STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315331	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Fair Lawn Edge	77 East 43rd Street Paterson, NJ 07514

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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 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** 31656 Based on observation, interview, record review and review of facility documents, it was determined that the facility failed to adhere to acceptable standards of nursing practice. This deficient practice was identified in 4 of 7 residents who had medication improperly prepared for administration, 1. Resident #86, #199, #73, #200, 2. facility failed to ensure a resident's medication times were adjusted to accommodate their dialysis (a clinical purification of blood as a substitute for the normal function of the kidneys) schedule for 1 of 3 Residents reviewed for accurate dialysis scheduling of medication times, Resident #84, 3. failed to ensure that the oxygen rate was administered according to Physician's Order (PO), for 1 of 1 Residents reviewed for Oxygen use, Resident #2 4. facility failed to ensure recommendations made by the Registered Dietician was acted upon in a timely manner as per facility policy and in accordance with professional standards of clinical practice for one (1) of two (2) residents reviewed for tube feed, Resident #122. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. 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 and 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 wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 4/15/24 at 1:01 PM the surveyor entered the 3rd Floor medication room. The surveyor observed the Licensed Practical Nurse (LPN) #2 standing by her medication cart with a stack of medication cups on top of the cart. Closer examination by the surveyor of the medication cups revealed 4 stacked cups all with medication in them. Examination of each cup with LPN#2 revealed that each cup had the resident's first name written on each cup except the bottom cup, which had no name written on it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor requested that LPN#2 identify the resident and what was in the medication cup. LPN#2 could not identify the residents or the medication in the cup without referring to the electronic medication administration record (eMAR). Along with LPN#2 each cup was examined and identified: Cup 1 was identified as belonging to Resident #86 and contained 3 tablets of Hydralazine 25mg (an antihypertensive medication). Cup 2 was identified as belonging to Resident #199 and contained 1 tablet Depakote 25 mg (an antiseizure and mood stabilizing medication). Cup 3 was identified as belonging to Resident # 73 and contained 2 tablets of Methadone 10 mg (a controlled substance used for pain relief). Cup 4 was identified as belonging to Resident # 200 and contained 3 tablets of Depakote 250 mg (mood stabilizing medication). Review of the Individual Patient Controlled Substance Administration Record (Inventory Sheet) for Methadone 10mg tablets with LPN#2 revealed that there were 46 tablets left in stock. Examination of the actual inventory of Methadone 10 mg tablets in stock was 44 tablets. The surveyor interviewed LPN#2 who stated, I didn't give it yet. LPN#2 was not aware that the Inventory Sheet needed to be signed out for the tablets removed from inventory at the time of the removal. The surveyor continued the interview with LPN#2 who could not explain why she prepared the medications for 4 residents in advance, instead of individually preparing and administering medication to each resident. LPN#2 stated that she knows that this was not best practice. The surveyor reviewed the facility hybrid documents: A. Review of the facility Admission Sheet for Resident #86 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to Chronic Obstructive Pulmonary Disease, Pulmonary Hypertension, Chronic Kidney Disease and Diastolic Heart Failure. A review of Resident #86's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 3/29/24, reflected that Resident #86 had a BIMS score of 15 out of 15, indicating an intact cognition. The surveyor reviewed the April 2024 eMAR which documented a Physician's order (PO) dated 10/29/23 for Hydralazine 25 mg Give 3 tablets by mouth every 8 hours for Hypertension. B. Review of the facility Admission Sheet for Resident #199 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to Seizures, Adjustment Disorder with Anxiety, and Other Psychoactive Substance Induced Disorder. A review of Resident #199's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/31/24, reflected that Resident #199 had a BIMS score of 8 out of 15, indicating a moderately impaired cognition. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the April 2024 eMAR which documented a Physician's order (PO) dated 11/3/23 for Depakote Tablet Delayed Release 125 mg 1 tablet 3 times daily for convulsion. C. Review of the facility Admission Sheet for Resident #73 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to Other Psychoactive Substance Abuse, Complicated, Adjustment Disorder with Anxiety, and Acquired absence of right and left leg above the knee. A review of Resident #73's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/19/24, reflected that Resident #73 had a BIMS score of 15 out of 15, indicating an intact cognition. The surveyor reviewed the April 2024 eMAR which documented a Physician's order (PO) dated 11/27/23 for Methadone 10 mg Give 2 tablets by mouth 3 times a day for pain. D. Review of the facility Admission Sheet for Resident #200 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to Epilepsy, Schizophrenia, and Mood Disorder. A review of Resident #200's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 4/11/24, reflected that Resident #200 had a BIMS score of 9 out of 15, indicating a moderately impaired cognition. The surveyor reviewed the April 2024 eMAR which documented a Physician's order (PO) dated 3/29/24 for Depakote Delayed Release 250 mg Give 3 tablets 3 times daily for Schizophrenia. Review of the facility Administering Medications Policy explains, Medications shall be administered in a safe and timely manner, and as prescribed. The policy continues to explain, 4. The individual administering medications must verify the resident's identity before giving the resident his/her medications. and 5. The individual administering the medication must check the label against the Physician's order to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Review of the facility Documentation of Medication Administration Policy explains, 4. When giving controlled subtance when removed from the lock box, it must be signed on the declining sheet. Once administered it must be signed on the eMAR. On 4/15/24 at 1:45 PM, the surveyor discussed the above deficient practice with the Director of Nursing (DON) and the Assistant DON who could not explain why LPN#2 prepared the medication for Resident #86, #199, #73 and #200 in a stack of cups. The DON stated that this is not the proper way to administer medication to residents in the facility. The DON added that all medications administered to a resident should be reviewed, administered, and documented, one resident at a time. The DON commented that LPN#2 should not have prepared medication for a number of residents and should have known to sign out narcotics from the inventory sheet when she removed the narcotic medication from inventory. 39399 2. On 04/16/24 11:29 AM, the surveyor observed that Resident #84 in bed, awake and alert. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility Admission Sheet for Resident #84 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to End Stage Renal Disease, Anemia, Benign Prostatic Hypertrophy, Dependence on Renal (kidney) Dialysis and Dementia. A review of Resident #84's Quarterly Minimum Data Set (MDS) an assessment tool used to facilitate management of care, dated 3/31/24, reflected that the resident had a Brief Interview Mental Status (BIMS) score of 12 out of 15, which indicated that the resident had moderate cognitive impairment. A review physician's orders for April 2024 read: HEMO-DIALYSIS THREE TIMES WEEKLY ON (TUES, THURSDAY, SATURDAY 6:30 AM) at [dialysis center's name, address and telephone number] pick up at 5:45 AM by [Transportation company's name and telephone number]. A physician's order dated 12/23/23 read: Calcium Acetate tab (tablet) 667mg (milligrams) give 2 tabs (tablets) by mouth three times a day every TThS (Tuesday, Thursday, Saturday) timed at 9:00 AM, 1:00 PM and 5:00 PM. A review of the January 2024 electronic Medication Administration Record (eMAR) revealed that the resident was scheduled to receive the Calcium Acetate medication as ordered above every TThS at 0900 [9 AM]. The entries for 1/4/24, 1/6/24, 1/23/24 and 1/27/24 were signed by the nurses with 7 which indicated Other/See nurses notes and that the medication was not administered. A review of the February 2024 eMAR revealed that the resident was scheduled to receive the Calcium Acetate medication as ordered above every TThS at 0900 [9 AM]. The entry for 0900 on 2/7/24, was signed by the nurse with 7 which indicated Other/See Nurse Notes, and on 2/17/24 was signed by the nurse with 3 which indicated Hold/See Nurse Notes and that the medication was not administered. A review of the March 2024 eMAR revealed that the resident was scheduled to receive the Calcium Acetate medication as ordered above every TThS at 0900 [9 AM]. The entry for 0900 on 3/7/24, 3/9/24, 3/12/24, 3/14/24, was signed by the nurse with 7 which indicated Other/See Nurse Notes, and on 3/30/24 was signed by the nurse with 3 which indicated Hold/See Nurse Notes and that the medication was not administered. A review of the nurses' progress notes in the Electronic Medical Record (EMR) revealed that the medication was not administered on the entries identified above as the resident was out to dialysis during the medication administration time. On 4/19/24 at 2:38 PM, the surveyor discussed the above concern to the facility's the Licensed Nursing Home Administrator (LNHA), the [NAME] President of Operations (VPO), the Director of Clinical Services (DCS), the Regional Registered Nurse (RRN), the Director of Nursing (DON), Assistant DON. The DON stated that the facility's protocol for medications to be scheduled to accommodate resident when they are out for dialysis. The facility's DON, VPO, RRN acknowledged that the medication should have been scheduled to accommodate the resident dialysis schedule. A review of the facility's policy titled Hemodialysis , did not reveal anything related to medication timing to ensure that medications are times with the dialysis days/schedule of the resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 04/15/24 12:10 PM, the surveyor observed Resident #2 seated in their wheelchair. The surveyor further observed that the resident was on continuous oxygen via nasal canula with the rate set at 8 liters/minutes. The resident was Spanish speaking. A review of the facility Admission Sheet for Resident #2 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Hypertension and Parkinsonism. A review of Resident #2's Quarterly Minimum Data Set (MDS) an assessment tool used to facilitate management of care, dated 1/19/24, reflected that the resident had a Brief Interview Mental Status (BIMS) score of 8 out of 15, which indicated that the resident had moderate cognitive impairment. A review of the physician's order dated 4/8/24 revealed a PO for Oxygen at 2 l/min (liters/minute) via nasal cannula continuously. On 4/15/24 at 12:35 PM, the surveyor interviewed the 3rd floor Unit Manager (UM)/LPN #2 who confirmed that the PO for oxygen was to be administered at the rate of 2 l/min. The UM/LPN #2 in the presence of the surveyor went inside the resident's room. The UM/LPN #2 stated to the surveyor that the resident was on oxygen rate set at 8 l/min. On 4/15/24 at 12:41 PM, the surveyor in the presence of another surveyor who speaks Spanish interviewed Resident #2. The resident stated in Spanish that he/she does not touch the oxygen to change the flow rate. On 4/15/24 at 12:48 PM, the surveyor interviewed LPN #3 assigned to Resident #2 who stated that he checked the oxygen including the rate set of every resident in the morning during the beginning of his shift at 7:00 AM and before the end of the shift at 3:00 PM. On 4/19/24 at 2:38 PM, the surveyor discussed the above concern to the facility's the Licensed Nursing Home Administrator (LNHA), the [NAME] President of Operations (VPO), the Director of Clinical Services (DCS), the Regional Registered Nurse (RRN), the Director of Nursing (DON), Assistant DON. There was no further information provided. 45449 4. On 4/15/23 at 12:59 PM, the surveyor observed Resident #122 seated in a geri-chair (a large, padded chair that is designed to help seniors with limited mobility), combed, and well dressed. The resident was conversant and stated that they felt well that day. The surveyor observed a bottle of Osmolite 1.5 (nutritional formula) hanging on an intravenous (IV) pole. The Osmolite 1.5 bottle had a light brown liquid remainder less than 200 milliliters (ml/s). The pump was off but was set to a rate of 65 and had delivered 985 milliliters at that time. The surveyor reviewed the hybrid medical record for Resident #122. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #122's Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to congestive heart failure (CHF; a chronic condition wherein the heart does not pump blood as well as it should), type 2 diabetes without complications (high blood sugar), dysphagia (difficulty or discomfort in swallowing) and gastrostomy status (resident with feeding tube). A review of Resident #122's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 3/31/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated that Resident #122's cognition was severely impaired. Additionally, the MDS revealed that the resident was independent for eating. Review of the qMDS, Section K - Swallowing/Nutritional Status reflected the resident had a feeding tube and was on a therapeutic diet. Further review of the qMDS, dated [DATE], Section M - Skin Conditions indicated the resident was at risk of developing pressure ulcers and had no pressure ulcer for that review date. A review of the resident's wound assessment dated [DATE], indicated the resident had a stage 2 sacrum pressure ulcer that had reopened and was acquired on 4/9/24. A review of the Order Summary (physician orders) that were active as of 4/17/24, included the following: -Enteral feed order, every day shift document total ml infused; the order start date was on 4/10/24. -Enteral feed order, every evening shift for patency check tube for residual prior to continuous feeding. Of residual is greater than 100 ml, hold feeding for 1 hour and recheck. If residual is greater than 50 mls on recheck, notify MD; the order start date was on 4/14/24. -Osmolite 1.5 at 65ml/hr (per hour) via gastrostomy tube (g-tube), up at 4:00 PM and infused until total volume (TV) of 1300 ml is infused, providing 1950 kcal/day (kilo calorie per day), 82 g (gram) of PRO (protein); the order start date was on 4/10/24. -Enteral Feed Order six times a day for patency, provide water flushes via PEG-tube (percutaneous endoscopic gastrostomy; feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall) of 155 ml 6 times a day; the order start date was on 2/6/24. -Monthly weight;the order was started on 1/26/24. A review of the Registered Dietician's (RD), Nutrition Progress Note (NPN) dated 4/10/24, included the following recommendations: - Resident #122 was noted with vomit on 4/9/24. - Trial of Osmolite for tolerance, monitor blood glucose/A1C (a blood test that reveals the average blood sugar over the past two to three months) - Osmolite 1.5 via PEG continuous at 65 ml/hr, TV 1300ml with free water of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 15 g of PRO from Prostat (protein supplement) - 150 ml of free water flush from 150ml 6 times per day an additional