STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315332	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Ocean Center	1361 Route 72 West Manahawkin, NJ 08050

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to notify the resident and or resident representative in writing of the reason for transfer or discharge to the hospital for 1 of 3 residents (Resident #108) reviewed for hospitalization . This deficient practice was evidenced by the following: During the initial tour of the facility on 04/24/24 at 11:08 AM, the surveyor observed Resident #108 lying in bed awake. The resident was unable to be interviewed at that time due to a language barrier. Review of Resident #108's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: age-related debility, muscle wasting and atrophy (waste away, unspecified site), and obstructive and reflux uropathy (disorder of the urinary tract that occurs due to blocked urinary flow). Review of Resident #108's Progress Notes (PN) revealed a PN dated 03/26/24 at 01:05 AM, Follow-up care for abnormal labs. Vitals taken BP-(blood pressure) 132/58, P-103, RR (respirations, breathing) 17, T-(temperature) 97.1 (tympanic, temperature taken by inserting thermometer in the ear), SpO2-(pulse oximetry, probe placed on finger to obtain percentage of oxygen in the blood) 99% on room air. Skin flush. Slow to react to care. Send to .hospital at 12:52 am via stretcher x 2 assist. Call placed to Son .and left a message. There was no documented evidence that either the resident or responsible party were provided with written notification that the resident was transferred to the hospital in the resident's electronic health record (EHR). On 04/29/24 at 11:23 AM, the surveyor interviewed the Social Services Director (SSD) who stated that she had worked at the facility for [AGE] years. SSD stated she was responsible to notify the Ombudsman (an appointed official who investigates individual complaints) when a resident was hospitalized and nursing notified both the resident and their family with written notice on their way out of the facility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/24 at 09:55 AM, the surveyor interviewed the Director of Nursing (DON)who stated that nursing was responsible to phone both the resident, family and physician and document the details of hospital transfer in the Progress Notes. DON stated that there was no written documentation provided to the resident or family upon hospital transfer from the facility. On 04/30/24 at 10:30 AM, The DON provided the surveyor with a policy related to Discharge and Transfer. She stated that the nurses had not been notifying the resident or representative in writing prior to discharge or of bed hold. DON stated the resident's were sick when they were leaving and the families sometimes got mad. Review of the facility policy, Discharge and Transfer (Revision Date 11/15/22) revealed the following: .A Center must immediately inform the patient/patient representative, consult with the patient's physician, and notify consistent with below when there is a decision to transfer or discharge the patient from the Center. The patient and patient representative must be notified in writing prior to the transfer or discharge and in a language and manner they understand . NJAC 8:39-4.1(a) 31

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NAME OF PROVIDER OR SUPPLIER Southern Ocean Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1361 Route 72 West Manahawkin, NJ 08050	

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 37547 Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to complete a significant change assessment within 14 days after a resident elected hospice services using the Resident Assessment Instrument (RAI) process. This deficient practice was identified for 1 of 2 residents (Resident #24) reviewed for hospice and end of life care. This deficient practice was evidenced by the following: On 04/24/24 at 9:48 AM during the initial tour of the facility, the surveyor observed Resident #24 lying in bed asleep. The resident was accompanied by the hospice aide who provided personal care to the resident at the time of the observation. Review of Resident #24's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included, but were not limited to: Alzheimer's disease. Review of the resident's Order Summary Report revealed an order dated 11/01/23, Hospice Eval (evaluation) and Tx (treat). Review of Resident #24's Care Plan revealed an entry dated 11/3/23, with a Focus of Hospice start