

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |

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) |
|---|---|
| <p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327</p> <p>Based on interviews and a review of facility provided documents, it was determined that the facility failed to consistently respond to issues and concerns presented during resident council meetings and resident questionnaires obtained from residents in lieu of a formalized resident council meeting for two (2) of three (3) resident council minutes reviewed.</p> <p>This deficient practice was evidenced by the following:</p> <p>According to the Heritage Manor East (HME) Resident Council Meeting Minutes that was provided by the Director of Nursing (DON) revealed:</p> <p>1. July 18, 2024 at 02:30 PM</p> <p>-Staff in attendance: Director of Activities (DoA), Director of Food and Nutrition Services (DFNS), Assistant Director of Nursing (ADON), Social Worker (SW), Activities Assistant #1 (AA#1), and Activities Director (AD).</p> <p>-Residents in attendance: 18</p> <p>-Dietary Committee Meeting: residents would like to know could the supper be served at 5:45 PM instead of arriving at 6:00 PM? Residents would prefer it earlier, if possible. The DFNS will discuss with his team.</p> <p>2. August 15, 2024 at 02:30 PM</p> <p>-Staff in attendance: DoA, DFNS, Chief of Clinical Dietician (CoCD), Executive Director-Administrator ([NAME]), ADON, AA#2 and AA#3, and Director of Environmental Services (DES).</p> <p>-Residents in attendance: 27</p> <p>-Dietary Committee Meeting: [did not address the concern on 7/18/24 about supper to be delivered earlier]</p> <p>3. September 19, 2024 at 02:30 PM</p> <p>(continued on next page)</p> |

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: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-Staff in attendance: DoA, Director of Dining & Nutrition Services (DoDNS, also known as the DFNS), Registered Dietician (RD), ADON, Volunteer Ombudsman (VO), SW, Resident Relations Associate (RLA), and Activities Specialist (AS).</p> <p>-Residents in attendance: 25</p> <p>-Dietary Committee Meeting: The unsampled resident mentioned that the supper truck was arriving around 6:00-6:15 PM. The DoDNS will look into the time of arrival.</p> <p>During the resident council meeting conducted by the surveyor on 10/02/24 at 10:29 AM four (4) out of seven (7) residents stated that there was only one staff from the Activity Department assisted during supper time at the HME dining area. Four of seven residents also stated that supper was served late at HME. Furthermore, the four residents stated that the late delivery of meals for supper and one staff assisting during that time affected 15 to 20 residents who were in the dining room.</p> <p>On that same date and time, Resident #167 informed the surveyor that the above concerns with late delivery of meals for supper had been discussed as concerns to the facility management during Resident Council Meetings and there was no resolution. Resident #167 further stated that there was no consistency with meal deliveries. The resident also stated that the residents requested supper to be served before 6:00 PM.</p> <p>On 10/02/24 at 12:12 PM, the surveyor interviewed the Activity Person (AP) who was present on 10/01/24 dinner time at HME. The AP informed the surveyor that she worked the 9-5 shift yesterday and had to work overtime until 7 PM last night. The AP stated that most of the time she was by herself serving the HME dining room for residents of 15 to 20. She further stated that at times a Certified Nursing Aide (CNA) will help her. The AP acknowledged that it took time to serve the 15-20 residents and would be helpful to have extra hands.</p> <p>On 10/02/24 at 12:21 PM, the surveyor interviewed the Clinical Nutrition Manager (CNM) and DFNS in the presence of another surveyor. The surveyor asked both CNM and DFNS if they remembered that facility management or residents reported concerns that residents requested an earlier food truck delivery for dinner before 6:00 PM. Facility management responded that they did not recall that was discussed with them. The DFNS further stated that if it was discussed in the resident council meeting, the activity person should have documented that, and he would address it.</p> <p>At that same time, the DFNS provided a copy of the Dining Room Schedule and he indicated from the paper, the supper at HME Great Room/Media Room delivery time was at 5:45 PM-6:45 PM. The surveyor asked the DFNS if that was considered late for the 6:45 PM dinner delivery and there was no response from the DFNS.</p> <p>On 10/02/24 at 01:13 PM, the survey team met with the [NAME] (also known as the Licensed Nursing Home Administrator [LNHA]) and DON. The surveyor notified the facility management of the above concerns.</p> <p>On 10/03/24 at 12:32 PM, the survey team met with LNHA and DON. The DON stated that the concerns regarding the Resident Council Meeting, we will move it to 5:30 PM and we spoke to the staff, it was an oversight.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>At that same time, the surveyor asked the reason why it was not acted upon the July and September 2024 resident council meeting the residents' concerns with late meal delivery for supper and requested an earlier time to be delivered. The surveyor also asked what was the timeline that the facility should act upon on those requests and concerns and should the DFNS and Dietitian received those concerns. The LNHA stated that it was an expectation, same as grievances, concerns, and requests in the Resident Council Meeting of the residents should have a resolution. The LNHA further stated that we have a summary from resident council meetings that come out and distributed to those who attended, and he (DFNS) should receive a copy.</p> <p>A review of the facility's Diet Ordering Policy with an effective date of 01/24 that was provided by the DON revealed:</p> <p>Procedure:</p> <p>J. If a client is in need of an altered schedule for meals or snacks, staff nurses and RD will make arrangements for accommodating the schedule for optimal intake.</p> <p>A review of the facility's Resident Council Meeting Policy with an effective date of 10/24 that was provided by the DON showed:</p> <p>Policy: It is the policy of the facility to provide its' residents with the opportunity to meet in a group atmosphere, on a regular basis, to take an active role in discussing various community related topics/issues in a non-threatening environment and to present those topics to the appropriate administrative persons. Residents have the right to express concerns, have them heard & reviewed and when possible, resolved .</p> <p>Procedure:</p> <p>B. If a resident in attendance brings up an issues/concern to be addressed by another Department, the appropriate department will receive a copy of the meeting minutes, indicating that a response is requested of them to address the issue.</p> <p>A review of the Grievance (complaint) Resolution Policy with an effective date of 10/24 that was provided by the DON showed:</p> <p>Policy: The facility strives to provide quality care and satisfaction in the delivery of its services. We understand that there may be times when our customers may not be completely satisfied with the services provided. Under those circumstances, we encourage dissatisfied customers to notify our staff of their concerns and/or to contact appropriate public agent(s) in order to provide the opportunity to rectify the issue.</p> <p>Procedure: Responsibilities of:</p> <ol style="list-style-type: none"> Residents and/or their representatives can express their concerns in writing, by telephone, or in-person to members of the facility . Appropriate department heads will follow through to seek resolution . <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |

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) |
|---|---|
| <p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>8. It is the responsibility of the department head where the concern occurred in collaboration with concierge to discuss final outcomes will all interested parties inclusive of the resident representative.</p> <p>On 10/08/24 at 12:25 PM, the survey team met with the LNHA, DON, Medical Director, and the VP (Vice President) of Senior Services for an Exit Conference. The facility management did not provide additional information and did not refute the findings.</p> <p>NJAC 8:39-4.1(a)(29)</p> |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>38327</p> <p>Based on interviews and a review of facility provided documents, it was determined that the facility failed to provide Saturday mail and package delivery services to residents. This deficient practice was identified for seven (7) of seven (7) residents interviewed during the resident council group meeting (Residents #10, #48, #167, #173, #212, #218, and 232) and was evidenced by the following:</p> <p>During the resident council meeting conducted by the surveyor on 10/02/24 at 10:29 AM with Residents #10, #48, #167, #173, #212, #218, and #232, the surveyor asked the residents if they received mail on Saturdays. All residents stated that there was no mail or packages on Saturdays because the mail room was closed.</p> <p>On that same date and time, Resident #212 informed the surveyor that a couple of weeks ago the resident had a delivery from an outside vendor [name of company] that was returned which the resident had known because the resident's representative told them. Resident #212 stated that they notified the Social Worker about it and the reason it was returned was because the packages were too many. The resident further stated that there was no mail and packages delivered to the residents on weekends because they (mail room) were closed.</p> <p>At that same time, Resident #167 informed the surveyor that they do not accept packages on a weekend, which was written on some paper, and I have a problem getting things. The resident further stated since then the resident knew that there were no mail/packages delivered to the resident on weekends. The resident further stated that in order for the resident to get packages, they were sent to the resident's representative (RR) to make sure delivery was received and will be given to the resident once the RR visited the resident.</p> <p>On 10/03/24 at 10:50 AM, the surveyor interviewed the Unit Clerk (UC) from Heritage Manor East (HME) unit regarding the facility's process and practice for receiving residents' mail and packages. The UC informed the surveyor that the mails and packages come from the Mail Room (MR) and usually the assigned person from the MR delivers them to the unit and the UC will deliver them to the residents. The UC stated that she signed the log when she received the mail and packages from the MR. The UC stated that the MR was open Monday through Friday and closed on weekends.</p> <p>At that same time, the UC stated that sometimes delivery personnel from the community left packages in the loading dock. She further stated that like two weeks ago Resident # 228 had a package that was left in the loading dock, and she had to pick it up and give it directly to the resident.</p> <p>On 10/03/24 at 11:14 AM, the surveyor interviewed the Shipping, Receiving & Inventory Manager (SRIM) who informed the surveyor that there was an assigned person also in the department that delivered mail and packages to the unit. The SRIM stated that the assigned person will hand over the mail and packages to the UC and the UC will sign the log that the mail and packages were received, and the UC will distribute them to the respective residents. He further stated that the MR and his department were open Monday through Friday and closed on weekends. The SRIM confirmed that was the facility's practice that the MR opened on weekdays and closed on weekends.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 10/03/24 at 12:32 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The surveyor notified the facility management of the above concerns.</p> <p>A review of the facility's POLICY: Requisition Ordering Process for Stock, Non-Stock Items, and Inventory Control Procedure with an effective date of 5/24 which the DON stated was the facility's policy for mail/packages and mail room, revealed:</p> <p>Procedure: The purpose of this policy is to identify the procedures used to properly acquire necessary supplies and place them into use in a timely manner .</p> <p>4. For non-stock items, this includes receiving non-stock requests, placing orders, receiving order items, verifying they are what was ordered and are in proper condition, and either delivering them to their intended recipient/department or returning them to the supplier if unsatisfactory .</p> <p>Definitions:</p> <p>d. Non-stock=items/goods or services that are non-inventory items for departments, patients/residents .</p> <p>D. Non-stock purchase requisition process:</p> <p>10. Materials management personnel will deliver the items to the intended recipient/department by the end of the day during normal business hours .</p> <p>On 10/08/24 at 12:25 PM, the survey team met with the LNHA, DON, Medical Director, and the VP (Vice President) of Senior Services for an Exit Conference. The facility management did not provide additional information and did not refute the findings.</p> <p>N.J.A.C. 8:39-4.1 (a)(19)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049</p> <p>Based on observation, interview, record review, and review of other facility documentation, it was determined the facility failed to ensure accurate documentation and review of a resident's advance directives for one (1) of five (5) residents (Resident #253) reviewed.</p> <p>This deficient practice was evidenced by the following:</p> <p>The surveyor reviewed the hybrid (electronic and paper) medical records of Resident #253.</p> <p>The Resident Face Sheet (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, dementia, spondylosis (degeneration of the bones and disks in the neck), and type 2 diabetes mellitus.</p> <p>A comprehensive Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, dated [DATE], indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #253 scored a 09 out of 15, which indicated the resident had moderate cognitive impairment.</p> <p>A physician's order (PO) dated [DATE] read, Do Not Intubate (DNI).</p> <p>A PO dated [DATE] read, Do Not Resuscitate (DNR).</p> <p>The resident's paper chart included a New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) form, dated [DATE], which documented the resident had advance directives (AD) that they desired attempt resuscitation/CPR[Cardiopulmonary Resuscitation] and Do not Intubate. The form was signed by the resident's representative (RR) and an advance practice nurse (APN).</p> <p>A review of progress notes revealed there was no documentation that indicated the resident desired to have a DNR status.</p> <p>On [DATE] at 10:44 AM, the surveyor interviewed a Registered Nurse (RN) about AD protocol. The RN stated nurses could find the resident's AD and code status in the electronic medical record (EMR). The RN further explained on the main screen for a resident in the EMR, the code status would be indicated at the top of the screen and could also be found under the PO. The RN stated the nurses, health care providers (physicians and APNs), and the social worker (SW) would follow up about AD.</p> <p>On [DATE] at 10:52 AM, the surveyor interviewed the Registered Nurse/Team Leader (RN/TL) about AD protocol. The RN/TL stated upon admission the resident/RR would be asked to provide AD, which would include living wills, and/or POLST. The RN/TL further explained if they had no AD, staff would provide education and offer to complete a POLST. The nurses and SW would follow up on a resident's AD. The physician would be notified, orders obtained for a resident's code status. Furthermore, a health care provider would review with the resident/RR the POLST, and it would be signed. The RN/TL stated the staff would make sure AD information in the EMR and provided AD documentation would match.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The surveyor reviewed with the RN/TL Resident #253's POLST and documentation in the EMR. The RN/TL stated she would follow up and provide further information.</p> <p>On [DATE] at 11:57 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) the facility's AD policy.