Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Wiley Mission		STREET ADDRESS, CITY, STATE, ZIP CODE 99 East Main Street Marlton, NJ 08053	

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Based on observation, interview and record review, it was determined that the facility failed to a.) identify the medical symptom that warranted the use of restraints; b.) perform an assessment and evaluation for restraint use; c.) obtain a consent with disclosure of risk versus benefits for use the of a restraint; d.) conduct on-going evaluations for the continued use of the restraints; e.) monitor the residents during the use of the restraints; f.) document interventions to decrease and/or discontinue the use of the restraints and; g.) release the restraints during supervised activities. This deficient practice was identified in 1 (one) of 1 (one) residents reviewed for restraints (Residents #19) and was evidenced by the following: Review of the Admission Record indicated that Resident #19 was admitted to the facility with the diagnoses which included but was not limited to: dementia without behavior disturbance, mood disturbance and anxiety, repeated falls, and metabolic encephalopathy (a neurological disorder that occurs when a chemical imbalance in the blood affects the brain). The significant change of status Minimum Data Set (MDS), an assessment that facilitates a resident's care dated 06/25/24, reflected that Resident #19 had severe cognitive deficits. The MDS also indicated that the resident required substantial/maximum assistance with dressing and transfers, dependent with toileting and showering. The MDS did not reflect that the resident utilized a truck restraint when in the chair or out of bed. On 09/23/24 09:14 AM, during tour, the surveyor observed Resident #19 sitting up in the wheelchair (w/c), at the activities wearing a blue velcro seat belt. The surveyor asked the resident if he/she could remove the belt independently and the resident stated, I can't remove it. The resident was very confused and could not explain to the surveyor what the purpose of the seat belt was. The surveyor reviewed the resident's electronic medical records (EMRs) which revealed the following: The physician's orders dated 04/28/24 reflected a PO for a self-releasing seat belt, apply every shift while in the w/c and to check for placement every shift. The EMR reflected that the resident was admitted to the hospital on 06/13/24 for a urinary tract infection and was readmitted to the facility on [DATE]. The PO dated 06/18/24 contained a PO for a self-releasing seat belt, apply every shift while in the w/c and to check for placement every shift. (continued on next page)