date: 11/03/23. Hospice care due to end stage of Senile Degeneration (Dementia) Review of Resident #24's Minimum Data Set (MDS), an assessment tool, revealed a Significant Change in Status assessment with an Assessment Reference Date (ARD) of 11/16/23. Further review of the assessment revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated that the resident was severely cognitively impaired. Review of Section O-Special Treatments, Procedures and Programs revealed under subsection K 1., that the resident received Hospice Care while a resident. Further review of the assessment on line Z0500 under Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was signed as completed on 01/04/24. Further review of the assessment revealed that the Certified Clinical Reimbursement Coordinator (CCRC) RN also documented that she completed Section O on 1/4/24, which indicated that the resident received Hospice Care. On 04/29/24 at 11:06 AM, the surveyor interviewed the CCRC who stated that she worked at the facility since February of 2023. CCRC stated that Resident #24's Significant Change MDS Assessment was initiated on 11/16/23, but was not completed until 01/04/24. CCRC stated that the Significant Change Assessment should have been initiated within 14 days of when the resident entered into hospice services. CCRC further stated that there could have been a delay, but she was not able to recall why the assessment was not completed until 01/04/24, 49 days later. CCRC stated that the assessment was accepted by CMS (Centers for Medicare and Medicaid Services) on 01/08/24. CCRC further explained that she worked alone in the building after her co-worker retired in October 2023, and that was why the assessment was completed late, and not within 14 days as required. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/24 at 10:11 AM, the surveyor interviewed the Director of Nursing (DON) who stated that a Significant Change MDS Assessment should have been entered upon the initial hospice admitted . DON stated that from 11/16/23 through 01/04/24, it was delayed. According to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18. 11 October 2023, a Significant Change in Status MDS must be completed by the 14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days). Review of the facility policy, OPS 183 MDS Remote Completion (Revision Date 12/27/21) revealed the following: .Centers will also follow the RAI Manual Instructions for completing the assessment process. .Purpose: To ensure compliance with the RAI process and timely completion of the MDS. NJAC 8:39-11.2(i)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 43936 Based on observations, interview, record review, and pertinent facility documents it was determined that the facility failed to provide appropriate treatment and care, based upon current standards of practice and the resident's comprehensive care plan specifically not securing a urinary catheter drainage bag properly resulting in the bag making contact with the floor. The deficient practice was identified for 1 of 3 (Resident # 15) investigated for Urinary Catheter. The deficient practice was evidenced by the following: A review of Resident # 15's Admission Minimum Data Set (MDS; an assessment tool) dated 04/08/2024 revealed that he/she had an indwelling catheter (tube inserted into the bladder to assist in the flow of urine). A review of Resident # 15's Electronic Medical Record (EMR) revealed under Med Diag that he/she was diagnosed with but not limited to Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms (needing to urinate frequently (during the day and night), a weak urine stream, and leaking or dribbling of urine) and Retention of Urine. A review of Resident # 15's EMR revealed under, Orders to, Empty catheter drainage bag at least once every eight hours to when it becomes 1/2 to 2/3 full every 8 hours. The order revealed a start date of 04/02/2024. A review of Resident # 15's Care Plan located in the EMR revealed a focus, [Resident # 15] requires indwelling foley catheter due to obstructive uropathy. The focus was created on 04/02/2024. The focus revealed an intervention that revealed, Record output and Keep catheter off floor. Both interventions had an initiated date of 04/02/2024. A review of Resident # 15'2 Treatment Administration Record (TAR) located in the EMR revealed the order to Empty catheter drainage bag at least once every eight hours to when it becomes 1/2 to 2/3 full every 8 hours. The TAR revealed the following dates and times were blank: 4/3 - 