| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315347 | A. Building<br>B. Wing | 04/26/2024 |

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| Hamilton Place at the Pines at Whiting | 507 Route 530<br>Whiting, NJ 08759 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>33106<br><br>Based on interview, record review, and review of facility documents, it was determined that the facility failed to develop person-centered comprehensive care plans for 2 of 13 residents (Resident #34 and #38) reviewed.<br><br>This deficient practice was evidenced by the following:<br><br>1. According to the Face Sheet, Resident #34 was admitted to the facility with diagnoses which included, but were not limited to, paraplegia (paralysis), pressure ulcer and colostomy.<br><br>The admission Minimum Data Set (MDS), an assessment tool, dated 03/05/24, indicated that the resident had severe cognitive impairment and required maximum assistance with activities of daily living. The MDS also indicated that the resident received antidepressants, had an indwelling urinary catheter, and a colostomy (an operation that redirects your colon from its normal route, down toward the anus, to a new opening in your abdominal wall).<br><br>The surveyor reviewed the resident's electronic medical records (EMR) which revealed the following information:<br><br>The Physician Order Sheet (POS) dated 02/28/24 reflected a physician's order Trazadone 50 milligrams (mg) tablet by mouth, give at hours of sleep for trouble sleeping.<br><br>The psychiatric consult evaluation and Treat was ordered by the physician on 04/17/24 for Depression was currently pending.<br><br>On 04/23/24 at 09:49 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that the resident's psychiatric consult was pending, however the resident was on the schedule for the psychiatrist to evaluate the resident for the use of antidepressant medications.<br><br>The surveyor reviewed the resident's Care Plan (CP) which didn not include the use of antidepressant medication nor related interventions.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 04/23/24 at 01:27 PM, the surveyor interviewed the MDS Coordinator who stated that the initial CP was developed when the resident was admitted to the facility. She explained that by day 14 of admission, the CP was fully developed and updated continuously. She stated that psychotropic medications should be included on the CP due to risk factors of taking the medication and that behaviors associated with depression should be included in a separate CP with interventions to manage behaviors. She stated that the CP was important for goal development and risk factors. She stated that the CP directed resident care was developed by the interdisciplinary team. She continued to add that the family and resident was also involved in care planning process.<br><br>On 04/24/24 at 08:32 AM, the surveyor interviewed LPN #2 who stated that if a resident was on a psychotropic medication, it should be documented on the CP with interventions to include any behaviors and important for the team members to know that the resident was on this medications and to communicate to the staff how to manage the behaviors according to the interventions. LPN #2 reviewed Resident #34's CP and confirmed that there was no documentation that the resident was on antidepressant medications and there were also no behaviors or interventions documented on the CP.<br><br>On 04/24/24 at 08:36 AM, the surveyor interviewed the LPN acting Charge Nurse (LPN/CN) who stated that she had been employed in the facility for 6 years. The LPN/CN stated that the registered nurses (RNs) usually update the CP with any resident changes. She stated that the CP was interdisciplinary and was important so the staff knew what type of care the resident wanted and needed. She stated that the CP should include use of antidepressant medication and psychosocial wellbeing. She explained that the interventions should include interventions for depressive symptoms and emotional support and diversional activities and monitor their appetite. She stated that the family should also be involved in CP interventions. She confirmed that a CP was not developed for Resident #34 to include the use of antidepressant medications.<br><br>2. The surveyor further reviewed the Resident #34's EMR which revealed the following information:<br><br>Review of the POS, dated 02/27/24, reflected an order from the physician for a 16 french urinary catheter for retention. Further review of the POS reflected a physician's order for colostomy check every shift and empty as needed.<br><br>Review of the POS, dated 03/30/24, reflected that the resident required catheter care every shift.