STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheshire Home	9 Ridgedale Ave Florham Park, NJ 07932

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 51226 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that the resident's call light was readily accessible within reach. The deficient practice was identified for one (1) of one (1) resident, Resident #1, reviewed for accommodation of needs. This deficient practice was evidenced by the following: On 9/03/2024 at 9:20 AM, the surveyor observed Resident #1 sitting in their wheelchair (w/c) beside the bed in their room. The resident was alert, awake, and verbally responsive with slurred speech. The surveyor observed the resident's call light was resting on the opposite side of the bed against the wall and the resident was unable to reach it. On 9/04/2024 at 9:41 AM, the surveyor observed the resident sitting in their w/c beside the bed in their room. The resident was alert, awake, and verbally responsive with slurred speech. The resident's call light was resting on the opposite side of the bed against the wall away from the resident. The resident was not able to reach their call light. A review of the medical record for Resident #1 revealed the following information: The Admission Record (an admission summary) indicated Resident #1 had diagnoses that included, but were not limited to, diffuse Traumatic Brain Injury (TBI-widespread brain damage) and neuromuscular dysfunction of the bladder. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated the resident had a Brief Interview for Mental Status (BIMS). Resident #1 scored a 15 out of 15 which showed that the resident was cognitively intact. Section GG- Functional Abilities and Goals, revealed that the resident had limitations and impairment in both upper and lower extremities. A care plan (CP) with a focus that read, [Resident #1] is at risk for falls r/t [related to] TBI .Hx [history] of standing without supervision .has Visual/hearing impairment .is bed, wheelchair bound and has decreased sensory perception rt [related to] TBI/ transfers are not steady requires 2 assists . was last revised on 4/22/2021. An intervention for the CP indicated to be sure that the resident's call light was within reach and the resident was encouraged to use it. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/04/24 at 11:13 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to care for Resident #1. The LPN stated that the resident required assistance with activities of daily living and used the call light to call for staff assistance when needed. The LPN confirmed that the call light should be within reach of the resident. The surveyor accompanied the LPN into the resident's room to observe the call light. Resident #1 was observed sitting in a w/c in their room. The LPN observed the call light resting on the bed against the wall, away from the resident. The LPN placed the call light within the resident's reach. On 9/05/2024 at 11:45 AM, the survey team met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The surveyor informed the facility of the above findings and observations regarding the call light not being within Resident #1's reach. The facility management acknowledged that all residents should have their call lights within reach. The surveyor requested any policy related to call lights. On 9/06/24 at 8:53 AM, the DON provided the surveyor with the facility's policy titled, Making an Open Bed. The surveyor reviewed the undated policy, which indicated under Procedure to .16. Make sure the call bell is within the resident's reach . NJAC 8:39-27.1 (a)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46049 Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure reference checks were completed for two (2) out of six (6) newly hired staff (Staff #1 and #2) prior to their start date of employment. This deficient practice was evidenced by the following: The surveyor reviewed six randomly selected new employee files. The review for reference checks for two of the six new employees revealed the following: -Staff #1's (S#1's) file, a Licensed Practical Nurse (LPN) who was hired on 02/25/24, showed there were no reference checks in their file. -S#2, a Registered Nurse (RN) who was hired on 4/06/24, showed there were no reference checks in their file. On 9/06/24 at 11:00 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and the Administrative Assistant (AA) about the concern that there were no references in the employee files of S#1 and S#2. The AA stated she would follow up with the Acting Human Resources Representative (AHRR) who was not in the facility today. The LNHA acknowledged it would be expected for there to be references documented in the employee files upon hire. On 9/06/24 at 11:09 AM, the surveyor interviewed the AHRR over the phone. The AHRR stated the previous HR representative left in May 2024 and that was when she began covering the position. The AHRR stated that two references from new employees were requested. There was a facility inquiry form that was emailed or faxed to previous employers. Additionally, personal references were called and there was a form to be filled out by the facility representative when conducting the interview. The AHRR further explained that sometimes you may not get a response back and they tried to get at least one reference. The AHRR stated that she had not experienced issue with getting two references. The surveyor discussed the concern with S#1 and S#2 not having any references checks documented in their file. The AHRR could not speak to those staff files as they were prior to when she started the position. The surveyor asked the AHRR about the expectation for the reference checks of newly hired staff. The AHRR replied that it would be expected for there to be an attempt to get a reference for the employee. On 9/06/24 at 12:20 PM, the surveyor informed the LNHA and the Director of Nursing (DON) of the concern that for two of the six new employee files reviewed, there were no reference checks found. On 9/06/24 at 12:47 PM, the AA provided a copy of an inquiry form that was faxed on 3/28/24 to a previous employer of S#2. The form was dated 3/27/24 and was not completed. The AA acknowledged there was no response received from this previous employer and no other references found for S#2. There was no additional information provided by the facility. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the facility's policy titled Personnel Management Reference Checks with a last revised date of 8/96. Under Procedure it read, .2. [facility name] will seek the maximum number of references possible on a new applicant, in order to obtain a solid work ethic and character background . N.J.A.C. 8:39-9.3 (a), (b)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, interview, and record review it was determined that the facility failed to provide care and services consistent with professional standards of practice for a resident with pressure ulcers. This deficient practice was identified in two (2) of two (2) residents (Resident #8 and #9), reviewed for pressure ulcer care and prevention. The deficient practice was evidenced by the following: 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 or 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 regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. 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. Reference: National Pressure Injury Advisory Panel's Pressure Injury Prevention Points include the following: Risk Assessment Consider bedfast and chairfast individuals to be at risk for development of pressure injury. Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within 8 hours after admission). Refine the assessment by including these additional risk factors. Fragile skin Existing pressure injury of any stage, including those ulcers that have healed or are closed Impairments in blood flow to the extremities from vascular disease, diabetes or tobacco use Pain in areas of the body exposed to pressure Repeat the risk assessment at regular intervals and with any change in condition. Base the frequency of regular assessments on acuity levels: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Acute care . Every shift Long term care . Weekly for 4 weeks, then quarterly Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. If the risk is from malnutrition, address those problems. 