1400 (2:00 PM) blank 4/4 - 0600 (6:00 AM) blank 4/11 - 1400 (2:00 PM) blank 4/12 - 0600 (6:00 AM) blank 4/14 - 0600 (6:00 AM) blank 4/15 - 0600 (6:00 AM) blank 4/17 - 0600 (6:00 AM) blank, 2200 (10:00 PM) blank (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/18 - 0600 (6:00 AM) blank 4/19 - 1400 (2:00 PM) blank, 2200 (10:00 PM) blank 4/22 - 1400 (2:00 PM) blank 4/24 - 1400 (2:00 PM) blank 4/26 - 0600 (6:00 AM) blank, 2200 (10:00 PM) blank 4/29 - 0600 (6:00 AM) blank On 04/24/2024 at 10:31 AM during the initial tour of the facility, the surveyor observed Resident # 15 in their room. At that time, the surveyor observed the urinary catheter drainage bag in contact with the wheels of the bed. On 04/26/2024 at 10:07 AM, the surveyor observed Resident # 15 in their room. At that time, the surveyor observed the urinary catheter drainage bag in contact with the floor. The urinary catheter drainage bag was not secured too the bed frame. On 04/29/2024 at 09:07 AM, the surveyor observed Resident # 15 in their room. At that time, the surveyor observed the urinary catheter drainage bag in contact with the floor. On 04/30/2024 at 11:11 AM during an interview with the surveyor, Certified Nurses Aide (CNA) # 1 said that when emptying the urinary catheter drainage bag, she measures and tells the nurse. CNA # 1 confirmed that the nurse documents the TAR. On the same date at 11:28 AM during an interview with the surveyor, the Unit Manager/Registered Nurse # 1 confirmed that the nurse documents in the TAR. On 05/01/2024 at 09:54 AM, the surveyor observed Resident # 15 in their room. At that time, the surveyor observed the urinary catheter drainage bag in contact with the floor. At that time, CNA # 2 was present in the room. At that time, CNA # 2 referred to Resident # 15's urinary drainage bag and stated, It's all twisted up. The surveyor asked her if it should be on the floor. CNA # 2 replied, No. On 05/01/2024 at 12:14 PM during an interview with the surveyor, the Director of Nursing (DON) replied, No when asked by the surveyor if the urinary drainage bag should be in contact with the floor. Secondly, the DON replied, Infection control when the surveyor asked why the urinary drainage bag should not be in contact with the floor. Also, the DON confirmed that nurses document urinary outputs in the TAR. Lastly, the DON replied, I know they [nurses] empty it but if it's not documented, it's not done . A review of the facility provided document titled, NSH113 Nursing Documentation revised 05/01/23 revealed under the section titled, Practice Standards that, 1. Documentation of nursing care is recorded in the medical record and is reflective of the care provided by nursing staff . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided document titled, Procedure: Catheter: Indwelling Urinary - Care Of revised 02/01/23 revealed, 13. Secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor . S 8:39-27.1 (a)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40744 NJ Complaint #159967, #159711, #169655, #170197, Based on interview, review of the Nurse Staffing Report and other facility documentation, it was determined that the facility failed to ensure there was sufficient nursing staff on a 24-hour basis to provide nursing care to the residents. This deficient practice was evidenced by the following: On 04/29/24 at 10:30 AM, the surveyor held a Resident Council meeting with six residents in attendance. During the Resident Council meeting the surveyor asked all residents in attendance if they received showers, or assistance with showers. Four of the six residents in attendance told the surveyor that showers were not offered twice weekly (Resident #21, #84. #94, and #122). All were aware of their shower day schedule but stated they do not always receive them because of staffing issues. 1.For the week of Complaint staffing from 10/02/2022 to 10/08/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -10/02/22 had 6.5 CNAs for 111 residents on the day shift, required at least 14 CNAs. -10/03/22 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/04/22 had 7 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/05/22 had 6 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/06/22 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/07/22 had 8 CNAs for 115 residents on the day shift, required at least 14 CNAs. -10/08/22 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. 