STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315314	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anchor Care and Rehabilitation Center	3325 Highway 35 Hazlet, NJ 07730

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50913 C #: NJ177500 Based on interviews, medical record review, and review of other pertinent facility documents on 12/04/24 and 12/05/24, it was determined that the facility staff failed to consistently document in the Resident CNA (Certified Nursing Assistant) Documentation Record (RCDR) on care provided to the resident according to the facility policy and protocol for 3 of 5 residents (Resident #2, Resident #3, and Resident #5) reviewed for documentation. This deficient practice was evidenced by the following: 1. According to the Resident Face Sheet (RFS), Resident #5 was admitted with diagnoses including but not limited to Stage 4 Sacral Pressure Sore (damage to the skin and tissue caused by prolonged pressure on a bony area of the body), and Age-related osteoporosis (a bone disease that causes bones to become weak and more likely to break). A review of the Minimum Data Set (MDS), an assessment tool dated 9/20/24, revealed that Resident #5 had a Brief Interview of Mental Status (BIMS) score of 02, indicating that Resident #5 had severe cognitive impairment and was dependent on staff with Activities of Daily Living (ADLs). Resident #5's CP (Care Plan) initiated on 9/07/24 indicated that Resident #5 had a focus for skin as evidenced by an actual pressure skin injury upon admission. Interventions included but were not limited to: providing daily skin care and once a week with showers, providing nutritional supplements as ordered: liquid protein, Zinc, and Vitamin C. Additionally, Resident #5 had a focus for nutrition with a goal to consume more than 75% of meals/fluids. Interventions included but were not limited to monitoring and encouraging fluid intake. Review of the RCDR (ADL Record), dated September 2024 for completion of ADL under Task did not indicate that Bed Mobility, Eating, and Nutrition were provided to the Resident at the following times: Bed Mobility: During the 7:00 a.m. to 3:00 p.m. shift, 22 out of 23 days did not have documentation. During the 3:00 p.m. to 11:00 p.m. shift, 12 out of 23 days did not have documentation. During 11:00 p.m. to 7:00 a.m. shift, 16 out of 24 days did not have documentation. (continued on next page)

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Turn and Position: At 12:00 a.m., 16 out of 23 days did not have documentation. At 2:00 a.m., 16 out of 23 days did not have documentation. At 4:00 a.m., 15 out of 23 days did not have documentation. At 6:00 a.m., 16 out of 23 days did not have documentation. At 6:00 p.m., 16 out of 23 days did not have documentation. At 8:00 p.m., 16 out of 23 days did not have documentation. At 10:00 p.m., 15 out of 23 days did not have documentation. Eating: During 7:00 a.m. to 9:00 a.m., 22 out of 23 days did not have documentation. During 11:00 a.m. to 1:00 p.m., 23 out of 23 days did not have documentation. During 4:00 p.m. to 6:00 p.m., 16 out of 23 days did not have documentation. Nutrition: At 10 a.m., 23 out of 23 days did not have documentation. At 2 p.m., 23 out of 23 days did not have documentation. At 8:00 p.m., 16 out of 23 days did not have documentation. Review of the RCDR, dated November 2024 for completion of ADL under Task did not indicate that Bed Mobility, Eating, and Nutrition were provided to the Resident at the following times: Bed Mobility: During the 7:00 a.m. to 3:00 p.m. shift, 24 out of 30 days did not have documentation. During the 3:00 p.m. to 11:00 p.m. shift, 3 out of 30 days did not have documentation. During the 11:00 p.m. to 7:00 a.m. shift, 29 out of 30 days did not have documentation. Turn and Position: At 12:00 a.m., 28 out of 30 days did not have documentation. At 2:00 a.m., 29 out of 30 days did not have documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 4:00 a.m., 26 out of 30 days did not have documentation. At 6:00 a.m., 29 out of 30 days did not have documentation. At 6:00 p.m., 10 out of 30 days did not have documentation. At 8:00 p.m., 16 out of 30 days did not have documentation. At 10:00 p.m., 20 out of 30 days did not have documentation. Eating: During 7:00 a.m. to 9:00 a.m. meal, 25 out of 30 days did not have documentation. During 11:00 a.m. to 1:00 p.m. meal, 23 out of 30 days did not have documentation. During 4:00 p.m. to 6:00 p.m. meal, 4 out of 30 days did not have documentation. Nutrition: At 10 a.m., 24 out of 30 days did not have documentation. At 2 p.m., 25 out of 30 days did not have documentation. At 8:00 p.m., 15 out of 30 days did not have documentation. 