STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315458	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Nursing & Rehabilitation Ctr	300 Broadway Newark, NJ 07104

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 38327 Based on observation, interview, and record review, it was determined that the facility failed to serve all residents seated at a table their lunch trays in a timely manner for one (1) of five (5) tables observed, involving a total of four residents (Residents #90, #91, #133, and #148) reviewed for Resident Rights. This deficient practice was evidenced by the following: On 1/31/24 at 12:11 PM, the surveyor observed the 4 East dining area having three Certified Nursing Aides (CNA), one (1) nurse, and 18 residents during lunch. There were five tables located in the 4 East dining area with residents seated for lunch. The 1st lunch truck was already in the process of being distributed at the time of the observation. On 1/31/24 at 12:12 PM, the surveyor observed table one, located near the wall with a total of 4 residents seated at the table. At table one there were two residents seated that had their lunch served at the time of the observation and two residents were already eating. At this time, the surveyor observed Table two with four residents seated. Resident # 90 seated at Table two was served with a lunch tray and started eating. The other residents at Table two did not receive their lunch trays, Resident #91, Resident #148, and Resident #133. On 1/31/24 at 12:16 PM, the surveyor interviewed CNA#1, a CNA who was distributing coffee to residents in the 4 East dining area. CNA #1 could not explain why all the residents at Table two were not served lunch at the same time. CNA #1 agreed that all residents should get their lunch trays at the same time. CNA #1 could not explain why the trays for Resident #91, #148, and Resident #133 were not delivered yet. On 1/31/24 at 12:20 PM, the surveyor observed the second food truck arriving to the 4 East dining area. On 1/31/24 at 12:21 PM, the surveyor observed lunch served to Resident # 91. On 1/31/24 at 12:22 PM, the surveyor observed lunch served to Resident # 148. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/24 at 12:23 PM, the surveyor interviewed CNA#2 regarding Table two. CNA #2 verified that Resident #133 still had not received their lunch tray. CNA #2 acknowledged that all the residents seated at the same table should receive trays at the same time. CNA #2 could not explain why residents seated at Table two did not receive their lunch trays at the same time. On 1/31/24 at 12:27 PM, the surveyor observed Resident #133 receive their lunch tray. On 1/31/24 at 3:02 PM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) for the facility's policy regarding dining services. On 2/05/24 at 01:21 PM, the survey team met with the LNHA and the Director of Nursing (DON) to inform them of the dining room observations and concern. On 2/06/24 at 8:39 AM, the LNHA provided the facility's Meal Service Policy with an effective date of 01/01/99. The policy did not include the procedure for serving residents in the dining room. On 2/06/24 at 11:30 AM, the survey teams met with the Director of Nursing (DON) and LNHA for facility responses. The LNHA did not provide any additional information regarding this issue. On 2/06/24 at 1:35 PM, the survey teams met with the LNHA, the DON, and the Business Office Personnel for an exit conference. There was no additional information provided by facility management. NJAC 8:39-4.1 (a) (12)(28)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 39399 Based on observation, interview, and record review, it was determined that the facility failed to ensure that the resident or resident's representative were offered the opportunity to formulate an Advance Directive (AD), a written statement of a person's wishes regarding medical treatment, often including a living will be made to ensure those wishes are carried out should the person be unable to communicate to them. This deficient practice was noted to 1 of 39 residents reviewed for AD, Resident #77. This deficient practice was evidenced by the following: On 2/5/24 at 10:15 AM, the surveyor observed Resident #77 lying in bed with eyes closed. The surveyor reviewed Resident #77's hybrid medical records. The Admission Record reflected that Resident #77 was admitted to the facility with medical diagnoses which included but were not limited to Dementia, Hypertension, Type II Diabetes Mellitus, and Anxiety Disorder. A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated 1/15/24 reflected that the resident had a Brief Interview for Mental Status score 3 out of 15 indicating that the resident had severely impaired cognition. A review of the active physician's orders (PO) revealed that the resident was documented having a Full code status indicating that all life saving measures would be implemented if the need arose. The surveyor was unable to locate any documentation that would indicate that the resident's end of life wishes had been discussed or addressed with the resident's responsible party. A review of the form titled, Advance Directive Up-Date 2023 dated 9/18/23, 5/28/22, 8/5/21, 9/16/20 reflected under comments that Resident #77 was unable to make any changes due to their cognition. Further review of the hybrid medical records revealed that the resident did not have a New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) form (a written medical order from physician, nurse practitioner or physician assistant that helps give people with serious illnesses more control over their own care by specifying the types of medical treatment they want to receive during serious illness). On 2/5/24 at 1:15 PM, the surveyor discussed the above concern with the facility's Licensed Nursing Home Administration (LNHA) and Director of Nursing (DON). The DON stated that if the resident does not have any AD or POLST indicated upon admission, the code status will be defaulted as a full code. On 2/6/24 at 10:30 AM, the surveyor interviewed the facility's social worker (SW) assigned to Resident #77. The SW informed the surveyor that she had not discussed the topic of AD with the resident's responsible party. The SW could not provide any further information as to why she did not discuss AD with responsible party for Resident #77, being that the resident was unable to make any decisions, due to their cognitive impairment. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Advanced Directives reflected under #3. If the resident is incapacitated and unable to receive information about his or her right to formulate an advanced directive, the information may be provided to the resident's legal representative. On 2/6/24 at 11:31 AM, the surveyor spoke with the LNHA and DON regarding the above concerns. There was no further information provided. NJAC 8:39-4.1(a)11; 31.1(b)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to provide the residents with a safe, comfortable, clean, and homelike environment. This deficient practice was identified in one (1) of three (3) residents' rooms, (Resident #132) and one (1) of two (2) dining areas on the 4th floor observed during environmental rounds. This deficient practice was evidenced by the following: 1. On 01/30/24 at 8:25 AM, the surveyor observed Resident #132 on the bed with an air mattress, indwelling catheter in use, and head of the bed elevated approximately 45 degrees while on tube feeding (TF, a way to provide nutrition when a resident cannot eat or drink safely by mouth) pump, at 75 ml/hr (milliliters per hour). The surveyor observed that the TF pole with scattered dried brownish color and resembled the color of the milk that was hung on the pole, and the surrounding floor area with the same dried brownish color. On that same date and time, the surveyor observed that the resident was on oxygen (O2) at 2 LPM (liters per minute) via a nasal cannula (N/C, a device that delivers extra oxygen through a tube and into the resident's nose) attached to a concentrator (is a type of medical device used for delivering oxygen to individuals with breathing problem). The concentrator had an accumulation of black and grayish substances around the concentrator. The electric fan was in use with an accumulation of a grayish substance around the metal part where it was blowing air. The fan was near the foot part of the resident's bed. The nightstand table near the window, the second drawer was broken, and no cover. On 01/30/24 at 02:06 PM, the surveyor asked Licensed Practical Nurse #1 (LPN#1) the assigned nurse of the resident to accompany the surveyor to Resident #132's room. Inside the resident's room, both the surveyor and LPN#1 observed the electric fan and the O2 concentrator with an accumulation of grayish and blackish substances, the TF pole and the floor beneath had brown dried substances, and the nightstand table near the window second drawer was broken with no cover. On that same date and time, the LPN stated that the dried brownish was from the milk residue, and she was not sure who should be cleaning it, LPN#1 confirmed it should be cleaned. The LPN further stated that the concentrator should have been cleaned. The LPN wiped out the concentrator with gloves on and noted grayish substances. The LPN also stated that it was the responsibility of the housekeeper to clean the dust around the fan and she will notify the housekeeper. On 02/01/24 at 8:46 AM, the surveyor interviewed LPN#2 regarding the resident. The LPN informed the surveyor that Resident #132 was cognitively impaired and required total assistance with adls (activities of daily living), on pleasure food but declined to eat, and currently on TF. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Afterward, the surveyor asked LPN#2 to accompany the surveyor inside the resident's room. Both the surveyor and LPN#2 observed that the electric fan was in use with an accumulation of dust, the floor where the TF pole was located had dried milk from the formula, and the nightstand's second drawer was broken. LPN#2 confirmed the observation and stated that he will ask Maintenance for the fan and drawer and that the floor should have been cleaned. The surveyor reviewed the hybrid (a combination of paper-based and electronic health records that primarily involves tracking and storing a resident's health records in several formats and places) medical records of the resident as follows: Review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to dysphagia oropharyngeal phase (difficulty swallowing), gastrostomy status (resident with TF), altered mental status unspecified, and need for assistance with personal care. The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, an ARD (assessment reference date) of 12/23/23, and Section C Cognitive Skills for Daily Decision Making showed that the resident's cognition was severely impaired. Section K Swallowing/Nutritional Status revealed that the resident was on TF. On 02/05/24 at 10:48 AM, the surveyor interviewed the Director of Nursing (DON) regarding the above concerns and findings. The DON stated that there should be no broken supplies and equipment inside the resident's room, and if the nurse was aware, it should be logged in the maintenance book. She further stated that the room should be cleaned. 2. On 01/31/24 at 12:12 PM, the surveyor observed 4 East during lunchtime. There were a total of five tables in the dining area. The 1st table was toward the nursing station and the 5th table was toward room [ROOM NUMBER], 443, 444, and 445. In the dining area, near the 5th table, in front of rooms [ROOM NUMBERS], the surveyor observed that there was a commode that was placed in the hallway, the leg part of the commode was noted with brownish, rust-like substances. Furthermore, in the same dining area, the surveyor observed across was room [ROOM NUMBER] and outside the room in the hallway were two blocks of wood. Inside room [ROOM NUMBER], the bed near the door (from 442-A), had a nightstand table that was broken, with a missing wood cover for the first drawer, at that time the Certified Nursing Aide (CNA) was inside room [ROOM NUMBER] washing her hands. Afterward, the surveyor interviewed the CNA when she came out of the room, and the surveyor asked why there were two blocks of wood outside the room. The CNA confirmed that was the broken part of 442-A's nightstand table for the 1st drawer and she did not know who put it outside. The CNA further stated that it should not be placed outside in the hallway for safety. The CNA confirmed that the broken nightstand table was for Resident #49. The surveyor then asked the CNA about the commode outside which was near Table 5 and in the hallway as well. The CNA stated that she did not know who the commode for and that it should not be there. The CNA took the wood but did not remove the commode from the hallway while the residents were eating in the dining area. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On that same date and time, Resident #71 who was seated at Table 5 with three other residents, confirmed that a staff left the commode and the resident did not identify the staff. The resident further stated that someone left the commode because the lunch came and had to distribute the trays to the resident. The resident also stated that she was not bothered because the resident knew that it would be removed later. On 01/31/24 at 12:25 PM, both the surveyor and LPN#3 observed the commode in the dining area. The LPN stated that she did now know who put the commode in the dining area. She further stated that the commode should not be there and would ask the CNA to take it out. At that same time, LPN#3 asked the CNA to remove the commode. The surveyor observed the CNA dragged the commode away from the 4 East dining area. On 01/31/24 at 3:02 PM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) for the facility's policy regarding the environment. On 02/05/24 at 01:21 PM, the survey teams met with the LNHA and DON. The surveyor notified the facility management of the above concerns and findings. On 02/06/24 at 11:30 AM, the survey teams met with the DON and LNHA for facility responses regarding the above findings and concerns. The LNHA informed the surveyors that the facility had a log for cleaning the O2 concentrators in the building. The LNHA stated that the facility had no cleaning log or accountability for other items that should include the TF and electric fans. On that same date and time, the DON informed the surveyors that the nurse did not put it in the log for maintenance of the broken nightstand table. She further stated that the log was the nursing communication to the maintenance for repairs. Furthermore, the DON stated that the wood should not be there for safety. The DON further stated that the commode should not be in the dining area. The surveyor then asked why was it important that the commode was not in the dining area, and the facility management did not respond. A review of the facility's Quality of Life-Homelike Environment Policy that was provided by the LNHA, with a revised date of August 2009 that included residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include cleanliness and order and personalized furniture and room arrangements; pleasant. On 02/06/24 at 01:35 PM, the survey teams met with the LNHA, the DON, and the Business Office Personnel for an exit conference. There was no additional information provided by facility management. NJAC 8:39-31.2 (e), 31.4(a)(b)(f)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39885 Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to ensure licensed staff credentials were verified upon hire. This deficient practice was identified for five (5) of seven (7) newly hired licensed staff reviewed, Staff #2, #4, #5, #7, and #10 evidenced by the following: On 02/05/24 at 10:03 AM, the surveyor reviewed ten randomly selected new facility employee files. The review for license verification for seven of the new licensed employees revealed the following: 1. Review of Staff Member #2 (SM2), an Occupational Therapist, hired on 5/02/22, had a New Jersey Division Consumer Affairs (NJDCA) license verification printout (used to verify the status of a license for license verification) dated 11/03/22. The verification was completed after the staff member was hired. There was no documented evidence that SM2's license was verified prior to the date of hire (doh). 2. Review of Staff Member #4 (SM4), a Registered Nurse, hired on 12/05/23, did not have a NJDCA license verification printout. There was no documented evidence that SM4's license was verified prior to the doh. 3. Review of Staff Member #5 (SM5), a Licensed Practical Nurse, hired on 6/21/22, had a NJDCA license verification printout dated 10/19/22. The verification was completed after the staff member was hired. There was no documented evidence that SM5's license was verified prior to the date of hire (doh). 4. Review of Staff Member #7 (SM7), a Certified Nursing Assistant (CNA #1), hired on 8/28/23, had a New Jersey Department of Health (NJDOH) online Public Registry license verification printout (used to verify the status of a CNA's license and to check the nurse aide registry) which did not include the date that the verification was done. There was no documented evidence that SM7's license was verified prior to the doh. 5. Review of Staff Member #10, a Certified Nursing Assistant (CNA #2), hired on 3/13/23, had a NJDOH online Public Registry license verification printout which did not include the date that the verification was done. There was no documented evidence that SM10's license was verified prior to the doh. On 02/05/24 at 10:47 AM, in the presence of the Licensed Nursing Home Administrator (LNHA), the surveyor interviewed the Director of Activities (DOA) who worked previously in the Human Resources (HR) department regarding the process for new employee hiring. The DOA stated that when she worked in HR she would perform license verification and that she used two different websites, one for CNAs and one for RNs as well as LPNs. The surveyor asked if the license verification printouts were dated (to show which date they were performed). The DOA was not sure if they were or were not dated. The DOA explained that the doh was the first physical day that the employee worked at the facility. The DOA verified that the license verification should be done prior to them starting, the doh. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/05/24 at 11:42 AM, the DOA reviewed the employee files and confirmed that the five employees did not have documented evidence that the license verifications were done prior to the doh. On 02/05/24 at 01:08 PM, the surveyor interviewed the Director of Nursing (DON) regarding the license verification. The DON stated that the license verification should be dated and done prior to the doh. On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor discussed their concern with the LNHA and DON regarding the five newly hired employees lacking documented evidence that their licenses were verified prior to their doh. On 02/06/24 at 9:26 AM, the LNHA stated that the facility did not have a specific policy for new employee hiring other than the checklist. The LNHA provided two documents in lieu of a policy regarding new hires. The first document was an Employee File Check List which included the following: The following shall be completed on each new employee as it pertains to his/her job Verification of License with Board of Nursing (if applicable) Date verified. The reviewed employee files did not include this or any check list. The second document was not titled but had entry areas for information that included the following: New Hire Orientation will be scheduled on .Original Documents Needed Any licenses or certificates pertaining to your position. A review of the facility provided policy titled Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure dated 2022, included the following: The Facility will not employ or otherwise engage individuals who: A. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. B. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. C. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. The facility did not provide any additional information. N.J.A.C. 8:39-43.15(a)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 39885 Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) an injury of unknown origin in accordance with federal and state requirements for reporting such injury to the state agency. The deficient practice was identified for one (1) of five (5) residents reviewed for falls (Resident #185) and was evidenced by the following: Reference: According to Centers for Medicare and Medicaid Services (CMS) definition: Injuries of unknown source - An injury should be classified as an injury of unknown source when all of the following criteria are met: The source of the injury was not observed by any person; and The source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. On 01/29/24 at 11:12 AM, the surveyor observed Resident #185 seated in a wheelchair in the day room of the unit. The surveyor observed a bump on the resident's head in the area of the left upper forehead. The resident also had a purplish, yellowish and greenish discoloration on the left side of his/her face below the bump. A review of Resident #185's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to chronic obstructive pulmonary disease (COPD, a condition involving constriction of the airways and difficulty or discomfort in breathing.), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should) and history of falling. Resident #185's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/12/23, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated that Resident #185's cognition was severely impaired. Further review of the MDS indicated that the resident had a fall in the last month prior to admission/entry or reentry to the facility. A review of Resident #185's Progress Notes included the following Nurses Note dated 01/25/24 23:43: I was the nurse yesterday for patient on 3-11 PM. I saw resident cared for and resident had no hematoma on his/her face then today when I came in I saw a hematoma on resident's forehead red in color. I asked the resident what happen to head first he/she said he/she does not know what I mean then I told him/her that he/she had a hematoma on his/her head that was not there yesterday. The resident then stated that he/she might have bump their head and did not tell anyone . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The only prior Nurses Note was on 01/21/2024 at 05:59. There was no documentation to indicate that there was any witnessed incident that could have caused the hematoma. On 01/30/24 at 9:10 AM, the surveyor requested from the Director of Nursing (DON) any incidents or accidents for Resident #185 since the resident's admission. The DON stated that Resident #185 had two incidents and that one was a fall and one was a bump on the head. At 9:30 AM, the DON stated that the bump was associated with the resident's side rail. She added that the bump was not there the day before according to the day shift nurse [that first observed the bump]. On 01/30/24 at 12:15 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) regarding Resident #185. The CNA stated that the resident was at risk for falls and that the resident would try to get up and walk without assistance. She added that the staff watch the resident and that the staff reminded the resident not to get up without assistance. The CNA stated that she asked the resident what happened to his/her head and that the resident told her that he/she fell but that when the CNA asked the resident where and how that the resident did not know. On 01/30/24 at 12:37 PM, the surveyor attempted to interview Resident #185. The surveyor asked the resident if he/she could tell the surveyor the name of the facility where he/she was currently located at and the resident answered [name redacted] hospital. The resident did not name the current facility's name. The surveyor asked the resident if he/she knew how he/she got the bump on his/her head and if the resident had fallen. Resident #185 stated that he/she was told that resident fell but that resident never fall. Resident #185 then stated that the rumor was that resident fell . On 01/30/24 at 01:58 PM, the surveyor reviewed the two facility provided incident report/investigations for Resident #185 which included the following information: Incident report #1, dated 12/08/23 indicated a fall. Incident report #2, dated 01/25/24 09:13 indicated a hematoma. Incident location: Unknown. Incident description: Nursing Description: Resident noted with hematoma red in color that was not present from the day before. Resident may have hit their head as resident does attempt to get out of bed unassisted due to resident's confusion and is closely monitored to prevent falls. The resident may have hit it on the side rail. Resident description: Aide reported when she asked the resident how he/she got the bump showed her [aide] the side rails. Mental status: Oriented to Person- checked. Oriented to situation-left blank. Oriented to Place-left blank. Oriented to Time-left blank. (continued on next page)

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	315458	A. Building B. Wing	02/06/2024

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New Vista Nursing & Rehabilitation Ctr	300 Broadway Newark, NJ 07104

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Other Info: Resident probably hit his/her face on the side rails because the resident normally tries to get out of bed and is closely monitored to prevent falls. Witnesses: No Witnesses found. Notes: 01/25/24 Resident was received in bed alert and verbally responsive noted with a redden hematoma on the left frontal lobe/face. On assessment the resident denied pain on touching to the site. When asked what happened to him/her resident stated that he/she don't know and then told aide he/she hit it and pointed to the side rail. Doctor notified with orders for a skull X-ray and neuro check. Family made aware. 