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

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #19's comprehensive Interdisciplinary Care Plan (CP) indicated that the resident had the self-releasing seat belt was applied on 04/29/24. There was no documentation that the resident was assessed that he could self-release the seat belt on request at the time the seat belt was applied. There was no supporting clinical documentation or medical symptom being treated or ordered for the use of the specific type of restraint. There was no evidence that ongoing reevaluation or documentation of the medical symptoms and use of the restraint for the least amount of time possible found in the medical record, and there was no documentation that the restraint could be released during supervised activities. The Certified Nursing Assistant CP (CNACP) indicated that the resident had a seat belt applied on 04/29/24. There was no documentation on the CNACP that the seat belt could be released at intervals or during supervised activities. The surveyor could not find any documentation in the progress notes any assessments or evaluations for the use of restraint, the medical symptom that warranted the use of restraint, a consent with disclosure of risk versus benefits for use the of a restraint, documentation of on-going evaluations for the continued use of the restraints, documentation that the resident was monitored during the use of the restraints, documentation of interventions to decrease and/or discontinue the use of the restraints or that the restraint was released during supervised activities The Fall Assessment (FA) dated 06/18/24, indicated that the resident was a high risk for falls, however the intervention section of the FA did not indicate that the facility applied the self-releasing seat belt even though the facility received a physician's order dated 06/18/24 to apply a self-releasing seat belt every shift while the resident was in the wheelchair. On 09/23/24 at 11:27 AM, the surveyor interviewed the resident's Certified Nursing Assistant (CNA) who stated that she did not know the last time Resident #19 had fallen. The CNA stated that Resident #19 had a seat belt on for safety. The CNA stated that the resident was able to get up and could possibly fall so therefore the seat belt prevents the resident from being able to get up on his own. The CNA stated that she believed that the resident was able to remove the belt on his/her own with instructions. The CNA accompanied the surveyor to observe Resident #19 who was sitting at the activity table wearing a velcro seat belt. The CNA asked the resident if he could remove the velcro seat belt and the resident responded that he was not able to remove the device on his/her own. Resident #19 stated, I don't think so, and no I can't take it off. When the surveyor asked the CNA if the seat belt was removed throughout the day, the CNA stated that the seat belt remained intact when the resident was OOB and that the seat belt was not removed as long as the resident was out of bed. The CNA stated that there should be a consent from the family or responsible party for the use of the seatbelt but did not know where in the medical record it could be found. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/23/24 at 11:40 AM, the surveyor interviewed the Registered Nurse (RN) who stated that she had been employed in the facility for approximately one (1) year. The RN explained that Resident #19 was very confused and could not follow commands or make his/her own decisions. The RN continued to explain that the resident used to be combative however his behavior had improved since he had been treated for a urinary tract infection (UTI). She stated that Resident #19 had not had any behavior issues since then. The RN stated that the resident's family was very support and visited daily. She continued to explain that the resident had no skin issues and was incontinent of bladder and bowel. She stated that the resident had the current fall prevention interventions; bed alarm, w/c alarm, self-releasing seat belt, assist of two with transfers, and had a blue bolster in the bed and that the bed was positioned in low position. The RN stated that she thought that to use the seat belt that the facility would need consent from the family because it would be considered a restraint. She stated that the resident had cognition issues and did not even realize the seat belt was in place. She stated that the only physician order documented in the Medication Administration Record (MAR) was for the nurse to sign out that the seat belt was in place. No other physician orders were required. The surveyor reviewed the MAR and there was an order for a self-releasing seat belt, apply every shift while in the w/c and to check for placement every shift, however there was no diagnoses for the use of the seat belt, nor were the staff documenting that the seat belt was being routinely released. On 09/23/24 at 11:56 AM, the surveyor interviewed the RN Supervisor (RNS) who explained that self-releasing seat belts were utilized as fall prevention interventions and as long as the resident was able to release the device, it would not be considered a restraint. She stated that there must be documentation in the resident's medical record that the resident was able to release it. She stated that there would be documentation in the nurses note on the day the seat belt was applied that the resident was assessed and was able to remove the device. The RNS reviewed the residents medical record in the presence of the surveyor and admitted that there was no documentation that the resident could remove the seat belt on request and there was no assessment completed when the device was applied on 04/28/24. The RNS revealed that that facility did not need consent from the family, however the nurses let the family know verbally. The RNS reviewed Resident #19's medical record in the presence of the surveyor and admitted that the self-releasing seat belt was applied 04/28/24 and put on the resident's CP on 04/29/24. The RNS stated that she was the nurse that added the self-releasing seat belt to the resident's CP on 04/29/24. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/24 at 10:24 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she had been employed in the facility for [AGE] years and the MDS Coordinator (MDSC) regarding seat belt use. The DON stated that self-releasing seat belts were utilized as positioning devices, for trunk control or for a cognitive assistance device which is a gentle reminder on not to get up without assistance. The DON explained that before application the interdisciplinary team evaluated the fall to determine the best intervention to prevent the falls. The process for application of self-releasing seat belt would be determined if the resident could demonstrate self-release at the time of application. She stated that this was determined because the resident continued to release the seat belt and continued to stand in April when it was applied but has since readmission to the facility on [DATE] had not tried to stand and get out of the w/c. She stated that at the time the seat belt was applied the nurse should have assessed and documented that the resident had demonstrated that he/she could release the seat belt. The MDS Coordinator stated that the CP interventions were reviewed each quarter to determine if the CP goals and interventions were still appropriate. The MDS coordinator stated that the nurses did not get verbal or written consent from the family because when the beat belt was applied it was not being used as a restraint. The DON admitted that there was no clinical documentation to determine why the restraint was being used. The MDSC reviewed the residents medical record in the presence of the surveyor and a physician's order was obtained 04/28/26, discontinued on 06/13/24 when the resident was discharged to the hospital and then reordered when the resident returned from the hospital on 06/18/24. The MDSC coordinator stated that a fall assessment should have been completed on 04/28/24 when an PO was received to apply the self-releasing seat belt. The MDSC and DON both admitted that the