2. According to the Resident Face Sheet (RFS), Resident #2 was admitted with diagnoses including but not limited to Type 2 Diabetes Mellitus (a long-term medical condition in which your body doesn't use insulin properly, resulting in high blood sugar levels). and Dermatitis (a common condition that causes swelling and irritation of the skin). A review of the Minimum Data Set (MDS), an assessment tool dated 9/20/24, revealed that Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15, indicating that Resident #2 had intact cognition and was independent with ADLs. Review of the RCDR, dated November 2024 for completion of ADL under Task did not indicate that Bed Mobility and Eating, were provided to the Resident at the following times: Bed Mobility: During 7:00 a.m. to 3:00 p.m. shift, 8 out of 30 days did not have documentation. During the 3:00 p.m. to 11:00 p.m. shift, 30 out of 30 days did not have documentation. During the 11:00 p.m. to 7:00 a.m. shift, 30 out of 30 days did not have documentation. Eating: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the 7:00 a.m. to 9:00 a.m. meal, 8 out of 30 days did not have documentation. During the 11:00 a.m. to 1:00 p.m. meal, 8 out of 30 days did not have documentation. During 4:00 p.m. to 6:00 p.m. meal, 30 out of 30 days did not have documentation. 3. According to the RFS, Resident #3 was admitted with diagnoses that included but were not limited to: Cerebral Palsy (a group of neurological disorders that affect a person's ability to move, balance, and maintain posture), Infection of amputation stump, and colostomy (a surgical procedure that creates an opening in the abdominal wall to divert the large intestine, or colon, and allow stool to drain into a bag). The MDS, dated [DATE] indicated that Resident #3 had a BIMS of 02 indicating severe cognitive impairment, and was dependent for all ADLs. Resident #3's CP (Care Plan) initiated on 11/11/24 indicated that Resident #3 had a focus for ADLs. Interventions included but not limited to: Extensive assist with bed mobility and extensive assistance with eating. Review of the RCDR, dated November 2024 for completion of ADL under Task did not indicate that Bed Mobility, turn and position and eating, were provided to the Resident at the following times: Bed Mobility: During 7:00 a.m. to 3:00 p.m. shift, 2 out of 30 days did not have documentation. During 11:00 p.m. to 7:00 a.m. shift, 2 out of 30 days did not have documentation. Turn and Position: At 12:00 a.m., 13 out of 30 days did not have documentation. At 2:00 a.m., 13 out of 30 days did not have documentation. At 4:00 a.m., 12 out of 30 days did not have documentation. At 6:00 a.m., 12 out of 30 days did not have documentation. At 6:00 p.m., 6 out of 30 days did not have documentation. At 8:00 p.m., 8 out of 30 days did not have documentation. At 10:00 p.m., 7 out of 30 days did not have documentation. Eating: During 7:00 a.m. to 9:00 a.m. meal, 3 out of 30 days did not have documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During 11:00 a.m. to 1:00 p.m. meal, 2 out of 30 days did not have documentation. Nutrition: At 10 a.m., 2 out of 30 days did not have documentation. At 2 p.m., 3 out of 30 days did not have documentation. At 8:00 p.m., 1 out of 30 days did not have documentation. During an interview with the surveyors on 12/05/24 at 9:35 a.m., the CNA, stated that CNAs were responsible for the primary care of the residents, and for documenting the ADLs on the kiosk (a computer that is located on each hall on the units that link to the residents' medical chart). She further stated that documentation includes incontinent care, skin assessment, feeding residents, and if showers and bed baths were performed. When the CNAs documented, they were to select performed or not performed, and if the CNA selected not performed, then a reason for the task not being completed needed to be entered. For example, a reason for a task not being completed would be, a resident out of the building for an appointment. The CNA further stated that the documentation needs to be completed by the end of the shift. During an interview with the surveyors on 12/05/245 at 10:46 a.m., the Unit Manager/Registered Nurse, stated that CNAs were responsible for ADL care on the unit. She stated that the CNAs have their own assignments and were responsible for documenting the care on the kiosk. She stated that ADL care should be documented by the end of their shift. She explained that the documentation must be completed in the residents' chart by the end of each shift to show that the care was provided to the residents, and to identify changes with residents. During an interview with surveyors on 12/05/24 at 1:23 p.m., the DON (Director of Nursing) and ADON (Assistant Director of Nursing), both stated that CNAs were responsible for ADL care on the floors, and that care is documented in the kiosk. DON states that documentation is important to show that care has been completed. Review of the facility policy titled Charting and Documentation, dated October 2018, and reviewed October 2024, reflected POLICY Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record .c. Treatment or services performed .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate . NJAC: 8:39-35.2 (d)(6)