</p> <p>On [DATE] at 01:14 PM, the Director of Nursing (DON) provided the AD Policy.</p> <p>On [DATE] at 01:26 PM, the RN/TL informed the surveyor that she had confirmed with the RR the desired AD. The RN/TL stated they wished resuscitation to be attempted and a DNI code status for the resident. The surveyor asked the RN/TL why a DNR order was entered in Resident #253's EMR. The RN/TL acknowledged the POLST was correct and the DNR order should not have been entered in the resident's EMR.</p> <p>On [DATE] at 01:15 PM, the survey team met with the DON and the LNHA. The surveyor notified the facility management of the above concerns for Resident #253's AD. There was no verbal response by the facility at this time.</p> <p>On [DATE] at 12:32 PM, the DON and the LNHA met with the survey team. The DON acknowledged the concern with Resident #253's AD. The DON stated an audit of other residents' medical records was conducted, and re-education was provided to the staff.</p> <p>A review of the facility provided policy titled, Advance Directives, POLST, Emergency Orders with an effective date of ,d+[DATE] read under Procedure, B. Choices and Orders for Emergency Care: a. A completed and executed POLST is a legal physician/LIP [Licensed Independent Practitioner] order and is transferrable and immediately actionable .</p> <p>N.J.A.C. 8:,d+[DATE].6</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48423</p> <p>Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for four (4) of 38 residents, (Residents #15, #153, #194, and #253) reviewed for accuracy for MDS coding.</p> <p>This deficient practice was evidenced by the following:</p> <p>According to the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual October 2024, for Use Effective October 1, 2024, revealed:</p> <p>Section C Cognitive Patterns:</p> <p>C0100: Should Brief Interview for Mental Status Be Conducted?</p> <p>Coding Instructions</p> <p>o Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available.</p> <p>Section J Health Conditions:</p> <p>J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment, whichever is more recent.</p> <p>Coding Instructions for J1900. Determine the number of falls that occurred since admission/entry or reentry or prior assessment and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury.</p> <p>Definitions: Injury (Except major) Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.</p> <p>Section M-5, under M0210 (Unhealed Pressure Ulcers/Injuries) Coding Instructions read: .Code 0, no: if the resident did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to M1030, Number of Venous and Arterial Ulcers .Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</p> <p>Chapter 3-page M-11, under M0300A (Number of Stage 1 Pressure Injuries) it read, Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence .</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>1. On 9/30/24 at 11:21 AM, Surveyor #1 (S#1) observed Resident #15 lying in their bed with a visitor at the bedside. The resident was using oxygen via nasal cannula (a medical device that consists of a small, flexible tube with two prongs that sit inside a patient's nostrils) that was attached to the concentrator.</p> <p>On 10/02/24 at 12:47 PM, Surveyor #2 (S#2) observed Resident #15 awake while resting in their bed. The surveyor greeted the resident.</p> <p>The surveyor reviewed the medical records of Resident #15 and revealed the following:</p> <p>A review of the Face Sheet (FS; an admission summary) reflected that the resident was admitted to the facility with a diagnoses that included but was not limited to: Diabetes mellitus (abnormal level of sugars in blood), and HTN (high blood pressure).</p> <p>A review of significant change in status MDS (SCMDS) with an Assessment Reference Date (ARD) of 9/13/24, under Section B0700. Makes Self Understood- Ability to express ideas and wants, consider both verbal and non-verbal expression- reflected Code 2 which indicated: 2.) Sometimes understood- ability is limited to making concrete request. Review of Section C - Cognitive Pattern did not reflect Resident #15's Brief Interview for Mental Status (BIMS) score. Further review of MDS question C0100: Should BIMS (C0200-C0500) be conducted? Reflected Code 0 which indicated No (resident is rarely/never understood) 'Skip to and complete C0700-C1000, Staff Assessment for Mental Status. On SMDS, Surveyor #2 observed that BIMS interview was not conducted.</p> <p>On 10/08/24 at 9: 47 AM, the surveyor met with Director of Nursing (DON) and notified the above findings and concerns.</p> <p>2. On 9/30/24 at 11:43 AM, during an initial tour, S#2 observed Resident #194 in Resident lounge/C lounge. The resident was resting, with eyes closed in their geri-chair.</p> <p>On 10/02/24 at 11:11 AM, S#2 observed resident asleep in their bed. There was an orange-colored round sticker [dot] next to their name on the name plate.</p> <p>The surveyor reviewed the medical records of Resident #194 and revealed the following:</p> <p>A review of the FS reflected that the resident was admitted to the facility with a diagnoses that included but was not limited to bipolar disorder, anxiety disorder and major depressive disorder.</p> <p>A review of SCMDS with an ARD of 8/09/24, under Section B0700. Makes Self Understood- Ability to express ideas and wants, consider both verbal and non-verbal expression- reflected Code 2 which indicated: 2.) Sometimes understood- ability is limited to making concrete request. Review of Section C - Cognitive Pattern did not reflect Resident #15's BIMS score. Further review of MDS question C0100: Should BIMS (C0200-C0500) be conducted? Reflected Code 0 which indicated No (resident is rarely/never understood) 'Skip to and complete C0700-C1000, Staff Assessment for Mental Status. On SCMDS, Surveyor #2 observed that BIMS interview was not conducted.</p> <p>During an interview with S#2 on 10/07/24 at 11:33 AM, Registered Nurse/MDS Coordinator #1 (RN/MDSC#1) stated that if a resident was coded as sometimes understood in Section B, BIMS would be attempted.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/07/24 at 01:09 PM, the survey team met with Licensed Nursing Home Administrator (LNHA) and DON and notified the above findings and concerns.</p> <p>38327</p> <p>3. On 9/30/24 at 11:29 AM, S#1 observed Resident #153 was not in their room. The room was observed with a bed alarm on top of the nightstand table and a low bed. The bed had a regular mattress [not specialized].</p> <p>S#1 reviewed the medical records of Resident #153 and revealed the following:</p> <p>The FS showed that the resident was admitted to the facility with a diagnosis that included but was not limited to Alzheimer's disease unspecified, dementia in other diseases classified elsewhere, muscle weakness (generalized), other sequelae of cerebral infarction (stroke), and repeated falls.</p> <p>A review of the provided Matrix for Providers by the DON showed that the resident was triggered for Alzheimer's dementia and fall.</p> <p>A review of the provided fall investigations by the DON revealed:</p> <p>-3/25/24 at 8:10 AM unwitnessed fall, hit head, and complaint (c/o) pain on the left side of the head.</p> <p>-5/11/24 at 10:15 AM unwitnessed fall and no injury.</p> <p>-8/04/24 unwitnessed fall, no injury, and pad alarm was sounding off.</p> <p>The most recent SCMDs, with an ARD of 6/29/2024, showed that the cognitive skills for daily decision-making were coded #2 which indicated that the resident had moderately impaired cognition. Section J Health Conditions indicated that the resident had a fall incident with no injury.</p> <p>The quarterly MDS (qMDS) with an ARD of 3/29/24 revealed that on Section J, the resident had a fall incident with no injury.</p> <p>Further review of the above documents showed there were three unwitnessed fall incidents with two with no injuries and one with c/o pain on the left side of the head on 3/25/24. The 3/29/24 qMDS showed that Section J for fall was coded for no injury even though the resident c/o pain (minor injury).</p> <p>On 10/02/24 at 8:57 AM, S#1 in the presence of another surveyor interviewed the MDS Manager (MDSM). The MDSM stated we follow the RAI manual and that there was no separate policy for MDS. The MDSM further stated we gather the information from the interviews, charts which included notes and orders when doing MDS. She also stated that for falls we check the investigation.</p> <p>On that same date and time, the surveyor asked the MDSM if the resident c/o pain during fall incident, would that be considered an injury. The MDSM stated yes, minor injury and should be coded in the MDS. S#1 then notified the MDSM of the above findings and concerns regarding MDS accuracy for qMDS on 3/29/24. The MDSM stated that she will get back to the surveyor.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/02/24 at 01:13 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above findings and concerns.</p> <p>46049</p> <p>4. On 9/30/24 at 10:18 AM, Surveyor #3 (S#3) observed Resident #253 lying in their bed, alert and verbally responsive. The resident reported they had a wound on their backside. The resident stated the wound was being treated by the staff and a wound consultant who would visit.</p> <p>S#3 reviewed the electronic and paper medical record for Resident #253.</p> <p>The Resident FS documented that the resident had diagnoses that included but were not limited to, dementia, spondylosis (degeneration of the bones and disks in the neck), dorsalgia (pain in the back), anxiety, and type II diabetes mellitus.</p> <p>A comprehensive MDS assessment with an ARD of 9/04/24, indicated the facility assessed the resident's cognition using a BIMS test. Resident #253 scored a 09 out of 15, which indicated the resident had moderate cognitive impairment. In Section M of the MDS, the resident was coded as having no unhealed pressure ulcers or injuries.</p> <p>An assessment dated [DATE] which included a skin exam of the resident documented Resident #253 had non-blanchable redness (stage I pressure injury) to the sacrum.</p> <p>On 10/03/24 at 01:56 PM, S#3 interviewed Registered Nurse/MDS Coordinator #2 (RN/MDSC#2) who stated a resident's medical records including but not limited to, assessments, physician orders, treatments and preventative measures would be reviewed. RN/MDSC#2 stated if a resident had a wound within the look back period from the assessment reference date of the MDS, it should be coded in the assessment.</p> <p>S#3 reviewed the concern for Resident #253 who had non-blanchable redness (stage I) at time of MDS assessment, and it was not coded. RN/MDSC#2 would review the medical record and provide further information.</p> <p>On 10/04/24 at 9:11 AM, the DON informed the surveyor that she audited with RN/MDSC#2 the MDS of Resident #253. The DON stated the non-blanchable redness (stage I) should have been coded in the MDS assessment.</p> <p>On 10/07/24 at 01:10 PM, S#3, in the presence of the survey team, informed the LNHA and the DON of the concern for Resident #253's MDS accuracy. The DON stated RN/MDSC#2 modified the MDS assessment.</p> <p>On 10/08/24 at 12:25 PM, the survey team met with the LNHA, DON, Medical Director, and the VP (Vice President) of Senior Services for an Exit Conference. The facility management did not provide additional information and did not refute the findings.</p> <p>NJAC 8:39-33.2 (d)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46049</p> <p>Based on observation, interview, and record review it was determined the facility failed to consistently follow standards of clinical practice with regards to ensuring completion of neuro (neurological) checks after a resident had a fall for one (1) of three (3) residents (Resident #415) reviewed for falls.</p> <p>This deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.</p> <p>On 10/01/24 at 11:57 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) the fall investigation for Resident #415.</p> <p>On 10/03/24 at 9:10 AM, the surveyor reviewed a fall investigation, dated 9/27/24 for Resident #415. The resident had an unwitnessed fall incident at approximately 3:00 AM in which Resident #415 was found lying on the floor. The resident reported they fell and hit their right knee and head. The physician and the resident's representative were notified. The resident had an abrasion to the right side of their head and neuro-checks (brief neurological assessments performed repeatedly to monitor and evaluate a person's mental status and brain function) were initiated.</p> <p>The surveyor reviewed the paper and electronic medical record (EMR) of Resident #415.</p> <p>The Resident Face Sheet (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, colon cancer, chronic obstructive pulmonary (lung) disease, muscle weakness, and atrial fibrillation (a heart condition that causes an irregular, often very fast heartbeat).</p> <p>A Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, with an assessment reference date of 10/01/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #415 scored a 12 out of 15, which indicated the resident had moderate cognitive impairment.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A physician's order (PO) dated 9/27/24 read, Neuro-checks every 30 minutes for an hour then every hour for 2 hours, and then every 4 hours for 24 hours.</p> <p>A nurse progress note (PN) by the Licensed Practical Nurse (LPN) dated 9/27/24 at 7:41 AM documented that the resident had a fall incident at three in which the resident was found on the floor with a small abrasion to the right side of their head.</p> <p>A PN by the LPN dated 9/27/24 at 7:41 AM, had a start date/time 9/27/24 3:38 AM, documented a detailed neuro check assessment and vital signs for resident. The other sections of the note included mental status assessments, pupil assessment, pain assessment, and range of motion of extremities were completed. In the section that read time observed, the LPN checked 3 AM, 4 AM, 5 AM and 6 AM. The note did not detail a neuro check assessment for each time indicated that the resident was observed.</p> <p>A follow up PN by LPN dated 9/27/24 at 7:46 AM documented that neuro checks were initiated, and the physician was notified.</p> <p>A PN dated 9/27/24 at 11:48 AM, included a detailed neuro-check assessment and vital signs with an observed time of 11:15 AM.</p> <p>A PN dated 9/27/24 at 4:27 PM included a detailed neuro-check assessment and vital signs with an observed time of 3:15 PM and 11:15 PM. The note did not detail a neuro check assessment for each time the resident was observed.</p> <p>A PN dated 9/27/24 at 7:47 PM, included a detailed neuro-check assessment and vital signs with an observed time of 7:15 PM.</p> <p>A PN dated 9/28/24 at 4:58 PM, included a detailed neuro-check assessment and vital signs with an observed time of 7:15 AM.</p> <p>There were no other PN found that documented any other neuro-check assessment done after the resident's fall.</p> <p>On 10/03/24 at 10:56 AM, the surveyor interviewed the Registered Nurse (RN) about falls and neurochecks. The RN stated for unwitnessed falls neuro-checks would be initiated and the PO would be obtained. The RN further explained the PO for neuro-checks would outline the frequency it was to be done.</p> <p>On 10/03/24 at 11:24 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) about neurochecks. The ADON confirmed neuro-checks would be performed with unwitnessed falls. The ADON reviewed in the EMR, the protocol of neuro-check orders to inform the surveyor of its frequency. The ADON stated neurochecks were to be completed every 15 minutes for one hour, every 30 minutes for one hour, every one for 2 hours, every four hours for 20 hours. The PO would prompt in the EMR for when the nurses were to document their neuro-check assessments.</p> <p>On 10/03/24 at 02:14 PM, the surveyor placed a call to the LPN who was assigned to care for Resident #415 at the time of the fall with no answer and a message to return the call was left. The surveyor did not receive a return call.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |

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) |
|--|---|
| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/04/24 at 02:40 PM, the surveyor informed the Director of Nursing (DON) of the concern regarding the neuro-checks completed for Resident #415. The DON confirmed the PO for neuro-checks would specify the frequency for assessments and documentation to be completed. The DON stated would follow up and provide additional information.</p> <p>On 10/07/24 at 01:10 PM, the Licensed Nursing Home Administrator (LNHA) and the DON met with the survey team. The DON acknowledged the neuro check assessments were not complete and in-service education was being provided to the nurse about it.</p> <p>On 10/08/24 9:00 AM, the surveyor requested for any policy related to neuro-check assessments.</p> <p>On 10/08/24 at 10:37 AM, the DON stated there was no policy related to neuro-checks found.</p> <p>On 10/08/24 at 12:04 PM, the LNHA and DON met with survey team. The DON stated for education was being provided regarding neuro-checks protocols and they were working to optimize the documentation process. There was no additional information provided by the facility.</p> <p>The surveyor reviewed the facility provided policy titled, Resident Safety Program- Fall Prevention with a last reviewed date of 5/24. The policy did not address neuro-check assessments or protocols.</p> <p>NJAC 8:39-11.2 (b); 27.1 (a)</p> |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38327</p> <p>Based on observations, interviews, record review and review of other pertinent facility provided documentation, the facility failed to provide appropriate interventions, implement interventions, and ensure that interventions to prevent further falls were documented and monitored for one (1) of three (3) residents, Resident #153, reviewed for incident and accident.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 9/30/24 at 11:29 AM, the surveyor observed Resident #153 was not in their room. The room was observed with a bed alarm on top of the nightstand table and a low bed. The bed had a regular mattress [not specialized].</p> <p>The surveyor reviewed the medical records of Resident #153 and revealed the following:</p> <p>The Resident Face Sheet (an admission summary) showed that the resident was admitted to the facility with a diagnosis that included but was not limited to Alzheimer's disease unspecified, dementia in other diseases classified elsewhere, muscle weakness (generalized), other sequelae of cerebral infarction (stroke), and repeated falls.</p> <p>A review of the provided Matrix for Providers by the Director of Nursing (DON) showed that the resident was triggered for Alzheimer's dementia and fall.</p> <p>A review of the provided fall investigations by the DON revealed:</p> <p>-3/25/24 at 8:10 AM unwitnessed fall. The Certified Nursing Aide (CNA) found resident in the bathroom sitting up on the floor with back in front of sink. The resident hit head, and complaint (c/o) pain on the left side of the head.</p> <p>-5/11/24 at 10:15 AM unwitnessed fall with no injury. The resident was found lying on the floor, outside the bathroom.</p> <p>-8/04/24 unwitnessed fall with no injury. The resident was found sitting upright by the foot side of the bed. The pad sensor alarm was sounding.</p> <p>Resolution Comment: New intervention: scoop mattress.</p> <p>The most recent Significant Change in status MDS, with an Assessment Reference Date of 6/29/2024, showed that the cognitive skills for daily decision-making were coded #2 which indicated that the resident had moderately impaired cognition. Section J Health Conditions indicated that the resident had a fall incident with no injury.</p> <p>A review of the personalized care plan (CP) revealed a focus on falls with interventions that included the following:</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-revised, effective date 3/25/24, offer toileting assistance prior to breakfast meal.</p> <p>-revised, effective date 5/11/24, offer toileting assist after breakfast.</p> <p>-active, effective date 8/03/24, scoop mattress as indicated for safety.</p> <p>-resolved, effective date 12/30/22, tab alarm to w/c (wheelchair).</p> <p>Further review of the above CP showed that there was no CP intervention for low bed, bed alarm, and pad sensor.</p> <p>On 10/01/24 at 12:03 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) from Heritage Manor East (HME). Afterward, both the surveyor and the ADON went to resident's room and the surveyor asked the ADON to check if the resident had scoop mattress. The ADON pulled the foot part bedsheets and touched the mattress. The ADON then performed hand hygiene with use of ABHR (alcohol base hand rub) that was inside the resident's room.</p> <p>On that same date and time, outside the resident's room the ADON confirmed that the resident had no scoop mattress, and it was a regular mattress.</p> <p>Furthermore, inside the ADON's office, the surveyor asked the ADON should the fall incidents be in the CP and why the scoop mattress intervention was not followed. The ADON confirmed that the scoop mattress was in the fall CP intervention. The ADON stated that she had to check why the scoop mattress was not in use at the time of observation. She further stated that they did not CP the actual fall but update the current CP for fall interventions. The surveyor notified the ADON of the initial observation on 9/30/24 that the resident had no scoop mattress.</p> <p>On 10/02/24 at 01:13 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON. The surveyor notified the facility management of the above findings and concerns.</p> <p>On 10/02/24 at 02:03 PM, the surveyor interviewed the DON. The surveyor asked the DON how the facility know and determine that the fall CP interventions were followed and if there were an accountability that the resident was offered toileting before and after breakfast. The DON acknowledged that there was no documented evidence that the resident was offered toileting according to fall interventions. The DON at that time checked the electronic medical records.</p> <p>At that same time, the DON stated that there was no option for the electronic records in the CP to add actual fall as the focus. The DON further stated that what facility can do was to update CP in each fall for new interventions and it was facility's process to update CP for new interventions for each fall.</p> <p>On 10/04/24 at 11:44 AM, the surveyor interviewed the assigned CNA of the resident. The CNA stated that Resident #153 was cognitively impaired had periods of incontinence. The CNA stated that she was unable remember if the resident had history of falls. The surveyor asked the CNA how she would know what kind of assistance and safety precautions the resident had. The CNA stated that it would be available in the kiosk (a small structure in public area used for providing information) where the CNA task and accountability can be found. She further stated that as for her a floater, she relied on the kiosk and nurse's verbal instructions.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>At that same time, the CNA stated that she was unable to remember if the resident should be with tab alarm. The surveyor and the CNA went to see the resident's mattress, the surveyor asked the CNA what kind of mattress the resident had. The CNA stated that it was not an air mattress, and it was a regular mattress.</p> <p>At that time, the CNA was not able to identify the scoop mattress which was in resident's bed.</p> <p>On 10/04/24 at 01:46 PM, the surveyor notified the DON the concern about tab alarm observed on the 1st day of tour on 9/30/24 on top of the nightstand and the 8/04/24 fall incident investigation that was mentioned about the pad alarm sounding off and that were not included in the active CP interventions. The DON stated that the facility discontinued (d/c) tab alarms before and not sure why it was in the fall incident investigation and why it was in the resident's room on the time the surveyor observed the resident's room.</p> <p>On 10/08/24 at 9:58 AM, the surveyor reviewed and printed out the CNA tab in the electronic medical records that included the aide's accountability and tasks and revealed:</p> <p>The electronic CNA Monitoring under Safety (searched data from December 2023 through October 2024) showed:</p> <ul style="list-style-type: none"> -4/13/24 at 6:06 PM, changed by Admission Nurse/Registered Nurse, and the details were blank. -8/06/24 at 9:38 AM, changed by ADON. Details: Notes changed from non-slip footwear, remind to call for assist to non-slip footwear, remind to call for assist, scoop mattress. -10/03/24 9:41 AM, changed by ADON. Details: Alarms changed from j-wander/elopement alarm to blank. Notes changed from non-slip footwear, remind to call for assist, scoop mattress to offer toileting assist before and after breakfast, non-slip footwear, remind to call for assist, scoop mattress. <p>Further review of the above CNA Monitoring under Safety for the CNAs tasks and accountability revealed that the fall interventions for offering toileting before and after breakfast were entered in the CNAs monitoring for safety not until 10/03/24, which was after surveyor's inquiry.</p> <p>On 10/08/24 at 10:30 AM, the surveyor showed to the DON the history when the CP interventions for fall incidents that happened on 3/25/24 and 5/11/24 for offer toileting before and after breakfast was entered to CNA task for monitoring for safety after surveyor's inquiry which was on 10/03/24. The DON acknowledged the surveyor's concerns about CP interventions entered in the CNAs task after surveyor's inquiry.</p> <p>A review of the facility's Resident Safety Program-Fall Prevention Policy with an effective date of 5/24 that was provided by the DON showed:</p> <p>Policy: All residents who are at risk for falls will be identified through a comprehensive assessment process. This risk will be addressed in the residents individualized treatment plan and be evaluated through the IDC (Interdisciplinary) Process.</p> <p>Procedure:</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |

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) |
|--|---|
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>1. Interventions are implemented based on risk areas identified by the Falls Risk Assessment .</p> <p>5. Safety devices (Physician Order is required) i.e. tab alarms to chair or bed or both, side rails up or down, self-release safety belt, wedge cushions, antitippers for wheelchairs.</p> <p>On 10/08/24 at 12:25 PM, the survey team met with the LNHA, DON, Medical Director, and the VP (Vice President) of Senior Services for an Exit Conference. The facility management did not provide additional information and did not refute the findings.</p> <p>NJAC 8:39-33.1(d)</p> |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide enough food/fluids to maintain a resident's health.</p> <p>46049</p> <p>Based on observation, interview, record review, and review of other pertinent facility provided documentation, it was determined that the facility failed to ensure a.) complete documentation of supplemental intake, for residents identified as at risk for malnutrition according to the physician's order and care plan interventions for two (2) of four (4) residents, Residents #90 and #124, and b.) monitored weight according to the physician order for one (1) of four (4) residents, Resident #124, reviewed for nutrition.</p> <p>This deficient practice was evidenced by the following:</p> <p>1. On 10/03/24 at 10:46 AM, the surveyor observed Resident #90 sitting up in bed, alert and verbally responsive. The resident stated that they would lose weight, gain weight back, and lose weight again. The resident stated recently they had a good appetite and did receive supplement drinks that they usually consumed. The resident had no concerns with their care.</p> <p>The surveyor reviewed the paper and electronic medical record (EMR) of Resident #90.</p> <p>The Resident Face Sheet (FS; a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, right lower leg fracture, anemia, thalassemia (a blood disorder that occurs when the body doesn't produce enough hemoglobin, a protein in red blood cells that carries oxygen), congestive heart failure, chronic kidney disease, and atrial fibrillation (a heart condition that causes an irregular, often very fast heartbeat).</p> <p>A comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 7/11/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #90 scored a 11 out of 15, which indicated the resident had moderate cognitive impairment.</p> <p>A physician's order (PO) dated 8/18/24 read, Ensure Plus, one can two times a day as supplement; every day at 10 AM and 7 PM; please record amount taken in monitoring section.</p> <p>A care plan (CP) with a focus that read, at risk for Nutrition/hydration deficits due to the following areas: recent surgery, bowel concerns; at risk for constipation; risk for skin breakdown; edema; characteristics of malnutrition; recent poor by mouth intake for food and fluids. The CP included goal, [Resident] will consume greater than 75% of fluids provided. Interventions included Encourage by mouth fluids and provide nutrient dense supplements Ensure BID [two times a day].</p> <p>A review of the August 2024 Medication Administration Record (MAR) and the monitoring section for intake documentation in the EMR revealed there was no recorded amount of the ensure supplement consumed by the resident on the following entries:</p> <p>8/01/24 at 10 AM and 7 PM</p> <p>8/02/24 at 10 AM</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | 8/03/24 at 10 AM and 7 PM 8/04/24 at 10 AM and 7 PM 8/05/24 at 10 AM 8/06/24 at 10 AM 8/08/24 at 10 AM and 7 PM 8/09/24 at 10 AM 8/10/24 at 10 AM 8/11/24 at 10 AM and 7 PM 8/12/24 at 10 AM 8/14/24 at 10 AM and 7 PM 8/15/24 at 10 AM A review of the September 2024 MAR and the monitoring section for intake documentation in the EMR revealed there was no recorded amount of the ensure supplement consumed by the resident on the following entries: 9/02/24 at 7 PM 9/03/24 at 7 PM 9/07/24 at 10 AM and 7 PM 9/08/24 at 10 AM and 7 PM 9/09/24 at 7 PM 9/11/24 at 7 PM 9/12/24 at 10 AM and 7 PM 9/13/24 at 7 PM 9/14/24 at 10 AM 9/16/24 at 10 AM and 7 PM 9/17/24 at 7 PM (continued on next page) |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>9/18/24 at 10 AM and 7 PM</p> <p>9/19/24 at 7 PM</p> <p>9/20/24 at 7 PM</p> <p>9/21/24 at 7 PM</p> <p>9/25/24 at 10 AM and 7 PM</p> <p>9/26/24 at 7 PM</p> <p>9/27/24 at 7 PM</p> <p>9/29/24 at 10 AM</p> <p>9/30/24 at 10 AM and 7 PM</p> <p>A review of the Dietician progress note (PN), dated 8/19/24 indicated the resident had a fair to good appetite, and had significant weight loss during a recent hospitalization . The resident weighed 198 pounds (lbs) on 7/08/24 and 176.8 lbs on 8/17/24, 21 lbs down. The Dietician's recommendations included but were not limited to, provide ensure plus two times a day and to monitor weights, labs (laboratory), by mouth intake and bowel movements.</p> <p>A follow up Dietician PN, dated 9/04/24, revealed the resident had some weight fluctuations, wanted to reduce the Ensure to once a day, and had varying by mouth intake.</p> <p>On 10/03/24 at 10:56 AM, the surveyor interviewed the Registered Nurse (RN) assigned to care for Resident #90. The RN stated the resident's appetite and food intake varied. Additionally, the RN stated the resident's supplement intake varied and they would refuse the supplement sometimes.</p> <p>On that same date and time, the surveyor asked about the documentation of the consumed intake by the resident. The RN confirmed the supplement entry in the MAR would be signed and the amount consumed recorded. The RN further explained when signing the entry, it would prompt the nurse to record the amount consumed. The surveyor asked about the blank entries observed in the MAR. The RN acknowledged it was expected for the supplement amount consumed to be recorded in the EMR and that there were times the resident did not want to drink the supplement at the time administered. The surveyor asked if the resident's intake of the supplement was monitored and recorded later. The RN stated no.</p> <p>On 10/04/24 at 01:10 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) about supplement documentation. The ADON stated the nurse would review the PO in the MAR, administer as ordered and record the amount the resident had consumed. The surveyor discussed the concern for entries identified in the EMR of the supplement amount consumed not be recorded by the nurses. The ADON acknowledged it was expected for the amount consumed to be documented and if it could not be entered at the time of administration a PN could be written by the nurses.