1. On 9/04/24 at 12:25 PM, the surveyor observed Resident #8 sitting in a specialized wheelchair in their room. Resident #8 was alert, verbally responsive, and greeted the surveyor. The resident stated they had wounds and had no concerns with their care. The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #8. The Admission Record (AR; a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to quadriplegia (paralysis that affects all four limbs) and neuromuscular dysfunction of the bladder. A comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 6/26/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #8 scored a 15 out of 15, which indicated the resident was cognitively intact. Under Section M-Skin Conditions of the MDS assessment, it was documented that determination of pressure ulcer/injury risk for the resident was determined by clinical assessment. Additionally, it was documented that Resident #8 had a pressure ulcer and was receiving treatment (tx). A review of physician's orders (PO) included the following: -A PO dated 4/20/24 that read, 'Complete Weekly Skin Check Tool in Assessments every day shift every Tue [Tuesday] for skin integrity'.' -A PO dated 9/03/24 read Left Lateral Ankle Bony Prominence: Cleanse with NSS [normal saline solution]. Pat dry. Apply Opticel, Cover with Foam. Secure with zinc tape as needed for soilage for 30 Days -A PO dated 9/03/24 read Left Lateral Ankle Bony Prominence: Cleanse with NSS [normal saline solution]. Pat dry. Apply Opticel, Cover with Foam. Secure with zinc tape every day shift for Routine Wound Care for 30 Days -A PO dated 9/03/24 read Right ischium [area of the large bone in the lower part of the hip]-cleanse NSS, Pat dry, pack wound with strip gauze, cover with dry dressing as needed for soilage/shower for 30 Days -A PO dated 9/03/24 read Right ischium-cleanse NSS, Pat dry, pack wound with strip gauze, cover with dry dressing every day shift every other day for wound care for 30 Days -A PO dated 9/03/24 read Right ischium-cleanse NSS, Pat dry, pack wound with strip gauze, cover with dry dressing every evening shift every other day for wound care for 30 Days (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A PO dated 4/21/23 read Sacrum - Cleanse area with NSS, pat dry, cover with border foam for protection. as needed for wound care -A PO dated 4/21/23 read Sacrum - Cleanse area with NSS, pat dry, cover with border foam for protection. every day shift every Tue for Protection -A PO dated 4/21/23 read Sacrum - Cleanse area with NSS, pat dry, cover with border foam for protection. every evening shift every other day for protection The resident had a care plan with a focus that read, [Resident #8] has actual impairment to skin integrity (chronic scabbing/callous L. (left) lateral calf & L. Malleolus.) Actual pressure ulcers to sacrum & Left ischium . The care plan was last revised on 9/05/24. Interventions of the care plan (CP) included: -Weekly tx documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Date Initiated: 10/19/2018; -Weekly wound assessment done by nursing (includes measurements, description of wound, interventions and behavior e.g non-compliance). [Resident #8] was followed by wound specialist in the facility see APN (Advance Practice Nurse). [APN] notes. Resident's wounds and overall status is discussed by IDT (Interdisciplinary team) e.g improvement or worsening of wounds weekly and PRN (as needed). Date Initiated: 12/13/2019; -Monitor/document location, size and tx of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. to MD (Medical Doctor). Date Initiated: 10/19/2018; -Left Ischial wound : cleanse with skin Integrity Wound Cleanser, pat dry, pack lightly with Opticell, cover with ABD (abdominal). Secure with [name] tape for wound care. Date Initiated: 07/11/2022; -Sacrum - Cleanse area with NSS, pat dry, puracol to wound bed, cover with small border foam daily and as needed x 30 days for wound care Date Initiated: 11/09/2021. A review of Resident #8's medical records indicated the interventions for the left ischial wound and sacrum did not reflect the current wounds of Resident #8. Additionally, the CP did not include the resident's current left ischial wound. A review of Assessments in the EHR (electronic health record) revealed weekly skin checks documented. There were no wound assessments completed weekly which included wound measurements, drainage, and wound tissue description. A review of nurse progress notes (PN) and the APN's PN revealed, there was no weekly documentation of the resident's wound assessment including measurements and wound description. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/05/24 at 9:25 AM, the surveyor interviewed the Director of Nursing (DON) about residents with wounds. The DON stated there were no formal investigation reports for new wounds acquired by residents. The DON further explained the protocol was for the wound to be assessed by the Registered Nurse (RN) supervisor/charge nurse, the physician was made aware and tx orders were obtained. The DON stated the nurses who assessed the wounds would document a PN and weekly skin checks were conducted. The surveyor asked the DON how the cause of a wound was determined and if it was discussed by the IDT. The DON stated that the cause was determined by discussion with the residents. She further explained that residents sometimes were non-compliant with pressure relieving interventions which contributed to new wounds. The DON stated that the tx RNs and RN supervisors assess wounds, there were CP for the residents, and wound notes would be documented in the nurses' notes. The DON stated the wound note should be an extensive note, that included wound description, discussion with the resident and education provided. The surveyor asked the DON for new wounds if a summary and conclusion about the wound was found in the nurse PN. The DON replied, It should be. The DON stated that all residents were considered at risk for developing wounds due to medical conditions and there was no formal assessment completed to assess a resident's risks for wounds. The surveyor requested any facility policies related to skin assessment, wound care, and wound assessments. On 9/05/24 at 10:08 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who provided resident wound treatments. The LPN stated wound skin checks were performed twice a week after a resident showered and wound changes were documented in the nurses PN. The RN supervisor would perform wound assessments. When a new wound was found, the RN supervisor or charge nurse would assess the wound, the physician would be notified, a tx would be ordered and nurse PN would document what was found. Nurse documentation for wounds were the weekly skin checks and nurse PN. All residents were considered at risk for wounds and there was no formal risk assessment tool. The LPN stated interventions to help prevent pressure ulcer/injury included repositioning residents every two hours and if a resident refused it would be documented. On 9/05/24 at 10:39 AM, the surveyor interviewed the RN/Nurse Supervisor (RN/NS) who performed wound treatments and weekly wound assessments. The RN/NS stated weekly wound assessments were performed on residents and that wound assessments with the APN would be done periodically. The RN/NS detailed that there was no routine schedule for when the APN would assess wounds with the RN and it would depend on the severity of wounds. The RN/NS stated that when wounds were assessed, it would be measured and findings would be documented in a wound PN. Additionally, there was a weekly log/tracking binder which would document the wound assessment and progression. The surveyor asked if the weekly log/tracking binder was documented in the resident's hybrid medical records. The RN/NS stated it was not. On 9/05/24 at 11:45 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the DON, Administration Assistant (AA), and the acting Human Resources Representative. The surveyor informed the facility of the concern related to documentation of Resident #8's wound assessments and follow up on newly acquired wounds. The DON stated that wound assessment documentation would be found in the PN and would provide to the surveyor. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On that same date and time, the surveyor asked the DON if the wound assessments including the measurements that were documented in the binder were found in the resident's medical records. The DON replied that she was not sure and that the APN may have documented wound measurements in her notes in the EMR. On 9/06/24 9:22 AM, the surveyor interviewed the DON and Assistant DON (ADON) about weekly wound rounds and documentation. The ADON stated there were the wound log binders in which wound assessments would be documented by the nurse. The ADON stated she would review the wound binders to complete residents' MDS assessments. On that same date and time, the DON provided weekly wound logs from the binder for Resident #8. The weekly logs were noted with blank entries. The surveyor reviewed with the DON. The DON replied that it may be that a resident refused, was out on an appointed or something else may have occurred for the assessment not to be completed. The DON acknowledged it would have been expected for the nurses to document if an assessment could not have been performed. At that time, the DON stated that daily update for residents were performed by the IDT and there was an internal worksheet that was signed. The DON added that it was facility documentation and not part of the medical record. The surveyor reviewed with the ADON about the concerns with Resident #8's CP. The ADON stated she would review to provide further information. On 9/06/24 at 9:56 AM, the ADON met with the surveyor. The ADON stated I have to update CP. She acknowledged the CP did not reflect the resident's current wound status. The ADON explained that the resident did have a history of a sacral wound and left ischium wound which has since resolved. The resident was currently being treated for a right ischium wound and a new left ankle wound. On 9/06/24 at 10:05 AM, the DON informed the surveyor that it is expected for there to be a weekly wound note documented. The surveyor asked the DON about APN documentation as there was not a weekly note by the APN found. The DON stated some residents had chronic wounds and that the APN did not see every resident weekly for their wounds. 39885 2. On 9/03/24 at 8:26 AM, the surveyor observed Resident #9 seated upright in bed on an air mattress. Resident #9 stated that they had a sacral Pressure Ulcer (PU) that opened over scar tissue from a previous PU. The surveyor reviewed the hybrid medical records of Resident #9. A review of the AR documented that the resident had diagnoses that included but were not limited to quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down), seizures (a sudden, uncontrolled burst of electrical activity in the brain) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #9's most recent quarterly MDS, reflected that the resident had a BIMS score of 15 out of 15, which indicated that Resident #9 was cognitively intact. Under Section M-Skin, it was documented that determination of pressure ulcer/injury risk for the resident was determined by clinical assessment. Additionally, it was documented that Resident #9 had a Stage 4 PU that was not present upon admission/entry or reentry. A review of Resident #9's EHR revealed that Resident #9 did not have any formal assessment instrument/tool like a Braden Scale (an assessment for Predicting Pressure Sore Risk which was developed to foster early identification of patients at risk for forming pressure sores) to determine the resident's risk for PU development. There was no documented evidence that a Braden Scale or other formal assessment instrument or tool was done quarterly to assess the risk for PU development. Further review of Resident #9's hybrid medical record revealed that there was no documentation of a clinical assessment related to determination of the resident's risk for developing a PU. A review of Resident #9's individualized CP indicated a focus area of resident was at risk for pressure ulcer development r/t (related to) quadriplegia, immobility, has h/o (history of) of pressure ulcers and has actual sacral wound. The CP included the following intervention: Assess/record/monitor wound healing (weekly) Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (Medical Doctor) with an initiated date of 9/22/2021. Further review of Resident #9's Assessments in the EHR revealed Weekly Skin Check documented. The Weekly Skin Check did not include consistent weekly documentation of the PU with measurements. There was occasional documentation of the description of the PU. A review of Resident #9's nurse PN and the APN's PN revealed, there was no consistent weekly documentation of the resident's PU assessment which included measurements and description. On 9/05/24 at 9:28 AM, the surveyor interviewed the DON regarding risk assessment for PU development. The DON stated that the facility did not do a Braden Scale because everyone is at risk for wounds and most [residents] come with wounds. On 9/05/24 at 10:03 AM, the surveyor interviewed the Assistant DON/MDS Nurse (ADON/MDSN) regarding the process for MDS and PU. The ADON/MDSN stated that for section M (skin conditions) she would use the documentation that was in the medical record and refer to the binder that has the information of when the last time the wound was looked at. The surveyor asked where she obtained the information for determination of risk for PU from. The ADON/MDSN stated that she did not check that a formal tool was used and that she checked that a clinical assessment was done because the nurse did an assessment like a skin check. She added that everyone that came to the facility was at risk. She added that there was no formal tool used at the facility. On 9/05/24 at 11:45 AM, in the presence of the survey team, the surveyor notified the LNHA, the DON, the AA, and the acting Human Resources Representative the concern that Resident #9 did not have a quarterly formal risk assessment or any documentation of a clinical assessment for risk of developing a PU. On 9/06/24 at 12:15 PM, in the presence of another surveyor, the surveyor notified the LNHA and DON the concern that Resident #9's weekly PU measurements were not in the resident's medical record. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide any additional information. On 9/06/24 at 12:40 PM, the survey team met with DON and LNHA. There was no additional response by the facility. The surveyor reviewed the facility's policy titled, Wound Management Program Staging, with a revised date of August 2018. Under Procedure, C. Ongoing Wound Assessment, it read: . 1. A system for weekly (or more frequent) wound assessment has been established. 2. An assessment tool in [EMR] is used. 3. Comprehensive wound assessment should include at least the following parameters: a. Location of wound . b. Length, width, and depth measurements . c. Direction and length of tunneling and undermining d. Appearance of the wound base e. Type and percentage of tissue in wound . f. Drainage amount and characteristics including color, consistency, and odor . g. Appearance of wound edges . h. Description of the peri-wound condition or evaluation of the skin adjacent to the wound . 7. Progress toward healing is monitored . a. If the wound shows no sign of healing within two to four weeks, the plan of care is reevaluated, and it is determined whether to continue or modify the plan of care. This discussed with the Medical Director and the wound care Nurse Practitioner . Policy [Facility name redacted] is committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being and to minimize the development of in-house acquired pressure ulcers, unless the individual's clinical condition demonstrates they are unavoidable . A commitment to the wound management program is demonstrated by implementation of processes founded on accepted standards of practice, research-driven clinical guidelines, and interdisciplinary involvement. Objectives (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The wound management program incorporates currently accepted standards of practice and guidelines, including ongoing assessment of the stage of development of decubitus ulcers. The policy did not include any information about risk assessment for PU development. Under F. Documentation and Care Planning, it read: . 