STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315419	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N J Eastern Star Home	111 Finderne Avenue Bridgewater, NJ 08807

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 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. 27193 Based on observation, interview, and record review it was determined that the facility failed to ensure that an indwelling urinary catheter drainage bag was stored in a manner to prevent potential urinary tract infections. This deficient practice was identified for 1 of 2 residents reviewed for indwelling urinary catheter (Resident #32), and was evidenced by the following: On 09/23/24 at 6:37 PM, the surveyor observed Resident # 32 in the room. At that time, the surveyor observed a used plastic bag tied to a handrail in the resident's bathroom. Inside the plastic bag was a used indwelling urinary catheter drainage bag dated 09/23/24. The urinary catheter drainage port was not capped, and was in direct contact with the plastic bag. On 09/24/24 at at 8:48 AM, the surveyor observed the resident resting in bed. The surveyor observed that the resident had an indwelling urinary Foley catheter (a flexible tube inserted into the bladder for urinary drainage) contained in a privacy bag and hung on the bedrail. On 09/24/24 at 12:06 PM, the surveyor observed Resident #32 sitting in a wheelchair at the bedside. The surveyor observed the Foley catheter drainage bag stored in a plastic bag in the bathroom. The drainage port was not capped. On 09/25/24 at 11:24 AM, the surveyor observed the Foley catheter drainage bag stored in a plastic bag in the bathroom, the drainage port was not capped. The Foley catheter drainage bag was dated 09/23/24. On 09/25/24 at 11:35 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who provided Resident #32's indwelling catheter care. The CNA stated that prior to switching the leg bag to the catheter drainage bag, he would wash his hands, don (put on) gloves and gown, remove the leg bag and applied the Foley catheter drainage bag. The CNA did not indicate that the drainage port was to be disinfected prior to apply the leg bag. (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/25/24 at 11:45 AM, the surveyor interview the Licensed Practical Nurse (LPN) assigned to the Unit. The LPN stated that the leg bag and the Foley catheter drainage bags were scheduled to be changed every Sunday. The LPN stated that when an indwelling urinary catheter drainage bag was not in use, staff were required to clean the bag of any residual urine and store the Foley catheter drainage bag in a plastic bag in the bathroom. The LPN further stated that the CNAs received training on how to store the bags/ drainage /leg bag. The surveyor then inquired specifically regarding the storage of the Foley catheter drainage bag. The LPN stated that the Foley catheter drainage bag must be cleansed of any residual urine and stored in a plastic bag in the bathroom. On 09/25/24 at 11:50 AM, the surveyor interviewed the LPN who cared for Resident #32. The LPN stated that Resident #32 had a suprapubic catheter (tube inserted into the bladder to facilitate urinary drainage). The LPN added that Resident #32 wore a leg bag during the day and a Foley catheter drainage bag at bedtime. The Foley catheter drainage bag would be stored in a plastic bag in the bathroom when not in use. The surveyor accompanied the LPN in the bathroom and we both observed the Foley catheter drainage bag in a plastic type basin, not in a plastic bag, and the drainage port was not capped. The Foley catheter drainage bag dated 9/23/24. The LPN confirmed that both bags were to be changed on Sunday and as needed. The LPN observed there was no cap on the drainage port, the LPN donned gloves and placed the Foley catheter drainage bag in the plastic bag. On 09/26/24 at 9:05 AM, the surveyor observed the resident sitting in a wheelchair in the room. The surveyor went to the bathroom and observed that the Foley catheter drainage bag was dated 09/23/24 and stored in a the basin in the bathroom, the drainage port was not capped. On 09/26/24 at 9:30 AM, the surveyor accompanied the Registered Nurse Supervisor (RN/SON) to the room and we both observed the Foley catheter drainage bag in the plastic bag with visible amount of urine, stored in the bassinet. The drainage port was not capped. The Foley catheter drainage bag was dated 9/23/24. That same day during an interview with Registered Nurse, Supervisor of Nursing (RN/SON), she stated that the Foley catheter drainage bag should be stored in a clean plastic bag and the drainage port should be capped to prevent infection. When inquired about how this information was communicated to the staff, the RN stated , in services education were provided to inform the staff of what needed to be done. On 09/24/24 at 11:30 AM, the surveyor reviewed