<br><br>The surveyor reviewed the resident's CP which did not include the resident's colostomy or indwelling urinary catheter.<br><br>On 04/24/24 at 09:49 AM, the surveyor interviewed the interim Director of Nursing (DON) who stated that a CP should have been developed with interventions for the colostomy and the indwelling urinary catheter. The DON stated that a CP was essential to address the resident needs and so that the staff knew what care the resident was to receive. She stated that the staff would be responsible to update that CP to address all the resident's needs and should be comprehensive for all residents.<br><br>41260<br><br>3. According to the Detailed Summary, Resident #38 had diagnoses which included, but were not limited to, urinary tract infection.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 03/07/24, included the resident had Brief Interview for Mental Status score of 08, which indicated the resident's cognition was moderately impaired. Further review of the MDS included the resident was frequently incontinent of urine.<br><br>Review of the admission progress note, dated 02/29/24 at 6:01 PM, included the resident was taught to increase fluid intake due to being on an antibiotic for a urinary tract infection (UTI).<br><br>Further review of a progress note, dated 02/29/24 at 8:07 PM, included the resident was incontinent of urine.<br><br>Review of the care plan, dated 03/26/24, did not include the resident was incontinent of urine with a history of UTI nor related interventions.<br><br>During an interview with the surveyor on 04/24/24 at 9:45 AM, the Certified Nursing Assistant, (CNA), stated that she performed incontinence rounds every two hours or as needed in order to prevent UTIs and skin breakdown. She further stated that Resident #28 wore incontinence briefs for periods of incontinence.<br><br>During an interview with the surveyor on 04/24/24 at 9:50 AM, the Licensed Practical Nurse (LPN #3) stated incontinent residents were changed twice a shift and as needed to prevent UTIs and skin breakdown. She further stated that the Charge Nurse was responsible for initiating care plans and that it was important for the care plan to be comprehensive for proper care of the resident.<br><br>During an interview with the surveyor on 04/24/24 at 10:00 AM, the LPN/Charge Nurse (LPN/CN) stated incontinent residents were changed every two hours and as needed. The LPN/CN further stated that the interdisciplinary team initiated the care plan upon admission so staff know how to care for the resident.<br><br>During an interview with the surveyor on 04/24/24 at 10:07 AM, the Director of Nursing (DON) stated interventions to prevent UTIs included offering fluids. The DON further stated the admission nurse initiated the resident care plans within 24 hours and the comprehensive care plan was completed within 14 days of admission. The DON added that it was important that the resident's care plan was comprehensive because it is available to all those involved in the care of the resident, and, the care plan is an overview of the resident's needs.<br><br>Review of the facility's Comprehensive Care Plans policy, dated 01/09/24, included, The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment, and, The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.<br><br>NJAC8:39-11.2 (f) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>43308<br><br>Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to obtain a physician's order for oxygen therapy and develop a care plan for respiratory care. This deficient practice was identified for 1 of 1 resident (Resident #43) reviewed for respiratory care.<br><br>This deficient practice was evidenced by the following:<br><br>On 04/22/24 at 07:37 AM, during the initial tour the surveyor observed Resident #43 lying in bed sleeping receiving oxygen (O2) via nasal cannula.<br><br>On 04/23/24 at 11:01 AM, the surveyor observed Resident #43 lying in bed watching TV. At that time, the surveyor interviewed the resident who stated that she received oxygen three (3) liters/minute (3 L/M) via nasal cannula and that the staff change the tubing but was not sure how often it was changed.<br><br>The surveyor reviewed the medical record for Resident #43.<br><br>A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included chronic obstructive pulmonary disease with (acute) exacerbation (COPD- airway blockage with breathing related problems and worsening respiratory symptoms such as shortness of breath -SOB), pneumonia, and dependence on supplemental oxygen.<br><br>A review of the significant change in status Minimum Data Sheet (MDS), an assessment tool, dated 4/12/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. A further review of the MDS in Section O: Special Treatments, Procedures and Programs reflected the resident received continuous oxygen therapy.