1. The wound management program documentation requirements include: a. Identification of the location and frequency of wound documentation b. Required comprehensive description of pressure ulcer weekly, at a minimum c. Goals of the wound CP collaboratively with the resident, family, and IDT d. Assigned responsibility/accountability for the initial CP and for subsequent updating e. Determined facility time frames for CP updating . A review of the facility provided undated policy titled, Standard Operating Procedure Prevention, Assessment and Containment of Pressure Areas, included the following: Policy The [facility name redacted] population is primarily spinal cord injury and other neurologically impaired residents. Diagnosis involves paralysis, diminished peripheral circulation and spasms. Therefore, careful attention is given to maintaining intact skin. The residents at [facility name redacted] are mostly traumatic spinal cord injuries. All of the residents are neurologically impaired. This diagnosis can lead to the development of pressure injuries. Once a resident develops a wound it becomes a secondary diagnosis. Contributing Factors Immobility Poor fitting clothing, shoes Poor nutrition Noncompliance with repositioning, turns and splints History of smoking Incontinence Procedure (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff is to follow all standard operating procedures upon admission involving but not limited to the following: 10. Skin checks are done weekly and PRN on resident designated in TAR (Treatment Administration Record) after their shower. A skin assessment must then be filled out by the nurse in EHR. The policy did not include any information about risk assessment for PU development or PU measurements. NJAC 8:39-27.1 (a)(e)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46049 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to provide care and services in a manner consistent with standards of practice for appropriate storage of urinary drainage bags for one (1) of one (1) resident reviewed for external urinary catheter care (Resident #15). The deficient practice was evidenced by the following: 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 or 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 regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. 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. On 9/03/24 at 9:10 AM, the surveyor observed Resident #15 lying in bed, alert and verbally responsive. Resident #15 stated they used an external urinary catheter (non-invasive urine collector worn externally) during the night and removed in the morning. The surveyor observed a urinary drainage bag hanging at the bedside with yellow colored urine and the tubing of the drainage bag was uncovered. The resident stated that the drainage bag was changed weekly by the nursing staff. On 9/04/24 at 9:51 AM, the surveyor observed a Certified Nurse Aide (CNA) at the resident's bedside preparing to assist Resident #15 out of bed to their specialized wheelchair (w/c). The surveyor observed the resident's urinary drainage bag hanging at bedside with yellow colored urine and the tubing of bag was not covered. On 9/04/24 at 10:13 AM, the surveyor interviewed Resident #15 who was sitting upright in their w/c about the storage of their urinary drainage bag. The urinary drainage bag remained hanging at the bedside with yellow colored urine and the tubing remained uncovered. The drainage bag was dated 8/29/24. Resident #15 stated they preferred to care for the drainage bag on their own. At that time, the surveyor asked if the drainage bag always remained at the bedside and if there was any cap/cover for the tubing of the drainage bag. The resident replied that they emptied the urine, washed the bag with water in the bathroom sink, and hung it in the bathroom to store for later use in the night. Resident #15 showed the surveyor where in the bathroom the drainage bag would be hung. The surveyor asked the resident if there was a cap or cover for their drainage bag. Resident #15 replied, they did not have one and was careful when handling their drainage bag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/04/24 at 10:21 AM, the surveyor interviewed the CNA who was assigned to care for Resident #15 about urinary drainage bag care and storage. The CNA stated the urinary drainage bag would be emptied, rinsed with warm water, the port of the tubing sanitized with an alcohol pad, covered with cap, and stored in the bathroom in plastic bag. The surveyor asked the CNA about the care for Resident #15's drainage bag. The CNA stated that Resident #15 preferred to care for their drainage bag and the resident was able to remove their external catheter, wash and store their drainage bag in the bathroom. On that same date and time, the surveyor discussed with the CNA about the observation of the resident's drainage bag that was uncovered. The CNA stated that the resident would not have a cap for their drainage bag because the resident did not have a leg bag which was where the cap came from. The CNA stated that it was not okay for the drainage bag to remain uncovered. On 9/04/24 at 11:15 AM, the surveyor interviewed Licensed Practical Nurse#1 (LPN#1) who had cared for Resident # 15. LPN #1 stated that drainage bags were stored by CNAs in the resident's bathroom in a specified area. LPN #1 could not explain the process of storing a urinary drainage bag, she was not sure and stated another staff could explain the process. LPN #1 stated she was not aware Resident #15 cared and stored their urinary drainage bag. On 9/04/24 at 11:18 AM, the surveyor interviewed LPN #2 who had cared for Resident #15. LPN #2 stated drainage bags were usually throw away bags, and a new bag placed. LPN #2 stated drainage bags when not in use should be capped. For residents using an external catheter, it should be taken off, the amount of urine measured, and the bag thrown away. LPN #2 clarified that a large urine drainage bag was saved, capped and placed in a plastic bag for storage for residents using indwelling catheter who switched to leg bags during the day, At that time, the surveyor discussed with LPN #2 the observation of Resident #15's drainage bag that was uncovered. LPN #2 stated the uncapped drainage bag was an infection control concern. She further explained it should be sanitized with an alcohol swab and stored appropriately. LPN #2 was not aware of the resident caring for their own drainage bag and storing. The surveyor reviewed the hybrid (paper and electronic) medical record of Resident #15. The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, paraplegia (paralysis that affects the legs and lower body), and neuromuscular dysfunction of the bladder. A quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 8/14/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #15 scored a 15 out of 15, which indicated the resident was cognitively intact. A physician's order (PO) dated 8/02/21 that read, Urine Output Log every shift for monitor output A PO dated 10/05/22 read Urosheath [external catheter] #32 to drainage bag per preference (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan (CP) with an initiation date of 6/14/21 for Resident #15 had a focus that read, [Resident #15] was dependent for toileting related to ., has neuro bowel/bladder and impaired mobility . [Resident #15] uses urosheath to manage incontinence . The CP was last revised on 01/09/23. Further review of the CP interventions showed it did not address the resident's use of an external catheter and urinary drainage bag care. There was no documentation of the resident receiving education or caring for their own urinary drainage bag. On 9/05/24 at 9:25 AM, the surveyor requested from the Director of Nursing (DON) facility policies related to storage of drainage bags and urinary catheter care. On 9/05/24 11:08 AM, the DON provided the facility document titled How To Take Care of Drainage bags, and a urinary tract infection policy that referenced urinary catheters. On 9/05/24 at 11:45 AM, the survey team met with the with Licensed Nursing Home Administrator (LNHA), the DON, the Administrative Assistant (AA), and the Acting Human Resources Representative. The surveyor informed the facility of the above concerns. The DON stated it would be expected for a drainage bag stored to be capped. The surveyor asked the DON if the resident was educated on the care and storage of their urinary drainage bag. The DON stated the staff probably spoke to the resident about it and stated that she believed the resident's education was not documented. At that time, the surveyor requested any additional policies related to external urinary catheters and urinary