resident should have had continued assessment for the continued use of the restraint and that since it was brought to their attention that the seat belt was discontinued. On 09/27/24 at 10:00 AM, the DON and Licensed Nursing Home Administrator (LNHA) did not provide any additional information. According to the facility policy titled, Restraints-Physical dated 04/23/19 indicated that restraints shall only be used for safety and well-being of a resident after all other alternatives have been utilized. Prior to use of any restraint, except emergencies, it was the facility policy to inform the resident and/or representative of the behaviors creating a risk of injury; describe alternatives that have been employed to address the risk and their lack of success and advise on the risk and benefits of such devices and interventions and request consent for their use. A restraint would only be used as it is medically necessary and with a physician's order. The restraint would be least restrictive for the least amount of time with ongoing evaluation of need for use. The restraint would only be used when other alternatives fail and were documented. Medical symptoms or problems that can't be controlled must be documented in the medical record and on the Care Plan. Verbal or written consent must be obtained. The potential or risk were to be explained. The policy also indicated that the facility should attempt to remediate the resident's condition or lessen the need for the restraint and if the use of restraints is needed beyond 1 (one) week the following should be done: -The need for the continued use of restraints should be implemented only as part of the physician's medical care plan. -Every resident in restraints should be assessed by a RN at least every 48 hours for continued use of restraints. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interdisciplinary review of the record of any resident whose assessment indicated the need for continued use of restraint. This should occur within 30 days of the initiation to the use of restraints. -Recommendation will be documented on the IDCT restraint review form. -At regular interval and as needed the nursing staff were responsible to release restraints at least every two hours to assess for circulation, perform skin care, provide an opportunity to perform range of motion exercises, assess the need for toileting or incontinence care, ensuring adequate fluid intake, adequate nutrition, assisting with bathing and ambulation if feasible. Review of the facility RN and LPN orientation dated 06/13, indicated that restraints such a seat belts may be ordered for upper trunk control support and should be removed during meals and activities with supervision. NJAC 8:39-19.4(h), (i), (j)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Complaint # NJ172381 and NJ173377 Based on interview, record review and document review it was determined that the facility failed to maintain documentation and ensure that a complete and thorough investigation was conducted for residents that had unwitnessed falls and sustained fractures. This deficient practice was identified for 2 (two) of 2 Residents (Resident #5 and #45) reviewed for fracture of unknown origin and was evidenced by the following: 1.) According to the quarterly Minimum Data Set, dated dated dated [DATE], an assessment that facilitates a resident's care, indicated that Resident #5 had the diagnoses that included but was not limited to cerebral vascular accident (stroke), disease (GERD) and hip fracture. The MDS also indicated that the resident was cognitively intact. On 09/23/24 at 10:03 AM, Surveyor #1 reviewed the Facility Reportable Event (FRE) dated 03/25/24 which revealed that Resident #5 had an unwitnessed fall in the resident's room on 03/23/24. The FRE indicated that while Resident #5 was trying to get something in the nightstand, the wheelchair (w/c) got away from him/her and the resident fell . The resident complained of pain in the right hip and was sent 911 to the hospital where the resident was diagnosed with a right hip fracture. On 09/23/24 at 10:05 AM during tour, Surveyor #1 interviewed Resident #5 who stated that on 03/23/24, he/she was trying to walk around the front of the bed and fell . Resident #5 stated that he/she was independent and did not ask for assistance at the time of the fall. The surveyor reviewed Resident #5's electronic medical record (EMR) which revealed the following information: The Nurse's note dated 3/23/2024 at 20:48 (08:48 PM), indicated that staff heard Resident #5 yelling for help from the resident's room. The nurse and 2 (two) Certified Nursing Assistance observed that Resident #5 was not in w/c and found the resident on the floor on his/her right side next to bed. The resident told the staff he/she was trying to get into the nightstand when he/she felt the wheelchair slip from under him/her. The staff observed the seat cushion to be halfway off w/c. The resident complained of right hip pain 7 out of 10 on the pain scale and the resident's right leg was internally rotated. The resident was transported to the hospital by emergency medical services (EMS) at 08:45pm. On 09/24/24 at 09:56 AM, Surveyor #1 reviewed the FRE and fall investigation form, root cause analysis and the care plan which was updated with new interventions after the resident returned from the hospital. The FRE did not contain any statements from the staff the that observed the resident lying on the floor on 03/23/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/25/24 at 09:55 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN #1) who stated that she had been employed in the facility for 9 1/2 years. The LPN revealed that she was the nurse that had entered the resident's room after the resident had fallen. The LPN stated that she had filled out the incident event in the computer and admitted that she did not recall filling out a witness statement form. She also stated that she did not remember if the CNAs that entered the resident's room with her, filled out witness statements. The LPN also explained that the MDS Coordinator (MDSC) or someone in administration assured that the witness statements were completed when they reviewed the investigation. On 09/25/24 at 10:07 AM, Surveyor #1 interviewed a Certified Nursing Assistant (CNA #1) who stated that she recalled that when Resident #5 was found on the floor, the resident indicated that he/she was trying get something out of the bedside drawer and slipped out of the w/c. She stated that a Registered Nurse (RN) on duty had her write a witness statement. She stated that after she wrote a statement, she brought it to the front desk and sat it on the desk and told the supervisor that the report was placed at the front desk. On 09/25/24 at 10:24 AM, Surveyor #1 interviewed CNA #2 who stated that Resident #5 had called for help and was reaching for something on the table and scooched forward and fell . CNA #2 could not recall if she was asked to fill out a witness statement form. On 09/25/24 at 10:30 AM, Surveyor #1 interviewed the Registered Nurse (RN #1) that CNA #1 stated had her write a witness statement. RN #1 stated that she was not present in the facility when Resident #5 fell . The RN explained the investigative process when a resident had an unwitnessed fall in the facility. She stated that an incident report, fall assessment, pain assessment, neuro-checks were all to be completed for an unwitnessed fall. She explained that all findings were documented in the medical record, progress, and incident (risk management) report. She stated that the supervisor's role was to assure the incident report was completed. She continued to add that the RN would complete the assessment and report to the Interdisciplinary Care Team (ICD) team in morning meeting. She stated that the IDC team was to assure that if the fall was unwitnessed, the nurse would be responsible to complete a witness statement and the CNAs involved would also complete a statement. RN #1 revealed that anyone involved in the incident would have to write a statement. She stated that a statement would be important to obtain so that that facility had all information regarding what, why, when, and how the fall