of 900 ml - Weekly weights for 2 weeks. The RD also documented that the family was made aware of the TF changes. A review of the resident's weights reflected the following: -4/17/24, 161 pounds via mechanical lift -4/10/24, 160 pounds via mechanical lift -3/4/24, 161 pounds via mechanical lift -2/14/24, 159 pounds via mechanical lift -1/15/24, 164 pounds via mechanical lift -1/9/24, 164 pounds via mechanical lift During an interview with the surveyor on 4/17/23 at 11:08 AM, the RD stated he reviewed the medical record for Resident #122 and made recommendations based on diagnosis, laboratory results, weights, therapeutic diet needs, hospital records, the resident's wishes, familial consent, and collaborated with nurses, physicians and other health care ancillary involved with the resident. At that time, the RD confirmed his recommendations for the decrease of free water to 150 ml six (6) times a day (for flushing and hydration), and the new order for Prostat (a protein supplement used to promote wound healing related to the stage 2 sacral pressure ulcer that had reopened on 4/9/24) were not part of the active orders on 4/17/24. The RD was unsure why it was not part of the active orders or of it the recommendation was missed. On 4/17/24 at 11:54 AM, during an interview with the surveyor, the Regional Registered Dietician (RRD) explained the process for recommendations made. The RRD stated that the recommendations were entered into the electronic Medical Record (eMR) as pending, then validated by a nurse and when the medical doctor (MD) or the nurse practitioner (NP) agreed, the order was changed from pending to an active order. At that time, the RRD clarified that if the MD or the NP did not agree with the recommendation, the RD would have entered a follow-up NPN documenting the recommendations were not followed. At that time, the RRD confirmed that there were no documented follow-up NPN for the recommendation of the 150ml free water six times a day and the Prostat order. At that time, the RRD acknowledged the recommendations should have been acted upon. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy provided Consults/Recommendation Policy with a copyright date of 2024 included the following: Policy: The attending physician shall authenticate orders for the care and treatment of assigned residents. Policy Explanation and Compliance Guideline: 1. Consulting physician/practitioner orders are those orders provided to the facility by a physician/practitioner other than the resident's attending physician .A consulting physician/practitioner may include, but is not limited to, a resident's .e. Nurse Practitioner, clinical nurse specialist, dietitian, or physician assistant to any of the above physicians. 2. For consulting physician/practitioner orders received in writing or via fax in a timely manner will: a. Call the attending physician to verify the order. b. Will confirm order in EMR system. c. Follow facility procedures for verbal or telephone orders including noting the order, submitting to pharmacy, transcribing to medication or treatment administration record. 3. For consulting physician/practitioner orders received via telephone the nurse will: a. Document the order on the physician order or EMR system, notating the time date name and title of the person providing the order, and the signature and title of the person receiving the order. b. Call the attending physician to verify the order. c. Follow facility procedures for verbal or telephone orders including noting the order, submitting to pharmacy, transcribing to medication or treatment administration record. On 4/18/24 at 1:36 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA), the [NAME] President of Operations (VPO), the Director of Clinical Services (DCS), the Regional Registered Nurse (RRN), the Director of Nursing (DON), Assistant DON and the concerns regarding the RD recommendations were discussed. At that time they confirmed the process was that the recommendations should have been entered as pending and it was not. No further information was provided. NJAC 8:39-27.1(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 39885 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) maintain infection control practices to reduce the risk of infection during a pressure ulcer (PU) treatment; b.) to assess a resident for risk for pressure ulcer quarterly and c.) ensure a physician's order was administered as ordered consistently for preventative measures for skin for 1 of 2 residents (Resident #25) reviewed for PU/injury. This deficient practice was evidenced by the following: On 4/15/24 at 11:44 AM, the surveyor observed Resident #25 asleep in bed with resident's daughter at the bedside. The surveyor interviewed Resident #25's daughter who stated that the resident had a PU, and that the PU was getting better. Resident #25's daughter further stated that the staff turned and changed the resident. On 4/18/24 at 9:56 AM, the surveyor observed the Assistant Director of Nursing (ADON) and Licensed Practical Nurse (LPN) #1 perform Resident #25's PU treatment. The ADON and LPN #1 performed hand hygiene (HH) with an alcohol based hand rub (ABHR) prior to donning (put on) a gown and gloves. The ADON and LPN #1 did not perform handwashing prior to the start of the PU treatment. Later in the PU treatment, the ADON removed the dressing on Resident #25's sacrum. The ADON removed her gloves and performed HH with ABHR and donned a new pair of gloves. LPN #1 prepared 4 X 4 dressings with Normal Saline (NS) and handed the NS moistened 4 X 4 dressings to the ADON. The ADON placed her left gloved hand on Resident #25's right buttock and left her hand on the buttock while the ADON used her right gloved hand to wipe the area around the PU with the moistened 4 X 4. The ADON then repeated the process with a new moistened 4 X 4 that LPN #1 handed to her, while her left hand remained on the resident's right buttock. The ADON then cleaned the PU with a new moistened 4 X 4 that LPN #1 handed to her with her right gloved hand while her left gloved hand remained on the resident's buttock. The ADON then repeated the process again with a new moistened 4 X 4. LPN #1 then removed a piece of foam gauze that was not a full piece and was previously cut from an already opened package. LPN #1 then cut a small piece of the foam gauze and placed Santyl ointment on the foam gauze with a tongue depressor and handed it to the ADON's right gloved hand. The ADON whose left hand was still on the resident's right buttock then used her right gloved hand to place the foam gauze on the resident's PU. LPN #1 opened the border gauze dressing and with her gloved hand took the pen that was attached to her badge and dated the border gauze dressing. LPN #1 then handed the border gauze dressing to the ADON who placed the border gauze dressing over the foam dressing on Resident #25's sacral area. The ADON did not doff (to take off) gloves, perform HH and don a pair of new clean gloves after cleaning the PU and prior to applying the Santyl and foam dressing. The ADON and LPN #1 did not use a new sterile foam dressing for the placement of Santyl to the PU. At the end of the PU treatment the ADON and LPN #1 doffed their gown and gloves and performed handwashing with soap and water. The ADON and LPN #1 did not disinfect the over the bed table that was used for the PU treatment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 10:42 AM, the surveyor interviewed the ADON regarding the PU treatment. The ADON confirmed that the foam dressing was not a new unopened packaged and that it had been opened and pieces cut from it for prior treatments. She added that the foam dressing was a large piece and that they cut a small piece to fit the size of the PU at each PU treatment for that resident. The ADON stated that she did not have to change her gloves after she cleaned the PU if the gloves were not visibly soiled. The ADON stated that she should have wiped the table after the PU treatment was done. A review of Resident #25's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to anemia, (condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body), Type 2 diabetes mellitus with hyperglycemia (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel with elevated blood sugars) and severe protein-calorie malnutrition (state of inadequate intake of food (as a source of protein, calories, and other essential nutrients) occurring in the absence of significant inflammation, injury, or another condition that elicits a systemic inflammatory response). A review of Resident #25's electronic Progress Notes included a note dated 01/03/24 which included the following: The resident is being evaluated for new skin alteration to sacrum. A review of Resident #25's Significant change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 01/10/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 01 out of 15, which indicated that Resident #25's cognition was severely impaired. Further review indicated that the resident had one (1) unstageable PU that was not present on admission/entry or reentry. A review of Resident #25's December 2023 Treatment Administration Record (TAR) included the following order: Apply Zinc Oxide (used to treat or prevent minor skin irritations such as burns, cuts, and diaper rash) on sacrum every shift. The December TAR included 6 of 30 day shifts, 11 of 30 evening shifts and 6 of 30 night shifts that were blank which indicated the nurse did not sign that the zinc oxide was not administered. A review of Resident #25's electronic medical record indicated that the resident had a Braden Scale for Predicting Pressure Sore Risk (BSFPPSR) dated 3/17/23. Further review of the medical record did not include any quarterly BSFPPSR assessments for the rest of 2023. There was a Nurses Quarterly Assessment, which included the BSFPPSR, dated 4/10/24. There was not a BSFPPSR assessment done in January 2024. On 4/18/24 at 11:28 AM, the surveyor interviewed the UM/LPN 2nd floor unit regarding how often the BSFPPSR was done. The UM/LPN stated that they were done quarterly. On 4/18/24 at 12:24 PM, the surveyor interviewed LPN #1. LPN #1 stated that zinc oxide was used to prevent skin breakdown. She added that she was not sure why there was blanks on the TAR and what the blanks meant. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/24 at 12:31 PM, the surveyor interviewed UM/LPN 2nd floor unit regarding Resident #25's quarterly BSFPPSR. The UM/LPN stated that she did not know why the resident did not have the assessments and that she did not know why they were not triggered in the computer. On 4/18/24 at 12:33 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated that the Braden Scale was done on admission and quarterly and it was documented in the computer system under the assessment tab. The DON stated that if there were blanks on the TAR that it meant that it was not given. The DON stated that zinc oxide was a skin protectant. The DON stated that Handwashing should be done prior to a PU treatment and the table should be wiped after the treatment. The DON stated that he had to check what the policy had in regard to changing gloves. The DON stated that a piece of foam could be saved to use that same day for the same resident but that it should not be saved for another day. On 4/18/24 at 01:16 PM, in the presence of the survey team, the surveyor told the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), ADON, VP of Operations (VPoO) and Regional Nurse the concern regarding Resident #25's wound treatment, Braden Scale not done quarterly and the missing administrations of zinc oxide. On 4/19/24 at 11:53 AM, in the presence of the survey team, LNHA, DON and VPoO, the Regional Nurse stated that the staff were in serviced on the wound treatment including changing gloves, not cutting the foam, and wiping the table. She stated that the staff applied the zinc oxide but that they just did not document it. She added that the staff were in serviced. The Regional Nurse stated that the facility policy has HH, and that handwashing did not have to be done if the hands were not visibly soiled or the nurse was not in contact with C. difficile (Clostridioides difficile; a bacterium that causes an infection of the colon, the longest part of the large intestine and symptoms can range from diarrhea to life-threatening damage to the colon). A review of the facility provided policy titled, Wound Care with an updated date of 5/2023 included the following: Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Steps in the Procedure: 2. Perform hand hygiene . 11. Wear clean gloves when physically touching the wound or holding a moist surface over the wound. 12. Place one (1) gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with normal saline as ordered. 13. Remove dry gauze. Apply treatments as indicated. 14. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time and date and apply dressing. Be certain all clean items are on clean field . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	19. Return the overbed table to its proper position. 20. Wipe reusable supplies with alcohol as indicated . A review of the facility provided policy titled, Assessment Frequency/Timelines with a copyright date of 2023, included the following: Policy: The purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI Manual. Policy Explanation and Compliance Guidelines: 4. A quarterly review assessment will be completed no less than once every 3 months On 4/19/24 at 01:23 PM, in the presence of the survey team, the Regional Nurse stated that Resident #25 did not have some of the quarterly Braden Scale assessments done. The facility did not provide any further information. N.J.A.C. 8:39-27.1

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Complaint #NJ 165064 Complaint #NJ 166666 Based on interviews, record review, and review of other pertinent facility documentation, it was determined that the facility failed to 1.) provide adequate supervision for a cognitively impaired, exit seeking resident and ensure exit doors were securely locked which resulted in Resident # 353 eloping from the facility on 06/15/2023 and 2.) follow facility elopement policy which resulted in Resident # 355 eloping from the facility on 08/17/2023. This deficient practice was identified for 2 of 3 residents (Resident # 353 and Resident # 355) reviewed for elopement. The facility failed to monitor and supervise a cognitively impaired, exit seeking resident from being able to exit the facility through an unsecured exit door. This posed a serious and immediate risk to the health, safety, and well-being of Resident #353. During an annual Recertification survey on 04/19/24, the survey team identified an Immediate Jeopardy (IJ) running from 06/15/23 at 8:53 PM, when the resident eloped from the facility, to 06/15/23 at 9:05 PM, when the resident was found. The Immediate Jeopardy (IJ) situation was determined to have existed on 06/15/2023, when Resident #353 exited the building without staff knowledge and was found by facility staff several blocks away from the facility, adjacent to a wide, double-lane roadway. The facility developed and implemented a corrective action plan, and the past-noncompliance IJ was determined to have been removed on 06/15/2023. The facility's noncompliance was corrected on 06/16/2023. On 04/19/2024 at 2:39 PM, the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and regional staff were informed of the past non-compliance IJ situation. This deficient practice was evidenced by the following: Part A 1. Review of a facility policy with a review date of 6/2023 titled, Elopement indicated under Policy Interpretation and Implementation, section I . Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. The surveyor reviewed the electronic medical record (EMR) for Resident #353 which revealed the following: Review of the Admission Record for Resident #353 included diagnoses but were not limited to; encephalopathy (a broad term for any brain disease that alters brain function or structure), epilepsy (a seizure disorder), and schizophrenia (a mental illness that affects how a person thinks, feels, and behaves). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/19/23, reflected the resident had a brief interview for mental status (BIMS) score of 0 out of 15, indicating that the resident had severe cognitive impairment. Review of a Quarterly Minimum Data Set (MDS) dated [DATE], reflected that the facility documented the resident was rarely/never understood and testing for a BIMS score was not performed. Review of a Quarterly Minimum Data Set (MDS) dated [DATE], reflected the facility documented under section G that the resident was able to Locomotion off unit-how resident moves to and from distant areas on the floor 2. Limited assistance 2. One person physical assist. A review of the physicians' orders revealed there were no physician orders for wandering or elopement risks for Resident #353. Review of an elopement risk assessment dated [DATE], indicated the resident scored a 7 upon the assessment, indicating the resident was a low risk for elopement. Review of a nursing progress note (PN) dated 5/17/23, documented that Resident # 353 was wandering in the unit hallway stating they wanted to go home. The PN further indicated the resident's family member was present and the resident was redirected by staff. Review of a PN dated 6/12/23 at 5:12 AM, documented the resident was found waiting around the lobby stating they were getting ready to go downtown. The resident was returned to their unit and would be monitored for exit seeking. Further review of the PNs, revealed documentation dated 6/15/23 at 1:53 PM, indicating that Resident #353 was alert and confused, ambulating up and down the unit hallway. Resident #353 had to be redirected from entering the elevator and was stating, I have to go home today. Review of the comprehensive care plan (CP) for Resident #353 initiated on 6/15/2023 indicated, At risk for elopement related to: Resident states 'I am leaving, going home'. The documented interventions in the CP included: involving the resident in preferred activities, involving resident in decision making regarding daily choices, redirecting the resident from doors, shift to shift endorsement to visually monitor resident especially during shift changes or when the resident talks about going home, involving family when the resident starts to verbalize desire to go home by having them call or visit (frequently when possible), encourage family to bring in personal possessions, and evaluate the effect of cognitive impairment with the resident's ability to understand changes in surroundings. Review of a PN dated 6/15/23 at 11:34 PM documented the following: -At 4:10 PM, Resident #353 was calm and seen sitting in the lobby downstairs. -At 5:00 PM, the assigned Licensed Practical Nurse (LPN) #5 received a call from the third-floor unit manager that the resident wanted to go home and did not want to return upstairs. The resident's family members were called and stated they would come to see the resident. The resident then agreed to return to their room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- At 7:00 PM, the resident's family members came, visited with the resident, and left the resident in their room. - At 8:00 PM, LPN #5 received a call from the receptionist that the resident was downstairs in the lobby. The receptionist escorted Resident #353 back to the unit and the resident was provided a snack. The resident was left in their room and did not verbalize to staff needing anything else. - At 8:53 PM, LPN #5 received a call from the front lobby that the resident had left the facility, code gray was initiated and the staff searched for the resident. - At 9:05 PM the resident was found near the facility sitting upright in no acute distress. The nursing staff stayed with Resident #353 until emergency medical services (EMS). The resident was sent to the hospital emergency room (ER) for a complete evaluation. A PN dated 6/16/23 at 6:47 AM documented the resident was admitted to the hospital with a diagnosis of hyponatremia. Resident #353 did not return to the facility. A review of an investigation report completed by the facility indicated that Resident #353 had an actual elopement on 6/15/23 at 8:53 PM, and the investigation revealed the following: At 8:53 PM, Resident #353 was observed by a housekeeping staff exiting the ground kitchen door from their view from the 2nd floor balcony. The housekeeping staff ran downstairs to inform the front desk. The facility's elopement protocol-code gray was initiated, and staff started to search for the resident. At 9:05 PM, Resident #353 was found sitting near the facility, staff stayed with the resident until EMS arrived and brought the resident to the hospital for further evaluation. The resident was uninjured during initial assessment by facility staff and was admitted to the hospital with a diagnosis of hyponatremia. A review of a written statement dated 6/15/23, documented by LPN #5 indicated the location of where Resident #353 was found which was several blocks away from the facility adjacent to a wide, double lane roadway. Interventions listed at time of the elopement included: An investigation and a search were initiated. The police were called at time of elopement. Immediate in-service education with the facility staff regarding elopement was initiated. An employee was assigned to guard the exit door. The summary and conclusion of the investigation included: The resident exited through the side kitchen door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The resident was a low risk for elopement, a score of 7, based on the 1/12/23, elopement assessment completed. The investigation further documented, The door is [NAME] locked (a type of door lock that uses magnetism to secure a barrier) but a staff member deactivated the alarm system to access the dumpster area thus allowing the resident to leave the facility. The elopement was reported to the New Jersey Department of Health and the Ombudsman's office the day of the incident. On 4/18/24 at 11:56 AM, the surveyor interviewed the DON about the elopement of Resident #353. The DON stated it was believed the door was not closed properly which left the door unsecured and the resident was able to exit the facility. The DON stated there was no camera footage and could not identify the last staff member who used the exit door. The DON explained that the exit door was used by kitchen staff to access the loading dock and dumpster area. On 4/18/24 at 1:40 PM, the survey team met with the LNHA, DON, and regional staff. The surveyor informed the facility of the concern for the unsecured door and the resident exhibiting exit seeking behavior. The LNHA stated that the alarmed and [NAME]-locked exit door was believed to have malfunctioned, which led the exit door to remain unlocked and not alarm at the time of the elopement. The LNHA confirmed that there was no camera footage, and he could not determine which staff member last used the exit door prior to the resident's elopement. The LNHA added that there was 24-hour receptionist staff in the lobby. On 4/19/24 at 8:48 AM, the surveyor interviewed Receptionist #1 who was working in the lobby on the shift of the resident's elopement. Receptionist #1 stated that he recalled the resident was in the lobby in the afternoon prior to the elopement. Receptionist #1 could not recall the specific time and stated the resident was assisted back upstairs to their room. Receptionist #1 stated for the actual elopement he recalled someone coming to the front desk informing him that the resident left the facility, and he called to inform nursing staff. A code gray was called and the search for the resident began. On 4/19/24 at 12:15 PM, the surveyor interviewed the Maintenance Director who stated there were no known issues with the kitchen exit door prior to Resident #353's elopement. On 4/19/24 at 2:39 PM, the survey team met with the LNHA, DON and regional staff about the elopement of Resident #353 and informed them of the IJ past non-compliance. The survey team informed the facility that the failure to ensure a secure door remained locked and provide supervision to Resident #353, who exhibited exit-seeking behaviors, led up to the actual elopement on 6/15/23, resulted in an IJ situation. On 4/22/24 at 9:30 AM, the facility provided a copy of their corrective action plan that was developed and implemented beginning 6/15/23, after Resident #353 eloped from the facility. Review of the plan revealed the following actions taken on 6/15/23: .Door noted to malfunction on 6/15/23. 