drainage bag care. The facility would follow up to provide additional information. On 9/06/24 at 8:53 AM, the DON provided a progress notes which indicated the resident was provided caps for their drainage bag and educated about its care. There was no additional information provided by the facility. Further review of the August 2024 and September 2024 electronic Medication Administration Record (eMAR) included the documentation of the resident's urine output every shift. There were entries 17 entries that did not document an exact total amount and were written as 400+. On 9/06/24 at 12:20 PM, the surveyor informed the DON and LNHA about the concern with nurses' documentation of the urine output. The surveyor reviewed the eMAR with the DON. The DON stated that it was okay for the nurses to add the + sign to the urine output instead of an exact number as the resident emptied their drainage bag on their own. The DON acknowledged it was expected for the nurses to document a note when the resident emptied on their own and she could not say if the resident was ever asked by staff to monitor their urine output. There was no additional information provided by the facility. The surveyor reviewed the undated facility policy titled, How To Take Care of Drainage Bags. Under Caring for your night drainage bag it read, .3. Rinse the bag with cool water. Hang it up to dry . The document did not further address storage of a urinary drainage bag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the facility policy titled Urinary Tract Infection related to indwelling catheters. The policy did not address external catheters and it did not address urinary drainage bag storage and care. N.J.A.C. 8:39-27.1 (a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48423 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) ensure nebulizer setup and masks were changed as per physician orders. b.) change suction setup tubing for the tracheostomy resident. This deficient practice was identified for one (1) of two (2) residents (Residents #11) reviewed for respiratory care according to the standard of clinical practice, and the facility's policy and procedure. This deficient practice was evidenced by the following: 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. 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. During initial tour on [DATE] at 9:01 AM, the surveyor observed Resident #11 resting in their room. The surveyor observed the resident's tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck) site which had a white cap. The resident stated that they received nebulizer (a device that turns medication into a mist for inhaling into lungs) treatment (tx) every day. The surveyor observed the nebulizer (neb) tubing labeled with a small piece of tape dated ,d+[DATE] and initials were written with a black pen. According to the Admission Record (an admission summary), Resident #11 was admitted to the facility with tracheostomy, paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), hemiplegia (paralysis of one side of the body.) and major depressive disorder. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [DATE], reflected a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was cognitively intact. A review of the active Physician's Orders (PO) revealed the following orders: -Ipratropium-Albuterol Outer UD (unit dose) 0XXX,d+[DATE] MG (milligrams)/3 AMPUL (ampule)-NEB 1 vial inhale orally every 6 hours (hrs) as needed (PRN) for congestion (via neb); separate from PRN by 4 hrs. And 1 vial inhale orally every night shift for respiratory maintenance (via neb) with a start date of [DATE]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Change neb setup every day shift starting on the 24th and ending on the 24th every month and PRN with a start date of [DATE]. -Change suction canister, tubing & filter every day shift starting on the 24th and ending on the 24th every month and PRN with a start date of [DATE]. The above PO was transcribed to the [DATE] electronic Medication Administration Record (eMAR) to change neb setup every day shift starting on the 24th and ending on the 24th every month and to change suction canister, tubing and filter every day shift starting on the 24th and ending on the 24th every month. The PO was signed off for [DATE]th reflecting it was completed. Further review of the August and [DATE] eMAR for Ipratropium-Albuterol Outer UD 0XXX,d+[DATE] MG/Ampul-neb 1 vial inhale orally every night shift for respiratory maintenance (via neb) was signed by nurses as administered from [DATE]th until [DATE]th. A review of the [DATE] nursing progress notes (PN) reflected that Resident #11 received duoneb breathing tx via facial mask. Further review of the August and [DATE] PN did not reflect any notes pertaining to changing of respiratory equipment such as neb setup and suction setup. During an interview with the surveyor on [DATE] at 10:23 AM, the Licensed Practical Nurse (LPN) stated that the neb setup and suction setup gets changed on the 24th every month. She further stated, If I see the expired date on neb setup then I would change it. The LPN stated the tx nurse was accountable to make sure the neb setup was changed as per protocol. She acknowledged that it was not an acceptable practice and if the resident was on neb treatments, you would make sure the mask was clean due to infection control. On [DATE] at 10:36 AM, the Infection Preventionist/Registered Nurse#1 (IP/RN #1) stated that it was important to change the neb mask as per PO to prevent the resident who were on respiratory tx and the staff providing care to the resident to be exposed to any bacteria. On that same date at 10:41 AM, in the presence of the surveyor, the LPN walked into Resident #11's room to check the neb setup, tubing and the suction setup. The LPN checked the dates on the neb tubing, and she took the neb mask out of the black bag. The mask had a small piece of tape marked with [DATE] and initials were written with a black pen. The nurse then checked the suction setup and observed a piece of tape marked with [DATE] and initials were written with a black pen. The LPN acknowledged that it was not an acceptable practice, and she would call the physician to get orders. On [DATE] at 11:39 AM, the survey team met with Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Administrator Floater and Administrator Assistant (AA). The surveyor discussed the above findings with the facility management. During an interview with the surveyor on [DATE] at 10:03 AM, the IP/RN #2 stated the nebulizer setup should be changed on time as scheduled, due to the secretions inside the mask. IP/RN #2 acknowledged that the above observations and findings were not an acceptable practice. A review of the facility provided Respiratory Equipment Set-up checklist that was provided by DON included: Under Neb set up - Change Neb set up once a week. Label and Date. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under Suction Machine Set up: Change suction machine set up (canister, tubing & antibacterial filter) once a month. Label and date. On [DATE] at 12:31 PM, the survey team met with LNHA, DON and AA for an Exit Conference and there was no additional information provided by the facility management. NJAC 8:,d+[DATE].2(b); 25.2(c)4; 27.1(a)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 46049 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to ensure the daily report of licensed nurses, certified nursing assistant staffing, and the resident census was posted at the beginning of the current shift for two (2) of four (4) days during the survey. This deficient practice was evidenced by the following: On 9/03/24 at 7:40 AM, upon entry to the facility, the surveyor observed a Nursing Home Resident Care Staffing Report (NHRCSR) posted at the front desk by the main entrance. The NHRCSR posted was dated 9/02/24, for the [8 AM to 4 PM] day shift. There was no NHRCSR for 9/03/24 posted. On 9/05/24 at 8:35 AM, the surveyor observed a NHRSCR posted at the front desk by the main entrance. The NHRCSR posted was dated 9/04/24 for the day shift. There was no NHRCSR for 9/05/24 posted. On 9/05/24 at 11:45 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), the Administrative Assistant, and the acting Human Resources Representative. The surveyor informed the facility of the concerns observed on two days with the NHRCSR not posted for the current shift. The DON