the medical record for Resident #32. According to the Admission Face Sheet, Resident #32 was admitted to the facility with diagnoses which included but were not limited to; unspecified Dementia, unspecified severity without agitation, benign prostatic hyperplasia with lower urinary tract symptoms and chronic kidney disease. The Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 7/4/24, reflected that Resident #32 had a Brief Interview for Mental Status (BIMS) of 12 out of 15, which indicated a moderate cognitive impairment. A review of the September 2024 Order Summary Report, revealed an order with an original date of 09/22/2023, to change the Suprapubic Catheter (SP) monthly on the 22nd of the month every night shift starting on the 22nd and ending on the 22nd every month for Preventative Care. Use size SP tube 22 French (diameter size), order dated 08/03/21. Have the Catheter leg bag on in AM, OFF at Bedtime two times a day. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's individualized Interdisciplinary Care Plan (ICP) revised on 3/10/22, included a focus area that the resident had bladder elimination dysfunction: use of indwelling Suprapubic catheter related to Neurogenic bladder. The goal of the ICP included that the resident will not show no signs/ symptoms of infection. Will be free from catheter related trauma. Will not develop Urinary Tract Infection (UTI). Interventions of the ICP included catheter care daily and as needed. Monitor for signs and symptoms of infection. On 09/26/24 at 11:40 AM, the surveyor reviewed the facility's policy and procedure on Foley Catheter Insertion and Care last revised 07/2019. The policy included to maintain Universal Precautions throughout procedure. Perform all manipulations of Foley system as clean procedure. Wipe the end of the Catheter with an alcohol pad. Wipe the connector on the new bag with the second alcohol pad. Cleaning the drainage bag Wash your hands thoroughly with soap and water. Rinse the bag with soap and cool water. Do not use hot water because it can damage the plastic equipment. Cap after one hour and place in plastic bag for storage. Plastic storage bag is to be changed daily. Foley bags are to be replaced weekly. NJAC 8:39-19.4(a)5

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34033 Based on observation, interview, record review and review of facility documentation, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. This deficient practice was identified during the medication administration observation for 1 of 2 nurses, 2 of 4 residents (Residents #12 and #48), and for 27 opportunities. This resulted in two observed errors which resulted in a medication administration error rate of 7.41 % and was evidenced by the following: 1. On 9/24/24 at 9:34 AM, the surveyor conducted the medication administration and observed a Licensed Practical Nurse (LPN) preparing to administer nine (9) medications which included one Aspirin chewable 81 milligram (MG) tablet to Resident #12. The LPN stated that the Aspirin was an over the counter (OTC) house stock medication (stock bottles that the facility purchased for any resident that had a physician's order for the medication). On 9/24/24 at 9:56 AM, the surveyor observed the LPN administer the Aspirin chewable 81 MG tablet to Resident #12. On 9/24/24 at 10:57 AM, during reconciliation for the medication observation, the surveyor reviewed the Order Summary report which revealed an active physician's order (PO) with a start date of 1/5/23 for Aspirin Enteric Coated (EC)(a coating that allows the tablet to survive intact as it passes through the acidic stomach and dissolve in the small intestine to be absorbed) tablet delayed release 81 MG (Aspirin) Give 1 tablet by mouth in the morning for coronary artery disease (CAD) (a condition that happens when the coronary artery struggles to supply the heart with enough blood, oxygen and nutrients). On 9/24/24 at 11:31 AM, the surveyor, with the LPN, reviewed the electronic medication administration record (eMAR) at the medication cart. The eMAR revealed the same PO as above. The LPN stated that the PO was for Aspirin EC and was able to show the surveyor an OTC house stock bottle of Aspirin EC 81 MG tablets that were stored in the medication cart. The LPN then stated that she had administered Resident #12 the Aspirin chewable 81 MG tablet and realized that she should have administered Aspirin EC according to the PO. The LPN added that both were the same drug but one was EC and one was chewable. The LPN also stated that she was an agency nurse and was not usually on this medication cart. The LPN acknowledged that the PO specified EC and that she had administered the chewable formulation. (ERROR#1) The surveyor reviewed the medical record for Resident #12. A review of the Admission Record revealed diagnoses which included, but were not limited to, dementia, gasto-esophageal reflux disease (heartburn) and atherosclerotic heart disease of native coronary artery (a disease of the coronary arteries having plaques of fatty material on their inner walls causing a struggle to supply the heart with enough blood, oxygen, and nutrients). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 8:32 AM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone who stated that the CP who had been servicing the facility was no longer employed but that he was the owner and could speak to any questions. The CP stated that the nurses were to follow the PO. The CP stated that the facility would have the records of any medication observations and in services that were completed. On 9/26/24 at 8:25 AM, the surveyor interviewed the Assistant Nursing Home Administrator (ANHA) who stated that the Infection Preventionist (IP) was the staff educator. The ANHA added that there were no medication administration observations completed for the LPN and would have to check if there were any in services completed. The ANHA added that the IP was covering for the Director of Nursing (DON) while the DON was temporarily not available. On 9/26/24 at 11:11 AM, the surveyor interviewed the IP who stated that she only completed medication administration observations if there was an issue or problem identified such as being late with medications. The IP added that the CP also did medication administration observations and in-services. On 9/26/24 at 11:28 AM, the surveyor interviewed the IP who stated that agency nurses were not observed for medication administration. On 9/26/24 at 11:31 AM, the surveyor, in the presence of the survey team, interviewed the ANHA and IP. The ANHA stated that the competency for agency nurses for medication administration was completed by the agency and would have to reach out to the agency for the records. On 9/26/24 at 11:43 AM, the surveyor was provided by the IP a Medication Pass in-service completed on 1/30/24 by the CP. A review of the Med Pass In-Service/Meeting sign-in sheet revealed that the LPN had not attended the in-service. A review of the in-service document used for the Medication Pass reflected the Five Rights which included but not limited to; 2. Right Medication: Review MAR for medication to be administered at the time ordered and Precautions. On 9/26/24 at 12:54 PM, the survey team met with the Licensed Nursing Home Administrator, ANHA and IP and reviewed the above concern. There was no further documentation provided. A review of the facility policy dated 2/23/2021 for Medication Administration Time provided by the ANHA revealed that the policy was for medications to be administered per physician order. In addition, the procedure reflected 11. Staff should verify each time a medication is administered that it is the correct medication, . 2. On 9/24/24 at 10:05 AM, the surveyor observed the LPN preparing to administer six (6) medications, which included one Glipizide Extended Release (ER) 5 MG tablet to Resident #48. On 9/24/24 at 10:09 AM, the surveyor observed the LPN address Resident #48 who was seated in a wheelchair in the hallway and explained to the resident that before they went to an activity that she wanted to administer the resident's morning medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 10:12 AM, the surveyor observed the LPN administer the Glipizide ER 5 MG tablet to Resident #48. On 9/24/24 at 10:17 AM, upon returning to the medication cart, the surveyor, with the LPN, reviewed the labeling on the package of the resident's Glipizide ER which revealed a sticker that specified Take this medication 1/2 hour before a meal. Read label carefully for how many times to take each day. The LPN stated that she was unsure when breakfast was served and could not speak to what time the Glipizide ER was to be administered. The LPN acknowledged that the time of administration on the eMAR was 8 AM. The LPN stated that she does go out earlier and tries to give medications before breakfast but was unaware of this medication. (ERROR#2) On 9/24/24 at 11:31 AM, the surveyor interviewed the LPN who stated that she was an agency nurse and was not usually on this medication cart. The LPN stated that she had administered insulin (a medication used to lower blood sugar) before breakfast but was unaware that the Glipizide had to be administered earlier. The LPN stated, I go down the line on my unit. The LPN explained that she went room to room with the eMAR administering medications in the morning. The surveyor reviewed the medical record for Resident #12. A review of the Admission Record revealed diagnoses which included, but were not limited to, diabetes (a long-term condition where the body has trouble controlling blood sugar). A review of the Order Summary Report revealed a PO with a start date of 7/24/21 for Glipizide ER tablet Extended release 24 hour Give 5 MG by mouth in