STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315359	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alliance Care Rehabilitation and Nursing Center	155 40th Street Irvington, NJ 07111

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20940 Based on record review, interview, and policy review, the facility failed to provide three of three residents (Residents (R)77, R268 and R54) a Centers for Medicare and Medicaid Services (CMS) for Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) when they completed their Medicare A therapy services. This failure to provide the CMS for SNF ABN prevented the resident from knowing they had days remaining under Medicare A. Findings include: Review of the facility's policy titled Policy, Procedures and Information last reviewed 07/06/24, Policy: Medicare will only pay for services which are determined to be no longer meet skilled nursing or rehab need. The facility's policy fails to direct staff to complete the Skilled Nursing Facility Advanced Beneficiary Notice Centers for Medicare and Medicaid (CMS) form 10055 for residents at the anticipated end of their Medicare covered stay. 1.Review of the electronic medical record (EMR), under the census tab, for R77 revealed an admitted [DATE] with physician orders for skilled services including physical and/or occupational therapy. On 09/05/24, the facility determined that Medicare may longer pay for skilled services and issued R77 a Notice of Medicare Non-Coverage but failed to issue the CMS Form 10055. 2. Review of the EMR, under the census tab, revealed R268 was admitted on [DATE] with physician orders for skilled services for physical and/or occupational therapy. The facility determined R268 may no longer qualify for Medicare covered services as of 07/29/24 and issued R268 the Notice of Medicare Non-Coverage but failed to issue the CMS Form 10055. 3. Review of the EMR, under the census tab, revealed R77 was admitted on [DATE] with physician orders for skilled services including physical and/or occupational therapy. The facility determined R77 may no longer qualify for Medicare covered services as of 08/29/24 and issues R77 the Notice of Medicare Non-Coverage but failed to issue the CMS Form 10055. Interview with the Social Services Director on 10/17/24 at 1:00 PM confirmed the facility failed to issue the CMS Form 10055 when the facility determines resident may no long qualify for Medicare covered services. NJAC 8:39-5.4(b)(c)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46592 Based upon record review, interviews, and review of facility policy, the facility failed to prevent resident-to-resident abuse on 03/24/23 when Resident (R)54 pushed and hit R411 in the back. This deficiency has the potential to facilitate future resident-to-resident physical altercations resulting in serious injury or serious physical or psychosocial impairment. Findings include: 1. Review of the Census tab located in the electronic medical record (EMR) revealed R411 was admitted to the facility on [DATE]. Review of the Med Diag [Medical Diagnoses] tab located in the EMR revealed R411 had diagnoses including dementia, bipolar disorder, and dementia with agitation. Review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/13/23 and located in the EMR revealed R411 had a Brief Interview for Mental Status (BIMS) score of six out of 10 indicating severe cognitive impairment. R411 exhibited no behaviors as indicated in Section E. Review of the Care Plan (CP) located in the EMR revealed R411 had a concern related to dementia initiated on 07/14/22 with interventions including administering medications and cueing, reorienting, and supervising R411 as needed. 2. Review of the Census tab located in the EMR revealed R54 was admitted to the facility on [DATE]. Review of the Med Diag tab located in the EMR revealed R54 had diagnoses including end-stage renal disease, vascular dementia, and previous stroke. Review of the quarterly MDS located in the EMR revealed R54 had a BIMS score of 13 out of 15 indicating no cognitive decline. R54 did not exhibit any behaviors as indicated in Section E. Review of a Reportable Event Record/Report dated 03/27/23 and supplied by the Director of Nursing (DON), revealed staff had reported to them on 03/25/23 at around 1pm that on 03/24/23 at around 7pm R411 had been hit by another resident. The facility informed the appropriate authorities, reported the incident within the correct timeframe, and performed an investigation, although not a complete investigation. The facility questioned R54 at which time he admitted to pushing R411to get R41] out of his [R54] room and hitting R411 on the back. R54 stated he did not report anything to staff because R411 left the area. The facility educated R54 on reporting issues. X-rays were taken of R411 showing no injury. Review of R54's CP located in the EMR revealed a concern initiated on 03/25/23 related to R54 having the potential to become physically aggressive related to dementia/anger with interventions including anticipating needs and monitoring/documenting/reporting