STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315439	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Methodist Communities at Bristol Glen	200 Bristol Glen Drive Newton, NJ 07860

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 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. 46049 Based on observation, interview, and record review it was determined the facility failed to consistently follow standards of clinical practice with regards to: a.) following a physician's order as written for 1 of 15 residents (Resident # 1), and b.) completing neuro checks (an assessment of neurological status that must be done when a resident hits his or her head or if it is unknown if they hit their head) after a resident had a history of fall for 1 of 1 resident (Resident #14) reviewed for falls. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; 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. 1. On 5/15/24 at 11:34 AM, the surveyor observed Resident #1 seated in a wheelchair in their room. The resident was alert and oriented. Resident #1 stated they had a wound that was being treated by the nursing staff and verbalized no concerns. The surveyor reviewed the electronic medical records (EMR) of Resident #1 which revealed the following: The Admission Record (a summary of important resident information) documented Resident #1 had diagnoses that included, but were not limited to, osteoarthritis, peripheral vascular disease, hypertension, a pressure ulcer to the left heel, and a pressure ulcer to the right heel. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315439	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Methodist Communities at Bristol Glen	200 Bristol Glen Drive Newton, NJ 07860

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Quarterly Minimum Data Set (MDS) assessment, dated 4/9/24, indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). Resident #1 scored a 12 out of 15 which indicated that the resident had moderate cognitive impairment. A review of the Order Summary Report documented Resident #1 had a physician order (PO), dated 5/17/24, which read: Dakins (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) Apply to Left heel topically two times a day for wound treatment for 14 days .Cleanse with normal saline, pat dry, apply Dakin's moistened fluffed gauze and crushed Metrodinazole to base of wound the[then] secure with bordered foam. A review of the May 2024 electronic Treatment Administration Record (eTAR) for Resident #1 documented the above PO for the left heel wound treatment and it was signed by the nursing staff as administered twice a day in the morning and evening shifts. A review of the resident's care plans included a care plan with a focus that read I have potential for pressure ulcer development r/t[related to] Immobility and I currently have pressure injury to my left heel (stage 3). An intervention for the care plan dated 11/15/23 read, Administer treatments as ordered and monitor for effectiveness. On 5/21/24 at 9:50 AM, the surveyor observed Registered Nurse #1 (RN #1) perform the left heel wound treatment for Resident #1. RN #1 reviewed the wound treatment PO with the surveyor prior to starting the wound treatment. On 5/21/24 at 10:07 AM, during the wound treatment, the surveyor observed RN #1 wash her hands appropriately for 35 seconds at the bathroom sink and don gloves. RN #1 took gauze moistened with normal saline, cleansed Resident #1's left heel wound, and dispose the used gauze in the garbage bin. RN #1 took a clean, dry gauze, and patted the wound area dry. RN #1 took a gauze moistened with dakin's solution, cleansed the left heel wound bed, and then dispose of the gauze in the garbage bin. RN #1 took a gauze with crushed metronidazole and applied the medication to the wound bed. RN #1 then disposed of the gauze in the garbage and applied a bordered gauze dressing. On 5/21/24 at 10:32 AM, the surveyor observed RN #1 sign for the wound treatment being administered to Resident #1. RN #1 confirmed she had completed the resident's wound treatment. On 5/21/24 at 10:35 AM, the surveyor reviewed with RN #1 the wound treatment order and the application of the Dakin's solution. RN #1 acknowledged she did not perform the wound treatment as written in the physician order and she did not apply the Dakin's moistened gauze to the wound bed with the crushed metronidazole. On 5/21/24 at 12:50 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Executive Director (ED), and the Regional Director of Clinical Services about the concern observed during the wound treatment of the physician's order not being followed as written. There was no additional information provided by the facility. A review of the facility's policy titled, Pressure Injury Prevention & Managing Skin Integrity with a last revised date of 2/14/2024 read under Policy, Any resident with a wound shall receive treatment and services consistent with the resident's goals of treatment. The policy did not further address following written physicians' orders for wound treatments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315439	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Methodist Communities at Bristol Glen	200 Bristol Glen Drive Newton, NJ 07860

