STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Preakness Healthcare Center	305 Oldham Road Wayne, NJ 07470

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50913 Complaint#: NJ00179720 Based on interviews and review of pertinent facility documents, it was determined that the facility failed to follow the Medical Emergency Response policy for a resident (Resident #2) in respiratory distress. This deficient practice was identified for 1 of 3 residents reviewed for medical emergency response procedures. The facility also failed to provide the needed emergency transportation services to manage the acute respiratory symptoms of Resident #2, which resulted in the Resident's failure to improve. In addition, the facility failed to develop a policy and procedure for the staff to follow to determine the use of emergency or non-emergency transportation services based on residents presenting symptoms. The facility's failure to implement its Medical Emergency Response policy and to develop a policy and procedure for the staff to follow to determine the use of emergency or non-emergency transportation services based on residents presenting symptoms placed Resident #2 and all other residents in an immediate jeopardy (IJ) situation related to the State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J. This IJ was identified and reported to the facility's Executive Director (ED) and Director of Nursing (DON) on 11/21/2024 at 5:52 PM. The ED was presented with the IJ template that included information about the issue. The IJ began on 11/15/2024 and continued through 11/25/2024 when the facility submitted an acceptable Removal Plan (RP)the New Jersey Department of Health. On 11/26/2024, the Surveyor verified the Removal Plan was implemented, which included educating all staff on the Non-Emergent Medical Transportation Policy and the revised Emergency Medical Response Policy. The staff interviewed revealed knowledge of what a medical emergency is and the protocol for using 911 vs non-emergent transport for medical emergencies. The staff indicated that the Certified Nursing Assistance or nurse who identified the Resident in distress would first call 911, ensuring EMS services were dispatched as soon as possible. So, the noncompliance remained on 11/26/2024 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings included the following: On 11/21/2024, the Surveyors reviewed the following in the electronic medical record (EMR): (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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the Admission Record, Resident #2 was readmitted to the facility with diagnoses that included but was not limited to chronic obstructive pulmonary disease (COPD), acute and chronic respiratory, and heart failure. The annual Minimum Data Set (MDS), an assessment tool, dated 11/15/2024, indicated Resident #2 was cognitively intact, required substantial/ maximal assistance with Activities of Daily Living (ADLs), and depended on transfers. According to the progress note (PN) dated 11/15/2024 at 2:50 PM, written by the Licensed Practical Nurse (LPN) #1, at 9:25 AM, Resident #2 was found to be lethargic but was responsive to staff. The Resident's oxygen level was 96% (percent), but the Resident was using his/ her accessory muscles (use of muscles other than those typically used for breathing to take in and expel air) while breathing. The PN further showed the RN/ANS (Registered Nurse/Assistant Nursing Supervisor) assessed Resident #2 and r/t (Respiratory Therapy) assisted with re-applying the Resident's bi-pap machine (bilevel positive airway pressure machine, which is a noninvasive breathing machine that helps people with breathing difficulties). Resident #2's temperature (T) was 98, heart rate (HR) was 84, respirations (RR) were 20, blood pressure (BP) was 157/81, and the oxygen level (SPO2) was 100 %, while the Resident was wearing a bi-pap machine. In addition, the PN revealed that at approximately 9:30 AM, the nurse called the doctor and was waiting for the return call. At 9:52 am, the Nurse Practitioner (NP) returned the call to the facility. After she was given an update on Resident #2's status by LPN #1, the NP gave an order to send the Resident to the emergency room (ER) for evaluation for Acute Respiratory Distress. LPN #1 notified the RN/ANS of the order and received assistance from LPN#2 by calling the Pulse ambulance service and notifying the ER of the transfer. At 10:57 AM, Pulse ambulance representatives arrived to pick up Resident #2 for transport and were given a report of Resident #2's status. Resident #2 waited from 9:52 AM to 10:57 AM for transport to the hospital with symptoms of Respiratory Distress. A review of the New Jersey Universal Transfer Form (a document prepared by the facility for the Resident's transfer to the hospital), dated 11/15/2024 and timed at 10:45 AM, revealed the Resident's vital signs were BP 157/81, HR 84, RR 28, T 98, SPO2=100% with BiPAP. A review of the Physician's Orders for Resident #2 revealed an untimed telephone order from the NP dated 11/15/24 to send to [Acute care hospital] ER for evaluation of Acute Respiratory Distress . A review of the ED Nursing Note from 11/15/2024, signed at 4:43 PM, revealed, 1100 pt (patient) brought in via BLS (Basic Life Support) to ED from [Nursing Facility] for c/o (complaint of) AMS (Altered mental status). On arrival to ED pt was found to be in respiratory distress with agonal breathing, (an abnormal breathing that's characterized by gasping, labored breathing, and strange vocalizations, usually a symptom of a medical emergency). Pt (patient) on NRB (Non-rebreather) at 10L (Liters) by BLS. Pt intubated (a procedure that involves inserting a tube into the trachea (windpipe) to help a person breathe) by MD. RT at bedside to adjust ventilator along with this RN . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Surveyor on 11/19/2024 at 1:04 PM, the RN/ANS stated he was the Supervisor on the day Resident #2 was sent to the ER. He said that, around 9:30 AM, he received a call from Resident #2's nurse, who stated that Resident #2 was short of breath and wanted to be placed back on the bi-pap machine. RN/ANS stated that he assessed Resident #2 and ruled out a cardiovascular accident (CVA), but Resident #2 appeared weak, was breathing rapidly, but calmed down after receiving his/her medication. The RN/ANS stated that respiratory therapy was called to put the BiPAP back on the Resident and that LPN #1 called the doctor because Resident #2 was short of breath. RN/ANS stated he went back to see Resident #2 around 9:45 AM, and the Resident had a bipap back on and appeared calmer. He further stated that while re-assessing the Resident, the doctor called back and ordered him to send the Resident to the hospital. The RN/ANS further stated that LPN #1 and LPN #2 gathered the paperwork to send to the Resident and called the ambulance, ER, and Resident #2's family. In addition, RN/ANS stated that if a resident is stable, the protocol is to send them out using Pulse ambulance service. He explained that if they cannot stabilize the Resident or the ambulance cannot come in less than one hour; they call 911. According to the RN/ANS, they did not call 911 because there was no code blue, 911 would need to be called for code blues. RN/ANS stated that Resident #2 appeared stable and had normal vitals. During an interview on 11/19/2024 at 1:43 PM, LPN #2 stated LPN #1 asked her to look at Resident #2. LPN #2 stated that the Resident had a glazed look on his/ her face and was staring; it appeared that the Resident wasn't focusing. She further stated that Resident #2 did not look or act normal, but all the vitals were normal. LPN #2 also stated that Resident #2 was usually more interactive and would communicate and tell you if he/ she needed anything. LPN#2 said she was unsure if the NP specified which transport to call. She explained that 911 would be called for an emergency such as respiratory distress. The Surveyor and LPN#2 reviewed the NP's order to send Resident #2 to the ER for evaluation of Acute Respiratory Distress. LPN #2 stated that she was unaware that the NP's order stated to send the Resident out for evaluation of Acute Respiratory Distress. During an interview with the Surveyor on 11/19/2024 at 1:54 pm, the NP stated they received a call at 9:50 AM from the nurse (LPN #1) taking care of Resident #2. The LPN stated Resident #2 was in distress. The NP said she requested Resident #2 to be sent to the hospital and recalled the order for Acute Respiratory Distress. The NP stated they should have called 911 if the vital signs had changed. On 11/19/2024 at 3:19 PM, the Director of Nursing (DON) and Executive Director (ED) were interviewed. The DON and the ED stated that the administration is notified when a resident is transported to the hospital. The ED stated security sends an email notification each time a resident enters and leaves the building for census purposes. The DON stated that the Nursing Supervisors also notify them when a resident is transported to the hospital during report. The ED and the DON stated they use Pulse, Life Ride, and TLC for stable residents requiring transport and 911 for emergencies. According to the DON, a nurse does not need to call a Supervisor to call 911; they can use their nursing judgment in an emergency. The DON further stated that he is familiar with Resident #2 and was notified by the RN/ANS of the Resident being transported to the ER for issues with their respirations after the Resident had left the building. According to the DON, he was informed that the Resident's breathing had improved and was not aware of Resident #2's condition at the time of pick up. The DON stated that if the vital signs change at any time while waiting for transport to the hospital, he expects the staff to call 911. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/21/2024 at 1:31 PM, the Assistant Director of Nursing (ADON) stated that if the transport did not have an ambulance or if the wait was too long, they would call 911. She said that 2 hours would be too long of a wait time for an ambulance to pick up any resident for transport for evaluation, and in that situation, 911 would be called for the Resident to be transported. The ADON further stated that if the Resident's status changes, 911 should be called instead of waiting for medical transportation. She also stated that if a resident is experiencing respiratory distress, then the Resident should be sent to this hospital via 911. During an interview on 11/21/2024 at 2:12 pm, LPN#1 stated she recalled the day Resident #2 was sent to the hospital. She stated while she was doing her rounds around 8 am, the Resident's bipap was removed, and a nasal cannula (a device to deliver oxygen through nostrils) was applied to the Resident through respiratory therapy. She stated that when she returned to give Resident #2 their medication, the Resident did not appear to be focusing and appeared to be using his/ her abdominal muscles while breathing. She stated she called the Supervisor to assess the Resident because the Supervisor was able to speak to Resident #2 in Spanish. While Resident #2 spoke with the Supervisor, the Resident requested that the bipap machine be placed back on. She informed the Supervisor that she would call the Resident's doctor. LPN #1 stated that the NP returned her call and told her to send the Resident out for respiratory evaluation. She stated that she called the family and completed the paperwork, and LPN #2 called the ER and for the ambulance. During a telephone interview on 11/21/2024 at 3:23 pm, the Medical Director (MD) stated that staff should assess the Resident and provide clinical information to the doctor to discuss what orders are needed. For instance, if the Resident needs stat (immediate) orders or if they need to go out to the hospital. She explained that if a resident is unstable and their vital signs are abnormal, they should be transported to the hospital via 911. If a resident is in Acute Respiratory Distress, she expects the staff to call 911. The MD further stated that anyone on oxygen or bipap should be transported by paramedics, which should be a standard of care, and anyone on a ventilator, trach, or bipap should be transported by 911. Review of the facility's Policy titled Code Blue Medical Emergency Response, with a last revised date of 12/9/2020, revealed the following: Under Policy: (The Facility) will utilize standard procedure in responding promptly to a medical emergency. Definitions included: Medical Emergency- Examples include but not limited to: An unconscious person; a person in respiratory distress; a person who is choking; a person who us having seizures; a person with severe bleeding; a person who falls which leads to a serious injury. Procedure: Medical Emergency Response 1. A person in a medical emergency is identified and code blue is initiated. 2. Identify code status of a resident. NOTE: The medical record will also be checked to verify the code status of the Resident. If you are the first responder in an emergency situation: - Check the person for responsiveness, breathing and pulse. - Page Code Blue (x6164) and direct staff to call for ambulance and paramedics. (continued on next page)

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