<br><br>A review of the April 2024 physician's orders (PO) did not include any orders for oxygen therapy.<br><br>A review of the discontinued PO indicated, as of 3/21/24, the following orders were discontinued:<br><br>-Change and date humidifier bottle every Tuesday night.<br><br>-Change and date O2 nasal cannula/mask (tubing from humidifier bottle to resident) every Tuesday night.<br><br>-Oxygen 2 liters/minute (L/M) via nasal cannula continuously; SOB.<br><br>A review of the individualized Care Plan revealed there was no developed care plan for respiratory care.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 04/23/24 at 01:00 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated they had POs for oxygen to ensure they administered the appropriated amount of oxygen. She further stated they checked every shift to ensure the L/M matched the order. The LPN stated that the tubing was changed during the 11 PM to 7 AM shift and that she never had to change it but believed the tubing was changed every 72 hours. The LPN stated that there were POs in the electronic medical record (EMR) for the tubing to be changed, for how many L/M, and if continuous or PRN (as needed). The LPN emphasized there should be an order for O2 prior to administering to ensure the resident was properly assessed. When asked if respiratory care should be on the care plan, the LPN stated that most of the time it would be on the care plan. She further stated that when she completed her new admissions, she updated the care plan to reflect if the oxygen was continuous, PRN, and how many L/M. The LPN stated that the care plan was important so that staff was aware on how to care for the resident.<br><br>On 04/23/24 at 01:10 PM, the surveyor interviewed the Registered Nursed (RN) who stated that everyone who received oxygen had an order for it. She further stated that oxygen should also be on the care plan. The RN stated that the Charge Nurse (CN) was responsible for entering the POs in the EMR. She stated that the importance of an order was so it could be administered. The RN emphasized, you can't administer oxygen without an order. She further stated that the order also indicated how many liters the oxygen should be set to and if it was continuous or PRN. The RN stated that the CN or the MDS Coordinator was responsible for updating the care plan. She stated that the care plan tells the resident's plan of care, interventions, and goals for that specific resident. The RN concluded that there should be a PO for oxygen and that it should be on the care plan so everyone knew what to do.<br><br>On 04/24/24 at 11:29 AM, the surveyor conducted a follow up interview with the RN who showed the surveyor the Low Side Census Nurse's Flow Sheet which indicated Resident #43 was on oxygen. She stated that the flow sheet did not indicate the number of liters because it could change. The RN reviewed the orders in the EMR with the surveyor which revealed that all the oxygen orders were entered as new and to start that day 4/24/24.<br><br>On 04/24/24 at 11:48 AM, the surveyor interviewed the Licensed Practical Nurse/Charge Nurse (LPN/CN) who stated that one of the nurses had just entered the oxygen orders to start today. The LPN/CN stated that she reviewed the PO as well as another nurse, but they could not find any oxygen orders. When asked if there should be orders for oxygen, the LPN/CN stated, absolutely there should be an order for oxygen. She further stated that it was important to have orders, so everyone was aware that the resident was on oxygen. The LPN/CN stated, I'm just disappointed. She explained the resident was sent out to the emergency room in March and was on oxygen then and returned to the facility 04/05/24 on oxygen. She further explained that everything should be checked on the 11 PM to 7 AM shift to ensure that all the orders were entered. Upon further review, the LPN/CN stated that the order did not indicate how many L/M and stated that the order would have to updated to include the number of L/M.<br><br>On 04/24/24 at 11:56 AM, the LPN/CN and surveyor reviewed the Care plan in the EMR. The LPN/CN stated she did not see anything related to respiratory care. She stated that the care plan told the story of the resident, why they were there, what care should be provided and what they were at risk for. She further stated that all departments such as nursing, dietary, therapy, and activities could update the care plan because everyone was involved in the care. The LPN/CN acknowledged that oxygen should be on the care plan that there should have been POs for oxygen prior to surveyor inquiry.