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/07/24 at 01:10 PM, the surveyor, in the presence of the survey team, notified the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) of the identified in the EMR of the supplement amount consumed not be recorded by the nurses for a resident at risk for malnutrition.</p> <p>On 10/08/24 at 12:04 PM, the LNHA and the DON met with the survey team. The DON stated nursing staff were in-serviced about the supplement omissions and would continue to monitor to optimize the documentation process. There was no additional information provided by the facility.</p> <p>38327</p> <p>2. On 9/30/24 at 11:34 AM, the surveyor observed Resident #124 lying on their air mattress. The resident stated he/she was a picky eater, and aware that had loss some weight. The resident further stated that they were on a supplement to gain weight.</p> <p>On 10/02/24 at 8:30 AM, the surveyor interviewed the resident inside their room. The resident stated that the facility food was okay and had no concerns.</p> <p>The surveyor reviewed the medical records of Resident #124 and revealed:</p> <p>According to the Resident FS, the resident was admitted to the facility with a diagnosis that included but was not limited to hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, anemia (low blood count), anxiety disorder, and dependence on supplemental oxygen.</p> <p>The resident's most recent quarterly MDS (qMDS) with an ARD of 8/13/24 revealed in Section C Cognitive Status with a BIMS score of 14 out of 15 which reflected that resident was cognitively intact. The qMDS Section K Swallowing/Nutritional Status revealed that the resident had a weight loss of 5% or more in the last month or a loss of 10% in the last six months.</p> <p>The personalized CP with a focus on Nutrition with an effective date of 02/10/24 showed the resident's admission weight was 190 lbs. The CP interventions included but were not limited to provide nutrient-dense supplements and provide a selective menu for residents with an effective date of 02/10/24.</p> <p>A review of the PN that was electronically signed by the Registered Dietician (RD) on 9/23/24 showed that Resident #124 had a significant weight loss in the past six months, 39.5 lbs, the appetite was inconsistent, and ensure plus (strawberry) was offered and accepted by the resident. The PN included will continue to monitor intake/weight and intervene as appropriate.</p> <p>Further review of the PN showed that on 9/25/24 the Physician documented on their monthly notes that there was no mention in the conversation of any associated symptoms such as pain, and weight loss. The PN included an assessment and plan:</p> <p>-Diastolic CHF (congestive heart failure): on diuretics torsemide 10 mg (milligrams) once daily, monitor weights and cardiology follow-up outpatient.</p> <p>A review of the September and October 2024 PO revealed:</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-order date 8/23/24 Ensure plus one can 1 x a day as supplement flavor strawberry at 02:00 PM. Please record the amount taken in monitoring.</p> <p>-02/07/24 Please take daily weight in AM, before breakfast. Protocol: Please record weight in the monitoring section. Monitoring Weight.</p> <p>The above PO for Ensure plus and daily weight were transcribed to the MAR and showed:</p> <p>-September 2024 Ensure: four (4) out of 30 days were administered with 237 ml (milliliters) amount, five (5) out of 30 days coded with an asterisk (not administered), and the rest of the days were blank.</p> <p>-September 2024 Daily weight: two (2) out of 30 days had documentation of the resident's weight, 27 out of 30 days coded as refused, and one (1) out of 30 days was blank.</p> <p>-October 2024 Ensure: 2 out of 2 were blanks.</p> <p>-October 2024 Daily weight: 2 out of 2 were coded refused.</p> <p>Further review of the medical records showed that there was no documented evidence that the Physician was notified of the resident's refusal for daily weight and supplements. There was no documented evidence as to why the supplement and weight were refused and if they were addressed by the clinical team.</p> <p>On 10/03/24 at 10:59 AM, the surveyor interviewed the Team Leader/Registered Nurse (TL/RN) who was at the medication (med) cart for Beach St (street) in Heritage Manor East (HME). The TL/RN informed the surveyor that the supplement Ensure should be in the MAR and the intake amount should be documented in the MAR. The surveyor then notified the TL/RN of the above concerns and findings.</p> <p>At that same time, the surveyor asked the TL/RN what the expectation for nurses was when the resident had multiple refusals to obtain daily weight and the resident's supplement. The TL/RN stated that the nurse should have called the Physician and notify that daily weight was not done or refused as well as the ensure. She also stated that the nurse should document it in the EMR communication with the Physician.</p> <p>On 10/03/24 at 12:32 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above concern and findings.</p> <p>On 10/04/24 at 11:56 AM, the surveyor interviewed the RD in the nursing station of HME. The RD informed the surveyor that she had been working in the facility for four years and that she covered all LTC (Long Term Care) units including HME. While the surveyor and RD reviewing the white binder for weights, the RD stated that the records for weights were the monthly weights that she prepared for each unit and there was no separate list for daily weights, and it was the nurses who entered the daily weights. She further stated that the process for monthly weights, I put a list collected by the 6th of the month, I review who needs to reweigh and complete the reweigh. The RD also stated that everything should be completed including the reweigh on the 10th of the month.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |

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) |
|--|---|
| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On that same date and time, the RD informed the surveyor that the weight meeting was every 3rd of the week of the month. She stated that a significant weight loss of 5% in a month and 10% weight loss in 6 months weight loss of body weight then intervention provided. She further stated that she verbally follows up on how the resident takes supplements like Ensure or Glucerna. The RD also stated that I do not check the record or staff input of the intake, I don't know where to see and check them.</p> <p>At that same time, the surveyor asked how you know and follow up on the intervention if they were effective, and the RD stated, I don't know where to look. The surveyor also asked about the daily weight and how do you know it was being done. The RD stated, I don't order the daily weights, usually they order that daily weights in PACU (Post-acute care unit) specifically for CHF residents, and when the resident transitioned to LTC I usually recommend to discontinue (d/c) the order for daily weight.</p> <p>At that time, the surveyor notified the RD of the above concerns with Resident#124. The surveyor asked the RD if she recommended d/c the daily weight of the resident, and the RD stated, I can not answer that.</p> <p>On 10/07/24 at 01:09 PM, the survey team met with the LNHA and DON. The DON stated that I could only move forward with concerns with Resident#124. The facility did not provide additional information.</p> <p>On 10/08/24 at 12:04 PM, the survey team met with the LNHA and DON. The DON stated that from the clinical discussion, we had about the supplement, we did education and continually did tight audits. The DON stated that we talked about the omission to the MAR which we continually educate staff and auditing acuties.</p> <p>A review of the facility's High Calorie/High Protein Supplements Policy with an effective date of 01/24 that was provided by the DON revealed:</p> <p>Purpose: To provide supplemental caloric support to at risk residents.</p> <p>Procedure:</p> <p>A. Amount of supplement and frequency will be determined through nutrition assessment based on individual needs.</p> <p>B. All commercial medical food supplements will be ordered or approved by a physician or designee.</p> <p>C. Nursing staff will supervise the delivery and consumption of all supplements and record them appropriately in the MAR.</p> <p>D. Supplement acceptance will be documented in the progress notes, care plans, and assessments as appropriate</p> <p>A review of the facility's Weight Taking and Review Policy with an effective date of 01/24 that was provided by the DON showed:</p> <p>(continued on next page)</p> |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |

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) |
|--|--|
| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Policy: Residents will be weighed on a monthly basis unless more frequent monitoring is indicated. These weights will be reviewed for trending or significant changes with the IDC (Interdisciplinary) Team monthly.</p> <p>Procedure:</p> <p>D. The wing weight sheets will have specific dates for weighing residents</p> <p>J. Weighing intervals more often than monthly should be ordered for specified time periods and will be supervised by the wing nurse and recorded on the MAR for those specific time frames. These weights will be reviewed by the RD as per weighing interval and reported at the IDC meeting.</p> <p>K. All resident weights will be entered into the resident's medical record by the Nutrition Services or Nursing designee into the monitoring section of electronic medical records</p> <p>On 10/08/24 at 12:25 PM, the survey team met with the LNHA, DON, Medical Director, and the VP (Vice President) of Senior Services for an Exit Conference. The facility management did not provide additional information and did not refute the findings.</p> <p>NJAC 8:39-17.1(c), 17.2(d), 27.1(a)</p> |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>48423</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to monitor enteral tube feeding administration to assure the total volume administered was in accordance with physician's orders. This deficient practice was identified for two (2) of two (2) residents (Residents #157 and #230), reviewed for enteral tube feeding.</p> <p>This deficient practice was evidenced by the following:</p> <p>During an initial tour on 9/30/24 at 11:48 AM, Surveyor #1 (S#1) observed Resident #157 in bed, with their head of bed elevated. The surveyor observed there was a tube feeding (TF) pump and a pistol syringe hung on the pole, which was inside a plastic bag. The resident was not receiving TF at that time.</p> <p>On 10/03/24 at 11:07 AM, Surveyor #2 (S#2) observed Resident #157 sitting in chair. The surveyor observed the TF pump next to resident's chair. The resident was not receiving TF at the time.</p> <p>S#2 reviewed the paper and electronic medical record of Resident #157:</p> <p>The Resident Face Sheet (RFS; an admission summary) reflected that Resident #157 was admitted to the facility with diagnoses which included but was not limited to: Acute respiratory failure (a condition where there's not enough oxygen) with hypercapnia (too much carbon dioxide in your body), history of pneumonia (an infection of the air sacs of one or both lungs), anemia (deficiency of red blood cells), gastrostomy (a surgical procedure to make a hole into the stomach through the abdomen to insert a TF into the stomach), and dysphagia (difficulty in swallowing).</p> <p>A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 7/27/2024, the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating that the resident had a moderate impaired cognition. In Section K, Resident #157 was coded as receiving nutrition through a TF while a resident.</p> <p>A physician's order (PO) with a start date of 9/19/24 read: TF method with pump via PRN (as needed) tub: Nutren 1.5 stop enteral feedings when 1000 ml (milliliter) is delivered; stop time: 9 AM.</p> <p>The above PO for TF Nutren 1.5 was transcribed to the September 2024 Medication Administration Record (MAR). Further review of MAR revealed that the resident was delivered 1600 ml on 9/03/24 and 1900 ml of enteral feedings on 9/12/24, 9/20/24, 9/24/24, and 9/26/24.</p> <p>A review of the PO dated 8/01/24 revealed an order for Jevity 1.2 stop enteral feedings until 1350 ml is delivered; stop time 9 AM.</p> <p>The above PO for Jevity 1.2 was transcribed to the August 2024 MAR. Further review of the August 2024 MAR revealed that the resident was delivered 1450 ml on 8/03/24, 1720 ml on 8/05/24, and 2450 ml on 8/06/24.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Another PO dated of 8/06/24 for Nutren 1.5 stop enteral feedings when 1000 ml is delivered; stop time: 8 AM.</p> <p>The above PO for Nutren 1.5 on 8/06/24 was transcribed to the August 2024 MAR. Further review of MAR revealed that the resident was delivered 2100 ml on 8/07/24, 8/09/24 and 8/11/24. Resident was delivered 1100 ml on 8/15/24, 500 ml on 8/20/24, 100 ml on 8/21/24 and 1600 ml on 8/29/24.</p> <p>A review of PO dated 3/05/24 showed an order of Nepro stop enteral feedings until 1000 ml is delivered; stop time: 8 AM.</p> <p>The above order for 3/05/24 Nepro was transcribed to the July 2024 MAR. Further review of MAR revealed that the resident was delivered 0 ml on 7/01/24, 650 ml on 7/15/24, 100 ml on 7/21/24, 1400 ml on 7/22/24 and 1500 ml on 7/23/24.</p> <p>Further review of the above PO and MARs revealed that the PO for TF total volume to be administered was not followed.</p> <p>During an interview with S#2 on 10/07/24 at 10:26 AM, Licensed Practical Nurse #1 (LPN#1) stated that she would check PO for amount of total volume that would be delivered to the resident. The surveyor reviewed the July, August, and September 2024 MARs with LPN#1 and the LPN acknowledged that the Resident #157 should not have received more than what the physician had ordered. S#2 and LPN#1 checked the TF pump to look at the history of total volume the resident received during the previous shift and the total volume displayed 0 on the feeding pump screen.</p> <p>On 10/07/24 at 10:46 AM, S#2 interviewed Team Leader/Registered Nurse #1 (TL/RN#1) about the TF administration and total volume documentation. TL/RN#1 reviewed the PO in the presence of S#2 and stated, this order is clear, it said stop enteral feedings when 1000 ml is delivered. TL/RN#1 acknowledged that it was not acceptable that the resident received wrong total volume of tube feeding than ordered by the physician.</p> <p>On 10/07/24 at 12:21 PM, S#2 interviewed Registered Dietician #1 (RD#1) about TF administration and total volume documentation. RD#1 stated I am assuming the residents are receiving the prescribed amount of TF. RD#1 acknowledged that she did not review the MARs for Resident #157. S#2 reviewed the July, August, and September 2024 MARs with RD#1 and she could not speak as to why the documented amount of TF was incorrect.</p> <p>On 10/07/24 at 01:09 PM, S#2, in the presence of the survey team, notified the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) of the above concerns regarding the incorrect amount of total volume Resident #157 received upon completion of their feeding.</p> <p>On 10/08/24 at 12:05 PM, the survey team met with DON and LNHA. The DON stated the staff received in-service and education about total volume documentation. The DON did not provide any additional information.</p> <p>46049</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>2. On 9/30/24 at 11:27 AM, Surveyor #3 (S#3) observed Resident #230 lying in bed with the head of bed elevated, eyes open, and non-verbal. The resident was receiving an enteral feeding (a way of delivering nutrition directly to the stomach or small intestine) which was running at 55 milliliters/hour (ml/hr) on the TF pump.</p> <p>The surveyor reviewed the paper and electronic medical record of Resident #230.</p> <p>The RFS documented the resident had diagnoses that included but were not limited to, metabolic encephalopathy (brain disorder caused by a chemical imbalance in the blood that affects brain function), dysphagia, acute respiratory failure, and epilepsy (a chronic brain disorder that causes seizures).</p> <p>The QMDS with an ARD of 8/07/24, indicated the facility assessed the resident's cognition using a BIMS test. Resident #230 scored a 0 out of 15, which indicated the resident had severe cognitive impairment. In Section K (Swallowing/Nutritional Status), Resident #230 was coded as receiving nutrition through a TF while a resident.