might have occurred. On 09/26/24 at 12:44 PM, Surveyor #1 interviewed the Director of Nursing (DON) who stated that the nurse on duty was to be notified of any resident fall that occurs. The DON explained that if a resident fell , the nurse performed an assessment of the resident and if the resident was cognitively intact, ask the resident what happened. She stated that the nurse was responsible to fill out the incident report. The DON stated a witness statement form was to be complete by the nurse. She stated that the nurse in charge was responsible to obtain a handwritten statement from the CNA who was involved. She stated that the facility goes back so many hours and obtain a statement from the nurse and the CNA who cared for the resident at that time. She stated that it was important to obtain statement to see what happened and if there was anything that needed to be addressed to prevent further reoccurrence or future falls. On 09/27/24 at 10:48 AM, the DON admitted that the fall investigation was not completed due to lack of statements regarding the CNAs that were present in the residents room after the resident had fallen on 03/23/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45209 A review of the Facility Reported Event (FRE) dated 1/6/24, revealed that Resident #45 sustained a fall that resulted in a hip fracture. Further review of the FRE did not include a thorough investigation that included staff statements and maintain documentation that the investigation was thoroughly investigation that included the progress notes of the sequence of events leading to the fall. On 9/23/24 at 8:34 AM, Surveyor #2 observed Resident #45 in bed eating breakfast. On 9/26/24 at 9:24 AM, Surveyor #2 attempted to speak with Resident #45 regarding the fall. When asked if they fell , Resident #45 stated, that's what they tell me. The resident was unable to recall the events leading up to or after the fall. The surveyor reviewed the medical record for Resident #45. A review of the Admission Record revealed that Resident #45 had diagnoses which included, but were not limited to, fracture of unspecified part of neck of left femur and unspecified dementia. A review of the quarterly MDS dated [DATE], included the resident had a Brief Interview for Mental Status score of 6 out of 15; which indicated a severely impaired cognition. A review of Resident #45's Electronic Medical Record (EMR) Nursing Progress Note revealed an entry dated 1/6/24 at 10:30 AM that stated, Alerted by team nurse that resident had fallen in bathroom. Assist to [unknown] Ax3. Unable to move left leg and severe pain in left hip. Notified NP and daughter {name redacted} that resident will be evaluated at {name redacted}. EMS transfer. Another EMR Nursing Progress Note entry dated 1/6/24 at 11:08 AM revealed, Team nurse notified this nurse that resident was found on the floor in his bathroom. Ax3 to wheelchair. Resident unable to move his left leg and has 10/10 pain in left hip. NP and daughter notified of fall and possible left hip fracture. Sent to{name redacted} ER for evaluation. Further review of the EMR Progress Notes identified an Interdisciplinary Care Team Note on 1/8/24 at 9:59 AM that revealed, Round up review of fall on 1/6 at 10:20 AM. Resident was found on the floor in his bathroom. Resident was combing his hair in front of sink and lost his balance. Reported 10/10 left hip pain, sent to ER and admitted with hip fracture. Will address care plan upon readmission. A review of Resident #45's Risk Assessments did not reveal any assessments for the fall dated 1/6/24. During an interview on 9/25/24 at 10:27 AM, Registered Nurse (RN #1) stated that fall residents are first assessed before being moved. RN #2 explained that an assessment included documentation of vital signs (blood pressure, heart rate, respirations, level of consciousness, pain, neurological check). The nurse should also document the range of motion of all extremities and how the resident was found in the room. RN #2 identified that a fall investigation should have a full investigation, which included a risk management assessment in the electronic medical record and a paper based incident assessment that would have a drawing and statements. RN #2 advised that the fall investigation are completed by the supervisor. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 1:42 PM, the Certified Nursing Aide (CNA #3) confirmed that they were the CNA at the time of the Resident #45 fall on 1/6/24. CNA #3 stated that she found the resident on the floor and immediately got assistance. CNA #3 indicated that the registered nurse did an assessment and the resident was transferred to the hospital. When asked if they were required to write a full statement, CNA #3 responded that they only had to fill out a prompted questionnaire. During an interview on 9/26/24 at 11:17 AM, the Licensed Nurse Practitioner (LPN #2) advised that the facility expectation for fall documentation is that a patient assessment should be completed, which included vital signs (respirations, pulse, pulse ox, blood pressure, pain), range of motion, level of consciousness and if the resident was stable, then could then be transferred to position of comfort. LPN #2 stated that a fall assessment contained two parts a risk assessment and then an incident investigation. LPN #2 reviewed the EMR nursing progress notes for the dates of Resident #45's fall. LPN #2 confirmed that the progress notes did not contain vital signs, pain, no description of the leg, how the resident was found, no orders. LPN #2 also confirmed that there was no Risk Assessment completed for the date of the fall on 1/6/24, which also should have been completed. During an interview on 9/27/24 at 10:34 AM, the DON, in the presence of the survey team, confirmed that a thorough fall investigation was not completed based on the fact that statements were not obtained and documentation of the progress notes of how the patient was found, vital signs, and completion of the incident packet. A review of the undated facility provided document titled, Fall Events Process directed that, 2. Supervisor or Team Leader must completed the Falls Investigation Form. This includes the Supervisor or Team Leader interviewing the staff involved, drawing a diagram of the scene, sequence of events, contributing factors and the root cause of the fall Why?? Did it happen . On 9/27/24, the facility provided the following untitled documented dated 8/8/19 that directed, We will begin using a new Fall report form in PCC [point click care] starting next week crossed off and handwritten with 8/16/19] [.] 6. You will choose either witnessed or unwitnessed fall [.] In addition, the paper fall investigation form has been updated and must be completed . A review of the undated facility provided document titled, RN and LPN Orientation with a Revision date 06/13 indicated that, incident reports [.] get all witness statements immediately [.] care of the falling resident (assessment & documentation) . A review of the facility provided policy titled, Charting with a revision date of 6/2010, revealed under, Policy that all services provided to the resident or any changes in the resident condition shall be recorded in the resident's medical record. The policy further revealed under Procedure that, All treatments must be signed out on Treatment Administration Record . NJAC 8:39-9.4(f)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38680 Complaint # NJ00171237 Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to accurately assess the status of a resident in the Minimum Data Set (MDS). This deficient practice was identified for 1 of 22 sampled residents, (Resident #37) and was evidenced by the following: On 6/11/2021 at 9:34 AM, the surveyor observed Resident #11 in the hallway with a wander guard/elopement bracelet on his/her left ankle. On 09/23/24 at 08:53 AM, the surveyor observed Resident #37 in the room. The surveyor did not observe an elopement device. According to the Admission Record, Resident #37 was admitted with diagnoses including but not limited to Parkinson's Disease (a disease effecting the central nervous system). A review of the Order Summary Report with active orders as of 02/05/2024 