the morning related to Type 2 Diabetes Mellitus without complications. A review of the eMAR reflected the above PO with a time of administration of 0800 (8AM). On 9/25/24 at 8:32 AM, the surveyor interviewed the CP via the telephone who stated that the CP who had been servicing the facility was no longer employed but that he was the owner and could speak to any questions. The CP stated that the nurses were to follow the PO and any cautionaries associated with a medication. The CP stated that the facility would have the records of any medication observations and in-services that were completed. The CP further explained that cautionary warnings were usually on the eMAR as well as on the packaging of the medication and that the nurses should be looking at the cautionary information and following it. The CP added that if the cautionary information was only on the packaging, then it was still the responsibility of the nurses to follow the information. On 9/26/24 at 8:25 AM, the surveyor interviewed the ANHA who stated that the IP was the staff educator. The ANHA added that there were no medication administration observations completed for the LPN and would have to check if there were any in-services completed. The ANHA added that the IP was covering for the DON while the DON was temporarily unavailable. On 9/26/24 at 11:11 AM, the surveyor interviewed the IP who stated that she only completed medication administration observations if there was an issue or problem identified such as being late with medications. The IP added that the CP also did medication administration observations and in-services. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 11:28 AM, the surveyor interviewed the IP who stated that agency nurses were not observed for medication administration. On 9/26/24 at 11:31 AM, the surveyor, in the presence of the survey team, interviewed the ANHA and IP. The ANHA stated that the competency for medication administration was completed by the agency that the nurse was from and would have to reach out to that agency for the records. On 9/26/24 at 11:43 AM, the surveyor was provided by the IP a Medication Pass in-service completed on 1/30/24 by the CP. A review of the Med Pass In-Service/Meeting sign-in sheet revealed that the LPN had not attended the in-service. A review of the in-service handout for Medication Pass reflected the Five Rights included but not limited to 2. Right Medication: Review MAR for medication to be administered at the time ordered and Precautions. And 4. Right Time: Medication can be given 60 minutes before the time on MAR or 60 minutes after is considered correct, Exception medication to be given with regard to meals, either before meals (AC) or after meals (PC) need to be given as such. Further review of the in-service handout for Medication Pass reflected for Administration of Medication 7. All Cautionary labeling must be followed (separation from meds or food/fluid parameters.) On 9/26/24 at 12:54 PM, the survey team met with the Licensed Nursing Home Administrator, ANHA and IP and reviewed the above concern. There was no further documentation provided. A review of the facility policy dated 2/23/2021 for Medication Administration Time provided by the ANHA revealed that the policy was for medications to be administered following best practices. In addition, the procedure reflected 11. Staff should verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route at the correct rate, at the correct time, for the correct resident, as set forth in Medication Administration Times Schedule. A review of the Medication Administration Times Schedule that was part of the policy, reflected that AC hours of administration were 7:30 AM, 11:30 AM and 4:30 PM. In addition, with meals hours of administration were 8:00 AM, 12:00 PM and 5:00 PM. Additionally, the facility policy for Medication Administration Time reflected 19. Follow manufacturer medication administration guidelines. A review of the manufacturer specifications for Glipizide ER revealed for Patient Information to Take Glipizide extended-release tablets by mouth, 1 time each day with breakfast or your first meal of the day. NJAC 8:39-11.2(b), 29.2(a)(d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 27193 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure staff: a) performed appropriate hand hygiene (HH) during meal delivery services and b) removed soiled gloves upon exiting a resident room to prevent the potential spread of infection. This deficient practice occurred on 2 of 3 units, for 1 staff observed on 1 of 3 units and was evidenced by the following: a) On 09/25/2024 at 8:13 AM, Surveyor #1 observed the breakfast meal trays being delivered to residents on the B unit. Surveyor #1 observed two Certified Nursing Aides (CNA) delivering breakfast to residents without first performing HH or offering residents the opportunity to