24 hr. door monitor initiated . Elopement and wandering residents' policy was reviewed . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In-service education with all staff on Identification of Residents at Risk for Elopement, Elopement and Wandering policies . Daily door checks initiated daily x 2 weeks and weekly thereafter . The plan further indicated ongoing education to staff regarding elopement precautions and policies, keypad access doors and door safety education, weekly inspection of exit doors and function; Quality assurance performance improvement project to review and interpret all audit findings. After conducting observations, interviews, record review and review of pertinent documents, the survey team verified the facility implemented all components of the action plan and the deficient practice was corrected on 6/16/23, prior to the annual survey entrance. On 4/22/24 at 11:26 AM, the surveyor conducted a telephone interview with LPN #5 who stated Resident #353 was alert with periods of confusion, able to verbalize their needs, and ambulated independently. LPN #5 stated for wandering and elopement risk residents, interventions included keeping exit doors secured, encouraging recreational activity, performing visual observations of the resident. LPN #5 further stated that in the afternoon prior to the resident's elopement she received a call from the unit manager at the time that the resident was in the lobby and wanted to go home. LPN #5 explained she called the resident's family member who came to visit the resident and the resident agreed to stay at the facility. LPN #5 further stated she could only recall later that evening she received a phone call from Receptionist #1 who reported that the resident left the facility. She further explained a code gray was called and the search for the resident was initiated expanding outside the facility. The LNHA, DON, ADON, physician, the resident's family member and police were called and made aware of the resident's elopement. LPN #5 stated the resident was found by staff not far from the facility. The resident was unharmed. 44605 Part B 2. On 4/15/24 at 12:58 PM, the surveyor reviewed the Facility Reported Event (FRE), which revealed Resident #355 had eloped from the facility on 8/17/23, and did not return to the facility due to Resident #355 being arrested during the elopement. On 4/15/24 at 1:15 PM, the surveyor reviewed the Admission Record (AR) for Resident #355 which reflected the resident was admitted to the facility on [DATE], with diagnoses that included but were not limited to bipolar disorder, displaced segmental fracture of shaft right tibia and displaced fracture of proximal phalanx of left thumb. A review of the Admission MDS dated [DATE], indicated the resident had a BIMS score of 15, indicating Resident #355 was cognitively intact. A review of the Order Summary report included a discontinued physician's order dated 8/13/2023, which indicated, Resident can go out on pass with responsible party from 8 AM to 8 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #355's care plan listed under the intervention section stated, Out of pass (OOP) order discontinued (d/c), privileges were removed with an initiated date of 8/14/2023. On 4/16/24 at 12:10 PM, the surveyor reviewed the facility investigation report provided by the Director of Nursing (DON). The facility investigation report revealed that on 8/17/23 at 7:15 PM, Resident #355 told the front desk receptionist he/she has going outside to smoke and then would be going OOP. The receptionist did not verify with the nursing staff that Resident #355 was going OOP. At 8 PM during the medication pass, it was discovered Resident #355 eloped when his/her wheelchair was found in the front lobby. A search of the facility property was conducted, and the resident was not located. The [NAME] police were contacted and informed of the issue. Facility staff were able to contact Resident #355 on their cell phone and the resident stated he/she was at the [name redacted] in [NAME] dealing with a family issue and would return to the facility at 3:00 AM. At 3:20 AM, the staff attempted to contact Resident #355, but their phone went directly to voicemail. At 7:00 AM on 8/18/23, a [NAME] Police Officer arrived at the facility and informed the staff that they would go to the [name redacted] and return with Resident #355. Resident #355 was arrested due to an outstanding warrant and did not return to the facility. On 4/16/24 at 01:04 PM, the surveyor conducted an interview with the DON who stated the front desk receptionist should not have let Resident #355 outside to the first floor patio to smoke because all smoking is supposed to take place on the second floor patio as per their policy. The receptionist should have also confirmed the OOP with the nursing staff on the unit as per the facility policy. The DON confirmed that Resident #355 OOP privileges had been discontinued on 8/13/23, related to a previous issue and the receptionist should have been informed of Resident #355 OOP status. On 4/18/24 at 11:30 AM, the surveyor interviewed the 4th floor Registered Nurse Unit Manager (RN/UM). The RN/UM stated when a resident's OOP privileges are suspended or discontinued, the facility has a team meeting to discuss the concern, the social worker meets with the resident to alert them of their OOP status, the receptionist is alerted, and the resident's picture is added to the elopement risk sheet located at the front desk. On 4/18/24 at 12:47 PM, the surveyor interviewed Receptionist #2, who stated the OOP procedure is as follows, when a resident comes to the receptionist desk to go OOP, we call their unit to confirm they are allowed to go OOP. The resident and responsible party sign out in the logbook and sign in upon return. The surveyor asked if a resident had their OOP privileges suspended are you alerted? Receptionist #2 stated, In that event we are alerted by the administrator, director of nursing or the social worker that a resident cannot go out on pass and their picture is added to the elopement risk list. Receptionist #2 was asked if residents can smoke in the front on building? Receptionist #2 stated, any residents who are smokers go out on the second floor, which is the designated smoking area. On 4/19/24 at 09:05 AM, the surveyor interviewed the Social Worker (SW) who stated Resident #355 was made aware of their OOP privileges are suspended and understood why without issue. Resident #355's photo was added to elopement list at the reception desk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/17/24 at 12:20 PM the Regional Director of Clinical Services (RDCS) provided with surveyor with facilities policies titled, Smoking Policy - Residents, Staff and Visitors and Out on Pass Policy with a revision date of 10/2023. The smoking policy indicated under the policy interpretation and Implementation, 1. Prior to admission and upon entry, Residents, Staff and Visitors shall be informed of the facility smoking policy, including designated smoking areas, times for residents and the extent to which the facility can accommodate their smoking or non-smoking preferences. Review of the Out of Pass policy indicated under the procedure 6. Upon leaving the facility, the resident/responsible party will inform the Change Nurse and sign out on pass; 8. The resident/responsible party must sign in and out at the lobby desk; and 10. The nurse will notify security if a pass is rescinded. On 4/19/24 at 11:52 AM, the survey team met with the Licensed nursing Home