for Resident #37, did not include a physician's order for an elopement alarm. A review of the February 2024 Treatment Administration Record for Resident # 37 did not include a physician's order for an elopement alarm. A review of the Quarterly MDS dated [DATE] for Resident # 37, indicated under Section P0200 for alarms was coded as 2 indicating there was a wander/elopement alarm used daily. During an interview on 09/25/24 12:24 PM, the MDS Coordinator stated that the elopement alarm for Resident #37 was discontinued when resident went to the hospital on 2/3/24. The MDS Coordinator stated the Quarterly MDS dated [DATE] was coded incorrectly. NJAC 8:39-11.1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Wiley Mission		STREET ADDRESS, CITY, STATE, ZIP CODE 99 East Main Street Marlton, NJ 08053	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Based on observation, interview and record review, it was determined that the facility failed to develop and implement a comprehensive interdiciplinary care plan that a.) specified a resident's preferences for care and; b.) meets the medical needs identified on the comprehensive assessment for 2 (two) of 17 residents reviewed for comprehensive interdiciplinary care plans, (Resident #40 and #48). This deficient practice was evidenced by the following: 1.) According to the Admission Record (AR), Resident #40 was admitted to the facility with the diagnoses which included but was not limited to; compression fracture, fusion of the spine and osteomyelitis (infection in a bone). The quarterly Minimum Data Set (MDS), an assessment that facilitates a resident's care dated 08/03/2024, indicated that Resident #40 had moderate cognitive impairment and did not experience inattention or disorganized thinking. On 09/23/24 at 09:02 AM during tour, Surveyor #1 interviewed Resident #40 who appeared alert and oriented and was able to express his/her needs and wants. The resident stated that he/she was exhausted and tired daily. The resident stated, Look I have bags under my eyes and had made complaints multiple time regarding getting no sleep due to staff members coming into his/her room throughout the night waking him/her up. Resident #40 stated that the staff told him/her that they are waking him up at night due to safety, however he/she felt that the staff could just observe him/her without moving and adjusting the bed. The resident also stated that the staff continue to leave the door open at night after they leave. He stated that he/her did not think that the staff communicated his/her needs to have privacy at night and that due to different staff members, all staff don't know that he/she did not want to be woken up constantly at night. The surveyor reviewed Resident #40's comprehensive Interdisciplinary Care Plan (ICP) and there was no indication in the ICP that the resident's preference was not to be disturbed or woken up at night. The Interdisciplinary Team Note (IDC) dated 08/15/2024 at 13:43 (01:43 PM), did not indicated that the IDC team were aware of the resident's preference that he or she did not want to be disturbed or woken up at night. Surveyor #1 reviewed the Social Service Note dated 08/9/2024 at 17:24 (05:24 PM) did not reflect that the Social Worker (SW) was aware of Resident #40's preference not to be disturbed or woken up at night. On 09/25/24 at 12:44 PM, Surveyor #1 interviewed the residents Registered Nurse (RN) who stated that Resident #40 had mentioned it Monday (09/23/24) to her that staff had been coming into his/her room during sleeping hours and waking him/her up. The RN stated that she explained to the resident that the nurses conducted one-hour rounds and were responsible to check on him/her. The RN stated that she did not report this resident's concern to anyone or document the resident's concern in the medical record. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/25/24 at 12:49 PM, Surveyor #1 interviewed the day shift RN Supervisor who stated that Resident #40 was confused however the resident had been complaining about the staff waking him up since admission to the facility. She stated that staff were aware and that the night shift was aware, but she did not work at night and was not sure what they were doing about it. She stated that Resident #40 was occasionally incontinent, and the staff were required to change the resident at night. The RN supervisor stated, Am I wrong, or should we not change him/her at night. The surveyor explained that the resident should be able to make the decision if he wanted the staff to wake him/her up for changing. The surveyor asked the RN supervisor if a conversation was had with the resident concerning his/her preference and if he/she wanted to be woken up and changed when incontinent. The RN supervisor did not know if the staff had a conversation with the resident regarding the residents' preferences not to be woken up at night. The RN stated that the resident was confused and continued to repeat the same story repeatedly. The RN then admitted that the resident did not have a Care Plan developed according to his preferences regarding not to be woken up at night. On 09/25/24 at 01:18 PM, Surveyor #1 interviewed the Social Worker (SW) who stated that the resident had no complaint regarding the staff waking him/her up at night a not being able to get a good night's sleep. The SW stated that if this was a concern for the resident and the staff knew about it then it should have been brought to her attention so that the resident and the staff could come up with ideas to help make sure the resident got a good night's sleep. The SW also stated that it would be important to include this preference in the resident's ICP. On 09/25/24 at 01:43 PM, Surveyor #1 interviewed a Certified Nursing Assistant (CNA) who stated that Resident #40 was slightly confused, however he/she was able to communicate his/hers needs and wants. The CNA stated that the resident was occasionally incontinent however utilized the bathroom independently during the day and would let the staff know if he/she had an accident. She stated that the resident was continent of bowel. The CNA stated that Resident #40 only required supervision with activities of daily living (ADLs) and propelled self around the facility independently. She stated that he/she utilized his/her call bell appropriately. The CNA stated that the resident did not have any complaints to her regarding the staff waking him/her up at night. She stated that she was not the resident's regular CNA but that the resident did not complain to her today while under her care. On 09/26/24 at 01:02 PM, Surveyor #1 interviewed the Director of Nursing (DON) who stated that it would have been importance that the staff had a meeting regarding the resident's preferences. She stated that resident's preferences should have been documented on the resident's Care Plan and on the 24-hour report so that all shifts were aware that the resident did not want to be disturbed at night. 49712 2. A review of Resident # 48's AR revealed that, Resident # 48 was admitted with but not limited to Neuromuscular Dysfunction of Bladder (a condition caused by the nerves along the pathway between the bladder and the brain not working properly), Retention of Bladder,(Retention of Bladder (a condition where the bladder doesn't empty all the way or at all when urinating), and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms (enlarged prostate). A review of the Resident #48's admission MDS dated [DATE] revealed under section H that the resident had an indwelling catheter (tube inserted in the bladder to drain urine). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Wiley Mission		STREET ADDRESS, CITY, STATE, ZIP CODE: 99 East Main Street Marlton, NJ 08053	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the current ICP for Resident #48 did not include documentation of a ICP focus area or interventions for the care of indwelling catheters. During an interview on 09/26/2024 at 09:53 AM, Surveyor #2 interviewed the Licensed Practical Nurse (LPN) who stated, how and when to clean , any precautions, when the catheter needs to be changed, and that there should be a privacy bag, when asked what should be on the CP for a resident with an indwelling catheter. When asked if there should be a focus on the indwelling catheter on the resident's baseline CP, LPN #3 replied. yes. During an interview on 09/26/2024 at 12:30 PM with Surveyor #2, the DON stated, that they have a catheter, what care needs to be done, and how often it is to be changed, when asked what should be on the ICP for a resident with an indwelling catheter. When asked if there should be a focus on the indwelling catheter on the resident's baseline ICP, The DON replied, yes. A review of a facility provided policy titled Resident Assessment and Care Planning revealed under section Policy that, Dependent upon the assessment, the care plan is developed or updated in order to meet the resident's needs. NJAC 8:39-27.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45209 Based on interview, review of medical records and other facility documentation, it was determined that the facility failed to a.) follow physician's order to remove a left hand appliance during the day and b.) ensure that there was an active order for a right hand appliance for 1 of 17 residents reviewed for accuracy of physician's orders (Resident #8) c.) supervise the administration of medications for 1 of 4 residents (Resident #27) reviewed for medications and 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 state: 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. The deficient practice was evidenced by the following: On 9/23/2024 at 8:20 AM, during initial tour, the surveyor observed Resident #8 in the area of the nursing wing with a hand appliance on both right and left hand. On 9/24/2024 at 12:26 PM, the surveyor observed Resident #8 in the main dining room with hand appliance on both the right and left hand. On 9/25/2024 at 9:11 AM, the surveyor observed Resident #8 in the television area of the nursing wing with the hand appliance on both right and left hand. The surveyor reviewed Resident #8's medical Record: A review of the Admission Record revealed that Resident #8 had diagnoses which included, but were not limited to, Parkinsonism (a set of movements associated with Parkinson's disease and other disorders that include slow movements plus one or more of the following: stiffness, walking difficulties, balance problems, tremor), and Chronic Inflammatory Demyelinating Polyneuritis (autoimmune condition that affects the myelin sheath around your peripheral nerves). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 8/9/2024, reflected a brief interview for mental status (BIMS) score of 13 out of 15, which indicated that the resident was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #8's Order Summary Report identified the following active physician's order (PO): Left Hand Splint every evening shift ON AT BEDTIME, OFF IN MORNING. Upon review of the October Treatment Administration Record (TAR) the PO was located with a check mark and initials. A review of the individualized comprehensive care plan (ICCP) included a focus area area dated 2/16/2023 for decline in [activities in daily living] related to advancing Parkinson's Disease [.]. Interventions included: left hand splint on at bedtime, off in morning. The Care Plan did not specify any treatment for the right hand. A review of Resident #8 Nurse's Aide Information Care Plan revealed an entry under section titled Adaptive Equipment: Splint: Left Hand Bedtime-On; Morning-Off. The Nurse's Aide Care Plan did not specify any treatment for the right hand. During an interview with the surveyor on 9/25/2024 at 9:54 AM, the Certified Nursing Aide (CNA #1) stated that every resident has a resident care plan that can be viewed in their wardrobe. This care plan would identify their preferences and care needs. When asked about care needs and specialized adaptions, CNA #1 indicated that nursing was responsible for putting on and taking off any specialized equipment and ensuring specialized equipment is in use after therapy provides training and instruction. CNA #1 stated that the resident has a left palm guard that is on during the day and is off when sleeping. During an interview with the surveyor on 9/25/2024 at 12:10 PM, the Director of Rehabilitation (DOR) informed the surveyor they were familiar with the resident and that the physician's order incorrectly identifies the resident's hand appliances and splints, which I really don't like because are palm guards. The DOR confirmed that there is only an order for the left hand and that would make more sense for me because that hand is more contracted. The DOR further stated that the right hand would not have an appliance since that hand has functional use. During an interview with the survyeor on 9/25/2024 at 12:38 PM, the surveyor requested Registered Nurse (RN #1) to visit the room of Resident #8. At this time, RN#1 confirmed that right and left palm guards were on the resident. Upon reviewing the physicians orders, RN #1 acknowledged that the order was identified for a left palm splint that should have been removed. RN #1 further identified that there was no order for a right palm guard. During an interview with the surveyor on 9/26/2024 at 11:14 AM, the surveyor requested Licensed Nurse Practitioner (LPN #1) to visit the main dining room where Resident #8 was engaged in activities. LPN #1 confirmed that Resident #8 was wearing right and left palm guards. LPN #1 confirmed that based on the physician order, the left palm guard should not be on and that there should not be a palm guard on the right since there was not a physician's order. LPN #1 confirmed that this appliance was not a splint and that it should have been clarified by nurses. During an interview with the surveyor on 9/27/2024 at 9:34 AM, the Director of Nursing and Licensed Nursing Home Administration, in the presence of the survey team, confirmed that the right appliance was being applied without an order and that the left hand was not being taken off during the day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided policy titled, Physicians Orders with an unknown revision date revealed under, Procedure that, Medications, diets, therapy, or any other treatment may not be administered to the resident without the written approval from the attending physician /nurse practitioner . A review of the facility provided policy titled, Charting with a revision date of 6/2010, revealed under, Policy that all services provided to the resident or any changes in the resident condition shall be recorded in the resident's medical record. The policy further revealed under Procedure that, All treatments must be signed out on Treatment Administration Record . 51232 2.) On 09/24/2024 at 7:40 AM, during medication administration surveyor # 2 observed the Registered Nurse (RN #1) prepare an omeprazole capsule 40 milligram (mg) (reduce stomach acid), acidophilus capsule (probiotic supplement), glipizide tablet 10 mg (lowers blood sugar), and preservision capsule (eye supplement) to Resident #27 in a disposal paper cup. Resident #27 said to RN #1 that he/she did not want to take the acidophilus capsule and preservision capsule right now. Resident #27 swallowed the glipizide tablet 10 mg and omeprazole capsule 40 mg. Resident #27 kept the disposal paper cup with the acidophilus capsule and preservision capsule inside placing it on his/her bedside table. The RN #1 walked out of Resident #27 bedroom to the medication cart leaving the medications in the disposal paper cup in Resident #27's room on the bedside table. Surveyor #2 asked RN #1 does she always leave medications at residents' bedside, RN #1 stated, I will come back in 10 minutes as the resident does this all the time. RN #1 then went back into Resident # 27's bedroom and removed the medications from the bedside table. During an interview with surveyor #2 on 09/24/2024 at 09:17 AM, he Director of Nursing (DON) said Resident #27 should not have medications left in the bedroom on the bedside table. During an interview with surveyor #2 on 09/24/2024 at 1:27 PM, the Registered Nurse Charge Nurse (RNCN #1) said medications should not be left in a resident's room. A reviewed of the facility policy and procedure on oral medication administration under special considerations number 10 