stated that the Unit Clerk (UC) was responsible for posting the NHRCSR for the day and evening shift. A nurse would post the NHRCSR for the night shift. There was no further verbal response from the facility at this time. The surveyor requested any policy related to the posting of the NHRCSR. On 9/05/24 02:01 PM, the DON provided the policy titled Staffing Nursing Staffing Information. On 9/06/24 at 8:58 AM, the surveyor interviewed the day shift UC who was responsible for posting the NHRCSR for the 8-4 shift on weekdays. The UC stated each shift was responsible for ensuring the NHRCSR was posted. The UC acknowledged that the NHRCSR may be posted late. The UC could not speak to the other shifts and stated that ultimately the charge nurse was responsible for ensuring that the NHRCSR was posted for each shift. The UC further explained that it was discussed by staff that it was important to ensure that the NHRCSR was posted and accurate. On 9/06/24 at 12:45 PM, the survey team met with the DON and the LNHA. There was no additional information provided. The surveyor reviewed the facility's policy titled, Staffing Nursing Staffing Information dated 12/21. Under Procedure it read: . A. The facility will post the following information on a daily basis: a. Facility name b. The current date (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. The total number and the actual hours worked by following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered nurses ii. Licensed practical nurses . iii. Certified nurse aides . B. The facility will post the nurse staffing data on a daily basis at the beginning of each shift . NJAC 8:39-41.2

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 38327 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 as needed pain medications for one (1) of five (5) residents, (Resident #21) reviewed for unnecessary medications in accordance with facility's practice and policy. This deficient practice was evidenced by the following: On 9/03/24 at 10:42 AM, the surveyor observed Resident #21 with limitation to the right hand and could use the electric wheelchair with no problem. The resident had a splint on their right hand. On that same date and time, the resident stated that he/she was currently on pain management and included in their pain medications (meds) were as needed (PRN) Oxycodone to be given with PRN Tylenol for pain level of 7-10. The resident further stated that at times their PRN Tylenol was not given when PRN Oxycodone was administered. Resident #21 was unable to state why the nurse at times did not include the PRN Tylenol when PRN Oxycodone was administered. The resident also stated that they were aware that the physician order (PO) for PRN Oxycodone and PRN Tylenol should be given together. The surveyor reviewed Resident #21's hybrid (a combination of paper-based and electronic medical records that primarily involves tracking and storing a patient's health records in several formats and places) medical records. According to the Admission Record (an admission summary), the resident was admitted to the facility with diagnoses that included but were not limited to quadriplegia (the condition in which both the arms and legs are paralyzed and lose normal motor function) C1-C4 complete, neuralgia and neuritis (neuralgia refers to severe, sharp, often shock-like pain that follows the path of a nerve. On the other hand, neuritis is an inflammation of the nerves) unspecified, other chronic pain, major depressive disorder, recurrent, unspecified, and essential hypertension (occurs when abnormally high blood pressure is not the result of a medical condition). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 8/14/24 revealed a brief interview for mental status (BIMS) score of 15 out of 15 which indicated that resident was cognitively intact. A review of the September 2024 Order Summary Report (OSR) showed a PO dated 6/12/24 for Acetaminophen (or Tylenol) Tablet (tab) 325 mg (milligram) Give 2 tablets (tabs) by mouth every 6 hours (hrs) PRN for severe pain 7-10, 2 tabs=650 mg; give along with Oxycodone 10 mg; max (maximum) of 4 gms (grams)/24 hrs for all sources. Further review of the September 2024 OSR revealed a PO dated 6/12/24 for Oxycodone HCl (Hydrochloride) oral tab 10 mg give 1 tab by mouth every 6 hrs PRN for severe pain (7-10); give along with Acetaminophen 650 mg. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheshire Home	9 Ridgedale Ave Florham Park, NJ 07932

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above PO for PRN Acetaminophen and PRN Oxycodone were transcribed to the electronic Medication Administration Record (eMAR) and signed by nurses as administered for July, August, and September 2024, and revealed: July 2024 eMAR: PRN Acetaminophen was signed by nurses as administered 32x (32 times) while the PRN Oxycodone was signed by nurses as administered 77x. August 2024 eMAR: PRN Acetaminophen was signed by nurses as administered 47x while the PRN Oxycodone was signed by nurses as administered 67x. September 1-4, 2024 eMAR: PRN Acetaminophen was signed by nurses as administered 2x while the PRN Oxycodone was signed by nurses as administered 9x. Further review of the above July, August, and September 2024 eMAR showed that the PRN Acetaminophen along with PRN Oxycodone PO were not followed: July 2024 eMAR: PRN Acetaminophen was not administered 45x when it should have been a total of 77x. August 2024 eMAR: PRN Acetaminophen was not administered 20x when it should have been a total of 67x. September 2024 eMAR: PRN Acetaminophen was not administered 7x when it should have been a total of 9x. A review of the July, August, and September 2024 Progress Notes (PN) revealed that there was no documented evidence that the Consultant Pharmacist (CP) identified the above irregularity for PRN Acetaminophen and PRN Oxycodone. A review of the CP Monthly Report (also known as Medication Regimen Review or MRR) showed that there was no documented evidence that the CP identified the irregularity for PRN Oxycodone and PRN Acetaminophen. On 9/04/24 at 8:44 AM, the surveyor interviewed Registered Nurse Supervisor/Infection Preventionist #1 (RNS/IP#1) and RNS/IP#2. RNS/IP#1 stated that Resident # 21 was cognitively intact. RNS/IP#2 stated that Resident # 21 has chronic pain in the shoulder and back, being followed up by a pain management Doctor who adjusts the resident's pain medication (med). On that same date and time, the surveyor asked both RNS/IPs to check the eMAR of the resident for September 2024 for PRN Acetaminophen along with PRN Oxycodone. The surveyor asked should the nurse administer both meds together and what the order meant. The RNS/IP#1 and #2 stated that the nurse should follow the PO to administer both PRN Acetaminophen and PRN Oxycodone together. The surveyor then asked why there were more signatures of nurses for PRN Oxycodone than PRN Acetaminophen if they should be administered together. RNS/IP#1 and #2 both stated that they were not sure why, but they would talk to the nurses about it to make sure to follow the PO to administer both PRN Acetaminophen and PRN Oxycodone. The surveyor then notified RNS/IP#1 and #2 of the above findings and concerns. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/05/24 at 9:34 AM, the surveyor interviewed the Licensed Practical Nurse (LPN). The surveyor notified the LPN of the above findings and concerns. The LPN stated that the Nursing Supervisors made her aware of the concern yesterday. She further stated that she should have signed both the PRN Tylenol and PRN Oxycodone at the same time when administering the meds according to the PO. The LPN stated that she administered the PRN Tylenol at that time but failed to sign it in the eMAR, and now she was aware, and she will make sure that they were signed both. The LPN acknowledged that she was one of the nurses who administered the PRN Oxycodone and did not follow the PO to sign the PRN Tylenol when both PRN pain meds were administered. On 9/05/24 at 10:30 AM, the surveyor interviewed the CP via phone conference. The CP informed the surveyor that she was responsible for the facility's monthly MRR and unit inspections. The CP stated that reports from the monthly MRR and unit inspections were submitted via email to the Director of Nursing (DON). On that same date and time, the surveyor notified the CP of the above findings and concerns regarding PRN Acetaminophen and PRN Oxycodone. The surveyor asked should the CP had identified the irregularities that the nurses were not signing the PRN Acetaminophen when administered along with PRN Oxycodone. The CP stated that she would have to check the record first and would get back to the surveyor. On 9/05/24 at 11:39 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Administrator Floater, and the Administrative Assistant (AA). The surveyor notified the facility management of the findings and concerns. On 9/05/24 at 12:36 PM, the CP informed the surveyor that after checking the record of Resident # 21, she (CP) should put something in writing to address the irregularity for not signing the PRN Acetaminophen when the PRN Oxycodone was administered. The CP acknowledged that the CP did not address the irregularity of signing both PRN Acetaminophen and Oxycodone when administered for a pain level of 7-10 as ordered in their monthly MRR. On 9/06/24 at 12:31 PM, the survey team met with LNHA, DON, and the AA. The facility management did not provide additional information for the above findings and concerns. A review of the facility's Medication System Drug Regimen Review & Unit Inspections Policy with date of 10/18 that was provided by the DON revealed: Policy: It is the policy of the facility that a licensed pharmacist will review the resident drug regime including the resident's chart at least once a month. The CP may need to conduct med regimen review more frequently depending on the resident's condition, review of short stay residents, and risk of adverse consequences. The licensed pharmacist will report in writing, any irregularities to the attending physician, the facility's medical director and the DON to be acted upon. On 9/06/24 at 12:52 PM, the survey team met with the LNHA, DON, and the AA for an Exit Conference. The facility management did not provide additional information. NJAC 8:39-29.3 (a)(1)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) psychiatric recommendations from 7/24/24 for laboratory (lab(s)) and b.) routine lab orders for January and June 2024 were followed and obtained in a timely manner. The deficient practice was identified for one (1) of five (5) residents reviewed for unnecessary medications (Resident #21), and was evidenced by the following: On 9/03/24 at 9:12 AM, the surveyor observed Resident # 21's room was closed. The Staff stated that the resident was about to get showered, and the surveyor had to return at a later time. The surveyor reviewed Resident #21's hybrid (a combination of paper-based and electronic medical records that primarily involves tracking and storing a patient's health records in several formats and places) medical records. According to the Admission Record (an admission summary), the resident was admitted to the facility with diagnoses that included but were not limited to quadriplegia (the condition in which both the arms and legs are paralyzed and lose normal motor function) C1-C4 complete, neuralgia and neuritis (neuralgia refers to severe, sharp, often shock-like pain that follows the path of a nerve. On the other hand, neuritis is an inflammation of the nerves) unspecified, other chronic pain, major depressive disorder, recurrent, unspecified, and essential hypertension (occurs when abnormally high blood pressure is not the result of a medical condition). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 8/14/24 revealed a brief interview for mental status (BIMS) score of 15 out of 15 which indicated that resident was cognitively intact. Section N Medications (meds) showed that the resident received antidepressant meds. A review of the September 2024 Order Summary Report (OSR) showed a physician's order (PO): -order date 01/21/22 for labs: CBC (complete blood count; a blood test that measures amounts and sizes of red blood cells, hemoglobin, white blood cells, and platelets) and CMP (complete metabolic panel; a blood test that gives doctors information about the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys and liver are working) every six months (January-June) r/t (related to) Baclofen (used to treat muscle spasms caused by certain conditions such as multiple sclerosis, spinal cord injury/disease). -order date 12/20/21 for Psychiatric Evaluation with [name] psychiatry. -order date 12/20/21 for Baclofen tablet (tab) 20 mg (milligrams) give one tab by mouth four times a day for muscle spasms. -order date 9/19/23 for Cymbalta delayed release particles 30 mg give three capsules (caps) by mouth one time a day for depression (total dose: three caps=90 mg). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-order date 02/15/22 for Trazodone HCL (hydrochloride) tab 50 mg give one tab by mouth one time a day for depression. The above PO for Baclofen, Cymbalta, and Trazodone were transcribed to the electronic Medication Administration Record (eMAR) and signed by nurses as administered from January 2024 through September 4, 2024. A review of the electronic medical records (eMR) showed that there was a Psychiatric Consult note dated 7/24/24 with a diagnosis and a plan to continue with Cymbalta and Trazodone for depression. Also, continue to monitor labs for ALT (Alanine transaminase) and AST (Aspartate transaminase) [are liver enzymes produced by the liver. If high levels of ALT and AST in blood, it could be a sign of liver disease] every 3-6 months. Further review of the eMR showed there was no PO to monitor labs for ALT and AST every 3-6 months. There was no documented evidence that the recommendations of the Psychiatrist were followed and/or why it was not followed. Further review of the hybrid medical records showed that there was no documented evidence that the order for routine labs for CBC and CMP every January (Jan) and June were followed and/or why it was not followed. On 9/06/24 at 11:50 AM, the surveyor interviewed the Director of Nursing (DON) regarding the facility's practice with regard to standing orders for labs. The DON stated that as the facility's practices all standing orders for labs, will be electronically entered into the eMR and should be done according to the POs. On that same date and time, the surveyor asked the DON should the requisition for the labs to be done also comes out electronically or need to order the requisition manually (or handwritten). The DON stated and responded that it depends on the nurse, if it will be the Registered Nurse Supervisor/Infection Preventionist assigned on that date, the requisition will come out electronically but if it will be another nurse they do it manually the requisition form for the kind of labs to be drawn. The surveyor then asked why some electronically and others manually, and then the DON responded, that it should be electronically printed. At that time, the surveyor notified the DON of the above findings and concerns regarding routine labs ordered on 01/21/22 for CBC and CMP for Jan and June, and recommendations of the Psychiatrist for AST and ALT on 7/24/24 every 3-6 months were not followed. The DON stated that she would get back to the surveyor. On 9/06/24 at 12:09 PM, the DON stated that there were labs done on 3/06/24 that were recommended by the Dietician and the result for 3/06/24 was okay. The surveyor asked the DON should the standing order for labs had been followed for Jan and June. The DON stated that she would get back to the surveyor. On 9/06/24 at 12:31 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and the Administrative Assistant (AA). The surveyor notified the facility management of the above findings and concerns. The DON did not provide additional information. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/06/24 at 12:52 PM, the survey team met with the LNHA, DON, and the AA for an Exit Conference. The facility management did not provide additional information. NJAC 8:39-27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene, use of personal protective equipment (PPE), and disinfect equipment practices for one (1) of four (4) staff (Physical Therapist, Dietary Staff, and two nurses) and b.) follow appropriate infection control practices prevent the potential spread of infection for two (2) of two (2) rooms observed during laundry area tour in accordance with the Center for Disease Control and Prevention (CDC) guidelines and facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient . Before moving from work on a soiled body site to a clean body site on the same patient . After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. According to CDC Recommendations for Disinfection and Sterilization in Healthcare Facilities, dated 12/07/23, revealed: 5. Cleaning and Disinfecting Environmental Surfaces in Healthcare Facilities: . 