01/26/24 IDCP Team met to discuss hematoma on resident noted to be red and was not there prior. Nurse on the night shift reported that patient tries to get out of bed during the night and was leaning toward side rails and was reposition and she [nurse] left pt (patient) was sleeping she [nurse] had seen resident leaning on side rails and had placed a pillow to prevent resident from hitting their head on the side rail. When morning aide came in he/she told her [aide] asked him/her what happened and resident told her [aide] he/she bumped it on the side rail No evidence of abuse or neglect noted. There was one handwritten statement included with the incident report which was dated 01/25/24 shift 7-2 which included the following: On arrival on duty doing my rounds I saw my pt (patient) with red swelling on head I told nurse. nurse said night shift said resident was moving around in bed and probably hit on side rail so the[they] put pillow. On 01/31/24 at 11:31 AM, the surveyor interviewed the Registered Nurse (RN) who documented Incident report #2 regarding the process for an injury of unknown origin. The RN stated that she would assess the resident, ask what happened, get X-ray if ordered and get statements from previous shifts. The surveyor then asked the RN if Resident #185's hematoma was an injury of unknown origin. The RN stated that it looked like it was. She added that she came in morning and saw the bump and that she had the resident the day before and there was no bump. The RN stated that she did an incident report and an investigation was done. She added that the physician assessed the resident, an X-ray was done and neuro checks were implemented. The RN stated that a conclusion was done by the DON and that the resident was on supervision and reminded to call for help. The RN stated that the resident did not know what the bump was from. She added that initially the resident told her that the resident did not know, then resident said maybe it was from the floor and then resident told someone it was from the bedrail. The surveyor asked if it was witnessed. The RN stated that it was not witnessed and that she considered it an injury of unknown origin. On 01/31/24 at 12:46 PM, the surveyor interviewed the DON regarding Resident #185's hematoma. The DON stated that she did not report the incident to the NJDOH because she did not think the incident was abuse or neglect. She added that based on the information she had received, she could substantiate how the injury happened and that she knew how it happened. The DON stated that the nurse saw Resident #185's head against the siderail and placed a pillow. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/01/24 at 10:21 AM, the DON provided the surveyor an additional handwritten statement that was not initially provided with Resident #185's Incident Report #2's investigation documents to the surveyor. The surveyor asked the DON what the process was for an incident investigation. The DON stated that at the time of the incident the nurse would make an incident report and then gather statements from staff to determine if there was abuse or neglect and if the incident needed to be reported or not reported. She added that if the supervisor determines it was a reportable incident, then they would tell me and I would call it in. The surveyor asked the DON what incidents were reportable. The DON stated that they were abuse, neglect and elopement. The surveyor asked the DON if an injury of unknown origin was reportable. The DON stated that it was not. The surveyor asked the DON why the statement that was just provided to the surveyor was not with the investigation. The DON added that she had called the 11-7 nurse on the day of the incident and got a telephone statement from the nurse and then asked the nurse to write the statement. She added that the nurse left it with the 11-7 supervisor. A review of the additional facility provided statement on 02/01/24 which was dated 01/25/24 included the following: I am the nurse in charge of Resident #185 on 11-7 shift. Around 11:30 PM I made my rounds and saw the resident trying to get out of bed and stripping his/her clothes which he/she usually does every time. Resident was reminded not to get out of bed and clothes was put back on and made him/her comfortable in bed. Bed kept at lowest position and mattress was placed on both side of the bed on the floor. 12:30 AM resident found leaning on the side rails with left side of the face on the railings. I placed him/her back on the center of the bed and pillows were placed to both side of the rails for protection. Resident was monitored frequently every hour. He/she was sleeping comfortably. 5:30 AM given neb and morning care was done. 6:50 AM left resident sleeping. There was no documentation in the statement that the resident was observed to have hit their head on the side rail. There was no documentation in the statement that indicated there was any observation of redness or a hematoma by the nurse. On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor told the Licensed Nursing Home Administrator (LNHA) and DON the concern that Resident #185, who was coded as having severely impaired cognition, had an injury of unknown origin that was not reported to the NJDOH. On 02/06/24 at 9:26 AM, the LNHA stated that the facility did not have a specific policy for injury of unknown or specific policy for reporting. On 02/06/24 at 9:54 AM, the DON provided the surveyor a Physician's Progress Note for Resident #185 which was not included in the Incident Report #2's investigation that was provided to the surveyor. A review of the document dated 01/25/24 included the following: Examined patient accompanied by nurse. Resident denies falling when asked how he/she developed bruise red in color. He/she pointed to side rails said He/she hit it there in his/her native language. Translated by nurse. Nurse placed pillow to prevent further bruise. Further review of the document indicated that the document was faxed to the facility with a fax date of 02/05/24 11:51p (11:51 PM). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/24 at 12:08 PM, in the presence of the survey team, two federal surveyors and the LNHA, the DON stated that the incident happened on the 11-7 shift and that the physician saw the resident at the time of incident. She added that the resident specifically told the physician. The DON stated that the nurse documented incorrectly. She added that the nurse came in late and did not listen to report from the night shift nurse. The surveyor asked the DON if the Physician's progress note should have been in the resident's medical file and included in the investigation file. The DON stated that it should be in the chart and a copy should be in the investigation file. She added that there was a break in communication. The DON stated that she reviewed the incident and wrote the summary. On that same date and time, the surveyor asked what the definition of injury of unknown origin was. The DON stated that the definition was if you cannot determine what happened. She added that for her, she did not consider it an injury of unknown origin. The surveyor asked if anyone witnessed the resident hit their head. The LNHA stated that there was an obvious discrepancy. He added that the DON believed that she [DON] knew what happened. The facility did not provide any additional information. A review of the undated facility provided policy titled Incident/Accident Reporting included the following: 15. Reporting will be completed if necessary once abuse or neglect cannot be ruled out. A review of the facility provided policy titled Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure dated 2022, included the following: XIII. Response A. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility shall a) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source are reported in the proper timeframe pursuant to this policy e) Facility will ensure that all alleged violations involving abuse, neglect, exploitation mistreatment, including injuries of unknown source .are reported immediately, but not later than 2 hours after the allegation is made N.J.A.C. 8:39-5.1(a)

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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. 38327 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to complete a thorough investigation of a fall incident for one (1) of five (5) residents, (Resident #149) reviewed for falls. This deficient practice was evidenced by the following: On 01/30/24 at 12:56 PM, the surveyor asked the Director of Nursing (DON) for investigations and incidents/accident records of Resident #149, and the DON stated that she would get back to the surveyor. On that same date at 02:02 PM, the surveyor observed the resident laying on the bed, awake, nonverbal, and the tube feeding (a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely) was off. The surveyor reviewed the hybrid (a combination of paper-based and electronic health records that primarily involves tracking and storing a resident's health records in several formats and places) medical records of Resident #149 as follows: The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to dysphagia (difficulty swallowing), gastrostomy status (alternate means of feeding through the stomach), heart failure, chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys), bipolar disorder (causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression), and anxiety disorder. The quarterly Minimum Data Set (qMDS) with an assessment reference date (ARD) of 12/08/23, and Section C Cognitive Skills for Daily Decision Making showed that the resident was severely impaired. A review of the Progress Notes (PN) dated 7/05/23 at 6:12 AM, the type of PN was an Incident Note that was electronically documented and signed by Licensed Practical Nurse (LPN) that Resident was found on the floor by resident's assigned Certified Nursing Aide (CNA) as she about to render am (morning) care. Resident was assessed for injuries, none noted. Placed a call to Physician #1 (P#1) but was told that P#2 was on call. Placed a call to resident's responsible party (RP) and notified RP. 11-7 Supervisor notified. Will continue to monitor resident. Further review of the PN showed that there was no further documentation what was the cause of the fall and what interventions were put into place to prevent the recurrence of the fall. A review of the Fall Risk Assessment (FRA) revealed that no FRA was done on 7/05/23 when the resident had a fall incident. The care plan revealed the following interventions for focus of fall: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Was created by the DON on 12/05/23 included 7/05/23: Resident was assessed for injuries, none noted. Placed a call to P#1 but was told that P#2 was on call. Placed a call to resident's RP and notified RP. Skin assessment done pain assessment done X-ray ordered by md (medical doctor). 