revealed, Administer medication and remain with resident after medication swallowed. a.) Never leave a medication in a resident's room, except for residents with bedside storage and self-administer orders. NJAC 8:39-29.2(d)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49712 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that an indwelling urinary catheter (tube inserted in the bladder to drain urine) drainage bag was secured in a manner to prevent contamination for 1 of 1 resident reviewed for a urinary catheter, (Resident #48). The deficient practice was evidenced by the following: During the initial tour of the unit on 09/23/2024 at 08:44 AM, Resident #48 was in bed with a urinary catheter drainage bag in contact with the floor, with no privacy bag, and visible from the hallway. It was not secured to the bed frame. A review of Resident # 48's admissions record revealed that, Resident # 48 was admitted with but not limited to Neuromuscular Dysfunction of Bladder (a condition caused by the nerves along the pathway between the bladder and the brain not working properly), Retention of Bladder (a condition where the bladder doesn't empty all the way or at all during urination), and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms (enlarged prostate). A review of the Resident #48's admission Minimum Data Set (MDS) dated [DATE] revealed under section H that the resident had an indwelling catheter. During an interview on 09/25/2024 at 12:51 PM with the surveyor, the Infection Prevention (IP) nurse stated, Catheters should be hung below the hip or bottom rail of the bed so they don't touch the floor. When asked if there should be a privacy bag, the IP replied, in their rooms we don't have privacy bags, when out of the room they do. During an interview on 09/25/2024 at 01:12 PM with the surveyor, the Director of Nursing (DON) stated, the foley bags should be hung on the side, never on the floor and should have privacy bags at all times. A review of a facility policy title Using Urinary Catheter Leg Drainage Bags revealed under In Changing Leg Bag to Foley Bag that, All foley drainage bags will be covered and positioned off the floor. N.J.A.C. 8:39-19.4(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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 45209 Based on interview and record review, it was determined that the facility failed to ensure that appropriate assistive devices were provided to residents (Resident #8) to maintain and improve their ability to drink independently for 1 of 3 residents reviewed for activities of daily living. The deficient practice was evidenced by the following: On 9/23/2024 at 8:20 AM, during initial tour, the surveyor observed Resident #8 with adapted water bottle attached to the right side of resident's chair. The long flexible straw of the bottle was observed to be coiled around itself and the tip was not located near the resident's mouth, leaving the resident unable independently drink. On 9/24/2024 at 12:22 PM, the surveyor observed Resident #8 in the main dining room being assisted during lunch. The resident's water bottle was not observed attached to the resident's chair. A staff member approached holding a new bottle and asked what the resident would like. At 12:41 PM, the resident was observed being removed from the main dining room to their room with no water bottle. On 9/25/2024 at 9:11 AM, the surveyor observed Resident #8 in the television area of the nursing wing. The resident's water bottle was not observed attached to the resident's chair. A review of the Admission Record revealed that Resident #8 had diagnoses which included, but were not limited to, Parkinsonism (a set of movements associated with Parkinson's disease and other disorders that include slow movements plus one or more of the following: stiffness, walking difficulties, balance problems, tremor), and Chronic Inflammatory Demyelinating Polyneuritis (autoimmune condition that affects the myelin sheath around your peripheral nerves). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 8/9/2024, reflected a brief interview for mental status (BIMS) score of 13 out of 15, which indicated that the resident was cognitively intact. A review of the individualized comprehensive care plan (ICCP) included a focus area area dated 8/15/2024 for risk related [diagnosis] of Parkinson's disease, dysphagia, need for texture modified diet [.] . Interventions included: specialized drinking cup attached to wheelchair for independent hydration [.]. A review of Resident #8 Nurses Aide Information Care Plan revealed an entry under section titled Adaptive Equipment: Drinking cup with straw to [wheelchair]- position straw for independent drinking. A review of the facility requested Occupational Notes revealed a note dated 7/16/2024 [.] spoke to nursing regarding having pt's adapted cup within reach for self hydration [.] modification to move cup within reach [.]. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #8's Electronic Medical Record (EMR) Nursing Progress Note revealed an entry dated 9/11/14 at 09:55 AM that stated, Discussed placement of water bottle and straw. Will add to the care plan to ensure straw is placed properly for independent drinking. Care Plan reviewed and updated. During an interview on 9/25/2024 at 9:54 AM, the Certified Nursing Aide (CNA #1) stated that every resident has a resident care plan that can be viewed in their wardrobe. This care plan would identify their preferences and care needs. When asked about care needs and specialized adaptions, CNA #1 indicated that nursing was responsible for putting on and taking off any specialized equipment and ensuring specialized equipment is in use after therapy provides training and instruction. The surveyor inquired if CNA #1 was familiar with Resident #8, CNA #1 confirmed and stated that they have a water adaptor bottle with a snake straw that should be positioned by the resident's head so that they can turn and sip. CNA #1 specified that Resident #8 does not like the straw in front of them, but rather to the side. During an interview on 9/25/2024 at 12:10 PM, the Director of Rehabilitation (DOR) informed the surveyor that based on a previously held Interdisciplinary Team Meeting, Resident #8's cup should be at their side at level of head as it allowed the resident to independently increase hydration. The DOR confirmed that nursing should have been made aware of this intervention. When asked if it should be available at mealtimes, the DOR stated that it should absolutely be there during meals so that they can drink at will. During an interview on 9/25/2024 at 12:38 PM, the surveyor requested Registered Nurse (RN #1) to visit the room of Resident #8. At this time, RN#1 confirmed that the water bottle is not on the chair and that it is the responsibility of the nursing staff to ensure that it is on the chair and that the resident has accessibility to drink. During an interview on 9/26/2024 at 11:09 AM, the Licensed Nurse Practitioner (LPN #1) confirmed that Resident #8's water bottle should be available at their preference. The surveyor explained that on 9/24/2024, a staff member approached the resident to inquire about the water bottle but it was never given to them and the resident was brought to their room without the water bottle. LPN #1 indicated that Resident #8 does enjoy having access to their water bottle and that she recalled the resident asking for the bottle on Tuesday and it should have been given to them right away. A review of the facility provided policy titled, Accommodation of needs and preferences and homelike environment with an unknown revision date of 7/22/2023 revealed under, Procedure that [the facility] will assess and interview [the] resident to make reasonable accommodations such as: [.] adaptive devices necessary to maintain/restore resident at their highest level of functioning . During an interview on 9/27/2024 at 9:34 AM, the Director of Nursing and Licensed Nursing Home Administration, in the presence of the survey team, acknowleged that the water bottle should be accessible at all times. NJAC 8:39-27.5(b)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wiley Mission	99 East Main Street Marlton, NJ 08053