any signs of posing a danger to himself or others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R411's CP revealed a concern related to being at risk of victimization initiated on 03/25/23 with interventions including monitoring behaviors, monitoring interactions with other residents, and intervening when needed. Review of the Alliance Incident List provided by the DON revealed R54 had not been involved in a resident-to-resident incident since 03/24/23. Review of the Abuse, Mistreatment, Neglect, Misappropriation of Resident's Property - Policy, Procedure, and Information reviewed 01/11/24 and supplied by the DON revealed the facility, .shall provide the residents with considerate and respectful care designed to promote the resident's independence and dignity. Each resident has the right to be free of abuse, mistreatment, neglect, and misappropriation of property. This includes the identification of residents and the development of intervention strategies to prevent occurrence, monitoring changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis. Additionally, the facility shall ensure the screening and training of employees, protection of residents, and for the prevention, identification, investigation, and reporting of abuse, mistreatment, neglect, and misappropriation of property. The Purpose of the policy was to ensure that all residents are protected from abuse of any kind by anyone. NJAC 8:39-4.1(a)(5)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09262 Based on interview, record review, and facility policy review, the facility failed to thoroughly investigate resident-to-resident abuse incidents for three residents (Residents (R)54, R210, and R411) reviewed for abuse out of a sample size of 31. This failure has the potential for further resident-to-resident abuse occurring and not being investigated so interventions can be put in place. Refer to F600 Findings include: 1. Review of the Census tab located in the electronic medical record (EMR) revealed Resident (R)411 was admitted to the facility on [DATE]. Review of the Med Diag [Medical Diagnoses] tab located in the EMR revealed R411 had diagnoses including dementia, bipolar disorder, and dementia with agitation. Review of the Census tab located in the EMR revealed R54 was admitted to the facility on [DATE].Review of the Med Diag tab located in the EMR revealed R54 had diagnoses including end-stage renal disease, vascular dementia, and previous stroke. Review of a Reportable Event Record/Report dated 03/27/23 and supplied by the Director of Nursing (DON) revealed staff had reported to them on 03/25/23 at around 1pm that on 03/24/23 at around 7pm R411 had been hit by another resident. The facility informed the appropriate authorities, reported the incident within the correct timeframe, and performed an investigation The facility questioned R54 at which time he admitted to pushing R411to get him [R411] out of his [R54] room and hitting him [R411] on the back. R54 stated he did not report anything to staff because R411 left the area. The facility educated R54 on reporting issues. X-rays were taken of R411 showing no injury. The facility investigation indicated the DON, law enforcement, the family, and the physician were notified. Skin checks and care plan updates were completed. The investigation stated staff education related to abuse/timeline abuse allegation was completed. The facility investigation did not contain staff education or resident interviews aside from R54 and R411. Review of the Alliance Incident List provided by the DON revealed R54 had not been involved in a resident-to-resident incident since 03/24/23. In an interview on 10/17/24 at 11:30 AM the DON stated the only investigation information related to the R54 and R411 incident was in the file supplied. The DON stated she started earlier this year, inherited the reported event, and has no more information to provide. She verified the investigation did not contain staff interviews, resident interviews, or staff education related to R54 hitting R411 in the back. 2. Review of R210's electronic medical record (EMR) revealed per the Census tab resident was admitted on [DATE] and discharged on [DATE]. Review of the facility's Incident list provided by the Regional Nurse indicated on 03/08/24 at 4:00PM, R210 was identified on the document with allegation of abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigative file provided by the Regional Nurse on 10/17/24 at 11:58 AM, contained a narrative that indicated that the alleged physical abuse occurred on 03/08/24 at approximately 3:00PM, in which R210 stated that the previous Social Service Director (SSD) pushed R210 out of his wheelchair and twisted his arm. The narrative indicated, Social Worker served patient with discharge notice. He became agitated and started screaming at her that he was not going to leave. Resident stood in between the elevator doors and continued to scream at staff members. Social worker was about eight feet from him and never made physical contact with the patient. The narrative contained a witness