2. For the week of Complaint staffing from 10/16/2022 to 10/22/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -10/16/22 had 5 CNAs for 119 residents on the day shift, required at least 15 CNAs. -10/17/22 had 7 CNAs for 119 residents on the day shift, required at least 15 CNAs. -10/17/22 had 5 CNAs to 12.5 total staff on the evening shift, required at least 6 CNAs. -10/18/22 had 8 CNAs for 119 residents on the day shift, required at least 15 CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/19/22 had 8 CNAs for 119 residents on the day shift, required at least 15 CNAs. -10/20/22 had 9 CNAs for 120 residents on the day shift, required at least 15 CNAs. -10/21/22 had 8 CNAs for 120 residents on the day shift, required at least 15 CNAs. -10/22/22 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs. 3. For the week of Complaint staffing from 11/20/2022 to 11/26/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -11/20/22 had 9 CNAs for 114 residents on the day shift, required at least 14 CNAs. -11/21/22 had 7 CNAs for 113 residents on the day shift, required at least 14 CNAs. -11/22/22 had 9 CNAs for 109 residents on the day shift, required at least 14 CNAs. -11/23/22 had 9 CNAs for 109 residents on the day shift, required at least 14 CNAs. -11/23/22 had 6.5 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. -11/24/22 had 8.5 CNAs to 108 residents on the day shift, required at least 13 CNAs. -11/25/22 had 6 CNAs for 107 residents on the day shift, required at least 13 CNAs. -11/26/22 had 8.5 CNAs for 107 residents on the day shift, required at least 13 CNAs. 4. For the week of Complaint staffing from 12/04/2022 to 12/10/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -12/04/22 had 8.5 CNAs for 113 residents on the day shift, required at least 14 CNAs. -12/05/22 had 5 CNAs for 113 residents on the day shift, required at least 14 CNAs. -12/05/22 had 6 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. -12/06/22 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. -12/07/22 had 7 CNAs for 113 residents on the day shift, required at least 14 CNAs. -12/08/22 had 9.5 CNAs for 113 residents on the day shift, required at least 14 CNAs. -12/09/22 had 8 CNAs for 112 residents on the day shift, required at least 14 CNAs. -12/10/22 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. For the week of Complaint staffing from 12/10/2023 to 12/16/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs total staff on 3 of 7 evening shifts as follows: -12/10/23 had 8.5 CNAs for 111 residents on the day shift, required at least 14 CNAs. -12/11/23 had 12.5 CNAs for 110 residents on the day shift, required at least 14 CNAs. -12/11/23 had 6 CNAs to 18 total staff on the evening shift, required at least 9 CNAs. -12/12/23 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -12/12/23 had 7 CNAs to 17.5 total staff on the evening shift, required at least 9 CNAs. -12/13/23 had 9.5 CNAs for 108 residents on the day shift, required at least 13 CNAs. -12/13/23 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. -12/14/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -12/15/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -12/16/23 had 12.5 CNAs for 108 residents on the day shift, required at least 13 CNAs. 6. For the week of Complaint staffing from 12/31/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 2 of 7 evening shifts as follows: -12/31/23 had 8 CNAs for 131 residents on the day shift, required at least 16 CNAs. -12/31/23 had 6 CNAs to 15 total staff on the evening shift, required at least 7 CNAs. -01/01/24 had 7 CNAs for 131 residents on the day shift, required at least 16 CNAs. -01/02/24 had 10 CNAs for 131 residents on the day shift, required at least 16 CNAs. -01/03/24 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs. -01/04/24 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs. -01/04/24 had 7 CNAs to 15.5 total staff on the evening shift, required at least 8 CNAs. -01/05/24 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs. -01/06/24 had 10 CNAs for 132 residents on the day shift, required at least 16 CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. For the 2 weeks of staffing prior to survey from 04/07/2024 to 04/20/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shift, deficient in total staff for residents on 1 of 14 evening shifts, deficient in CNAs to total staff on 10 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -04/07/24 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -04/07/24 had 5 CNAs to 12 total staff on the evening shift, required at least 6 CNAs. -04/08/24 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -04/08/24 