Administrator (LNHA), the DON, the RDCS and [NAME] President of Operations (VPO) to discuss the above concerns. The LNHA stated there was a breakdown in communication and facility policies with regards to Resident #355 elopement and in-services will be conducted. There was no further information provided. NJAC 8:39-33.1(d)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 44605 Based on observation, interview, and record review, it was determined that the facility failed to assure that the physician responsible for supervising the care of residents completed monthly progress notes. This deficient practice continued over several months for 5 of 31 residents reviewed, Resident #71, #142, #352, #138 and #63 reviewed for physician progress notes and current physician orders. This deficient practice was evidenced by the following: 1. On 4/15/24 at 11:36 AM, the surveyor observed Resident #71 sitting in a wheelchair in their room. The resident was lethargic and non-arousal. The surveyor reviewed the hybrid medical records of Resident #71 which revealed the following: Review of Resident #71 Admission Record (AR) reflected that Resident #18 was admitted to the facility with medical diagnoses that included but were not limited to major depression, schizophrenia, type 2 diabetes mellitus and heart failure. A review of Resident # 71's hybrid medical records revealed that from 6/4/21 to 1/26/24 the Primary Physician (Physician #1) had not written any monthly Medical Progress Notes (PN) in the electrotonic or paper chart. On 4/17/24 at 10:40 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor team with a facility policy titled, Physician Visits. with a revised date of April 2020. Under the policy interpretation and implementation section of the policy it states, 5. The Attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation. On 4/19/24 at 11:52 AM, the surveyor team met with the LNHA, Director of Nursing (DON), Regional Director of Clinical Services (RDCS) and [NAME] President of Operations (VPO) with discuss concerns. The RDCS stated the Physician #1 should be documenting on their residents at the time of visit, they have spoken the Physician # and provided an in-service on timely documentation. On 4/23/24 at 10:29 AM, the surveyor team conducted a phone interview with Physician #1. Physician #1 stated, he sees the residents' multiple times per week at the facility but does not always put his notes in the computer but will write handwritten notes in the physical chart. Physician #1 further stated, he needs to document more in the electronic chart, and agreed that most of his resident visits were not documented. On 4/23/24 at 12:10 PM, the surveyor team met with the LHNA, DO, RDCS and VPO. No further comments made regarding physician visit documentation. 39885 (continued on next page)

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Complete Care at Fair Lawn Edge	77 East 43rd Street Paterson, NJ 07514

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 4/18/24 at 9:45 AM, the surveyor reviewed Resident #142's hybrid medical record which revealed that the resident's physician only documented one visit which was dated 4/11/24. There was not a documented physician's visit for Resident #142's admission and subsequent monthly visit for February 2024 and March 2024. On 4/18/24 at 9:47 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) of the second floor unit. The UM/LPN stated that Resident #142's physician visited residents a couple times a week but that she did not know how often the physician would write a note regarding the visit. She added that the physician would document the notes in the electronic medical record. On 4/18/24 at 12:44 PM, the surveyor interviewed the Director of Nursing (DON) regarding physician visits. The DON stated that the physician should write a note monthly. He added that Resident #142's physician did not have a partner or any other staff that would have written a note. On 4/18/24 at 01:16 PM, in the presence of the survey team, the surveyor told the Licensed Nursing Home Administrator, DON, Assistant DON and Regional Nurse the concern that Resident #142's physician did not have any documented visits prior to 4/11/24. On 4/19/24 at 12:00 PM, in the presence of the survey team, the Regional Nurse stated that there was no other documentation by Resident #142's physician and that there should have been. 39399 3. On 4/22/24 at 12:23 PM, the surveyor reviewed Resident #352's hybrid medical records. The resident was discharged from the facility on 1/31/24. The Admission Record (AR) documented that Resident #352 had diagnoses that included but were not limited, Acute Respiratory Failure, Pneumonia, Type II Diabetes Mellitus and Bipolar Disorder. A review of the physician progress notes (PN), revealed there were no notes written by Physician #1 from November 2023 to January 2024. 46049 4. On 4/16/24 at 12:00 PM, the surveyor reviewed Resident #138's hybrid medical records. The Admission Record (AR) documented that Resident #138 had diagnoses that included but were not limited, schizoaffective disorder, depression, and hyperlipidemia. A review of the physician progress notes (PN), revealed there were no notes written by Physician #1 from November 2023 to March 2024. 5. On 4/16/24 at 12:00 PM, the surveyor reviewed Resident #63's hybrid medical records. The Admission Record (AR) documented that Resident #138 had diagnoses that included but were not limited, cerebral infarction (stroke) with hemiplegia (paralysis on one side of the body) and hemiparesis (weakness affecting one side of the body), hypertension, and type 2 diabetes. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the PN, revealed there were no notes written by Physician #1 from November 2023 to March 2024. On 4/17/24 at 11:34 AM, the surveyor interviewed LPN/UM #2 about PN. LPN/UM #2 stated Physician #1 did not work with a nurse practitioner and documented in the electronic medical record (EMR). On 4/18/24 at 10:53 AM, the surveyor interviewed the ADON who stated Physician #1 documented in the EMR. The ADON reviewed the EMR of Resident #138 and Resident #63. The ADON could not find PNs by Physician #1 who was the residents' primary physician. The ADON stated she would follow up to provide further information. On 4/18/24 at 1:40 PM, the survey team met with the LNHA, DON and regional staff. The surveyor informed them of the concern of Resident #138 and Resident #63 not having any PN by their primary physician. On 4/19/24 at 9:13 AM, the surveyor interviewed the Medical Director who stated it was expected for physician visits at least monthly and every two months when alternating visits with a nurse practitioner or physician assistant. The Medical Director acknowledged it would be expected for physicians to document upon visiting residents. On 4/19/24 at 11:53 AM, the survey team met with the LNHA, DON and Director of Clinical Services (DCS). The DCS stated Physician #1 was in-serviced about documentation. The facility provided a PN that Physician #1 completed yesterday for April 2024. There was no additional information provided by the facility. On 4/23/24 at 10:32 AM, the survey team interviewed Physician #1 over the phone who stated physicians were required to visit residents at least once a month and he visited his residents in the facility 3-4 times a week. Physician #1 stated when visiting, he wrote PN, but would handwrite notes sometimes when computers were not available. Physician #1 further explained he would put it in the resident's paper chart and that it should be there. The surveyor informed Physician #1 there were no notes found in the paper chart of the residents identified and the facility did not provide any additional documentation. Physician #1 could not speak to why there were no PN for the residents identified. Physician #1 stated he understood the importance of completing PNs as it shows he is reviewing the residents' plan of care and visiting the residents. NJAC 8:39-23.2(b)(d)

