

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2024
NAME OF PROVIDER OR SUPPLIER  Complete Care at Brakeley Park, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  290 Red School Lane Phillipsburg, NJ 08865	

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)
<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48617</b></p> <p>Based on observation, interview, and record review it was determined that on 09/24/24 the facility failed to: (a) ensure a lip plate and a Kennedy cup was provided to a resident during a meal service, (b) follow this intervention as deemed necessary in the resident's Comprehensive Care Plan (CCP), and (c) provide supervision or assistance in feeding the resident. This deficient practice was identified for 1 of 3 residents (Resident #2) reviewed for need of feeding assistance and was evidenced as follows:</p> <p>According to Resident #2's Admission Record (AR), Resident #2 had the following diagnoses but not limited to Dementia without Behavioral Disturbance, Dysphagia following Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Hypertensive Chronic Kidney Disease, Muscle Weakness, and Lack of Coordination.</p> <p>According to the Minimum Data Set (MDS), an assessment tool that provides a comprehensive assessment of each resident's functional capabilities, dated 09/17/2024, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 02 indicating her/his Cognitive Skills was severely impaired. Resident #2 MDS further revealed in Section GG Functional Abilities and Goals that Resident was dependent on staff for the completion of his/her ADLs such as personal hygiene, dressing, toileting, shower, or bath, and was supervision or touching assistance on eating or feeding.</p> <p>On 09/24/2024 at 12:29 pm, the surveyor observed Resident #2 in bed in her/his hospital gown in room with lunch tray on a over bed tray table in front of her/him. Resident #2 was noted picking food from her/his plate with her/his right hand and feeding self. Her/his head of bed was raised, and Resident was seen leaning on her/his left side while eating. Multiple food debris were observed on her/his chest area. The surveyor noted Resident #2's left hand appeared weak. No staff member was in the room beside or near the Resident providing assistance. Surveyor attempted to interview the Resident. Resident was verbally responsive, confused, speech was slurred. On Resident #2's tray, surveyor observed a regular white dish in warmer plate, a regular coffee cup, and a liquid supplement in carton. At that point, a Certified Nursing Assistant (CNA) #1 went inside the Resident's room appeared to be picking up trays. When asked by surveyor, CNA #1 stated Resident #2 needed assist in feeding. CNA #1 further stated she was the Aide assigned to Resident #2. She said Resident #2 can feed self at times and that she [CNA #1] would oversee her every now and then.</p> <p>(continued on next page)</p>

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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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #2 Care Plan (CP) initiated 03/11/2024 showed Focus: ADL self-care performance deficit r/t [related to] dementia, CVA and under the Interventions: .Provide [Resident's name] with assist of one feed for eating as needed; can feed self at times. Furthermore, the CP revealed under same Interventions: adaptive equipment with meals: Kennedy cup and lip plate with date initiated on 09/01/2024 and revision on 09/24/2024.</p> <p>A review of Order Summary Report (OSR) Active Orders As Of: 09/24/2024, the OSR revealed a physician order of Regular diet Regular texture, Thin consistency, lip plate, Kennedy cup all trays for DYSPHAGIA with Order and Start Date of 04/16/2024.</p> <p>A review of Resident #2's document Kardex, a comprehensive list of plans of care for residents, indicated under Communication: adaptive equipment with meals: Kennedy cup and lip plate.</p> <p>On 09/24/2024 at 3:14 pm [afternoon], the surveyor interviewed the Director of Rehab (DOR) and the Speech Therapist (ST). The DOR stated, together with ST, would assess and evaluate need for adaptive devices for the residents. ST stated the lip plate, a plate with a raised or scooped periphery is indicated for residents with difficulty scooping their food from plate. The function of the raised side would enable the resident to scoop food whereas the Kennedy cup is a cup with a handle and straw in the middle of the lid. She further stated the Kennedy cup is indicated for residents who frequently have spillage accidents while drinking. The ST affirmed that Resident #2 uses lip plate and Kennedy cup as adaptive devices while and during eating. Furthermore, ST stated Resident #2 required supervision or touching assistance during feeding as reflected in the Section GG of the Resident's recent MDS.</p> <p>On 09/25/2024 at 3:08 pm, the surveyor interviewed the Food Service Director (FSD) who stated each resident had a meal slip ticket that indicated which type of diet the resident was to receive, portion size, the menu items and any adaptive equipment required. The ST would give the updated diet slips and FSD would enter in the system computer and print out. The FSD added the dietary aides were responsible for adding the adaptive equipment to the meal trays. The surveyor reviewed the Resident Adaptive Equipment Report the FSD provided. The list showed Resident #2 was on the list with her/his diet and the adaptive equipment as follows: [NAME] Cup with Dinner, [NAME] Cup with Breakfast, Lip Plate with Breakfast, [NAME] Cup with Lunch, Lip Plate with Lunch, and Lip Plate with Dinner.</p> <p>A review of the facility Policy on Adaptive Feeding Equipment revised August 2024 under Policy Explanation and Compliance Guidelines: .5. Appropriate utensils should be placed on the resident's food tray, at each meal, and returned to the dietary department, on the food tray, for sanitization.</p> <p>NJAC 8:39-27.5 (b)</p>		