had 11 total staff for 119 residents on the evening shift, required at least 12 total staff. -04/08/24 had 4 CNAs to 11 total staff on the evening shift, required at least 5 CNAs. -04/09/24 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -04/09/24 had 4.5 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. -04/10/24 had 9 CNAs for 119 residents on the day shift, required at least 15 CNAs. -04/10/24 had 4 CNAs to 13.5 total staff on the evening shift, required at least 7 CNAs. -04/11/24 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -04/11/24 had 5 CNAs to 12.5 total staff on the evening shift, required at least 6 CNAs. -04/12/24 had 9.5 CNAs for 116 residents on the day shift, required at least 14 CNAs. -04/13/24 had 7.5 CNAs for 116 residents on the day shift, required at least 14 CNAs. -04/13/24 had 5.5 CNAs to 15.5 total staff on the evening shift, required at least 7 CNAs. -04/14/24 had 6 CNAs for 116 residents on the day shift, required at least 14 CNAs. -04/14/24 had 4 CNAs to 13.5 total staff on the evening shift, required at least 7 CNAs. -04/15/24 had 10 CNAs for 116 residents on the day shift, required at least 14 CNAs. -04/15/24 had 5 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. -04/16/24 had 9 CNAs for 116 residents on the day shift, required at least 14 CNAs. -04/16/24 had 8.5 CNAs to 17.5 total staff on the evening shift, required at least 9 CNAs. -04/17/24 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-04/17/24 had 5.5 CNAs to 12.5 total staff on the evening shift, required at least 6 CNAs. -04/18/24 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. -04/19/24 had 13.5 CNAs for 118 residents on the day shift, required at least 15 CNAs. -04/20/24 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -04/20/24 had 7 total staff for 118 residents on the overnight shift, required at least 8 total staff. On 04/30/24 at 10:20 AM, the surveyor reviewed the policy titled, ADLs (Activities of Daily Living) with a revision date of 05/01/23. Under the section titled, Practice Standards, number five indicated that documentation of ADL care is recorded in the medical record and is reflective of the care provided by the nursing staff. ADL care will be documented in real time, as close to the time that the care was provided, and information obtained as possible. ADL care is documented every shift by the nursing assistant. On 04/30/24 at 12:10 PM, the surveyor interviewed CNA #1 (Certified Nursing Assistant) on the subacute unit. CNA#1 told the surveyor that the shower schedules were in the assignment book which included the days and shift for showers. CNA#1 said that the nurse or unit manger tells the CNA which showers were due for the day. On 05/01/24 at 11:11 AM, the surveyor interviewed CNA#4 of the Lighthouse Unit on the first floor. CNA #4 stated residents get showered twice weekly and if one shower was skipped, we would make sure the resident got the second shower later that week. On 05/01/24 at 11:21 AM, the surveyor interviewed CNA#3 on the second-floor unit at the facility. CNA#3 told surveyor that there are times when they are so short staffed that showers are not able to be completed. CNA#3 said she believes it happens on all shifts and if unable to give a shower she would offer a bed bath or a shower in the afternoon. On 05/01/24 at 11:30 AM, the surveyor reviewed the bathing task list for Resident #21 for the month of April. For the month of April, the task list was blank for the first 22 days indicating care was not rendered. The task was signed by staff for 4/23, 4/25, 4/26, and 4/29 by the CNA, indicating the resident had a bath and not a shower. The surveyor reviewed the bathing task list for Resident #94 for the month of April. The resident had received a bath six of the 30 days. It was documented that the resident received a bath and not a shower. The surveyor reviewed the bathing task list for Resident #84. The resident was scheduled for showers on Wednesday and Saturdays on day shift. For the month of April, the only shower documented as completed was on 4/20/24. The other scheduled days were left blank. The surveyor reviewed the bathing task list for Resident #122. The residents task list showed a shower schedule for Sundays and Thursdays on evening shifts. The resident was scheduled for 4/22/24, 4/25/24 and 4/29/24 and they were left blank as not completed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/24 at 12:28 PM during an interview with the Director of Nursing (DON) regarding documentation, the