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

49712

Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness.

This deficient practice was evidenced by the following:

On 09/23/2024 from 07:57 AM to 08:27 AM the surveyor, accompanied by the Dietary Clerk (DC), observed the following in the kitchen:

1. The surveyor observed a dietary worker walking around the kitchen with a full beard and no beard guard.

2. In refrigerator #1 an unopened package of hot dogs with a use- by-date of 09/18/2024. There was also a large metal tray of raw salmon covered with plastic wrap that was not labeled or dated. The DC removed and discarded items.

3. In refrigerator # 9 there was a plastic container of hard-boiled eggs, a plastic container of feta cheese, a plastic container of mozzarella cheese, and a plastic container of grilled chicken all with the use by date of 09/21/2024. There was also an open carton of potato salad in a plastic bag with no date. There was also a plastic container or peeled mandarin oranges with a use by date of 09/22/2024. The DC removed and discarded all items.

4. In refrigerator # 7 there were 2 tray metal trays of raw chicken wrapped in plastic labeled 9/14-12/14. When asked what those dates meant the DC stated, I am not sure what that means and removed and discarded the trays. Also found was a large plastic bin of sliced ham with a metal pan of chunks of ham inside of it all wrapped in plastic with no label or date. The DC said the ham was prepped yesterday and should have been labeled. There were also 3 crates of milk cartons directly on the floor.

5. In the walk-in freezer there was an opened bag of pepperoni slices wrapped in plastic with no label or date. The DC removed and discarded the items.

During an interview on 09/23/2024 at 11:09 AM with the surveyor, the Food Service Director (FSD) stated, Everything in the fridge and freezer should be labeled and removed after the use-by-dates. When asked if staff with beards should be wearing beard guards in the kitchen, the FSD replied, yes. When asked about milk cartons being directly on the ground the FSD replied No they shouldn't be on the ground.

During an interview on 09/25/2024 at 12:49 PM with the surveyor the Infection Preventionist (IP) stated, In the kitchen I go in early and look for anything on the floors, check the fridge temps, hairnets, that they are washing their hands. when asked what the process for surveilling the kitchen was. When asked if staff with beards should be wearing a beard guard, the IP replied Yes.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wiley Mission	99 East Main Street Marlton, NJ 08053

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of an undated facility provided policy titled Employee Sanitary Practices, revealed under Procedure that All employes will: 1. Wear restraints (hairnet, hat and or beard restraint) to prevent hair from contacting exposed food. A review of an undated facility provided policy titled Food Storage revealed under Procedure: that 10. Food should be stored at a minimum of 6 inches above the floor, 18 inches from the ceiling and 2 inches from the wall with adequate space on all sides of stored items to permit ventilation . 13. Refrigerated food storage: f. All foods should be covered, labeled, and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded. 14. Frozen foods: c. All foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. N.J.A.C. 8:39-17.2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Wiley Mission		STREET ADDRESS, CITY, STATE, ZIP CODE 99 East Main Street Marlton, NJ 08053	

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 45209 Based on interview and record review, it was determined that the facility failed to ensure that the pneumococcal vaccination was offered to all residents upon admission to the facility to prevent incidence of pneumonia for 2 of 5 residents (Resident #4, Resident #32) reviewed for immunization administration. This deficient practice was evidenced by the following: 1. On 9/23/2024 at 8:38 AM, during the initial tour of the facility, the surveyor observed Resident #4 sleeping in bed in their room. A review of Resident #4's Admission Record revealed that the resident was admitted to the facility with diagnosis which included, but were not limited to, presence of unspecified artificial hip joint and encounter for other specified surgical aftercare. A review of Resident #4's Electronic Medical Record (EMR) could not provide documentation that the resident received or declined the pneumococcal vaccination. On 9/24/2024 at 12:26 PM, the facility provided Resident #4's computer generated immunization record that did not identify a pneumonia vaccination date. The facility also provided Resident #4's New Admission/ Readmission Chart Review for Infections which indicated under Pneumovax: Yes but a ? under Date. In addition the consent boxes were not checked and the documented in electronic records were not checked. On 9/26/2024 at 10:08 AM, during an interview with Surveyor #1, the Infection Preventionist (IP) advised that Resident #4's family could not provide any documentation that they received the Pneumovax. The IP confirmed that it is facility policy to offer the Pneumovax, which was not offered and a declination was not signed. The IP also acknowledged that it was their responsibility to ensure that their policy is followed. On 9/12/2024 at 11:22 AM in the presence of the survey team, the Director of Nursing and Licensed Nursing Home Administrator confirmed that there was no proof on Pneumovax administration for Resident #4 and moving forward we will put it in the chart. NJAC 8:39-19.4 (h) (i) 49712 2. On 09/23/2024 at 8:38 AM, during the initial tour of the facility, the surveyor observed Resident #32 dressed sitting in bed reading a paper. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wiley Mission	99 East Main Street Marlton, NJ 08053

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #32's Admission Record revealed that the resident was admitted to the facility with diagnosis which included, but were not limited to, Myelodysplastic Syndrome (a type of rare blood cancer where you don't have enough healthy blood cells), Neutropenia (a condition where you have low levels of neutrophils, a type of white blood cell that fights infections), and Pancytopenia (a condition that lowers all three types of blood cells: red, white and platelets). A review of Resident #32's Electronic Medical Record (EMR) could not provide documentation that the resident received or declined the pneumococcal vaccination. On 09/24/2024 at 09:33 AM, the facility provided Resident #32's New Admission/ Readmission Chart Review for Infections which indicated under Influenza and Pneumovax: NO. In addition, the consent boxes were not checked and the documented in electronic records were not checked. During an interview on 09/25/2024 at 09:45 AM with Surveyor #2, the Infection Preventionist (IP) said that Resident #32 refuses all vaccines. When asked if there was a declination form that the resident signed, the IP stated, No we don't have a form if they decline When asked how refusals are documented the IP replied, there is no documentations on refusals, I am not sure why. During an interview on 09/25/2024 at 01:12 PM with Surveyor #2, The Director of Nursing (DON) stated, we don't document that at this time, I think the IP sometimes writes it on the admission check off sheet if they refuse when asked where refusals of vaccines were documented. When asked if refusals should be documented the DON stated, yes, from here on out they will be. A review of the facility provided Immunization of Residents Policy, with a Version date of April 15, 2015, revealed under the title Procedure that, 2. All new residents (Health Care Center and Residential Health Care) must be assessed for influenza and pneumococcal vaccine upon admission: 3. Because long-term care residents are prone to developing serious complications when they contact the flu, all residents receive a flu vaccination during the fall of each year, unless otherwise ordered by the residents attending physician or the resident refuses: 5. The original consents are filed in the resident's medical record. NJAC 8:39-19.4 (h) (i)