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's provided wound treatment competency titled, UMC-Wound Treatment Observation Utilizing Clean technique read under Quality of Care, .Physician order is checked before starting treatment . Physician Order includes location of wound, frequency of treatment, method for cleaning wound, medication to be applied if any and type of dressing to be utilized . 2. On 5/15/24 at 12:20 PM, the surveyor observed Resident #14 seated in their wheelchair in the dayroom of the unit. Resident #14 was alert and verbally responsive to simple questions. On 5/20/24 at 9:47 AM, the surveyor reviewed a fall investigation report, dated 3/5/24 for Resident #14. The resident had a fall incident at approximately 6:45 pm in which Resident #14 attempted to assist another resident move their wheelchair and fell out of their wheelchair. Resident #14 fell on their right side to the floor and bumped the right side of their head. There were no visible injuries, an ice pack was provided and neuro-checks were initiated. The surveyor reviewed the EMR of Resident #14 which revealed the following: The Admission Record documented Resident #14 had diagnoses that included, but were not limited to, Chronic Kidney Disease, Dementia, and Hypertension. A Quarterly MDS assessment, dated 5/7/24, indicated the facility assessed the resident's cognitive status using a BIMS. Resident #14 scored a 3 out of 15 which indicated that the resident had severe cognitive impairment. A nurse progress note dated 3/5/24 at 20:17 [8:17 pm], documented Resident #14 attempted to move another resident's wheelchair and fell out of their wheelchair onto their right side in the dining room area. The note further detailed the resident had bumped the right side of their head on the floor and neuro-checks for the resident were WNL [within normal limits]. A nurse progress note dated 3/6/24 at 23:05 [11:05 pm], detailed a neuro-check completed for Resident #14 which included, a neurological assessment and vital signs obtained. There were no other progress notes found that documented any additional neuro-checks being completed after the resident's fall. A review of the Order Summary Report for March 2024 revealed, there were no PO to account for neuro-checks being completed after the resident's fall incident. A review of the March 2024 electronic Medication Administration Record (eMAR) and eTAR revealed that there were no entries for the neuro-checks being completed after the resident's fall incident. A review of the March 2024 list of vital signs (VS) revealed that there were no VS documented to account for the neuro-checks being completed after the resident's fall incident. On 5/20/24 at 11:20 AM, the surveyor requested from the DON for further documentation of the neuro-checks related to the fall incident of Resident #14. The DON stated she would review and provide further information. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315439	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Methodist Communities at Bristol Glen	200 Bristol Glen Drive Newton, NJ 07860