5.g. Use a one-step process and an EPA-registered hospital disinfectant designed for housekeeping purposes in patient care areas where uncertainty exists about the nature of the soil on the surfaces (e.g., blood or body fluid contamination versus routine dust or dirt); or uncertainty exists about the presence of multidrug-resistant organisms on such surfaces . 1. On 9/03/24 at 9:15 AM, the surveyor observed the Physical Therapist (PT) in the hallway with a pair of gloves. The surveyor also observed the PT checked residents' electric wheelchair (w/c) cushions with the use of handheld equipment. The handheld equipment was not disinfected after each use. The PT passed the resident rooms that included from 38 through 33. Afterward, the surveyor observed the PT on the other side of the hallway with the same pair of gloves and checked the other w/c that were in front of rooms 35 through 33, between rooms [ROOM NUMBERS], and rooms [ROOM NUMBERS]. The PT did not change gloves, did not perform hand hygiene, and did not disinfect the handheld equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, the surveyor interviewed the PT. The surveyor asked the PT if it was appropriate to wear gloves in the hallway, and the PT responded that he had to wear gloves because he checked the w/c cushion weekly. The surveyor then asked how about changing the gloves in each w/c, and the PT stated, This is how I was told. The surveyor also asked who the facility staff instructed him to wear the same gloves and he said his director. On 9/03/24 at 10:34 AM, the surveyor notified the Director of Nursing (DON) of the above findings and observations about the PT regarding gloves use in the hallway, not changing gloves in between residents' w/c, and not disinfecting the equipment to check the cushion of w/c. The DON stated that the PT should have cleaned and changed gloves in each check of residents' w/c. On 9/04/24 at 8:59 AM, the surveyor interviewed Registered Nurse Supervisor/Infection Preventionist #1 (RNS/IP#1) and RNS/IP#2. The surveyor notified RNS/IP#1 and #2 of the above observations and findings with the PT on 9/03/24. On that same date and time, RNS/IP#1 informed the surveyor that she was made aware by the DON of what had happened yesterday about the gloves in the hallway by the PT. RNS/IP#2 informed the surveyor that the Nurse Educator (NE) provided education to PT yesterday about appropriate hand hygiene. RNS/IP#2 further stated that the NE educated the PT that the use of gloves in the hallway was not appropriate. Both the RNS/IP stated that it was not appropriate that staff wear gloves in the hallway, PT should have changed gloves, performed hand hygiene in between w/c, and disinfected the pump used for checking the cushion in the w/c for infection control. A review of the facility's Infection Prevention & Control Hand Hygiene Policy with a revision date of 8/21 that was provided by the Administrative Assistant (AA) showed: Policy: The objective is to ensure all residents/patients are cared for by staff following hand hygiene protocols. 2. On 9/05/24 at 9:28 AM, the surveyor toured laundry area #1 (LA#1) with the District Manager (DM) from the contracted company for the facility's laundry services. During the tour, the DM stated that LA#1 was for linens, blankets, and fitted sheets. The 1st door upon entry of LA#1 washer and dryers were being used at that time, next door, the folding room where there was an electric fan hung on the wall. The electric fan was in use and there was an accumulation of grayish and whitish substances around the fan while blowing air, next to it were two metal racks with folded blankets uncovered. The folding table had the folded incontinence pad uncovered. On that same date and time, the surveyor asked the DM if those folded incontinence pads and blankets were considered clean, and the DM responded Yes. The surveyor asked the DM what the accumulation of grayish and white substances in the electric fan was. The DM stated and claimed it was dust and should have been cleaned. The DM further stated that he would ask someone to remove the fan. Later on, the surveyor and the DM went to LA#2 which was in the nursing area in front of rooms [ROOM NUMBERS]. LA#2 was an open area with two washers and two dryers actively being used, and unattended. There were multiple empty laundry bins near the dryers. The folded incontinence pads, folded socks, and other personal clothing on top of the 1st washer not bagged, uncovered, and exposed to the environment. The DM stated that LA#2 was for washing residents' clothing. He further stated that the residents' clothing and incontinence pad on top of the 1st washer were considered soiled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, the surveyor asked the DM why the soiled residents' clothing was left on top of the washer not properly stored and unattended. The DM stated, Maybe someone had put it there. He further stated that it would be washed next. The surveyor asked the DM if it was appropriate for the soiled residents' clothing left exposed to the environment, and the DM had no response. Furthermore, the surveyor asked the DM what he should do with the blankets in LA#1 that were exposed to dust. The DM stated that he would ask someone to remove the fan from the room. The surveyor then asked how the blanket and linen should be stored. The DM stated that he would ask if the facility could order a cover for the clean blankets. On 9/05/24 at 10:23 AM, the surveyor asked the DM what happened to LA#2 soiled residents' clothing, the DM stated it was washed immediately and that should have been in a bag with the resident's name. The DM stated that he did not know who put the soiled residents' clothing on top of the washer. On 9/05/24 at 11:39 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Administrator Floater, and the AA. The surveyor notified the facility management of the above findings and concerns with the PT and the laundry tour. On that same date and time, the DON stated that LA#2 was being used by residents to wash their clothes and no staff was assigned to LA#2 to monitor that area. The surveyor asked the DON if they have a list of residents who does their own laundry and if they were educated about proper use of laundry and specifically infection control. The DON stated residents were not provided with education about infection control regarding washing their own clothes. The DON further stated that LA#2 was not being cleaned after each wash or being cleaned at all. The DON also stated that they did not have a list of residents who use the laundry area and that was a busy area all day, and no one monitors them. On 9/06/24 at 9:47 AM, the survey team met with the LNHA and the Chief Officer (CO) from the contracted agency for laundry services. The CO informed the surveyor that LA#1 was where the soiled blankets, linens, and residents' clothing were being washed. The CO stated that soiled meant anything with body fluids and vomit. She further stated that LA#2 was where the dirty residents' clothing was being washed, dirty meant anything that was not soiled. At that same time, the LNHA stated that after the residents washed their clothes, the residents themselves were not wiping or disinfecting LA#2 environment (top and areas in the washers and dryers). The CO stated, We know now we have a gap, and we are working on the gap now. On 9/06/24 at 12:31 PM, the survey team met with LNHA, DON, and the AA. The facility management stated that they were no additional information for the surveyor's concerns and findings. A review of the facility's undated Soiled Laundry Collection Policy that was provided by the DON showed: Procedure: . 4. Once the fabric is collected, it should be put in a hamper, laundry bag, or other device to facilitate the transport to the laundry apartment without the risk of having the laundry contaminate other surfaces . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/06/24 at 12:52 PM, the survey team met with the LNHA, DON, and the AA for an Exit Conference. The facility management did not provide additional information. NJAC 8:39-19.4(a)(1),l,n