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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. 31656 Based on observation, interview, and record review it was determined that the facility failed to properly store and accurately label medications found during the initial unit inspection. This deficient practice was observed for 1 of 3 facility units examined, as evidenced by the following: On 4/15/24 at 12:50 PM, the surveyor inspected the 2nd floor low medication cart. Within the low medication cart the surveyor observed an opened 10ml bottle of Acetylcysteine 20% that was not labeled. Further examination of the bottle of Acetylcysteine revealed that the bottle did not have any documentation of a date or time the bottle was opened. Inspection of the bottle of Acetylcysteine 20% indicated on the label, Store in refrigerator after opening. and Discard opened vial after 96 hours. The surveyor interviewed the 2nd floor UM/LPN#1 who stated that it might belong to Resident #146 who does have an order for Acetylcysteine. The UM/LPN#1 confirmed that the medication should not have been stored without a label, date/time opened. Review of the facility Admission Sheet for Resident #146 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to Acute Respiratory Failure with Hypoxia and Chronic Obstructive Pulmonary Disease. A review of Resident #146's Comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 3/26/24, reflected that Resident #86 had a BIMS score of 15 out of 15, indicating an intact cognition. The surveyor reviewed the April 2024 electronic medication administration record (eMAR) which documented a Physician's order (PO) dated 3/20/24 for Acetylcysteine Solution 20% 10 ml inhale via nebulizer every 6 hours for mucous secretions. On 4/15/24 at 1:30 PM, the surveyor discussed the unlabeled, undated/untimed Acetylcysteine with the Director of Nursing (DON) who could not explain why the medication was stored this way. No further information was provided. NJAC 8:39- 29.4(b)2

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 39399 Based on observation, interview, and record review, it was determined that the facility failed to provide the mandatory annual dental care services. This deficient practice was observed for 1 of 31 residents reviewed for dental care services, Resident #56, as evidenced by the following: On 04/15/24 12:27 PM, the surveyor observed the resident in bed, awake and alert. A review of the Admission Record for Resident #56 reflected that the resident was admitted to the facility with diagnoses that included but not limited to Depression, Post Traumatic Stress Disorder, Anorexia, Hypertension and Fracture of the left femur. A review of Resident #56's Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated 1/11/24, reflected that the Brief Interview for Mental Status score of 15 of 15 indicating that the resident had intact cognition. The resident was admitted in the facility on 2/9/2023 and was recipient of Medicaid effective 3/19/23 and should have had at least an annual examination and treatment by a Dentist. The surveyor could not find any documentation that revealed visits from a Dentist nor any refusal of dental visits. On 4/19/24 at 2:38 PM, the surveyor discussed the above concern to the facility's the Licensed Nursing Home Administrator (LNHA), the [NAME] President of Operations (VPO), the Director of Clinical Services (DCS), the Regional Registered Nurse (RRN), the Director of Nursing (DON), Assistant DON. On 4/23/24 at10:45 AM, the facility's RRN confirmed to the surveyor that Resident #56 was not seen and evaluated by a Dentist since the resident was admitted to the facility. There was no further information provided. NJAC 8:39-15.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44605 Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices as well as store potentially hazardous foods in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 4/15/24 at 09:21 AM, the surveyor in the presence of the entered the Food Service Director (FSD) observed the following during the kitchen tour: 1. During the kitchen inspection, the surveyor observed inside walk-in freezer, multiple boxed items stacked above 18 inches from ceiling. FSD stated he will do rearrange the boxes, so they are stored below the 18 inches from the ceiling. 2. On 4/16/24 at 10:38 AM, during the lunch meal preparation, the surveyor observed the Dietary Chef (DC), check the temperature of ground pork with a non-disinfected thermometer. The FSD had given the thermometer to the DC, who opened the thermometer probe and inserted the thermometer into the ground pork without disinfecting. The surveyor asked the chef why they did not disinfect the thermometer prior to checking the temperature of the ground pork, the chef stated, I thought the FSD disinfected the thermometer. The FSD stated, this was my fault, I should have told the chef to disinfect the thermometer prior to checking the food temperatures. We will discard the ground pork, because we contaminated the product. On 4/18/24 at 12:52 PM, the Regional Director of Clinical Services (RDCS) provided the surveyor with multiple facility policies including Food Receivable and Storage Policy and Kitchen Cleaning Policy both with a revised date of February 2024. The Food Receivable and Storage Policy states under the procedure section, 5. Store all items at least 6 off the floor, 18 from ceiling and aways from refrigerator, freezer, and dry storage area walls. The Kitchen Cleaning Policy states under the procedure section, All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. On 4/19/24 at 11:52 AM, the surveyor team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), RDCS and [NAME] President of Operations (VPO) with discuss concerns. The DON agreed that the DC had made a mistake by not disinfecting the food thermometer prior to checking the food temperatures and all stored items in the freezer must below stored below 18 inches from the ceiling. The DON further stated that the FSD has conducted an in-service with his staff for both kitchen concerns. No further comments made. NJAC 8:39-17.2(g)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31656 Based on observation, interview, and record review, it was determined that the facility failed to maintain proper infection control practices to mitigate the spread of infection for 2 of 3 Nurses observed during medication administration, and [NAME] statement observed during wound treatment. The deficient practice was observed on 2 (3rd and 4th floor) out of 3 nurses observed during medpass or facility floors during medication administration observation. This deficient practice was evidenced by the following: 1. On 4/18/24 at 8:39 AM, the surveyor observed medication administration (med pass) performed on the 3rd floor, performed by a Licensed Practical Nurse (LPN) #3. The State Surveyor observed LPN#3 put his soapy hands immediately under the running water without scrubbing away from the water first. LPN#3 could not explain why he did not scrub his soapy hands away from the running water prior to rinsing the soap off. 2. On 4/18/23 at 8:52 AM, the surveyor observed med pass performed on the 4th floor, performed by LPN#4. The State Surveyor observed LPN#4 scrub her soapy hands for 5 seconds away from the water before rinsing them clean. LPN#4 could not explain why she did not scrub her soapy hands away from the running water for 20 seconds prior to rinsing the soap off. Review of Handwashing/Hand Hygiene Policy documented, The facility considers hand hygiene the primary means to prevent the spread of infections. Documented under Procedure, under Washing Hands 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds. 2. Rinse hands thoroughly under running water. On 4/18/23 at 11:52 AM, the surveyor met with the Director of Nursing, and the Assistant DON to discuss medpass. Medpass evaluations of LPN#2, 3/27/24 and LPN#3 2/6/24 were provided that showed requirements met during the evaluation. No further information was provided to explain the deficient practice during observation of hand washing. NJAC 8:39 - 19.4(a)