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 12:40 PM, the DON provided the surveyor a document titled UMC NEUROLOGICAL CHECK LIST dated 3/5/24 and timed 19:41 [7:41 pm], which was found in the resident's EMR. A review of the document revealed under the section titled, Vital Signs, the VS documented were dated 3/1/24. The other sections of the document which included mental status assessments, pupil assessment, pain assessment, and range of motion of extremities were completed. There was no additional documentation to indicate additional neuro checks being performed after the resident's fall. On 5/21/24 at 12:40 PM, the surveyor informed the LNHA, DON, ED and Regional Director of Clinical Services about the concern that there was no documentation to indicate neuro-checks for the resident were completed after their fall on 3/5/24. The DON and the LNHA acknowledged it would be expected for neuro-checks to be completed and documented for an unwitnessed fall or a bump to the head. On 5/22/24 at 9:58 AM, the surveyor interviewed the DON who stated there was no additional information found for completion of the neuro-checks. The DON stated the facility protocol for neuro checks once initiated was that it would be done every 2 hours for 12 hours, then every 3 hours for 24 hours, and every 4 hours for another 24 hours. The DON further stated a physician order should have been written and the facility's policy was for neuro checks to be initiated when a resident had an unwitnessed fall, a head injury or if a head injury could not be ruled out. On 5/22/24 at 10:13 AM, the surveyor interviewed over the phone Registered Nurse #2 (RN #2) who was the assigned nurse for Resident #14 at the time of the fall incident. RN #2 stated for unwitnessed falls or falls with possible head injury, neuro checks were to be initiated. RN#2 could not explain the facility's protocol on how often neuro checks were to be performed and stated the facility policy was different from what she was used to. RN #2 further stated neuro checks were entered as physician's orders and would be triggered for nurses to assess the resident's vital signs at a certain frequency. RN #2 was not sure where the triggered neuro check documentation would be found in the EMR and stated she would write her neuro-check assessments in her progress notes instead. RN #2 could not recall the details of the 3/5/24 fall incident for the resident. The surveyor discussed with RN #2 the concern that there were no neuro checks found for the resident other than the two progress notes and the neuro checklist documentation provided by the DON. RN #2 could not speak to why there was not further documentation of the neuro checks and no physician order found. A review of the facility's policy titled, Fall Prevention and Management with a last reviewed date of 7/6/2023 read under Post Fall Management, B. Minor Head Trauma or Impact, it read: .performs neuro-checks every two hours for the first 12 hours, every three hours for the next 24 hours, every four hours for the following 24 hours .2. Neuro-checks shall be implemented if a resident cannot communicate that they may have hit their head due to cognitive impairment . NJAC 8:39-11.2 (b); 29.2(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315439	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Methodist Communities at Bristol Glen	200 Bristol Glen Drive Newton, NJ 07860

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44605 Based on observation, interview, and record review, it was determined that the facility failed to clarify a Physician's Order (PO) in accordance with professional standards of practice for 1 of 16 residents (Resident #16) reviewed. The deficient practice was evidenced by the following: 1. On 5/15/24 at 11:15 AM, the surveyor observed Resident #16 in a Geri-chair (a specialized chair designed specifically for seniors and individuals with limited mobility), receiving oxygen (O2) via nasal cannula (medical device to provide supplemental oxygen therapy to people who have lower oxygen levels) at 3 Liters Per Minute (LPM.) The surveyor reviewed the medical records of Resident #16, who was admitted to the facility with diagnoses that included but not limited to Human Metapneumovirus Pneumonia, Chronic Respiratory Failure, and Chronic Obstructive Pulmonary Disease. A review of the Minimum Data Set Assessment (MDS), an assessment tool, used to facilitate the management of care, dated 4/21/24, revealed that the resident had a score of 13 out of 15 on the Brief Interview for Mental Status, which indicated that the resident was cognitively intact. Further review of the MDS under Section O also revealed that the resident received continuous oxygen therapy. A review of the PO for Resident #16 revealed a PO, dated 4/17/24, for 2-4 LPM Oxygen via nasal cannula, keep oxygen saturation (SpO2) above 90% every shift for Shortness of Breath (SOB). On 5/17/24 at 9:18 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#1), who was assigned to Resident #16, and stated that Resident #16's O2 rate was set at 2 LPM but would increase the rate if their SpO2 (the amount of oxygen in your blood that can be measured by a device called a pulse oximeter) would decrease below 90%. LPN#1 further stated that the PO for O2 rate must be at a specific rate and not in a range. On 5/17/24 at 10:05 AM, the surveyor interviewed the Registered Nurse/Nurse Mentor (RN/NM #1), who stated oxygen orders should not be written with a range but a specific number setting, like 3 LPM. On 5/17/24 at 12:35 PM, the surveyor interviewed the Respiratory Therapist, who acknowledged that the PO for the O2 rate should have been at a specific rate and not in a range. On 5/17/24 at 1:00 PM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a facility policy titled, Oxygen Management Clinical Practice Guideline, with a revised date of 4/22/22. The facility policy does not specifically address the O2 rate order administration. On 5/20/24 at 01:18 PM, they survey team met LNHA, Director of Nursing (DON), Regional Director of Clinical Service (RDCS) and Executive Director (ED) to review concerns. The DON stated the O2 orders should be clearer and not have a range. The facility did not provide any further information. NJAC 8:39- 27.1 (a)