</p> <p>A PO with a start date of 9/04/2024 read, NPO [nothing by mouth] TF method with pump via PEG tube; Jevity 1.5 administer at 55 ml/hr until total volume of 1100 ml/day is delivered; start at 4 PM.</p> <p>A review of the September 2024 MAR revealed there was no documentation of when the TF was completed or the total volume of feeding the resident had received daily.</p> <p>A review of Resident #230's weight history did not present any significant weight loss in the last month.</p> <p>On 10/02/24 at 10:59 AM, S#3 interviewed LPN#2 about TF care and documentation. LPN#2 stated that TF was administered per the PO which would be found in the MAR. The MAR entry included the type of feeding to administer, the feeding rate, and for how long it was to run. LPN#2 confirmed the nurses would sign the MAR entry when the TF was started. The surveyor asked LPN#2 asked about the nurse documentation for when the resident received the total volume, and the feeding was completed. LPN#2 stated it could be written in the progress note (PN) that the feeding was completed.</p> <p>On 10/02/24 at 11:06 AM, S#3 interviewed Team Leader/Registered Nurse #2 (TL/RN#2) about TF administration and total volume documentation. TL/RN#2 stated the nurses were to review the MAR for the feeding order for the time and the total volume to be infused. S#3 asked TL/RN#2 about the documentation for the total volume received by the resident and when the administered feeding was removed. TL/RN#2 stated that the total volume was indicated with the TF order entry.</p> <p>On 10/02/24 at 11:13 AM, S#3 interviewed the Assistant Director of Nursing (ADON) about TF administration and total volume documentation. The ADON stated the nurses were to check the PO and administer the TF as ordered. S#3 asked the ADON about the documentation of the total volume of feeding infused and completion of the feeding. The ADON stated the nurses could document in their PN.</p> <p>On 10/02/24 at 11:32 AM, S#3 reviewed with the ADON the September 2024 MAR's TF entry for Resident #230. The ADON explained the nurses would sign the entry when the TF was administered and the box underneath the signed entry would document the total volume to be given to the resident.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A review of the nurse PN revealed, one nurse had documented the time the feeding was completed for the resident on 9/04/24, 9/05/24, 9/07/24, 9/08/24, 9/09/24, 9/11/24, and 9/12/24. There was no additional documentation found.</p> <p>On 10/02/24 at 12:02 PM, S#3 interviewed Registered Dietician #2 (RD#2) about residents receiving TF. RD#2 stated the total volume the resident was to receive would be documented in the MAR and the pump was set by the nurses to deliver the specified amount and would shut off when it was completed. She stated she would be notified by the nurses if there were any significant changes with the resident. RD#2 could not speak further to the required documentation by the nurses.</p> <p>On 10/02/24 at 01:15 PM, S#3, in the presence of the survey team, notified the DON and the LNHA of the above concerns regarding the documentation of the total volume the resident received upon completion of their feeding. S#3 asked about nurse documentation with TF administration and if there should be documentation for the total volume of feeding the resident received. The DON did not provide a verbal response and that stated she would review to provide further information.</p> <p>On 10/03/24 at 9:30 AM, the DON provided the surveyor documentation from another resident receiving TF which revealed there were two separate entries for when the feeding was to be administered and another for when the feeding was completed. The DON further explained for the entry for when the feeding was completed the nurse would document the total volume the resident received. The ADON acknowledged that Resident #230's MAR should have also had a second entry to indicate the feeding was completed and documentation of the total feeding volume received.</p> <p>A review of the facility provided policy titled Enteral Feeding and Accidental Tube Displacement, with an effective date of 02/24. Under Procedure, I. Enteral Feedings: A. Preparation: 1. Verify PO. III. Additional Nursing Care/Responsibilities/Documentation it read: .2. Document amount of residual, type and amount of feeding administered, amount of water administered as a flush, and resident/patient tolerance of procedure .</p> <p>On 10/08/24 at 12:25 PM, the survey team met with LNHA, DON, Medical Director, and [NAME] President (VP) of Senior Services for an Exit Conference. The facility did not refute the findings.</p> <p>NJAC 8:39-25.2(c)2; 27.1 (a)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39885</p> <p>REPEAT DEFICIENCY</p> <p>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure: a.) the resident's oxygen (O2) tubing was dated for two (2) of five (5) residents, Residents #9 and #38, b.) a physician's order for O2 and SPO2 (saturation of peripheral oxygen) monitoring was administered as ordered for two (2) of five (5) residents, Resident #9 and #124, and c.) proper storage of O2 cannula and tubing for one (1) of five (5) residents, Resident #157, reviewed for respiratory care, according to standards of clinical practice and facility policy and procedure.</p> <p>This deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.</p> <p>1. On 9/30/24 at 11:09 AM, Surveyor #1 (S#1) observed Resident#9 lying in bed with their eyes closed. Resident #9 was receiving O2 therapy at 2 LPM (liters per minute) via nasal cannula (n/c; a device that delivers extra O2 through a tube and into the nose) from an O2 concentrator (a medical device that provides supplemental oxygen). The surveyor observed that the O2 tubing was not dated to indicate when the tubing was last changed.</p> <p>On 10/01/24 at 10:36 AM, S#1 observed Resident#9 lying in bed with their eyes closed. Resident#9 was receiving O2 therapy at 2 LPM via n/c from an O2 concentrator. The surveyors observed that the O2 tubing was not dated.</p> <p>A review of Resident#9's Resident Face Sheet (FS; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to atherosclerotic heart disease (a condition where plaque builds up in the arteries of the heart, narrowing them and reducing blood flow), hypertension (high blood pressure) and tachycardia (a heart condition where the heart rate is faster than 100 beats per minute (bpm) while at rest).</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Resident #9's most recent annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's cognitive skills for daily decision making were severely impaired. Further review of the MDS indicated that the resident had not received O2 therapy.</p> <p>On 10/01/24 at 10:41 AM, S#1 interviewed the Licensed Practical Nurse (LPN) regarding O2 therapy. The LPN stated that the O2 tubing was changed every 3 days and that it was dated with a piece of tape. She added that it was not documented when changed. As needed (PRN) use based pulse ox (oximeter), not documented when changed.</p> <p>On 10/01/24 at 11:02 AM, S#1 interviewed Team Leader/Registered Nurse #1 (TL/RN#1) from Heritage Manor [NAME] (HMW) regarding O2 therapy. TL/RN#1 stated that the O2 tubing was changed weekly and was dated. She added that there was an order in the Medication Administration Record (MAR) to change the tubing. The surveyor then asked TL/RN#1 to view Resident #9's O2 tubing. TL/RN#1 confirmed that the O2 tubing was not dated and that it should have been.</p> <p>On 10/01/24 at 11:32 AM, S#1 reviewed Resident #9's September 2024 electronic MAR/TAR (Treatment Administration Record) which included the following order: O2 n/c PRN 2 LPM for SOB (shortness of breath) or to maintain SPO2 (a measurement of the amount of O2 in the blood) above 92%; check SPO2 q (every) shift with a start date of 10/03/2023. Further review of the MAR/TAR reflected that the order was not signed by the nurse as administered on 9/30/24 when the surveyor observed that Resident #9 was receiving O2. There was no indication that the O2 had been administered for the month of September. Further review of the order reflected that the residents SPO2 should be check q shift. Review of Resident #9's medical record reflected that the SPO2 was documented as being checked on 9/20/24 and 9/27/24. There was no documented evidence in the resident's medical chart that the SPO2 was being checked q shift.</p> <p>On 10/01/24 at 11:57 AM, S#1 interviewed the LPN regarding O2 order. She stated that if there was an order for PRN O2 then it would be documented in the TAR and the SPO2 would also be documented. The surveyor asked the LPN about Resident #9. The LPN stated that the resident was on hospice and the staff would check the SPO2 if it came up in the TAR. She added that it was not coming up in the TAR but that it was listed in the order section.</p> <p>On 10/01/24 at 12:10 PM, S#1 interviewed TL/RN#1 regarding O2 order. TL/RN#1 stated that if it was a PRN it would be in the TAR. She added that if the O2 was administered to the resident then it should be documented in the TAR. She then stated that if it was needed for a lower SPO2 then the SPO2 would be documented also. S#1 then asked TL/RN#1 about Resident #9's O2 order. She stated that she would have to look at the order and then get back to the surveyor.</p> <p>On 10/02/24 at 12:26 PM, S#1 interviewed the Director of Nursing (DON) regarding O2. The DON stated that O2 tubing was changed weekly and dated with tape. She added that it was a collaboration with the respiratory therapist and that nurses were also responsible. The surveyor then asked the DON about Resident #9's O2 order. The DON stated that she knew an issue was identified by the surveyor and that she gave the staff an inservice. She added that they had to click monitoring for the SPO2 part of the order. The DON stated that the order should have been followed, the nurse should have signed that the PRN order for O2 was administered and there should be an additional order for SPO2.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 10/02/24 at 01:29 PM, in the presence of the survey team, S#1 notified the Licensed Nursing Home Administrator (LNHA) and DON, the concerns that Resident #9 O2 tubing was not dated and that there was no documented evidence that the O2 had been administered and the SPO2 was being monitored q shift.</p> <p>On 10/03/24 at 12:35 PM, in the presence of the survey team and the LNHA, the DON stated that education was provided to staff on O2 and transcribing the order. She added that the SPO2 was ordered but that monitoring was not clicked.</p> <p>A review of the undated facility provided policy titled, Oxygen Therapy included the following:</p> <p>14. Change all disposable equipment weekly or per institution's infection control guidelines.</p> <p>The facility did not provide any additional information.</p> <p>49078</p> <p>2. On 9/30/24 at 10:52 AM, Surveyor #2 (S#2) observed Resident #38 sitting in a wheelchair, awake and willing to converse. Resident #38 was receiving O2 therapy at 2 LPM continuously via n/c from an O2 concentrator. The surveyor observed that the O2 tubing was not dated to indicate when the tubing was last changed and the humidifier bottle (a bottle of sterile water to add moisture to the O2) attached to the concentrator had a date written on the label of 9/25.</p> <p>A review of Resident FS reflected that the resident was admitted to the facility with diagnoses which included but were not limited to acute and chronic respiratory failure (a condition where the lungs cannot properly supply O2 to the blood), and chronic obstructive pulmonary disease (COPD; a condition where damage to the lungs limits inflow and outflow of air).</p> <p>A review of Resident #38's most recent Quarterly MDS (QMDS) dated [DATE], reflected that the resident's cognitive skills for daily decision making were intact.</p> <p>A review of the EMR reflected a physician's order (PO) for O2, via n/c, continuous. The EMR also reflected an order to clean O2 concentrator filter, change tubing and humidifier weekly and PRN.</p> <p>On 10/01/24 at 10:41 AM, S#2 observed Resident #38 sitting in a wheelchair (w/c) receiving O2 therapy at 2 LPM from an O2 concentrator. The resident stated to S#2, my tank is empty, it needs to be replaced. The surveyor observed that the gauge on the O2 tank hanging on the back of the resident's wheelchair reflected the needle in the red zone, indicating empty. S#2 observed that the tubing was not dated, and the humidifier bottle had the same date of 9/25 as previously observed.</p> <p>On 10/01/24 at 11:05 AM, S#2 interviewed the Assistant Director of Nursing (ADON) assigned to the Heritage Manor East (HME). S#2 asked the ADON who was responsible for changing residents' O2 tubing, moving the tubing from a concentrator to an O2 tank and what was the procedure. The ADON stated that the nurse on duty, for that room, should change the humidifier bottle and tubing at least once a week if the concentrator or tank is in use and the tubing and bottle should be dated. Tubing should be stored in a bag. The ADON also stated that a nurse must do any switch between a concentrator and a tank.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 10/02/24 at 12:57 PM, S#2 observed Resident #38 sitting in a w/c in their room. The surveyor interviewed the resident who stated they got a new O2 tank this morning. S#2 observed the tank and tubing, and the tank was full. S#2 did not observe a date on the tubing.</p> <p>On 10/03/24 at 10:16 AM, S#2 observed Resident #38 in a w/c, with an O2 with a n/c attached to an O2 tank. The surveyor did not observe a date on the tubing and observed a date of 9/25 on the humidifier bottle attached to the concentrator. This was the same date as observed 9/30/24 by this surveyor.</p> <p>On 10/03/24 at 12:39 PM, S#2 notified the DON and LNHA in the presence of the survey team of the concern regarding the dating of Resident #38's tubing and humidifier bottle. S#2 asked the DON who was responsible for changing and dating the tubing and humidifier bottles. The DON stated it was responsibility of nursing or respiratory therapist to date those items when they were changed or cleaned.</p> <p>A review of the facility provided policy titled, O2 Therapy dated 4/24, included the following:</p> <p>14. Change all disposable equipment weekly or per institution's infection control guidelines.</p> <p>The facility did not provide any further pertinent documentation.</p> <p>38327</p> <p>3. On 9/30/24 at 11:34 AM, Surveyor #3 (S#3) observed Resident #124 lying on the air mattress. The resident had an O2 via n/c attached to a concentrator at 2 LPM. The O2 humidified water bottle was dated 9/26. The resident stated that they always use O2.</p> <p>On 10/02/24 at 8:30 AM, S#3 observed the resident lying on the bed with an O2 via n/c at 2 LPM.</p> <p>The surveyor reviewed the medical records of Resident #124 and revealed:</p> <p>According to the Resident FS, the resident was admitted to the facility with a diagnosis that included but was not limited to hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, anemia (low blood count), anxiety disorder, and dependence on supplemental O2.</p> <p>The resident's most recent QMDS, with an assessment reference date (ARD) of 8/13/24 revealed in Section C Cognitive Status Brief Interview for Mental Status (BIMS) score of 14 out of 15 which reflected that resident was cognitively intact.</p> <p>The personalized care plan (CP) with a focus on respiratory dysfunction, at risk for breakthrough SOB with the goals of SPO2 with an effective date of 6/04/24. The active CP interventions included but were not limited to monitor for s/s (signs and symptoms) SOB-obtain SPO2 q shift and PRN for s/s SOB-see PRN O2 with an effective date of 6/04/24.</p> <p>A review of the September and October 2024 PO revealed:</p> <p>-order date 6/04/24 O2 n/c PRN for SOB 2 LPM to maintain SPO2 greater than 90% monitoring: O2 SPO2.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-order date 6/04/24 Obtain SPO2 q shift and PRN for s/s of SOB</p> <p>The above orders for PRN O2 at 2 LPM and obtain SPO2 q shift and PRN were transcribed to the MAR for September and October 2024 and showed:</p> <p>-September 2024 Obtain SPO2 q shift and PRN: On 9/02/24 at 7 AM-3 PM shift the SPO2 was recorded at 90%. On 9/04/24 at 11 PM-7 AM shift the SPO2 was blank (no SPO2 obtained). On 9/05/24 at 11 PM-7 AM shift the SPO2 was blank.