statement from the Director of Rehab who stated, . previous SSD was six to eight feet away from R210 and the previous SSD did not touch resident. The narrative indicated that Licensed Practical Nurse (LPN)1 witnessed the incident but the narrative nor the investigative file contained LPN1's statement. The investigative file did not include a statement from the previous SSD. Interview with the Regional Nurse on 10/17/24 11:58 AM, she confirmed that everything that was in the investigative file was all the information she could find for this allegation of abuse investigation. Review of the facility's policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident's Property dated 01/11/24 indicated, .Section V-Investigation 17. Upon receipt of the resident's accident/incident report .The investigation shall include a. statement from all parties involved including but limited to the resident involved, family members and other residents and staff . 46592 NJAC 8:39-9.4(f)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 42440 Based on observation, record review, interview, and facility policy review, the facility failed to ensure a resident was appropriately positioned with head elevated while receiving nutrition through a feeding tube for one of one resident (Resident (R) 91) reviewed for tube feeding out of a sample of 31 residents. The lack of head elevation could result in aspiration. Findings include: Review of the facility's policy titled, Tube Feeding Policy, last reviewed 05/10/24, revealed, All resident [sic] to remain in Semi-Fowler's position [head of the bed elevated between 30 degrees and 45 degrees] during the feeding and for one hour following the feeding to prevent aspiration. Review of R91's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/25/24 and located in the MDS tab of the electronic medical record (EMR), revealed the resident was unable to complete a Brief Interview for Mental Status (BIMS), and the staff assessment for cognition indicated severely impaired cognition. R91 had a gastrostomy tube and received over half of his nutrition through tube feeding. Review of R91's Care Plan, located in the Care Plan tab of the EMR, revealed a focus area, revised 08/08/24, [R91] is NPO [nothing by mouth] and dependent on PEG [feeding tube] as his sole source of nutrition/hydration. Further review of the Care Plan revealed interventions head of bed elevated to 30-45 degrees unless providing care or resident request, revised on 03/01/23 and [R91] needs the HOB [head of the bed] 45 degrees during and thirty minutes after tube feed, revised on 05/29/23. Review of R91's Order Summary Report, located in the Orders tab of the EMR revealed an order, dated 09/27/24, for enteral feeding to run at 90 milliliters (ml) per hour with total volume infused of 1620 ml in 24 hours. Further review revealed an order, dated 09/27/24, to elevate the head of the bed 30 to 45 degrees every shift. During an observation on 10/14/24 at 11:19 AM, R91 laid in bed with the head of the bed elevated less than 30 degrees and the enteral feeding running at 90 ml per hour. During an observation on 10/15/24 at 11:00 AM, R91 laid in bed, on his left side, positioned low in bed so that the head of the bed, which was elevated less than 30 degrees, did not elevate his head. The enteral feeding was running at 90 ml per hour. During an observation on 10/15/24 at 4:21 PM, R91 laid flat in bed on his back without the head of the bed elevated. The enteral feeding was running at 90 ml per hour. During an observation on 10/16/24 at 8:18 AM, R91 laid flat in bed on his back, positioned slightly down in the bed with the head of the bed elevated less than 30 degrees. The enteral feeding was running at 90 ml per hour. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/16/24 at 9:02 AM, Certified Nursing Assistant (CNA) 6 completed cares, with the tube feeding paused, and then positioned R91 with the head of the bed elevated less than 30 degrees. During a concurrent interview on 10/16/24 at 9:02 AM, CNA6 stated if the head of the bed was up, R91 was more likely to fall off the bed. During an interview on 10/16/24 at 9:06 AM, Charge Nurse (CN) 2 stated the head of the bed should be at 45 degrees and raised the head of the bed. During an interview on 10/16/24 at 10:50 AM, Licensed Practical Nurse (LPN) Supervisor stated she noticed R91 lying in bed the day prior without the head of the bed raised appropriately and had raised it. LPN Supervisor stated staff were to keep the head of the bed elevated at least 30 degrees, unless they paused the feeding for cares or another reason. During an interview on 10/16/24 at 5:30 PM with the Director of Nursing (DON), the DON stated she expected staff to follow the standard practice of elevating the head of the bed to 30 degrees or greater when a tube feeding was running, to prevent aspiration. NJAC 8:39-27.1(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42440 Based on observation, record review, interview, and facility policy review, the facility failed to have medications available to administer as