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 04/24/24 at 12:05 PM, the surveyor interviewed the Interim Director of Nursing (DON) who confirmed that the resident did not have any oxygen orders prior to surveyor inquiry. The Interim DON stated, of course the resident should have orders for oxygen. She stated they completed an audit on oxygen and care plans last week. She further stated that the resident slipped through the cracks. She acknowledged the nurses entered the orders today 4/24/24 for changing the oxygen tubing and the continuous oxygen 2 L/M via nasal cannula. She explained it should be in the EMR and the nurses should be signing it off.<br><br>On 04/24/24 at 12:13 PM, the surveyor continued to interview the Interim DON who stated that a care plan addressed specific problems that the resident may have or the potential problems as well as interventions put into place to resolve those problems. She explained for example Respiratory care is the problem, and the intervention would be oxygen which should be on the care plan. The Interim DON stated that the care plan should be implemented on admission and updated whenever there was a change. The DON acknowledged the orders and care plan should have been updated prior to surveyor inquiry.<br><br>On 04/26/24 at 09:14 AM, the Licensed Nursing Home Administrator (LNHA) acknowledged in the presence of the Interim DON, the Director of Plant Operations, and the survey team that the care plan and the orders should have been updated prior to surveyor inquiry.<br><br>A review of the facility's Oxygen Administration policy, dated reviewed 12/23/2019, included, A practitioner's order is required to initiate oxygen, except in an emergency situation, when oxygen therapy is ordered an order will also be entered to change all disposable components weekly.<br><br>A review of the facility's Comprehensive Care Plans policy dated revised 1/9/24, included, to develop and implement a comprehensive person-centered care plan for each resident .to meet a resident's medical, nursing .needs that are identified in the resident's comprehensive assessment.<br><br>A review of the facility's Care Plans - Updating for Status Change policy dated revised 1/9/24, included, 1. The comprehensive care plan will be reviewed, and revised or updated as necessary, when a resident experiences a status change. 2. C. The care plan will be updated with the new or modified interventions accordingly. F. The Charge Nurse/Nurse designee and, or other team member who updated the care plan will coordinate that all care plan intervention updates are communicated to team members involved in the resident's care.<br><br>NJAC 8:39- 19.4(a); 27.1(a) |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observe each nurse aide's job performance and give regular training.<br><br>41072<br><br>Based on interview and record review, it was determined that the facility failed to evaluate the performance of all Certified Nursing Assistants (CNAs) on an annual basis. This deficient practice occurred with 2 of the 5 CNAs whose personnel records were reviewed and was evidenced by the following:<br><br>On 04/24/2024 at 10:48 AM, the surveyor reviewed the employee files of 5 randomly selected CNAs which were provided by the facility. The surveyor identified the following:<br><br>CNA #1 had a hire date of 02/20/19. According to CNA #1's personnel record, the last documented performance appraisal was 05/27/22. There were no annual performance reviews conducted within the past year.<br><br>CNA #2 had a hire date of 07/26/21. According to CNA #2's personnel record, the last documented performance appraisal was 12/16/22. There were no annual performance reviews conducted within the past year.<br><br>During an interview with the surveyor on 04/24/24 at 12:05 PM, the Licensed Nursing Home Administrator (LNHA) stated she had been employed at the facility for the last four months. The LNHA stated that performance appraisals should be done annually. The surveyor then showed the LNHA the personnel records of CNA #1 and CNA #2 and confirmed that their performance appraisals were not completed annually.<br><br>During a follow up interview with the surveyor on 04/25/2024 at 10:02 PM, the LNHA stated that the Director of Nursing (DON) was responsible for performance appraisals and the Human Resource (HR) Manager was responsible to send a list of performance appraisals that were due to the DON.<br><br>During an interview with the surveyor on 04/25/24 at 10:10 AM, the HR manager stated that the performance appraisals should be completed on the anniversary date of the date of hire. The HR Manager stated he had sent the prior DON several email reminders to complete the performance appraisals.<br><br>A review of the facility policy titled, Performance Appraisal, undated, indicated that a performance appraisal measures and evaluates an individual team member's performance and accomplishments over a period of time. Typically, supervisors will complete performance appraisals as follows: a) at the end of the orientation period, b) annually, and c) when considering a team member for promotion. The policy further revealed that a performance appraisal system should be on-going, and in no case should evaluations be given less than once a year.<br><br>NJAC 8:39-43.17(b) |