</p> <p>-September 2024 PRN O2: there was no signature of the nurse that the PRN O2 was administered on and 9/02/24 at 7 AM-3 PM shift and 9/30/24.</p> <p>Further review of the above PO and MAR revealed that there was no documented evidence that the resident received the PRN O2 on 9/02/24 at 7 AM-3 PM shift when the SPO2 was below 91%. There was no documented evidence that the nurse signed the MAR on 9/30/24 when the surveyor observed the resident with O2 at 11:34 AM of 9/30/24. In addition, the nurses did not follow the PO to obtain the SPO2 q shift on 9/04/24 and 9/05/24 of the 11 PM-7 AM shift.</p> <p>On 10/03/24 at 10:59 AM, S#3 interviewed TL/RN#2 who was at the medication (med) cart for Beach St (street) in HME. TL/RN#2 informed S#3 that the SPO2 should be documented in the MAR and signed when PRN O2 was administered according to the PO. S#3 then notified TL/RN#2 of the above concerns and findings.</p> <p>On 10/03/24 at 12:32 PM, the survey team met with the LNHA and DON. S#3 notified the facility management of the above concern and findings.</p> <p>On 10/07/24 at 01:09 PM, the survey team met with the LNHA and DON. The DON stated that I could only move forward with concerns with Resident#124. The facility did not provide additional information.</p> <p>On 10/08/24 at 12:04 PM, the survey team met with the LNHA and DON. The DON stated that we talked about the omission to the MAR which we continually educate staff and auditing acuities.</p> <p>48423</p> <p>4. During the initial tour on 9/30/24 at 11:48 AM, S#3 observed Resident #157 in bed with an O2 concentrator with humidifier at their bedside, which was on and set to 2 LPM. The humidifier was dated 9/27 with black marker.</p> <p>S#4 reviewed the medical record for Resident #157.</p> <p>The Resident FS reflected that Resident #157 was admitted to the facility with diagnoses which included but was not limited to: Acute respiratory failure (a condition where there's not enough O2) with hypercapnia (too much carbon dioxide in your body), history of pneumonia (an infection of the air sacs of one or both lungs), anemia (deficiency of red blood cells), gastrostomy (a surgical procedure to make a hole into the stomach through the abdomen to insert a feeding tube into the stomach), and dysphagia (difficulty in swallowing).</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>A review of the QMDS dated [DATE], the resident had a BIMS score of 10, indicating that Resident #157 had a moderate impaired cognition.</p> <p>A review of Resident #157's PO reflected the following orders:</p> <p>Monitoring: Check for use of O2 concentrator weekly- clean, filter, change tubing and humidifier dated 5/28/24.</p> <p>Monitoring: Obtain SPO2 q shift and PRN for s/s SOB *see PRN O2 order for SPO2 less than 93% schedule dated 5/28/24</p> <p>Respiratory Therapy- O2: [X]n/c; [X] PRN for SOB - 2 LPM to maintain SPO2 > 92% dated 5/28/4.</p> <p>On 10/02/24 at 11:48 AM, Surveyor #4 (S#4) observed Resident #157 sitting in chair and was not using O2 at the time. S#4 observed the O2 tubing was connected to the concentrator and the other end was hanging on the tube feeding pole which was behind the resident's chair. The tubing was not placed in a plastic bag or stored properly.</p> <p>During an interview with S#4 on 10/02/24 at 12:09 PM, the LPN stated that when O2 was not in use, the O2 tubing would be placed in a plastic bag and the bag would be placed in nightstand drawer. The LPN further stated it was important to do that so that the tubing does not get contaminated if it was touched by staff and you can give micro-organisms to the resident and complicate their health. It was important to prevent the infection to the residents.</p> <p>At 12:25 PM, S#4 and the LPN visited Resident #157's room and both observed the resident's O2 tubing hanging on the feeding pump pole. LPN #1 stated that she would have to dispose off the O2 tubing and get a new one because she could not tell how long the O2 tubing had been there for. The LPN acknowledged that it was not acceptable practice to place the O2 tubing on the tube feeding pole.</p> <p>During an interview with S#4 on 10/02/24 at 12:29 PM, TL/RN#2 stated that when O2 was not in use, the O2 tubing would be placed in a special plastic bag with white strings. To store the O2 tubing in the plastic bag was important for infection control. S#4 notified TL/RN#2 of what was observed in Resident #157's room and TL/RN#2 acknowledged that it was not acceptable practice for infection control.</p> <p>On 10/02/24 at 01:13 PM, the survey team met with the LNHA and DON. S#4 notified the facility management of the above findings. The DON who acknowledged the O2 tubing should not be hanging on the tube feeding pole and further stated that the tubing should be bagged for infection control.</p> <p>A review of the facility's policy, Respiratory Therapy with effective date 4/24 did not address the protocol for the nurses regarding how to store O2 equipment properly when not in use.</p> <p>On 10/08/24 at 12:25 PM, the survey team met with LNHA, DON, [NAME] President (VP) of Senior Services and VP of Medical Affairs for an Exit Conference. The facility did not refute the findings.</p> <p>NJAC 8:39-11.2(a)(b); 19.4(a); 27.1(a)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>46049</p> <p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident's routine pain level assessment was being completed and documented according to the facility's policy and standards of practice. This deficient practice was identified for one (1) of one (1) resident reviewed for pain management (Resident #253), and was evidenced by the following:</p> <p>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.</p> <p>On 9/30/24 at 10:18 AM, the surveyor observed Resident #253 lying in bed, alert and verbally responsive. The resident reported they had pain to a wound on their backside. The resident stated the wound was being treated and could not verbalize anything they would receive for pain.</p> <p>On 10/01/24 at 10:40 AM, the surveyor observed Resident #253 lying in bed, alert and verbally responsive. The resident stated that they had pain and reported to the nurse who had changed their wound dressing. The resident also explained that they repositioned while in bed for comfort. The resident was asked if they were offered anything else for their pain, such as pain medication (med). The resident stated Yes .but I don't want it.</p> <p>On 10/01/24 at 10:44 AM, the surveyor interviewed the Registered Nurse (RN) assigned to care for Resident #253. The RN stated the resident was alert with periods of forgetfulness and able to communicate their needs. The RN further stated the resident did occasionally have complaints of pain, usually to the backside area at a pain level from 2 to 3. The RN explained the resident had as needed (PRN) pain med orders, didn't like taking pain med, and won't take anything stronger than Tylenol if the did agree to take med.</p> <p>At that same time, the RN stated the resident also had a lidocaine patch order which previously was routine, but the resident refused at times. The surveyor asked about non-pharmacological interventions for the resident. The RN stated they would reposition the resident, encourage the resident to get out of the bed during the day, and had a pressure relieving device for the resident's chair. The RN further explained that a specialized air mattress was provided for the resident, the resident did not like it and refused the air mattress.</p> <p>On 10/01/24 at 11:46 AM, the surveyor interviewed the RN about pain assessment protocol. The RN stated when giving a PRN pain med, the pain level would need to be documented in the MAR at the time of administration and upon follow up for the pain med's effectiveness. She stated it could also be documented in a progress note (PN), and there was a weekly pain assessment documentation that could be completed.</p> <p>The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #253.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The Resident Face Sheet (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, dementia, spondylosis (degeneration of the bones and disks in the neck), dorsalgia (pain in the back), anxiety, and type 2 diabetes mellitus.</p> <p>A comprehensive Minimum Data Set (MDS), an assessment used to facilitate the management of care, dated 9/04/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #253 scored a 09 out of 15, which indicated the resident had moderate cognitive impairment. Under Section J- Health Conditions, it documented the resident had not received any schedule or PRN pain med during the look back (review) period.</p> <p>A physician's order (PO) dated 9/03/2024 read, acetaminophen 325 mg (milligram) tablet, give 2 tablets (650 mg) by oral route every 6 hours PRN for mild pain.</p> <p>A PO dated 9/03/2024 read, tramadol 50 mg tablet, give 1 tablet (50 mg) by oral route once daily PRN for moderate to severe pain.</p> <p>A PO dated 9/25/24 read, lidocaine 5% topical patch, apply 1 patch by transdermal route once daily PRN lower back pain.</p> <p>There were no PO for pain assessment and monitoring.</p> <p>Under monitoring in the electronic medical record (EMR), a review of the pain level monitoring revealed two entries on 9/06/24 and 9/26/24 in which the resident had a pain level of 3 of 10 (0 representing no pain to 10 representing the worst possible pain). There were no other entries.</p> <p>A review of the September 2024 Medication Administration Record (MAR) revealed the resident received PRN Tylenol on 9/06/24 and 9/26/24 for a documented numeric pain level, 3 out of 10.</p> <p>Additional review of the MAR revealed the resident had not been administered PRN tramadol or the PRN lidocaine patch. The resident also previously had a routine order for a lidocaine patch once daily, from 9/03/24 to 9/25/24 in which the resident had refused the med for 12 of the 22 days.</p> <p>A review of the resident's care plans (CP) included a CP with the focus of skin integrity. The CP for skin integrity related to the resident's sacral wound which was dated 9/16/24. An intervention dated 9/16/24 read, Monitor for signs and symptoms of pain and medicate as needed and as ordered.</p> <p>On 10/01/24 at 11:57 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) a policy regarding pain and pain assessment.</p> <p>On 10/02/24 at 11:06 AM, the surveyor interviewed the Registered Nurse/Team Leader (RN/TL) about pain assessment protocol. The RN/TL stated it was expected for residents to be assessed for pain at least every shift and PRN. The surveyor asked about the nurse documentation of pain assessments. The RN/TL stated pain assessment would be documented upon giving a resident pain med and could be written PRN/per episode in a PN.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |

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) |
|--|---|
| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/02/24 at 01:15 PM, the surveyor, in the presence of the survey team, notified the Director of Nursing (DON) and the LNHA of the concern that there was no routine pain assessment documented for Resident #253. The surveyor asked the DON about the facility's protocol. The DON stated a weekly pain assessment should be completed especially if the resident had orders for pain meds. The DON further stated there was an active Quality Assurance Performance Initiative (QAPI) on pain assessment in progress.</p> <p>On 10/03/24 at 12:32 PM, the DON and the LNHA met with the survey team. The DON provided the QAPI for pain assessment. The DON acknowledged there was no weekly pain assessment found for Resident #253 and that there should have been a routine pain assessment for the resident.</p> <p>A review of the facility provided policy titled, Pain Management-Senior Care Division with an effective date of 7/24 read under Procedure: A. Pain is assessed by the nurse on all residents/patient's condition and self-reporting of pain .E. Each patient is reassessed for pain at regular intervals .</p> <p>NJAC 8:39-27.1 (a)</p> |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>46049</p> <p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to provide care and services in accordance with professional standards clinical practice with regards to: a.) clarify and follow a physician's order (PO) for midodrine medication, and b) document the consumed fluid intake for a resident with a PO for fluid restrictions. This deficient practice was observed for one (1) of one (1) resident reviewed for dialysis care and services, Resident #188.</p> <p>This deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.</p> <p>On 10/03/24 at 10:38 AM, the surveyor observed Resident #188 was not in their room. The resident was at hemodialysis (HD; process of filtering blood due to kidney was not functioning as should be) which was scheduled every Tuesday, Thursday, and Saturday.</p> <p>The surveyor reviewed the paper and electronic medical record (EMR) of Resident #188.</p> <p>The Resident Face Sheet (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, End stage renal disease, and dependence on renal [kidney] dialysis.</p> <p>A comprehensive Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, dated 7/25/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #188 scored a 15 out of 15, which indicated the resident was cognitively intact.</p> <p>A PO dated 8/27/24 read, Dialysis every Tuesday/Thursday/Saturday at [HD Center Name, phone number and address], chair time 10:30 AM.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A PO dated 8/27/24 read, Fluid Restriction: 1000 ml (milliliters) per day; Nursing allotment: 280 ml (120 ml with each 7-3 and 3-11 for meds (medications); 40 ml on 11-7 for meds); Dietary allotment: 720 ml; Nursing to monitor and record all fluid taken at meals/snacks/medication pass per shift and enter ml into monitoring section of [EMR].</p> <p>A PO dated 8/27/24 read FYI [For your information] please document if PRN [as needed] midodrine is utilized at HD .every day at 7:00 AM-3:00 PM; 3:00 PM -11:00 PM</p> <p>A PO with a start date of 9/19/24 read midodrine 5 mg (milligram) tablet (tab) . give 1 tablet (5 mg) by oral route 3 times per week PRN For B/P [blood pressure] below 90/50 and hold for SBP (systolic blood pressure) >130 PLEASE SEND IN A BOTTLE TO HD .every 3 weeks on Tuesday; Thursday; Saturday at 9:00 AM</p> <p>A review of September 2024 Medication Administration Record (MAR) revealed the following:</p> <p>The above midodrine (a medication to treat low B/P) 5 mg medication (med) order was scheduled for 9 AM in which the nurses signed on 9/24/24 and 9/26/24 that the resident was administered the med.</p> <p>A discontinued order entry in the MAR with a start date of 8/27/24 read, midodrine 5 mg tab . give 1 tab (5 mg) by oral route 3 times per week PRN For B/P below 90/50 and hold for SBP >130 PLEASE SEND IN A BOTTLE .and it was scheduled as PRN. The medication was documented as administered on 9/5/24 at 8:59 AM.</p> <p>The above fluid restriction PO was scheduled for every shift. On the following days there was no documented amount for the resident's fluid intake: 9/2/24 on 3-11 shift, 9/3/24 on 7-3 shift, 9/8/24 on 11-7 shift, 9/11/24 on 3-11 shift, and 9/21/24 on 7-3 shift.</p> <p>A care plan with a focus of HD, dated 7/26/24 included the following interventions:</p> <p>Fluid Restriction: 1000 ml per day; Nursing allotment: 280 ml (120 ml with each 7-3 and 3-11 for meds; 40 ml on 11-7 for meds); Dietary allotment: 720 ml; Nursing to monitor and record all fluid taken at meals/snacks/med pass per shift and enter ml into monitoring section of [EMR].</p> <p>Document if PRN midodrine is utilized at HD.</p> <p>Administer med as ordered.</p> <p>On 10/04/24 at 12:40 PM, the surveyor interviewed the registered nurse (RN) assigned to care for Resident #188. The RN stated that it was expected for fluid intake of the resident to be documented every shift and a note written for any episodes of non-compliance by the resident. The RN acknowledged that entries on the MAR should not be left blank.