ordered, document why the medications were not given, and maintain accessible records for a controlled medication for three of seven residents (Resident (R) 141, R261, and R366) reviewed for medication administration or pain. This had the potential to result in adverse health outcomes. Findings include: 1. Review of R366's Admission Record under the electronic medical record (EMR) Profile tab revealed she was admitted to the facility on [DATE]. R366 had diagnoses which included failure to thrive. Review of R366's Order Summary Report, located in the Orders tab of the EMR revealed orders which included: -magnesium oxide 400mg 1 tablet twice daily as a supplement, ordered 10/08/24, and -dronabinol 2.5mg twice daily for appetite stimulant, ordered 10/08/24 Review of R366's Medication Administration Record (MAR), located in Orders tab of the EMR, revealed the dronabinol and magnesium oxide were scheduled for 9:00 AM and 5:00 PM. During an interview on 10/15/24 at 4:35 PM, R366 stated she was hungry and had no nausea. During an observation on 10/16/24 at 9:10 AM, Charge Nurse (CN) 3 administered morning medications to R366. CN3 did not administer R366's dronabinol or magnesium oxide. During an interview on 10/16/24 at 9:20 AM, CN3 stated the facility was waiting for the pharmacy to send the dronabinol. It needed a script, which sometimes took a couple of days to get. In addition, CN3 stated the medication cart had no magnesium oxide in it. She had just used the last one and needed to check other carts for a bottle. Further review of R366's MAR on 10/16/24 at 10:00 AM revealed that since she admitted to the facility on [DATE], nursing had documented the administration of dronabinol with a chart code 9 which referred the reviewer to other/see progress notes. Review of R366's Progress Notes under the Prog Notes tab of the EMR revealed the following documentation regarding the dronabinol: -on 10/10/24 at 8:50 AM reschedule -on 10/12/24 at 9:51 AM on order -on 10/12/24 at 6:45 PM on order (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on 10/14/24 at 8:56 AM on resident -on 10/15/24 at 10:13 PM reschedule In addition, on 10/09/24, 10/11/24, and 10/13/24, staff documented on order with no specific medication mentioned. During a follow-up interview on 10/16/24 at 10:31 AM, CN3 reported she had not located any magnesium but would order it. She stated the nurse who admitted R366 may have checked for a script for the dronabinol. CN3 stated she planned to follow up with her supervisor and/or the nurse practitioner regarding the medication. During an interview on 10/16/24 at 10:40 AM, Licensed Practical Nurse (LPN) Supervisor stated if a medication required a script and was not available, the nurse should address it. If unable to address it, it should be endorsed to the next shift or passed through to the supervisor. LPN Supervisor was unaware that the dronabinol for R366 had not arrived. LPN Supervisor stated she had instructed the person who stocks medications that they needed magnesium oxide for R366. 2. Review of R141's Admission Record under the EMR Profile tab revealed he was admitted to the facility on [DATE]. R141 had diagnoses which included encounter for surgical aftercare following surgery on the digestive system and encounter for attention to colostomy. Review of R141's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/20/24 and located in the MDS tab of the EMR, revealed R141 scored a 12 out of 15 on his Brief Interview of Mental Status (BIMS), which indicated moderately impaired cognition. R141 reported rare, mild pain. During an observation and interview on 10/14/24 at 12:47 PM, R141 grimaced when he moved from a lying to sitting position in bed. R141 reported pain and pulled up his shirt to show a colostomy bag intact to his left abdominal area. He pointed to his colostomy area and reported pain for three months but could not state what helped the pain. Review of R141's Order Summary Report located under the Orders tab of the EMR revealed R141 had two orders, dated 07/15/24, for lidocaine patches. One order was for application to the left rib and one was for application to the right rib, both at 9:00 AM with removal at 9:00 PM. Review of R141's Care Plan, located in the Care Plan tab of the EMR, revealed no focus area on pain or any mention of rib area pain or interventions. During an observation and interview on 10/14/24 at 3:53 PM, R141 again lifted the left side of his shirt, when asked if he had a lidocaine patch placed. R141 stated sometimes he had a lidocaine patch on but not now on either side. No lidocaine patch was observed to the left side. R141 did not show his right side. During an observation and interview on 10/16/24 at 1:00 PM, R141 laid on his right side in bed and reported pain as sometimes but not now. R141 stated he had no patch on his left side and pulled up his shirt to reveal no lidocaine patch. He did not move to show his right side. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R141's October MAR located in the Orders tab of the EMR, revealed nurses had initialed the lidocaine patch to the left side as administered both 10/14/24 and 10/16/24 at 9:00 AM. During an interview on 10/16/24 at 1:05 PM, CN3 stated she put a lidocaine patch on the right side but did not have one available to put on the left side. She needed to re-order the patches.CN4 confirm she should not have initialed the patch as being administered. 3. Review of R261's Admission Record under the EMR Profile tab revealed she was admitted to the facility on [DATE] and discharged on [DATE]. She had diagnoses which included malignant neoplasm of cervix, pain in right lower leg, chronic embolism and thrombosis of left popliteal vein, and pain in left lower leg. Review of R261's admission MDS, with an ARD of 01/30/24 and located in the MDS tab of the EMR, revealed R261 scored a 15 out of 15 on her BIMS, which indicated intact cognition. R261 reported occasional pain, rated as nine, at its worst, on a zero to ten scale, with ten being the worst pain possible. R261 reported the pain did not, or seldom, affected sleep, therapy, or day-to-day activities. She received scheduled and prn pain medications, to include opioids. Review of R261's January, February, and March MARs, located under the Orders tab of the EMR revealed she had orders for a fentanyl patch 100mcg/hr to be applied every three days for pain. Further review revealed on 01/30/24, 02/03/24, and 03/01/24, nursing documented the administration of the patch with a chart code 9 which referred the reviewer to other/see progress notes. On 02/09/24, the patch was documented as on hold, and on 02/12/24 and 02/18/24 the fentanyl patch was not signed off as administered. On 02/27/24 and 03/13/24, nursing documented R261 refused the patch. Review of R261's Progress Notes located under the Prog Notes tab of the EMR revealed an entry on 01/31/24 of awaiting for pharmacy to deliver, med faxed and called. There was no documentation about why the fentanyl patch was on hold on 02/09/24, why it was not signed off on 02/12/24 or 02/18/24, or why the resident refused it on 02/27/24 and 03/13/24. The facility was unable to provide controlled substance administration records for fentanyl patches prior to 03/15/24. During an interview on 10/16/24 at 8:30, CN2 stated if a medication was not available, nurses notified the doctor and got an order to hold the medication or replace it with a different medication until it arrived from pharmacy. Pharmacy sent medications stat if needed, and the facility had a pyxis (emergency supply) of many narcotics as well as other medications. During an interview on 10/16/24 at 9:41 AM, Registered Nurse (RN) Supervisor stated a nurse practitioner, who provided scripts, was in the facility Monday through Friday and was available by phone as well. If a medication was not available, staff called the provider to see if the provider wanted to order an alternative medication. During an interview with the Director of Nursing (DON) on 10/16/24 at 5:30 PM, the DON stated she expected nurses to tell the unit manager and/or her when medications had not arrived from the pharmacy. R366 should not have gone eight days without her dronabinol. After the observed medication pass, the facility had called the pharmacy and clarified the medication was on backorder from the manufacturer. The facility notified the physician, who ordered an alternate medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 12:09 PM CN6 stated the R261 had a lot of pain but was able to make her needs known and ask for pain medication. CN6 did not recall not having fentanyl patches available. NJAC 8:39-29.3(5) NJAC 8:39-29.6(a)

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	315359	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alliance Care Rehabilitation and Nursing Center	155 40th Street Irvington, NJ 07111

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, record review, interview, and facility policy review, the facility failed to ensure a medication error rate of less than five percent during observation of medication administration. The facility had three errors in twenty-five opportunities, which resulted in a 12 percent error rate. This affected one (Resident (R) 366) out of four residents observed. Medication errors have the potential to result in adverse health outcomes. Refer to F755. Findings include: Review of the facility untitled policy regarding medication administration, dated 06/22/24, revealed, Medications are to be administered within a two-hour time frame (i.e. one hour before or after the medication order time. The licensed nurse Immediately notifies nursing supervisor if medication is unavailable for administration and notifies Physician/NP [nurse practitioner] of the same. Contacts pharmacy to obtain medication. The licensed nurse Assures the 5 rights: Compares the medication name, strength, route and dosage schedule on the medication administration record against the prescription label. Always checks three times prior to administration of medication. Review of R366's Admission Record under the electronic medical record (EMR) Profile tab revealed she was admitted