided policy titled Labeling and Dating System Protocol rev 5/23/23, revealed All fresh and frozen foods must be dated with the date it was received into the kitchen, unless it has a Purveyor shipping label on it. Also included was All food in freezer storage - 6 months. N.J.A.C. 18:39-17.2(g)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 48964 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris. This deficient practice was evidenced by the following: On 03/18/2024 during initial kitchen tour with the Food Service Director (FSD), the surveyor observed debris and trash around the dumpster area. The FSD stated that housekeeping was responsible for this area. He also stated that it was Monday and he guessed nobody had gotten out there as of that time. On 03/21/2024 at 12:28 PM the surveyor noted debris and trash in the area behind the dumpster area. On 03/25/2024 at 12:44 PM the surveyor interviewed the Director of Housekeeping who stated that housekeeping, maintenance and the kitchen are all in charge of the parking lot. He was shown a photo of the dumpster area and stated that they should go further than just the parking lot. A review of facility provided policy Sanitation: Dumpster/Garbage Disposal, dated November 15, 2022, included: o Keep dumpster and dumpster site areas clean and free of debris o If any trash is on the ground or around the dumpster, you are responsible to pick it up and put it in the dumpster N.J.A.C. 8:39-19.3(c)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43936 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to 1.) implement appropriate transmission-based precautions specifically by applying precautions to a room that contained a resident with a potentially infectious disease for 1 of 1 resident (Resident #6) and 2.) failed to perform effective hand hygiene for a minimum of twenty seconds. The deficient practices were identified for 1 of 1 resident (Resident # 6) reviewed for Transmission-Based Precautions under the Infection Control task and 2 of 3 nurses observed during the Medication Administration task . The deficient practices were evidenced by the following: 1.) A review of Resident # 6's Admission Record located in the Electronic Medical Record (EMR) revealed that on 03/18/2024, he/she was diagnosed with unspecified diarrhea. A review of Resident # 6's Order Summary Report located in the EMR revealed that on 03/18/2024 a, C DIFF DNA RT-PCR(STOOL) (test to determine the presence of clostridium difficile; a potentially deadly bacteria in the stool) was ordered. On 03/19/2024 at 10:47 AM, the surveyor observed that Resident # 6's room did not have a transmission-based precaution sign near the doorway nor was there any personal protective equipment (gowns, gloves, and masks worn to limit the potential of spreading pathogens) outside of the room. On the same date at 10:53 AM, the surveyor knocked on Resident # 6's door which was answered by Certified Nurses Aide (CNA) # 2. CNA # 2 was not wearing a gown. The surveyor observed another unidentified CNA also located within the room. The unidentified CNA did not have a gown on. At that time, CNA # 2 confirmed they were providing care to Resident # 6. On the same date at 11:04 AM, the surveyor observed Licensed Practical Nurse (LPN) # 3 enter Resident # 6's without applying a gown. At approximately six minutes later, LPN # 3 exited the resident room and used alcohol-based hand rub (ABHR) for hand hygiene. On the same date at 11:30 AM during an interview with the surveyor CNA # 1 said Resident # 6 is continent of his/her bowels however he/she cannot hold it [bowel movement] when the staff provides incontinence care. CNA # 1 confirmed that Resident # 6 had loose stool today. CNA # 1 said that there was no PPE because Resident # 6 did not have an infection. On the same date at 11:40 AM during an interview with the surveyor, LPN # 3 said Resident # 6 had a pending clostridium difficile test. She said that it may take forty-eight to seventy-two hours to get the test results. At that time, she confirmed results were not found. On the same date at 11:48 AM during an interview with the surveyor, The Licensed Practical Nurse/Unit Manager (LPN/UM) # 3 confirmed that if the physician orders a clostridium difficile test, there should be a transmission-based precaution sign on the resident's door. At that time, the LPN/UM # 3 denied knowing if any residents were on transmission-based precautions for clostridium difficile. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the same date at 12:24 PM during an interview with the surveyor, the Infection Preventionist (IP) confirmed she would stress enteric isolation such as gowns, gloves, and to clean with a product that would kill clostridium difficile. She clarified that enteric is a form of a contact transmission-based precaution (gowns and gloves required on upon entering the resident's room). Further, she confirmed soap and water used for hand hygiene is most effective against clostridium difficile instead of ABHR. On the same date at 12:41 PM during an interview with the surveyor, the Director of Nursing confirmed that if a resident is suspected of having clostridium difficile, they should place contact transmission-based precautions on the resident's room at the time it was suspected. On 03/26/2024 at 1:40 PM during an interview with the surveyor, the Chief Clinical Officer confirmed Resident # 6 should have been on transmission-based precautions while awaiting the test results. NJAC 8:39 - 19.4(a) 44833 2.) On 3/21/24 at 8:56 AM, during medication administration observations, the surveyor observed Registered Nurse (RN) #1 wash her hands after administering medication to a resident. RN #1 doffed (removed) and disposed of her gloves, as she approached the sink in the resident's room. She turned on the water and proceeded to dispense soap from the wall mounted dispenser into her hand rubbed her hands together briefly and began to rinse the soap off under the running water. During this time, the surveyor was able to time her hand washing using a digital stopwatch timer to be approximately three (3) seconds. The nurse did not perform any other form of hand hygiene in addition to this instance during this time. On the same date at 9:28 AM during an interview with the surveyor, RN #1 said hand washing should be sixty seconds with soap. On 3/21/24 at 9:50 AM, during medication administration observations, the surveyor observed Licensed Practical Nurse (LPN) #1 wash her hands. After administering medication to a resident, LPN #1 went to the sink in the resident's room, turned on the water, dispensed soap into her hands and began to lather her hands with soap. She then rinsed her hands under the running water. The surveyor, using a digital stopwatch timer, timed LPN #1's hand washing technique to be 14 seconds. The nurse did not perform any other form of hand hygiene in addition to this instance during this time. At 9:51 AM, the surveyor interviewed LPN #1, who said hand washing should be 30 seconds. LPN #1 concluded by stating, I sang happy birthday (to time herself), but you made me nervous. On 3/25/24 at 1:15 PM, the surveyor interviewed the Director of Nursing (DON), who stated nurses should wash their hands or use hand sanitizer in between residents when administering medication. Hand washing should be between 20-30 seconds. She further acknowledged that 14 seconds is not sufficient time for hand washing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF PROVIDER OR SUPPLIER Aristacare at Whiting		STREET ADDRESS, CITY, STATE, ZIP CODE 23 Schoolhouse Road Whiting, NJ 08759	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated Handwashing/Hand Hygiene policy included but was not limited to: for the purposes of infection control, handwashing/ hand hygiene must meet the following requirements: be a multidisciplinary hand-hygiene program, handwashing must be done using antimicrobial soap, all surfaces of the hands must be vigorously rubbed together, handwashing must occur for at least twenty seconds, include the use of alcohol-based hand rubs. NJAC 8:39 - 19.4(a)(n); 27.1 (a)