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| F 0836<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43308<br><br>Based on interview and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in the facility's name in accordance with 42 CFR (Code of Federal Regulations) 424.516.<br><br>This deficient practice was evidenced by the following:<br><br>According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program:<br><br>(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements:<br><br>(1) Compliance with title XVIII of the Act and applicable Medicare regulations.<br><br>(2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare.<br><br>(3) Not employing or contracting with individuals or entities that meet either of the following conditions:<br><br>(i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act.<br><br>(ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76<br><br>(d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:<br><br>(1) Within 30 days -<br><br>(i) A change of ownership;<br><br>(ii) Any adverse legal action; or<br><br>(iii) A change in practice location.<br><br>(continued on next page) |

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| F 0836<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | (2) All other changes in enrollment must be reported within 90 days.<br><br>On [DATE] at 9:00 AM, the surveyor reviewed the facility's Long-Term Care Facility Application for Medicare and Medicaid (form CMS-671) which reflected under name of facility as Skilled Nursing Home at Pines Village. At that time, the surveyor requested additional information and the Licensed Nursing Home Administrator (LNHA) provided the New Jersey Department of Health (NJDOH) Division of Certificate of Need & Licensing documents which indicated Skilled Nursing at Pines Village; Effective: [DATE]; Expired [DATE], and Issued: [DATE]. The LNHA stated that she knew it used to be named [NAME] Place at the Pines at [NAME] prior to the name change.<br><br>On [DATE] at 9:52AM, the LNHA stated she started at the facility four (4) months ago and to her knowledge the facility was named Skilled Nursing at Pines Village. She stated in her files she had where an application was submitted but needed to look for the approval letter. At that time, the LNHA provided a letter which indicated the NJDOH confirmed they were in receipt of the documents reflecting [DATE] as the completion date for the final transfer of ownership of [NAME] Place at the Pines at [NAME]. It further included the new facility name was Skilled Nursing at Pines Village and that the transfer of ownership approval was in transaction. The surveyor asked if there was any additional information of the approval from CMS and not just from the NJDOH and the LNHA stated she would continue to look it in her files.<br><br>On [DATE] at 10:23 AM, the surveyor inquired if the Medicare Enrollment Application for institutional Providers application (form CMS 855A) was completed and submitted and the LNHA stated she would have to find out.<br><br>On [DATE] at 12:51 PM, the surveyor followed back up with the LNHA who stated that she was still waiting to hear back from the corporate office regarding the licensing.<br><br>On [DATE] at 09:54 AM, the LNHA confirmed that the CMS 855A application was not submitted. She stated that the business office was in the process of completing it today [DATE]. The LNHA acknowledged that the CMS 855A application should have been done prior to surveyor inquiry.<br><br>On [DATE] at 09:06 AM, the LNHA provided an email from the business office that the Medicare Enrollment Application was submitted on [DATE].<br><br>On [DATE] at 09:14 AM, the LNHA acknowledged in the presence of the Interim Director of Nursing, the Director of Plant Operation, and the survey team that the application should have been completed and received approval from CMS prior to the name change.<br><br>A review of the facility's Name Change for the Entity policy, dated [DATE], included, Notify the state in which your business operated and any other agencies. File the official name change with the IRS [Internal Revenue Service]. Update permits and licenses with regulatory agencies.<br><br>NJAC 8:,d+[DATE].1 (a) |