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The surveyor asked about the resident's midodrine med. The RN stated the midodrine med was sent with the resident to HD and the resident would receive midodrine in HD PRN. The RN further explained it was to be documented by the nurses if the resident received the med at HD. The surveyor asked if the resident was to receive midodrine in the facility or only at HD. The RN stated if the resident's B/P was low before HD, the resident may receive midodrine, the physician would be made aware, and it would be written on the HD communication form that was sent with the resident. The RN showed the surveyor a countdown sheet for the midodrine med in a prescription bottle for Resident #188. The countdown sheet was for the HD nurse to sign when the med was given to the resident at HD. The RN provided the surveyor with Resident #188's HD communication binder.</p> <p>On 10/04/24 at 12:51 PM, the surveyor reviewed the HD communication binder for Resident #188 which included HD communication forms. The HD communication forms included two sections to be completed. The first section was to be filled by the facility nurse before the resident left for HD. The nurse would have to write the date, pre-HD weight, B/P, temperature and pulse and any concerns to be communicated to the HD center. The second section was to be completed by the HD center nurse after the resident completed HD. The dialysis nurse was to write the post HD weight, B/P, temperature, and pulse and any recommendations/concerns from the HD center.</p> <p>A HD communication form dated 9/05/24 revealed the resident received midodrine 5 mg prior to HD by the facility nurse and the physician was made aware.</p> <p>A HD communication forms dated 9/10/24 indicated the resident received midodrine 5 mg at 9 AM prior to going to HD by the facility nurse.</p> <p>A HD communication forms dated 9/19/24 indicated the resident received midodrine 5 mg at 8:58 AM prior to going to HD by the facility nurse.</p> <p>On 10/04/24 at 01:10 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) about fluid restriction documentation. The ADON stated it was expected for the nurses to document for residents on fluid restrictions every shift and MAR entries should not be left blank. The surveyor informed the ADON of the concern of the missing entries found for fluid restriction monitoring in the MAR. The ADON stated she would review and provide any additional information.</p> <p>At that same time, the surveyor notified the ADON about the concern for the midodrine med order for Resident #188. The DON stated that the resident was to receive the med at HD as needed for low B/P. The ADON could not speak to if the resident was to receive midodrine med at the facility prior to HD or only at the HD center. The ADON stated she would have to review the resident's PO and MAR to provide additional information.</p> <p>On 10/04/24 at 02:30 PM, the surveyor notified the Director of Nursing (DON) about the concern for the resident's midodrine order. The DON stated she was aware the midodrine was sent with the resident to HD, to treat low B/P. The DON could not speak further to the midodrine med order and would review Resident #188's medical record to provide additional information.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |

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) |
|--|---|
| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/07/24 at 01:10 PM, the surveyor, in the presence of the survey team, notified the Licensed Nursing Home Administrator (LNHA) and the DON of the above concern for the midodrine med order for Resident #188. The DON stated the midodrine order was clarified to reflect for the med to be sent with the resident to HD and for it to be documented that the med was given at HD. There was additional information provided by the facility.</p> <p>A review of the facility's policy titled Dialysis Policy, last revised 10/23, under Procedure it read: .2. Any concerns will be documented in communication book by [the facility] and the HD center for each facility to review .10. The nurse will follow the PO for vital signs, nutrition, weight and fluid needs .12. Fluid restriction will be monitored. As per our policy .</p> <p>NJAC 8:39-27.1(a)</p> |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48423</p> <p>COMPLAINT #: NJ170023 and NJ172045</p> <p>Based on interview, record review, and review of pertinent facility documentation, it was determined the facility failed to ensure sufficient nursing staff and ensure call bells were answered timely without waiting a long period of time for two (2) of (2) two residents (Residents #463 and #513).</p> <p>This deficient practice was evidenced by the following:</p> <p>1. Surveyor #1 (S#1) reviewed the Alarm Average Response Time Report for Heritage Manor [NAME] 327-336 bed, from 02/20/24-3/15/24 for Resident #463, who was admitted to room [ROOM NUMBER]W.</p> <p>For room [ROOM NUMBER]-W, the section under Report Detail reflected the following dates and response times (>15 minutes):</p> <p>3/14/24 at 05:15 PM response time was 17 minutes (mins) and 32 seconds (secs)</p> <p>3/12/24 at 10:17 PM response time was 18 mins and 19 secs</p> <p>3/12/24 at 09:51 PM response time was 23 mins and 11 secs</p> <p>3/11/24 at 11:19 PM response time was 16 mins and 21 secs</p> <p>3/10/24 at 10:46 PM response time was 24 mins and 58 secs</p> <p>3/10/24 at 06:55 PM response time was 22 mins and 22 secs</p> <p>3/09/24 at 09:24 PM response time was 19 mins and 01 secs</p> <p>3/08/24 at 03:10 PM response time was 15 mins and 51 secs</p> <p>3/06/24 at 06:59 AM response time was 24 mins and 22 secs</p> <p>3/05/24 at 07:26 PM response time was 24 mins and 58 secs</p> <p>3/05/24 at 11:08 AM response time was 54 mins and 26 secs</p> <p>3/03/24 at 04:23 PM response time was 24 mins and 20 secs</p> <p>3/03/24 at 03:44 AM response time was 48 mins and 48 secs</p> <p>2/27/24 at 04:36 PM response time was 16 mins and 50 secs</p> <p>2/23/24 at 09:16 PM response time was 78 mins and 59 secs</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>S#1 reviewed Resident #463's closed electronic medical records (EMR) which revealed the following:</p> <p>A review of Resident Face Sheet (RFS; an admission summary) reflected that Resident #463 was admitted to the facility with diagnoses which included but was not limited to: limitation of activities due to disability, pleural effusion (is a collection of fluid around lungs), non-Hodgkin lymphoma (a type of cancer that begins in lymphatic system, which is part of the body's germ-fighting immune system), and squamous cell carcinoma (a common type of skin cancer from squamous cells) of skin of scalp and neck.</p> <p>A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 02/27/2024, reflected that Resident #463 had a Brief Interview for Mental Status (BIMS) score of 10, indicating that the resident had a moderate impaired cognition.</p> <p>On 10/03/24 at 12:31 PM, the survey team met with Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). S#1 notified the facility management of the above concerns and findings about call bell response time as mentioned above.</p> <p>49078</p> <p>2. Surveyor #2 (S#2) reviewed Resident #513's closed EMR which revealed the following:</p> <p>The RFS documented that the resident had diagnoses that included but were not limited to, displaced intertrochanteric fracture of right femur (a type of hip fracture), essential hypertension (high blood pressure), depression.</p> <p>On 10/03/24 at 9:30 AM, the LNHA provided the requested reports titles Alarm Average Response Time Report (Call Bell Report) for rooms 332-D and 349-W for the dates 12/19/24 to 01/01/24.</p> <p>S#2 reviewed the Call Bell Report which revealed the following:</p> <p>For room [ROOM NUMBER]-D, the section Report Detail reflected the following times and dates:</p> <p>12/31/23 at 06:26 PM response time 33 mins and 22 secs</p> <p>12/29/23 at 08:15 PM response time 27 mins and 42 secs</p> <p>12/29/23 at 02:08 PM response time 19 mins and 03 secs</p> <p>12/28/23 at 08:15 PM response time 24 mins and 41 secs</p> <p>12/24/23 at 06:03 PM response time 54 mins and 03 secs</p> <p>For room [ROOM NUMBER]-W, the section Report Detail reflected the following times and dates:</p> <p>01/01/24 at 11:00 PM response time 46 mins and 25 secs</p> <p>01/01/24 at 05:41 PM response time 16 mins and 29 secs</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>01/01/24 at 02:08 PM response time 23 mins and 05 secs</p> <p>01/02/24 at 09:36 AM response time 81 mins and 46 secs</p> <p>On 10/04/24 at 12:47 PM, S#2 interviewed the DON in the presence of the survey team. The DON stated that call bell issues were resolved in real time. Any outlier reports were addressed to determine the cause. The DON also stated that some long call times were caused by the call bell not being shut off when the resident was assisted. The DON did not provide any supportive documentation.</p> <p>The facility did not provide any further pertinent information.</p> <p>3. A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the one-week period beginning 12/24/2023 and ending 12/30/2023 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for residents on 6 of 7 day shifts as follows:</p> <ul style="list-style-type: none"> -12/24/23 had 29 CNAs for 268 residents on the day shift, required at least 33 CNAs. -12/25/23 had 31 CNAs for 268 residents on the day shift, required at least 33 CNAs. -12/26/23 had 30 CNAs for 268 residents on the day shift, required at least 33 CNAs. -12/27/23 had 30 CNAs for 268 residents on the day shift, required at least 33 CNAs. -12/29/23 had 29 CNAs for 268 residents on the day shift, required at least 33 CNAs. -12/30/23 had 30 CNAs for 270 residents on the day shift, required at least 33 CNAs. <p>On 10/08/24 at 01:00 PM, the survey team met with the LNHA and DON. Surveyor #3 (S#3) notified the facility management of the above concerns for staffing.</p> <p>There was no additional information provided by the facility.</p> <p>NJAC 8:39-25.2(a,b)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>38327</p> <p>REPEAT DEFICIENCY</p> <p>Based on interviews, record review, and a review of pertinent facility documents, it was determined that the facility failed to identify the irregularity with regard to the physician's order for one (1) of 38 residents, Resident #12 reviewed for medication in accordance with facility's practice and policy.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 9/30/24 at 11:46 AM, Surveyor #1 (S#1) observed Resident #12 inside their room near the door seated in a wheelchair.</p> <p>The surveyor reviewed the medical records of Resident #12 and revealed:</p> <p>According to the Resident Face Sheet (an admission summary), the resident was admitted to the facility with diagnoses that included but were not limited to Barrette's esophagus without dysplasia (a change in the cellular structure of your esophagus [a tubular, elongated organ of the digestive system which connects the pharynx to the stomach] lining), gastro-esophageal reflux disease without esophagitis (a type of GERD that does not involve inflammation of the esophagus), and heartburn (burning pain or discomfort in the upper chest and midchest, possibly involving the neck and throat, that may worsen when lying down).</p> <p>The most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 7/04/24 revealed a brief interview for mental status (BIMS) score of 14 out of 15 which indicated that resident was cognitively intact.</p> <p>A review of the September and October 2024 Physician's Order (PO) revealed:</p> <p>-order date 8/31/24 for Florastor (a probiotic, or friendly bacteria, to prevent the growth of harmful bacteria in the stomach and intestines) 250 mg (milligram) cap (capsule) give one (1) cap by oral route every 12 hours as needed (PRN) for loose stool.</p> <p>The above order for Florastor was transcribed to the September and October 2024 Medication Administration Record (MAR), plotted at 9:00 AM and 9:00 PM and signed by nurses as administered routinely.</p> <p>A review of the Pharmacy Progress Notes (PN) dated 8/05/24 and 9/03/24 showed that Consultant Pharmacist #1 (CP#1) did not identify the irregularity for the PO Florastor PRN and the nurses signed the MAR as administered routinely for 9:00 AM and 9:00 PM.</p> <p>A review of the August and September 2024 Electronic Pharmacist Information Consultant reports (white binder) showed that CP#1 did not identify the irregularity for the PRN order of Florastor.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/01/24 at 12:17 PM, S#1 interviewed the Licensed Practical Nurse (LPN). The surveyor asked the LPN about the PO for Florastor, and the LPN stated that the order should have been clarified because the medication (med) should be given routinely and not PRN.</p> <p>On 10/02/24 at 10:45 AM, Surveyor #2 (S#2) interviewed CP#2 in the presence of two other surveyors. CP#2 stated for the Florastor order, the CP would at minimum ask to clarify the order if it was PRN or standing. CP#2 further stated that the Florastor not usually PRN, should be one way or another or have MD (Medical Doctor) document rationale if used as PRN.</p> <p>On 10/02/24 at 01:13 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The surveyor notified the facility management of the above concerns and findings.</p> <p>On 10/03/24 at 12:32 PM, the survey team met with LNHA and DON. The DON stated that the order for PRN Florastor should be scheduled routinely for 9 AM and 9 PM.</p> <p>A review of the facility's Medication Management Policy with an effective date of 01/24 that was provided by the DON revealed:</p> <p>Purpose: To provide effective and safe Med Management processes related to the planning selection/procurement, storage, ordering, preparing/dispensing, administration, monitoring, and evaluation of med management systems. The med management system is based on the care, services, and treatment that is provided to our patients.</p> <p>Policy: It is the facility's policy to address the med management needs of patients safely and effectively.</p> <p>Procedure:</p> <p>A. Transcription and Processing of Physician Orders</p> <p>1. Transcription and processing of PO is a critical element in assuring that clients receive correct medications, treatments, and tests.</p> <p>3. Acceptable types of orders:</p> <p>a. PRN orders-orders acted upon based on the occurrence of a specific indication or symptom .</p> <p>On 10/08/24 at 12:25 PM, the survey team met with the LNHA, DON, Medical Director, and the VP (Vice President) of Senior Services for an Exit Conference. The facility management did not provide additional information and did not refute the findings.</p> <p>NJAC 8:39-29.3 (a)(1)</p> <p>49078</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure medication error rates are not 5 percent or greater.</p> <p>49078</p> <p>Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to ensure that all medications were administered with an error rate of less than 5%. During the medication administration observation conducted on 10/02/24, the surveyor observed four (4) nurses administer meds to five (5) residents. There were twenty-eight (28) opportunities, and two (2) errors were observed which resulted in a medication error rate of 7.14%. This deficient practice was identified for one (1) of five (5) residents observed (unsampled resident), which was administered by one (1) of four (4) nurses.</p> <p>This deficient practice was evidenced by the following:</p> <p>According to the manufacturer's specifications for Carbidopa/Levodopa (Sinemet) (a medication used to treat Parkinson's disease), administration of Iron (a mineral supplement) or Iron containing products with Sinemet may reduce the amount of Levodopa available in the body.</p> <p>According to clinical documentation and accepted practice, Calcium (a mineral supplement) may reduce the absorption of Iron in the body.</p> <p>On 10/02/24 at 9:11 AM, the surveyor observed the Registered Nurse (RN) prepare medications (meds) for an unsampled Resident. The meds included an active physician's orders (PO) dated 9/13/24 for the following:</p> <p>Carbidopa 25 mg-Levodopa 100 mg (milligram) tablet (tab) give 2 tablets (tabs) by oral route 4 times per day for Parkinson disease. The order was plotted in the electronic Med Administration Record (eMAR) for 9:00 AM, 01:00 PM, 6:00 PM and 9:00 PM.</p> <p>Calcium 500 with D 500 mg-10 mcg (microgram) (400 unit) tab give one tab by oral route 2 times per day with meals for supplement. The order was plotted in the eMAR for 8:00 AM and 5:00 PM.</p> <p>Multivitamin with minerals tab give 1 tab by oral route once daily. The order was plotted in the eMAR for 9:00 AM.</p> <p>The surveyor observed the RN remove the Carbidopa/Levodopa, Calcium 500 with D and Multivitamin with minerals from the packaging and place in a medication (med) dose cup. The surveyor did not observe the RN check any of the med packaging for cautionary or informational warnings. The surveyor observed the RN administer all due meds to the resident.</p> <p>The surveyor asked the RN to see the bottle for multivitamin with minerals. The surveyor observed that the ingredients listed on the label included ferrous sulfate (Iron) 4.5 mg per tab. The surveyor showed the RN the label and asked if the med contained Iron. The RN agreed that the med contained Iron. The surveyor asked the RN if Iron should be given at the same time as Carbidopa/Levodopa and calcium. The RN stated she was not completely sure but would check.</p> <p>The surveyor completed the med pass observation.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |

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) |
|--|--|
| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/02/24 at 10:45 AM, the surveyor interviewed the facility's Consultant Pharmacist (CP) in the presence of two other surveyors. The surveyor asked the CP if Carbidopa/Levodopa and iron have and interaction and should be administered separately. The CP stated yes, there was an interaction, and they should be given separately. The surveyor asked the CP if there was and interaction between iron and calcium and should they be given separately. The CP stated that there was an interaction between calcium and iron, and they should be administered separately by at least two (2) hours.</p> <p>On that same date and time, the CP stated that the resident in question was a new admission, and she had not been in the building to review the chart yet.</p> <p>On 10/02/24 at 01:13 PM, the surveyor discussed the med pass results with the with Director of Nursing (DON) and the Licensed Nursing Home Administrator. The surveyor discussed the error rate, the med errors, and the interview with the CP. The surveyor asked the DON if there were any other systems in place other than the CP med review to catch drug interactions. The DON stated that they also rely on the Pharmacy provider to call the facility for any significant interactions.</p> <p>A review of the facility's Medication Management Policy dated 01/24 that was provided by the DON, the policy did not reflect any information regarding drug interactions or med errors.</p> <p>The facility did not provide any further pertinent documentation.</p> <p>N.J.A.C 8:39-29.2 (d)</p> |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>38327</p> <p>Based on the interview and review of facility documentation, it was determined that the facility failed to ensure that facility wide assessment included the resources required to establish policies and procedures a.) to ensure water management was included and b.) for the management of emergency food and water supply in order to meet the requirements and needs of all residents in the facility. This failure had the potential to affect all 277 residents who currently live in the facility.</p> <p>This deficient practice was evidenced by the following:</p> <p>During the entrance conference on 9/30/24 at 10:16 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) a copy of the facility's assessment. Both the LNHA and DON stated that the facility's census (the number of residents currently under the care of a specific facility) was 277.</p> <p>A review of the facility's Facility Wide Assessment (FWA) with a date of July 2024 that was provided by the DON on 9/30/24 at 01:31 PM did not include information about the facility's emergency food and water supply for the residents and employees. In addition, there was no documented evidence that the FWA included about the facility's water management, or measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in the building.</p> <p>On 10/07/24 at 8:19 AM, the surveyor met with the LNHA and the DON. The LNHA stated that the FWA process was that all IDT (Interdisciplinary Team) were involved in the input. The LNHA informed the surveyor that the IDT meets once a year and as needed for modifications, completes a thorough assessment, and presents to QAPI (Quality Assurance Performance Improvement) meeting. She further stated that the FWA was all about the residents' care. The LNHA also stated that they received the CMS (Centers for Medicare and Medicaid Services) Memo about the changes in the regulation for facility assessment and they were aware of it.</p> <p>On that same date and time, the surveyor notified the facility management of the above findings and concerns. The surveyor also asked where in the facility's FWA discussed emergency food and water supply and water management. Both the LNHA and DON stated that they would get back to the surveyor.</p> <p>On 10/07/24 at 10:27 AM, the DON presented an updated FWA in the presence of another surveyor. The DON informed the surveyor that the date was updated because it was confusing. The DON stated that the date of assessment was May 2024 and reviewed at the 2nd Quarter QAPI meeting in June 2024, and then the assessment was again reviewed and updated in July 2024. The DON further stated that page 17 was updated to reflect the water management and three (3) days of emergency food and water supply that should be included in the FWA. The DON acknowledged that the emergency water and food supply and water management should have been included in the FWA.</p> <p>On 10/07/24 at 01:09 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the concerns with the FWA that it did not include water management and emergency food and water supply.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>On 10/08/24 at 9:03 AM, the DON provided a copy of the facility's QAPI Policy with a review date of 01/22. The DON informed the surveyor in the presence of another surveyor that the QAPI policy included information about the Facility Assessment and there was no separate policy for Facility Assessment. The DON acknowledged that the concern of the surveyor that the water management and emergency food and water supply were not included in the Facility Assessment was an oversight.</p> <p>A review of the QAPI Policy provided by the DON revealed:</p> <p>Purpose: The facility will also identify in conjunction with the Facility Assessment high-risk, problem-prone, and high-volume areas to evaluate for improvement by identifying, collecting, and using data relevant to the unique characteristics and needs of those we serve.</p> <p>Procedure:</p> <p>6. Issues identified as part of the QAPI Program, such as new equipment, service, or facility resources, are addressed in the Annual Facility Assessment .</p> <p>On 10/08/24 at 12:25 PM, the survey team met with the LNHA, DON, Medical Director, and the VP (Vice President) of Senior Services for an Exit Conference. The facility management did not provide additional information and did not refute the findings.</p> <p>NJAC 8:39-5.1(a)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>48423</p> <p>REPEAT DEFICIENCY</p> <p>Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) ensure that the staff donned (put on) the appropriate personal protective equipment (PPE) prior to providing care to a high contact care resident room that required an Enhanced Barrier Precautions (EBP) for one (1) of two (2) residents, Resident #58, reviewed for pressure ulcer and b.) follow appropriate infection control practices by having direct care staff knowledgeable about identifying residents who require direct care, and when staff to use PPE, this deficient practice was identified for two (2) of three (3) Certified Nursing Aides, according to facility's policy and practice.</p> <p>This deficient practice was evidenced by the following:</p> <p>1. During on an initial tour on 9/30/24 at 11:26 AM, Surveyor #1(S#1) observed Resident #58 lying in their bed, with oxygen in use at 2 LPM (Liters per minute).</p> <p>On 10/03/24 at 11:57 AM, S#2 observed an orange-colored round sticker [dot] next to resident's name on the name plate, which was located outside the resident's room. The dot indicated, EBP (are interventions designed to reduce the spread of multidrug-resistant organisms (MDROs) in nursing homes. EBP involves the use of gloves and gowns during high-contact resident care activities, especially for those at increased risk of acquiring or spreading a MDRO (e.g., residents with wounds or indwelling medical devices). The surveyor did not see an original EBP sign from CDC (Centers for Disease Control and Prevention) at the door and PPE bin with gloves and gown was not noted at Resident's door.</p> <p>On that same date and time, S#2 observed the resident's door was closed. Certified Nursing Assistant #1 (CNA #1) informed the surveyor that the resident was receiving a bed bath by CNA #2.</p> <p>At 12:02 PM, CNA #1 knocked on the resident's door and accompanied S#2 in Resident's room. S#2 observed CNA#2, who had finished providing care to the resident. CNA #2 did not have a gown during observation. The surveyor interviewed CNA#2 who acknowledged that she did not have a gown on when she provided care to the resident. CNA#2 further stated that she did not know that she had to wear a gown while providing care to Resident #58.</p> <p>During an interview with S#2 on 10/03/24 at 01:59 PM, the Team Leader/Registered Nurse (TL/RN) stated that the residents who had any indwelling catheters, pressure ulcers/ wounds, and peg tube (feeding tube) were placed on EBP, that was why they had EBP sign outside the room and was also entered in electronic medical record (EMR). The TL/RN further stated that staff was required to wear PPE when providing care to high-contact residents. She also stated that PPE was important for infection control and to protect the residents from what we have on our clothes. The TL/RN acknowledged that Resident #58 had a pressure ulcer that was why the resident was placed on EBP, and CNA#2 was expected to wear PPE when she provided care to Resident #58. She further stated that CNAs were able to see the EBP written order under general for the CNAs in the EMR.</p> <p>S#2 reviewed the medical record for Resident #58 and revealed:</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The Resident Face Sheet (an admission summary) reflected that Resident #58 was admitted to the facility with diagnoses which included but was not limited to type 2 diabetes (improper levels of sugar in the blood) with diabetic polyneuropathy (is nerve damage caused by chronically high blood sugar and diabetes. It leads to numbness, loss of sensation, and sometimes pain in your feet, legs, or hands), diarrhea, and pressure ulcer of sacral region (base of the spine, just above the buttocks).</p> <p>The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 8/31/2024, the resident had a Brief Interview for Mental Status (BIMS) score of 03 out of 15 which indicated that the resident had a severely impaired cognition.</p> <p>The Physician Orders reflected an order dated 9/24/24 for EBP.</p> <p>A review of Care Plan with Focus area: Skin integrity - Current: stage III pressure injury sacrum, Interventions concluded: EBP with active effective date 9/18/2024.</p> <p>A review of Resident Nursing instructions (a sheet where the CNAs can see the tasks or special instructions that were assigned to them) that was provided by the Director of Nursing (DON), reflected notes for EBP.</p> <p>On 10/03/24 at 12:31 PM, the survey team met with Licensed Nursing Home Administrator (LNHA) and DON. S#2 notified the facility management of the above findings. The DON who acknowledged that CNA#2 should have been wearing PPE for high-contact care resident during care for infection control.</p> <p>A review of the facility provided Transcript reflected that NATCEP (Nurse Aide Training and Competency Evaluation Program) course was completed by CNA#2 on 7/19/24. The DON stated the course included lectures regarding EBP & MDRO and PPE required by CNAs during care.</p> <p>49078</p> <p>2. On 10/01/24 at 11:28 AM, S#3 interviewed CNA#3 on the Heritage Manor East (HME) wing. The surveyor asked CNA#3 what the round orange sticker located on a resident's room number plate next to their name was for. CNA#3 stated that the sticker identified the resident as a fall risk.</p> <p>At 11:34 AM, S#3 interviewed CNA#4 on the HME wing. The surveyor asked CNA#4 what the round orange sticker located on a resident's room number plate next to their name was for. CNA#4 stated that it means the resident has a catheter or something, usually a catheter. The surveyor asked CNA#4 if you need to do anything specific or different when giving care to that resident. CNA#4 stated, no, it's just there to let you know that they have one.</p> <p>At 11:38 AM, S#3 interviewed CNA#5 on the HME wing. The surveyor asked CNA#5 what the round orange sticker located on a resident's room number plate next to their name was for. CNA#5 stated that the orange dot tells you that the resident had a wound or other open area that requires you to wear a gown, gloves, and mask if you are going to give care to the resident, so you do not spread infections.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Christian Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 Sicomac Ave Wyckoff, NJ 07481 | |
| 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) | | |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/04/24 at 8:54 AM, S#1 in the presence of the survey team, interviewed the facility Director of Infection Control (DoIC). S#1 asked the DoIC if she was made aware of the survey team's concerns with two (2) out of three (3) CNAs interviewed by another surveyor were not aware of what the orange dots on the resident rooms indicated. The DoIC informed S#1 that EBP education was provided to all staff during the last week of March 2024. She further stated that it was an expectation that that staff wear a gown and gloves and, if required, additional PPE as needed such as a mask and eye protection, but basically always gloves and gown during direct contact care such as toileting, transferring, personal care, care near wounds, catheter care as protection for staff and residents against the transfer of infection. The DoIC also stated that she spoke to CNA#3 and CNA#4 regarding EBP, and that CNA#4 seemed to know and admitted that she attended the in-service, and CNA#3 needed a lot of reinforcement and education.</p> <p>On 10/04/24 at 10:34 AM, the DON provided a policy titled Isolation Precautions dated 9/24, in-service attendance sheets for nurses and CNAs that reflected topics including but not limited to EBP and PPE and a course curriculum list specific for CNA#3 that included but was not limited to the topic of EBP. The DON stated to S#3 that CNA#3 was new and was not yet certified when the in-service education was done in March 2024.</p> <p>A review of the facility provided policy Isolation Precautions with effective date 9/24 revealed under section Policy: It is the policy of the facility to prevent the spread of infection through the initiation of isolation precautions. Standard precautions are to be followed by all staff for patient/resident contact. Under section G: EBP are deemed necessary for residents with indwelling Medical Devices (e.g. central line, urinary catheter, feeding tube), wounds, colonization or infection with MDRO when performing high-contact resident care activities (in addition to all components of Standard Precautions): 1. Gloves and Gown, (masks/eye protection may be used) will be worn during high-contact care activities listed, and disposed in trash after use. 3. High-contact resident care activities are: Dressing; Bathing/showering . etc.</p> <p>Line 5, appropriate precaution signage will be placed by the patient/resident/client's door.</p> <p>No further pertinent information was provided by the facility.</p> <p>On 10/08/24 at 12:25 PM, the survey team met with LNHA, DON, Medical Director, [NAME] President (VP) of Senior Services and VP of Medical Affairs for an Exit Conference. The facility did not refute the findings.</p> <p>NJAC 8:39-19.4(a)(1-6)</p> | | |