to the facility on [DATE]. R366 had diagnoses which included hypothyroidism and failure to thrive. Review of R366's Order Summary Report, located in the Orders tab of the EMR revealed orders which included: Levothyroxine 75 microgram (mcg). Give two tablets daily, ordered 10/14/24, for hypothyroidism Magnesium oxide 400 milligram (mg). Give one tablet twice daily as a supplement, ordered 10/08/24, and Dronabinol 2.5 mg. Give twice daily for appetite stimulant, ordered 10/08/24 Review of R366's Medication Administration Record (MAR) under the EMR Orders tab revealed the levothyroxine 75mcg 2 tabs, which started on 10/14/24, was scheduled for 8:00 AM, one hour before any other medications. Prior to 10/14/24, the dose was 100mcg daily. R366's other morning medications were all scheduled at 9:00 AM, to include magnesium oxide and dronabinol. During an observation on 10/16/24 at 9:10 AM, Charge Nurse (CN) 3 administered morning medications to R366. CN3 punched two tablets out of a single medication card containing levothyroxine 100mcg tablets and administered them to R366 along with six scheduled 9:00 AM medications. CN3 stated the facility was waiting for the pharmacy to send the dronabinol. It needed a physician order, which sometimes took a couple of days to get. In addition, CN3 stated the medication cart had no magnesium oxide in it. She had used the last tablet for another resident and needed to check other carts for a bottle. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 9:41 AM, Registered Nurse (RN) Supervisor stated a Nurse practitioner, who provided physician order, was in the facility Monday through Friday and was available by phone as well. If a medication was not available, staff called the provider to see if the provider wanted to order an alternative medication. During a follow-up interview on 10/16/24 at 10:31 AM, CN3 reported she had not located any magnesium but planned to order it. She stated the nurse who admitted R366 may have checked for a physician order for the dronabinol. CN3 stated she planned to follow up with her supervisor and/or the Nurse Practitioner regarding the medication. When asked to check the dose on the medication card for levothyroxine, CN3 pulled two medication cards rubber-banded together which contained levothyroxine 75mcg tablets. When asked to check for the 100mcg card used for the observed medication pass, CN3 retrieved a card of 100mcg tablets from the medication cart. CN3 verified two tablets were missing from the 75mcg cards, although the MAR showed two tablets of 75mcg had been signed off for three days (six tablets total). CN3 stated she would remove the card containing the 100mcg tablets from the cart. She verified levothyroxine was scheduled for 8:00 AM. During an interview on 10/16/24 at 10:40 AM, Licensed Practical Nurse (LPN) Supervisor stated if a medication required a physician order and was not available, the nurse should address it. If unable to address it, it should be endorsed to the next shift or passed through to the supervisor. LPN Supervisor was unaware that the dronabinol for R366 had not arrived. LPN Supervisor the nurse who received the order for the change in dose of the levothyroxine should have removed the old medication card from the cart at the time of the order. During an interview with the Director of Nursing (DON) on 10/16/24 at 5:30 PM, the DON stated she expected nurses to tell the unit manager and/or her when medications had not arrived from the pharmacy. R366 should not have gone eight days without her dronabinol. The DON expected nurses to follow the five rights of medication administration. The DON expected that nurses administered medications from one hour prior to one hour after the prescribed time. NJAC 8:39-29.2(d)

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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. 42440 Based on observation, record review, interview, and policy review, the facility failed to utilize the proper personal protective equipment (PPE) for enhanced barrier precautions (EBP) and failed to perform proper hand hygiene for one of five residents (Resident (R) 91) reviewed for EBP out of a sample of 31 residents. This created a potential for the transmission of infection to staff and other residents. Findings include: Review of the facility's Enhanced Barrier Precautions policy, dated 04/01/24, revealed it stated: Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . The use of gown and gloves for high-contact resident care activities is indicated, . for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. The following situations would warrant Enhanced Barrier Precautions: (EBP) . Wounds and/or indwelling medical devices (regardless of their MDRO status) [such as] indwelling catheters, . Feeding tubes . Enhanced Barrier Precautions require: Use of gown and gloves during high-contact resident care activities [such as] dressing, bathing, . changing linens, changing briefs, incontinence pads, toileting assistance, device care or use of indwelling catheter, central line, feeding tube, . Review