DON stated, If it's not documented it's not done. On 05/01/24 at 12:32 PM, when the DON was asked about staffing numbers for the CNAs she stated, I know we are not meeting the numbers. NJAC 8:39-25.2 (a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to: a) promptly record the removal of a controlled drug from inventory b) maintain accurate accountability of controlled substances within the medication administration carts c) maintain accurate accountability of all controlled medications within the automated medication dispensing system d) accurately document and complete DEA (Drug Enforcement Agency)-222 forms. This deficient practice was identified in 2 of 4 medication carts on 2 of 3 nursing units and for 12 of 12 DEA-22 forms reviewed. This deficient practice was evidenced by the following: 1. On [DATE] at 12:14 PM, the surveyor inspected the Low Hall Garden Unit medication cart with Registered Nurse (RN) #1. When the surveyor requested to inspect the controlled medications RN #1 stated, The count was going to be off (not accurate count) with the Oxycodone (a controlled medication used to treat moderate to severe pain) 5 milligram (mg) immediate release tablets. When the surveyor asked why, RN #1 stated that she felt nervous after she was observed during the medication pass by another surveyor earlier that morning and forgot to sign it out when the medication was removed from the medication cart at approximately 10:30 AM. The surveyor reviewed the declining inventory sheet (DIS) that was issued to Resident #523 and indicated that 24 tablets of Oxycodone Immediate Release 5 mg tablets remained, when only 23 tablets actually remained. RN #1 stated that she knew that she was supposed to sign the medication at the time that it was removed from the medication cart and prepared for administration. On [DATE] at 12:42 PM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM) #3 who stated a controlled medication such as Oxycodone should be signed out at the time of administration. RN/UM #3 stated that if a discrepancy were noted at shift change, it would be caught and addressed at that time. Review of Resident #523's active orders revealed an order dated [DATE], for Oxycodone HCL (hydrochloride) oral tablet 5 mg give one tablet by mouth two times a day for chronic generalized pain. Review of the resident's Medication Administration Record revealed that RN #1 documented that she administered the dosage of Oxycodone HCL oral tablet 5 mg to the resident on [DATE] at 9:00 AM. On [DATE] at 12:05 PM, the surveyor obtained a copy of Resident #523's DIS for Oxycodone Immediate Release 5 mg tablet and noted that on [DATE] at 12:00 PM, RN #1 signed the resident's 9 AM scheduled dose of Oxycodone Immediate Release 5 mg tablet as administered, rather than at 10:30 AM, as RN #1 previously stated at the time of the initial observation on [DATE] at 12:14 PM. On [DATE] at 12:38 PM, the surveyor interviewed the Director of Nursing (DON) who stated that when a controlled medication was pulled from the medication cart it must be signed for right away because it was a counted process and may cause the count to be off. DON further stated that if the resident stated that he/she had not received the medication, than the process could be ruined at that time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On [DATE] at 1:02 PM, the surveyor inspected Post Acute Unit (PACU) medication cart #3 with LPN #2. The surveyor reviewed the Shift Count form with LPN #2 who stated that the outgoing nurse must have forgotten to sign the form in the space allotted for Nurse's Signature Going Off Duty this morning. LPN #2 stated that both nurses were required to sign the shift count to indicate that they were both in agreement for the amount of controlled medications that remained in the cart at the time of cart transfer for accountability purposes. LPN #2 stated that if one person did not sign, and the count was wrong, then the person who signed took more responsibility as they failed to ensure the other person signed and agreed upon the count. On [DATE] at 1:33 PM, the surveyor interviewed RN/UM #1 who stated that nurses must sign out on the Shift Count form to ensure that the controlled medication count was right at shift change. RN/UM #1 stated that she checked the book monthly to ensure compliance. RN/UM #1 stated, The oncoming nurse should not accept the medication cart from the outgoing nurse if she did not sign the Shift Count sheet because it was sloppy. RN/UM #1 further stated, The narcotic (controlled substance) count could be wrong, and you know the importance of narcotics. On [DATE] at 1:33 PM, the surveyor interviewed the DON who stated that the oncoming nurse and outgoing nurse were supposed to sign that they received the medication cart in good faith, narcotics were checked, and they were taking the cart and everything was good. DON stated there would be a write up if a shift to shift were not done. DON further stated that they should sign every time a narcotic count was done. 3. On [DATE] at 10:50 AM, the surveyor inspected the Post-Acute Unit (PACU) medication room and the automated medication dispensing system with RN/UM #1 and Licensed Practical Nurse (LPN) #3. RN/UM #1 stated that the night shift and morning nurse counted the controlled medications within the automated medication dispensing system daily and signed the Shift Count book when completed. The surveyor reviewed the book and noted that the book was not routinely signed to indicate that the count was completed daily as described by RN/UM #1. The surveyor observed that the Shift Count was completed on the following dates: [DATE]: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. February 2024: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. [DATE]: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. [DATE]: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed at that time, RN/UM #1 stated that the automated medication system Shift Count was reviewed by the Unit Manager who was responsible to ensure that the controlled medication count was completed. RN/UM #1 stated if the Shift Count were not signed, then the count was not done. RN/UM #1 stated that the purpose of the count was to ensure that the medications were in sufficient quantity, were not expired and the count was right to prevent diversion. On [DATE] at 12:38 PM, the DON stated that the automated dispensing medication system count was done every morning by ,d+[DATE] nurse that she specifically assigned to do the count on the first cart, with the , d+[DATE] nurse going off on the first cart. DON stated that there were some newly hired nurses who may have missed the education related to the Shift Count. 4. On [DATE] at 12:38 PM, the surveyor interviewed the DON who stated that she worked at the facility for five years. The surveyor reviewed the DEA-222 forms with the DON and questioned why 12 out of 12 forms reviewed did not have Part 5: To be filled in by purchaser and indicated the number of controlled medications received and the date received from the supplier/pharmacy. DON stated that she was not trained to fill in the amount received and copied the previous DON's method of completion. On [DATE] at 10:31 AM, the surveyor interviewed the Pharmacist in Charge (PIC) who stated that on the back of the DEA-222 form it says Part 5 to be filled in on the copy of the original form, and they should keep a copy. On [DATE] at 10:30 AM, in the presence of the survey team, the Administrator was informed that the DEA-222 forms reviewed failed to have Part 5 filled in by the purchaser as required. Review of the Instructions for DEA Form 222 that were available on the back of the form were reviewed and revealed the following: .part 5. Controlled Substance Receipt: 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages furnished on each line item and the date shipped . Review of the facility policy, 6.0 General Dose Preparation and Medication Administration (Revision Date [DATE]) revealed the following: .Administer medications within timeframes specified by Facility policy or manufacturer's information Document the administration of controlled substances in accordance with Applicable Law; . Review of the facility policy, 5.4 Inventory Control of Controlled Substances (Revision Date [DATE]) revealed the following: .Facility should ensure that the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion (used for purposes not intended by prescriber) at the change of each shift or at least once daily and document the results on a Controlled Substance Count Verification/Shift Count Sheet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy, 5.5 Routine Reconciliation of Controlled Substances (Effective [DATE]) Facility should routinely reconcile controlled substance emergency medications in .Omnicells (automated medication dispensing system) .and comparing the count to the number of emergency doses supplied by the pharmacy to the number of recorded doses removed by facility staff from controlled substance emergency supply . Review of the