2. Was revised by the MDS Coordinator/Registered Nurse (MDSC/RN) on 02/01/24, 7/05/23: Resident was assessed for injuries, none noted. Placed a call to P#1 but was told that P#2 was on call. Placed a call to resident's RP and notified RP. Skin assessment done pain assessment done Encourage to attend activities and keep in supervised environment while awake X-ray ordered by md. 3. Was created on 02/01/24 by the DON, Encourage to be in day room when awake and frequent room checks. A review of the provided fall investigations showed the following: 1. The MDS Coordinator/Registered Nurse (MDSC/RN) provided the fall investigation on 01/31/24 at 11:26 AM for a fall incident dated 7/05/23 that included information under Nursing Description: Resident was noted on the floor, on resident's stomach by resident's assigned CNA as she went to render am care. Vitals checked and was within normal limits. No injuries noted no apparent s/s (signs/symptoms) of pain or discomfort. brought back to bed. Due care rendered. The resident was unable to give a description and no witness was found. The person preparing the report was the LPN. There were no conclusions and summaries documented in the 7/05/23 fall investigation. 2. The DON provided the fall investigation on 02/01/24 at 10:35 AM for a fall incident dated 7/05/23 that included Resident was noted on the floor, on resident's stomach by resident's assigned CNA as she went to render am care she was noted trying to get of bed unassisted and fell . Vitals checked and was within normal limits. No injuries noted. No apparent s/s of pain or discomfort. Brought back to bed. Due care rendered. The resident was unable to give a description and no witness was found. The person preparing the report was the LPN. On the last part of the investigation was a note dated 7/06/23 which did not reflect on the first investigation provided to the surveyor by the MDSC/RN. The 7/06/23 notes included that the IDCP (interdisciplinary care plan) team met to discuss the plan of care for the resident and the plan to check the resident frequently and while awake and encourage to be in a day room or supervised environment, incontinent care and frequently used items within reach. Further review of the above showed that there were discrepancies on previously provided investigation of the MDSC/RN and that the submitted investigation of the DON included notes that reflected in the care plan interventions that were dated 02/01/24 for a fall incident that happened on 7/05/23 which was seven (7) months after the incident. Also, there were no documented statements from the CNA. On 02/01/24 at 12:09 PM, the surveyor interviewed the DON in the presence of the survey team. The surveyor asked the DON what was the facility's practices and policy regarding incidents/accidents and any reportables. The DON informed the surveyor that in the investigations process, we fill out the report in the electronic record in Risk Management. The DON stated that the nurse initiates it whenever it occurs, and gets statements if the incident was not witnessed, like for a fall that happened on 7/05/23 which was an unwitnessed fall. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On that same date and time, the surveyor asked the DON how long the facility would complete the investigation for the fall incident that happened on 7/05/23. The DON stated that the investigation should have been completed and closed within a week. The DON confirmed that the meaning of complete and closed within a week was that the Risk Management fall investigation was considered closed and complete when you can not add more documentation or revise the investigation. At this time, the surveyor asked the DON why there was a discrepancy between what the MDSC/RN and the DON provided 7/05/23 investigation from Risk Management and there was additional information that was added from the investigation from what the DON provided that was not seen in the investigation provided by the MDSC/RN. Also, the surveyor notified the DON of the above findings and concerns. The DON stated that she edited the information yesterday which did not reflect on the submitted Risk Management of the MDS Coordinator. She further stated that there were delays in completing of investigations. The DON also confirmed that the last note in the investigation was considered the conclusion wherein the interventions identified to prevent the recurrence of the falls should have been documented in the care plan. The DON had no response when asked why there was no CNA statement. The DON did not respond also when asked by the surveyor, if the last note was the conclusion and included the interventions that were dated 7/06/23 and why it was reflected in the care plan interventions that they were created on 02/01/24. On 02/05/24 at 01:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON. The surveyor notified the facility management of the above concerns. On 02/06/24 at 01:35 PM, the survey team met with the LNHA, the DON, and the Business Office Personnel for an exit conference, and there was no additional information provided by the facility management. The facility management did not provide the facility's fall policy. On 02/07/24 at 8:58 AM, the surveyor called the CNA, and the CNA did not call back. NJAC 8:39-27.1(a)(b)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to provide written notification of the emergency transfer to the Office of the Long-Term Care Ombudsman (LTCO) for one (1) of two (2) residents (Resident #149), reviewed for hospitalization s. This deficient practice was evidenced by the following: The surveyor reviewed the hybrid (a combination of paper, scanned, and computer-generated records) medical records of Resident #149. The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to dysphagia (difficulty swallowing), gastrostomy status (alternate means of feeding through the stomach), heart failure, chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys), bipolar disorder (causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression), and anxiety disorder. A review of the New Jersey Universal Transfer Form (a form that communicates pertinent, accurate clinical patient care information at the time of a transfer between health care facilities/programs) showed that the resident was transferred to the hospital on 4/19/23 and the reason for the transfer was due to vaginal bleeding. The Progress Notes that were a late entry on 4/26/23 (created date) for an effective date of 4/19/23 that was documented by the Licensed Practical Nurse (LPN) showed that the resident was transferred to the hospital due to [NAME] red vaginal discharge, the physician and the responsible party was notified. On 01/31/24 at 10:54 AM, the surveyor reviewed the provided binder for the Ombudsman Report Long Term Care Acute Transfer 2021-2024 and showed that there was no notification for transfer to the acute care facility (hospital) for the date of 4/19/23. On 01/31/24 at 10:59 AM, the surveyor interviewed the Nursing Clerk (NC), assigned person to LTCO notification of acute transfer (hospitalization). The NC stated that the process of LTCO notification was that she checks the electronic medical records of residents who went out for acute transfer to the hospital, lists them, and put into draft. She further stated that she prepares the draft every 5th of the month, then submits it to the Director of Nursing (DON) for checking and verification of the admitting diagnosis and completeness of the report, when the DON is finished, the NC will finalize and fax it to the Ombudsman. She indicated that the submission to LTCO was done monthly. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	On that same date and time, the surveyor notified the NC of the concern regarding 4/19/23 that there was no notification to LTCO. The NC confirmed also that no notification of LTCO was filed on the binder that was provided to the surveyor. The NC stated that she did not know what happened or why there was no notification submitted to the LTCO. She further stated that she thinks that because the previous DON who reviewed the notification missed it. On 02/01/24 at 9:08 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the survey teams stated that there was no facility policy regarding Ombudsman notification of acute transfer and that the facility just follows the regulations. On 02/05/24 at 01:21 PM, the survey teams met with the LNHA and DON. The surveyor notified the facility management of the above concerns. On 02/06/24 at 11:30 AM, the survey teams met with the DON and LNHA. The DON and LNHA confirmed that there were no other responses. On 02/06/24 at 01:35 PM, the survey teams met with the LNHA, the DON, and the Business Office Personnel for an exit conference, and there was no additional information provided by the facility management. NJAC 8:39-4.1(a)(32), 5.3; 5.4