of the facility's Infection Control: Handwashing (hand hygiene) policy, dated 01/11/24, revealed it directed staff to perform hand hygiene at times which included: before rendering care, between providing care where soiling is likely (i.e. incontinent care, removal of soiled dressing), and after touching resident furnishings/belongings. Review of R91's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/25/24 and located in the MDS tab of the electronic medical record (EMR), revealed the resident was unable to complete a Brief Interview for Mental Status (BIMS), and the staff assessment for cognition indicated severely impaired cognition. R91 had a gastrostomy tube (G-tube). Review of R91's Order Summary Report, located in the Orders tab of the EMR revealed an order for enhanced barrier precautions, dated 09/27/24. Review of R91's Care Plan, located in the Care Plan tab of the EMR, revealed a focus area, revised 10/11/24, [R91] is on Enhanced Barrier Precautions. At Risk for MDRO [multidrug-resistant organisms] due to G-tube feeding & right & left arms. Interventions included: We will provide enhanced barrier precautions during times of high contact resident care activities and We will use gloves, gowns and potentially goggles if we're expecting splashing. During an observation on 10/14/24 at 11:19 AM, a sign hung on the wall outside R91's door. The sign stated to wear gloves and gown for dressing, bathing/showering, transferring, changing linens, personal hygiene, device care or use: central line, urinary catheter, feeding tube, tracheostomy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/16/24 from 8:36 AM to 9:02 AM, Certified Nursing Assistant (CNA) 6 went into R91's room with clean bedding, linens, and a resident gown. CNA6 washed her hands, put on gloves, and filled a basin with water at the sink. While R91 laid on his back in bed, CNA6 raised the bed to working height with her gloved hand. CNA6 then washed R91's face, removed his gown, and washed his armpits and abdomen. CNA6 removed R91's hand splints and two small wedge positioning devices from the bed. CNA6 then unfastened and folded down the front of R91's incontinent brief, which contained urine and stool. CNA6 provided perineal care to R91's front and then used her gloved hands to roll R91 onto his left side. CNA6 removed the incontinent brief and washed R91's back side to complete the perineal cares. CNA6 applied barrier cream to R91's buttocks with her gloved hands and placed a clean incontinent brief, as well as a clean fitted sheet, under R91, after tucking the used fitted sheet under R91. CNA6 rolled R91 the other direction, removed the old fitted sheet from the bed, finished placing the new fitted sheet, and secured the incontinent brief by its adhesive tabs. CNA6 proceeded to dump the old water from the basin and, with the same gloves on her hands, turned on the water at the sink to re-fill the basin. She then washed R91's feet and legs. With gloved hands, CNA6 placed a cushion between R91's legs, removed the old flat sheet, and covered him with a clean sheet. CNA6 lowered the bed before she removed her gloves and washed her hands at the sink. CNA6 did not change her gloves during the cares and did not wear a gown. During an observation on 10/16/24 at 4:02 PM, Charge Nurse (CN) 4 washed her hands at the sink and gloved in R91's room. She removed R91's old feeding bag, disposed of it, retrieved a new bag, and hung it on the hook of the pole near the bed. CN4 then removed a syringe from a bag hanging on the pole, secured the syringe to R91's G-tube, pulled back to check for residual, and then flushed the G-tube with water poured into the syringe. CN4 placed the syringe back in the bag, grabbed the tubing from the feeding bag, and connected it to R91's G-tube. CN4 wore no gown. During an interview on 10/16/24 at 4:05 PM, CN4 stated that for residents with tube feedings and PICC lines, enhanced barrier precautions meant that those sites needed some kind of dressing covering them. Gowns were only expected to be worn when a resident was on isolation precautions for something like MRSA, c-diff, etc, and then the type of PPE worn depended on the type of precautions/isolation. During an interview on 10/16/24 at 5:11 PM, the Infection Preventionist (IP) stated enhanced barrier precautions were used by staff when they provided direct care for residents with central lines, chronic wounds, feeding tubes, tracheostomies, and indwelling catheters. Staff wore gowns and gloves for activities of daily living (ADLs) including dressing, washing, and bed making. When checking the residual of, or flushing a, tube feeding, there was the potential for contact with body fluids so staff wore gloves, and it was also best that they wore gowns. During an interview with the Director of Nursing (DON) on 10/16/24 at 5:30 PM, the DON stated she expected gloves and gowns to be worn for enhanced barrier precautions with contact activities of a resident with a tube feeding. Gloves should be removed, and hand hygiene completed, following incontinence cares. NJAC 8:39-19.4