facility policy, NSG 300 Controlled Drugs: Management of (Revision Date: [DATE]) revealed the following: .Ongoing inventory: A complete count of all Schedule II-IV controlled substances is required at change of shifts per state regulation or at any time in which narcotic keys are surrendered from one licensed nursing staff to another. The count must be performed by two licensed nurses and/or authorized nursing personnel, per state regulations . NJAC 8:,d+[DATE].7(c)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43936 Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to use appropriate infection control practices, specifically failing to adhere to the minimum time to lather hands during hand hygiene when providing wound care. The deficient practice was observed during wound care for 1 of 2 residents (Residents # 59) investigated for Pressure Ulcer/Injury. The deficient practice was evidenced by the following: A review of Resident # 59's Quarterly Minimum Data Set (MDS; an assessment tool) dated 01/22/2024 revealed that he/she had wounds. A review of Resident # 59's Electronic Medical Record (EMR) revealed under Orders to Cleanse Right heel with wound cleanser. Pat dry. Apply hydrogel fluffed gauze. Cover with ABD, wrap with kling [gauze-style bandage] every day shift for open wound for 14 Days AND as needed. The order was initiated on 04/25/2024. A review of Resident # 59's EMR revealed under Care Plan a focus that Resident # 59 has a documented pressure ulcer to the right heel. The focus was initiated on 04/24/2024. On 04/26/2024 at 10:38 AM, the surveyor obtained permission from Resident # 59 to observe his/her wound care. The wound care was performed by Licensed Practical Nurse (LPN) # 1. At this time, LPN # 1 applied disposable gloves and proceeded to remove the old dressing from Resident # 59's right heel. After that, LPN # 1 removed the disposable gloves. The surveyor observed LPN # 1 enter the resident room bathroom leaving the door open. The surveyor observed LPN # 1 turn on the faucet, apply hand soap from the dispenser, lather her hands and rinsed them in water. During this observation, the surveyor used the clock provided on the state-issued computer to determine the amount of seconds while LPN # 1 performed hand hygiene. The total hand hygiene process was 19 seconds. At that time, LPN # 1 applied a new pair of disposable gloves. LPN # 1 then proceeded to administer the hydrogel to 4x4 inch gauze, covered that with the ABD pad followed by wrapping the heel with kling. Afterwards, LPN # 1 removed the disposable gloves. The surveyor observed LPN # 1 enter the resident room bathroom leaving the door open. The surveyor observed LPN # 1 turn on the faucet, apply hand soap from the dispenser, lather her hands and rinsed them in water. During this observation, the surveyor used the clock provided on the state-issued computer to determine the amount of seconds while LPN # 1 performed hand hygiene. The total hand hygiene lathering process was 9 seconds. At that time, LPN # 1 applied a new pair of disposable gloves. LPN # 1 then proceeded to applied tape to the kling wrap. Afterwards, LPN # 1 removed the disposable gloves. The surveyor observed LPN # 1 enter the resident room bathroom leaving the door open. The surveyor observed LPN # 1 turn on the faucet, apply hand soap from the dispenser, lather her hands and rinsed them in water. During this observation, the surveyor used the clock provided on the state-issued computer to determine the amount of seconds while LPN # 1 performed hand hygiene. The total hand hygiene lathering process was 12 seconds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the same date at 10:46 AM during an interview with the surveyor, LPN # 1 replied, Yes when the surveyor asked if she felt like she lathered for twenty seconds. At that time, the surveyor asked LPN # 1 if the twenty seconds applied to lathering or the entire process. LPN # 1 replied, Lathering. Twenty seconds but it may take more time. On 05/01/2024 at 12:14 PM during an interview with the surveyor, the Director of Nursing replied, Twenty seconds when the surveyor asked how long should the lathering portion be during hand hygiene. A review of the facility provided policy titled, IC203 Hand Hygiene revised 05/01/23 revealed under, 2. Hand hygiene techniques: that, 2.1 To wash hands with soap and water: Wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously outside the stream of water for 20 seconds covering all surfaces of the hands and fingers . S 8:39-19.4 (a) 1