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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** 39399 Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for three (3) of 38 residents, Residents #77, #145, and #242, reviewed for accuracy of MDS assessment coding. This deficient practice was evidenced by the following: 1. On 02/05/24 at 10:15 AM, the surveyor observed Resident #77 lying in bed with eyes closed. The surveyor reviewed Resident #77's hybrid medical (combination of paper and electronic) records. The Admission Record (AR, admission summary) reflected that Resident #77 was admitted to the facility with medical diagnoses which included but were not limited to dementia, hypertension (elevated blood pressure), type II diabetes mellitus, and anxiety disorder. The surveyor reviewed the most recent MDS assessment dated [DATE] under Section O0250. Influenza Vaccine (IV) which reflected that Resident #242 received the IV on 10/14/22. The surveyor interviewed the facility's MDS Coordinator/Registered Nurse (MDSC/RN) who stated that the IV date did not reflect the most up to date for the influenza season for 2023. The MDSC/RN stated those dates auto populate from the resident's electronic medical health record and she missed to check it. A review of the Resident Assessment Instrument with a revision date of October 2023 under page O-12, Steps for Assessment 1.) Review the resident's medical record to determine whether an influenza vaccine was received in the facility for this year's influenza vaccination season. On 02/06/24 at 11:31 AM, the surveyor spoke with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) regarding the above concerns. There was no further information provided. 2. On 01/31/24 at 10:10 AM, the surveyor observed Resident #242 in the room lying in bed. The surveyor reviewed Resident #242's hybrid medical records. The resident was admitted to the facility with diagnosis that included but not limited to cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), type II diabetes mellitus, hypertension; and hyperlipidemia (A condition in which there are high levels of fat particles (lipids) in the blood). The surveyor reviewed the most recent MDS assessment dated [DATE] under Section O0250. IV which reflected that Resident #242 did not receive the influenza vaccine for the year's influenza vaccination season. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #242's hybrid medical records revealed under Immunization that the resident received the influenza vaccination on 11/28/23. The surveyor interviewed the facility's MDSC/RN who stated that the resident received the influenza and the MDS was coded in error. 46049 3. On 01/30/24 at 11:39 AM, the surveyor observed Resident #145, resting in bed in their room. Resident #145 was awake, alert, and verbally responsive. Resident #145 was receiving oxygen (O2) via a nasal cannula (NC-plastic prongs attached to a tube, inserted into the nostrils that O2 flows through) which was attached to a concentrator (an O2 delivery system) set at 2 liters per minute (LPM). On 01/29/24 at 12:17 PM, the surveyor reviewed the hybrid medical records of Resident #145 which revealed the following: The resident's AR revealed that Resident #145 was admitted with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease (COPD, A group of lung diseases that block airflow and make it difficult to breathe). A comprehensive MDS dated [DATE], indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a 12 out of 15 which indicated that the resident's had moderate cognitive impairment. Section O of the MDS assessment, the resident was not coded for O2 therapy use. A physician order dated 8/17/23 read, O2 at 2L/MIN [LPM].VNC [via nasal cannula] FOR COPD every shift for COPD. On 01/30/24 at 12:25 PM, the surveyor interviewed the MDSC/RN about Resident #145's MDS assessment and O2 therapy not being coded. The MDSC/RN stated she would review and provide further information. On 01/30/24 at 12:33 PM, the MDSC/RN informed the surveyor that it was a data entry error after reviewing the MDS assessment and the resident's medical records. She confirmed the resident was receiving O2 therapy at the time of the assessment and it should have been coded on the assessment. On 02/05/24 at 01:35 PM, the surveyor informed the LNHA and the DON about the above concern. There was no additional information provided. NJAC 8:39-33.2 (d)

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	315458	A. Building B. Wing	02/06/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38327 Based on observations, interviews, and review of medical records and facility documents, it was determined that the facility failed to develop and implement a comprehensive plan of care to meet residents' preferences and goals and address the resident's medical, physical, mental, and psychosocial needs. This deficient practice was identified for four (4) of 38 residents (Residents #19, #36, #132, and #267) reviewed for a care plan. This deficient practice was evidenced by the following: 1. On [DATE] at 12:54 PM, the surveyor observed Resident #19 in their room with tube feeding (TF, a way to provide nutrition when a resident cannot eat or drink safely by mouth). The surveyor reviewed the hybrid (a combination of paper-based and electronic health records that primarily involves tracking and storing a resident's health records in several formats and places) medical records of Resident #19 as follows: Resident's Admission Record (AR, admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; other cerebrovascular diseases (a group of conditions that affect blood flow and the blood vessels in the brain), hemiplegia unspecified affecting unspecified side (indicates partial paralysis), aphasia (a language disorder that affects a person's ability to communicate), heart failure, and essential hypertension (occurs when a resident have abnormally high blood pressure that's not the result of a medical condition). The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care with assessment reference date (ARD) [DATE] showed in Section C Cognitive Skills for Daily Decision Making that the resident's cognition was severely impaired. Section N Medications revealed that the resident received an anticoagulant (commonly known as a blood thinner, a chemical substance that prevents or reduces coagulation of blood, prolonging the clotting time) medication during the last seven days. The February 2024 Order Summary Report (OSR) revealed a physician order (PO) date of [DATE] for Apixaban (an anticoagulant medication used to treat and prevent blood clots and to prevent stroke) tablet (tab) 2.5 mg (milligram) to give one tab via TF every 12 hours (hrs) of VTE (Venous thromboembolism is a condition that occurs when a blood clot forms in a vein) related to abnormal coagulation profile. The above order for Apixaban was transcribed to the February 2024 electronic Medical Records (eMAR) and signed daily by nurses as administered. A review of the personalized care plan revealed that the resident did not have a plan of care for an anticoagulant. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:48 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) who informed the surveyor that Resident #19 was cognitively impaired and required total care with activities of daily living (adls). The LPN stated that the resident was recently hospitalized and came back three weeks ago with a diagnosis of pneumonia (lung infection) from the hospital. On that same date and time, LPN#1 stated that it was the responsibility of the Unit Manager (UM) to initiate, develop, and update the resident's care plan. The LPN further stated that there was no UM for one and a half (1 ,d+[DATE]) years and he did not know who does the care plan now. The LPN also stated there should be a care plan for anticoagulants. On [DATE] at 10:55 AM, the surveyor interviewed the Director of Nursing (DON) regarding the above concerns and findings. The DON stated that there should be a care plan for anticoagulants. 