clean their hands. On 09/25/2024 at 8:49 AM, CNA #1 stated that there were only 2 CNAs on the B unit and confirmed he should have washed his hands after each resident interaction to prevent the spread of infection. CNA #2 was assigned to observe the dining area with the residents. On 09/25/2024 at 9:40 AM, during an interview with Surveyor #1, the acting Food service Director (FSD) revealed that the facility kitchen did not have or provide anything on the meal trays for the residents to cleanse their hands with. On 09/25/2024 at 8:06 AM - 8:17 AM, Surveyor #2 observed the breakfast trays being delivered to residents on the A unit. Surveyor #2 observed CNA #3 deliver trays twice into the same room without any HH performed or offering the residents HH, CNA #3 then pushed the tray cart down the hall, and without first performing HH, delivered a tray into another resident room and did not offer the resident HH. Next CNA #3 exited the room, and without performing HH, obtained another resident breakfast tray, delivered it and assisted opening foods and setting the resident up to eat without offering the resident any HH. CNA #3 asked CNA #4 to assist her in repositioning a resident in another room without either CNA first performing HH and then CNA #3 began to assist the resident with eating without first performing HH. During the same meal delivery on A unit, CNA #4 was observed delivering a meal tray to a resident without first performing HH or providing the resident with HH. CNA #4 exited the room, did not perform HH, then delivered 2 more meal trays without performing HH or offering the resident HH. CNA #4 exited again without performing HH and then delivered another meal tray without providing the resident with HH. CNA #4 then assisted CNA #3 to reposition a resident without performing HH first or after positioning. On 09/25/2024 at 8:21 AM, CNA #3 stated the correct process was to stop resident care, wash our hands, and deliver the trays to the residents. When asked about HH, CNA #3 stated the residents would have their hands cleaned during morning care and that she should have used HH in between delivering trays to each resident but had no reason as to why she did not. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/25/2024 at 8:32 AM, CNA #4 stated the process was to take the trays to each resident room and set the resident up to eat. She stated the residents were provided hand hygiene before meals. When asked what was used or how this was performed, CNA #4 stated we don't use anything because the residents were cleaned up in the morning. CNA #4 did acknowledge she should have used HH in between delivering the meal trays to the residents and had no reason as to why she did not. A review of the facility provided Sign in Sheet dated August 2024, included but was not limited to; a topic of HH. The sign in sheet indicated that CNA #1 had not signed that he had attended the education. CNA #3 was not listed as part of the nursing staff. CNA #4 had signed and dated on 08/08/2024, that she had attended the HH education. b) On 09/25/2024 at 8:30 AM, Surveyor #1 observed a contracted laboratory technician (LT) enter a resident room on the B unit. The LT donned (put on) gloves, drew the resident's blood sample, and left the resident room while still wearing the soiled gloves. The LT was observed in the hallway with the same gloves on, then collected a specimen from the nurse and began arranging specimens collected on the nursing desk countertop, before placing them into a collection bag. On 09/25/2024 at 8:33 AM, the LT stated that he had not disposed of the soiled gloves prior to exiting the resident room, and stated I should have put them [soiled gloves] in the trash. A review of the facility provided Handwashing Pledge undated, included but was not limited to; It is recognized as the single most important means of preventing the spread of infection. I understand that the only cost to me is the time it takes to wash, and the benefit of this pledge is a reduction of cross infection in my facility. A review of the facility provided policy, Handwashing/Hand Hygiene revised August 2019, included but was not limited to; This facility considers hand hygiene the primary means to prevent the spread of infections. 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene . 2. All personnel shall follow the handwashing/hand hygiene procedures to prevent the spread of infections . 5. Residents, visitors . will be encouraged to practice hand hygiene . 7. Use an alcohol-based hand rub or soap and water for the following situations: b. before and after direct contact with residents; . j. after contact with blood or bodily fluids; . l. after contact with objects in the immediate vicinity of the resident; . o. before and after eating or handling food; p. before and after assisting a resident with meals . NJAC 8:39-19.4(a), 27.1(a) 38079