2. On [DATE] at 8:25 AM, the surveyor observed Resident #132 on the bed with an air mattress, indwelling catheter in use, and head of the bed elevated approximately 45 degrees while on TF pump, at 75 ml/hr (milliliters per hour). The surveyor reviewed the hybrid medical records of Resident #132. The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to dysphagia oropharyngeal phase (difficulty swallowing), gastrostomy status (resident with TF), altered mental status unspecified, and need for assistance with personal care. The qMDS with an ARD of [DATE], and Section C Cognitive Skills for Daily Decision Making showed that the resident's cognition was severely impaired. Section N revealed that the resident received an opioid (a broad group of medicines used to relieve pain and are considered controlled medications) medication during the last seven days. The February 2024 OSR revealed a PO date of [DATE] for Percocet oral tab ,d+[DATE] mg (Oxycodone [contains opioid] with Acetaminophen) to give one tab via TF two times a day for severe pain 30 minutes prior to wound treatment. The above order for Percocet was transcribed to the February 2024 eMAR and signed twice a day by nurses as administered. A review of the personalized care plan revealed that the resident did not have a plan of care for pain. On [DATE] at 8:46 AM, the surveyor interviewed LPN#1 regarding Resident #132. The LPN informed the surveyor that the resident had multiple hospital-acquired wounds and was currently on pain medication. The LPN further stated that the resident should have a care plan for pain. He confirmed that he was not responsible for initiating and developing a care plan because it was the responsibility of the UM. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:57 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN) in the presence of the survey team. The MDSC/RN informed the surveyor that the care plan was the responsibility of the admitting nurse to start the care plan for example for falls, skin, certain medications including anticoagulants, and pain. The MDSC/RN stated that upon admission, the next morning when she came to work, the MDSC/RN also updated and revised the care plan. She further stated that anyone from nursing including the DON and UM can write a care plan that requires a nursing care plan. She further stated that as an MDSC/RN, care plans also are reviewed during a quarterly MDS and any comprehensive MDS and that would be her responsibility to make sure that care plan was there. At that same time, the surveyor asked the MDSC/RN if the nurses in the unit were aware that they were responsible to initiate and update the care plan. The MDSC/RN stated, I know from previous DON that all nurses knew that they will do the care plan, but I did not talk to nurses if they were aware. The MDSC/RN informed the surveyor that she started to work at the facility in [DATE]. Furthermore, the surveyor asked the MDSC/RN why was it important that the resident have a personalized care plan for anticoagulants. The MDSC/RN stated that so the staff knows how to monitor side effects like bruising. In addition, the surveyor asked the MDSC/RN why was it important for the resident to have a personalized care plan for pain. The MDSC/RN stated that it was important to make sure that pain is controlled. On [DATE] at 10:48 AM, the surveyor interviewed the DON regarding the above concerns, and the DON stated that there should be a pain care plan. On [DATE] at 01:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON. The surveyor notified the facility management of the above concerns. On [DATE] at 11:30 AM, the survey team met with the DON and LNHA. The DON that she added an anticoagulant care plan after the surveyor's inquiry for Resident #19. The LNHA further stated that the care plan for pain for Resident #132 was added after the surveyor's inquiry. 3. On [DATE] at 01:01 PM, the surveyor observed Resident #36 in their room watching television. Resident #36 stated they are a smoker, and the smoking area is on the 6th floor. The resident further stated that the facility staff holds onto their cigarettes and lighters. The surveyor reviewed the hybrid medical records of Resident #36 as follows: Resident's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), hypertensive heart disease (a constellation of changes in the left ventricle, left atrium, and coronary arteries as a result of chronic blood pressure elevation), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and major depression disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). The annual MDS (aMDS) with an ARD [DATE] showed in Section J, that Resident #36 was a current tobacco user. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #36 last smoking assessment (an assessment may help the facility determine how you can help a patient who smokes. Variables worth assessing include amount smoked. degree of dependence (e.g., cigarettes per day, time to first cigarette) patterns of smoking) dated [DATE], indicated under Section E. Safety subsection 9. Plan of care is used to assure resident is safe while smoking, was checked of as yes. A review of Resident #36's care plan, last reviewed on [DATE], did not show a resident focused care plan for smoking. A review a Federal Guideline 42 CFR 483.25(H)(1) and (2) also requires that the care plan for residents that states, when smoking reflects specific information and that the resident's plan of care be reviewed and revised periodically as needed. On [DATE] at 11:17 AM, the surveyor interviewed the DON. The DON stated, on admission or re-admission the nursing department and MDS department create a care plan for each resident. The DON further stated all residents who are smokers, should have an individualized care plan that addresses the resident's goals and interventions with regards to smoking. On [DATE] at 01:21 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above concerns. A review of the facility's Safe Smoking Policy that was provided by the LNHA with a revised date of [DATE] stated under the procedure section; 1. Any resident who wishes to smoke will be assessed by the nurse on admission and quarterly. 4. On [DATE] at 10:54 AM, the surveyor reviewed the closed record for Resident #267, who expired in the facility. The surveyor reviewed the hybrid medical records of Resident #267 as follows: The [DATE] OSR revealed a physician order date of [DATE] for DNR (Do Not Resuscitate) DNI (Do Not Intubate) DNH (Do Not Hospitalize) Pt (patient) has cancer and choose palliative care. A review of Resident #267's nursing progress notes revealed a nursing note dated [DATE] at 11:55 PM, Resident placed on Palliative Care. Now DNR, DNI, DNH. The closed care plan dated [DATE] did not show a resident focused care plan for palliative care. On [DATE] at 11:17 AM, the surveyor interviewed the DON. The DON stated, on admission, re-admission and/or as changes occur the nursing department and MDS department create and update care plans for each resident. The DON further stated any residents who are placed on palliative care, should have an individualized care plan that addresses the resident's goals and interventions with regards to palliative care. On [DATE] at 01:21 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above concerns. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:30 AM, the survey team met with the DON and LNHA. The LHNA stated all the care plan concerns have reviewed and resident care plans will be updated as needed. A review of the facility's Care Plans-Comprehensive Policy that was provided by the LNHA with a revised date of [DATE] included an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. A review of the facility's Palliative/End-of-Life-Care Clinical Protocol that was provided by the LNHA with a revised date of [DATE] revealed under the assessment and recognition section, 3. The physician will review the resident's decision-making capacity and help the staff obtain maximum participation in the care plan. Under the treatment and management section of the policy it revealed, 5. Nursing staff will implement comfort measures identified in the comprehensive care plan. On [DATE] at 01:35 PM, the survey team met with the LNHA, the DON, and the Business Office Personnel for an exit conference, and there was no additional information provided by the facility management. NJAC 8:,d+[DATE].2 (e)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to ensure: a) medication was administered in accordance with manufacturer's cautionary specifications and professional standards of clinical practice for one (1) of three (3) nurses administered medications to one (1) of three (3) residents (Resident #69, observed during medication administration and b) care and services were followed for resident who was at risk for wandering for one (1) of two (2) residents, (Resident #55) reviewed for elopement according to physician's order, assessment and standards of clinical practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: 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 a medical regimen 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. 1. On 01/31/24 at 8:54 AM, during the medication (med) administration observation, the surveyor observed the Licensed Practical Nurse #1 (LPN#1) prepare eight meds for administration to Resident #69 which included the following: -Budesonide and Formoterol Fumarate combination aerosol 160-4.5 microgram/actuation (mcg/act; medication used to treat asthma). -MiraLAX (polyethylene glycol 3350, 17 grams; powder) one packet, one time a day for constipation. At that time, the surveyor observed the LPN#1 measure the MiraLAX powder and dissolve the powder into water. On 01/31/24 at 9:12 AM, the LPN#1 informed the surveyor that she was ready to administer the meds to Resident #69 and proceeded into the resident's room. The resident was seated behind the meal tray table with the breakfast tray and drinks on top. The resident was agreeable to the administration of his/her med. At that time, the LPN#1 administered the budesonide and formoterol fumarate combination inhalation to the resident followed by the dissolved MiraLAX liquid and then the remainder of the resident's meds. The resident began to eat their breakfast. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/31/24 at 9:18 AM, the surveyor and the LPN#1 reviewed the cautionary sticker on the box for Resident #69's budesonide and formoterol fumarate combination aerosol. Affixed on the box was a cautionary label that indicated Rinse mouth thoroughly. On 01/31/24 at 9:20 AM, during an interview with the surveyor, the LPN#1 acknowledged that she should have read and followed the cautionary on the box of the budesonide and formoterol fumarate combination aerosol. She stated that she should have provided water for the resident to rinse their mouth prior to administering the MiraLAX. This would have been the appropriate sequencing of the meds. At that time, the LPN#1 also acknowledged that the sequencing of the med administration was not in accordance with professional standards of clinical practice. The LPN#1 specified that she should have requested that Resident #69 rinse their mouth with water prior to administering an oral med that has to be swallowed, MiraLAX. A review of Resident #69's Admission Record (AR) (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to type II diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), hypertension (high blood pressure) and paranoid schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). Resident #69's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 01/09/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that Resident #69's cognition was intact. A review of the manufacturer's specifications for Symbicort (budesonide and formoterol fumarate; for oral inhalation aerosol) Section 2.1 Administration Information. Symbicort should be administered as 2 inhalations twice daily (morning and evening, approximately 12 hours apart), every day by the orally inhaled route only. After inhalation, the patient should rinse the mouth with water, without swallowing. Review of the manufacturer's specifications for Symbicort (Budesonide and Formoterol fumarate; for oral inhalation aerosol) Section 5.4 Local Effects, included: Advise the patient to rinse his/her mouth with water without swallowing following inhalation to help reduce the risk of oropharyngeal candidiasis [mouth and throat fungal infection]. On 01/31/24 at 12:37 PM, during an interview with the surveyor, the Director of Nursing (DON) was made aware of the concerns that occurred during the med pass observation for Resident #69. A review of the LPN#1's competency for med administration performed by the facility's employed Registered Nurse (RN), dated 10/12/23, revealed that the LPN#1 was coached on the following: - Med storage - Special directions for preparation and administration are followed, i.e., liquids, shaken, give with food . - External feeding tubes, checked for placement/residual. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A total of one (1) error was observed. A review of the facility provided policy of Administering Medications, dated/revised 4/2010, included the following under Policy Statement, Medications shall be administered in a safe and timely manner as prescribed. Continued review of the Policy Interpretation and Implementation explained, 6. The individual administering the meds must check the label three (3) times to verify the right med . and the right method (route) of administration before giving the med. On 02/06/23 at 12:27 PM, the surveyor discussed the above concerns with the facility DON and Licensed Nursing Home Administrator (LNHA). No additional information regarding the concerns discussed were provided. 39885 2. On 01/30/24 at 11:36 AM, the surveyor observed Resident #55 ambulating in the day room of the unit with a rolling walker. On 01/31/24 at 9:38 AM, the surveyor observed Resident #55 in their room with a wander guard bracelet (a bracelet or anklet that triggers alarms and can have the capability to lock monitored doors to prevent a resident from leaving a facility unattended) on the resident's left wrist. A review of Resident #55's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to end stage renal disease, hypertensive heart disease and dementia. A review of Resident #55's most recent comprehensive MDS, dated [DATE], reflected that the resident had a BIMS score of 5 out of 15, which indicated that Resident #55's cognition was severely impaired. Further review of the MDS indicated that Resident #55 had a wander/elopement alarm used daily. A review of the January 2024 Treatment Administration Record (TAR) revealed an order for wander guard every shift .check placement every shift. Further review included the following: There was no indication that the placement was checked on the day shift on 01/14/24, 01/15/24, 01/16/24, 01/26/24 and 01/29/24. There was no indication that the placement was checked on the evening shift on 01/03/24, 01/17/24, 01/25/24 and 01/26/24. There was no indication that the placement was checked on the night shift on 01/09/24. There was a total of ten shifts that a nurse did not sign, left blank on the January 2024 TAR to indicate the placement of the wander guard was checked. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/31/24 at 9:39 AM, the surveyor interviewed the LPN#2 regarding the process for a resident that had a wander guard bracelet. LPN#2 stated that the wander guard should be checked for placement every shift and that an alarm would go off if the resident went near an exit. On 01/31/24 at 12:36 PM, the surveyor interviewed the DON regarding the process for checking placement of the wander guard bracelet. The DON stated that the nurse should have checked the placement of the wander guard on each shift. The DON confirmed that Resident #55's January 2024 TAR had ten shifts that were blank. The DON stated that there should not be any blanks on the January 2024 TAR. A review of Resident #55's Wandering Risk assessment dated [DATE] indicated the resident was a low risk for wandering with no risks associated with wandering documented. This was inconsistent with the surveyor's observation of the resident with a wander guard bracelet and a diagnosis of dementia on the AR. On 02/01/24 at 10:09 AM, the surveyor interviewed the Registered Nurse (RN) regarding the wandering risk assessment. The RN stated that it was a questionnaire in the computer. The surveyor showed the RN Resident #55's Wandering Risk Assessment form. The RN stated that she would not expect that it would be blank. On 02/05/24 at 01:00 PM, the surveyor interviewed the DON regarding Resident #55's Wandering Risk Assessment form. The DON stated that Resident #55's Wandering Risk Assessment form looked like it was blank and that it should be filled out correctly. She added that she knew Resident #55 was at risk for wandering and that the resident's Wandering Risk Assessment form was not completed correctly. On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor informed the LNHA and DON of the concern that Resident #55's January 2024 TAR had ten blanks indicating that the wander guard bracelet was not checked and that the Wandering Risk Assessment was not accurate. A review of the facility provided policy titled, Elopement (Missing Resident) with an effective date of 02/28/2002, did not include any information about the wander guard bracelet or the Wandering Risk Assessment. On 02/06/24 at 12:20 PM, in the presence of the survey team and two federal surveyors, the DON did not provide any additional information. NJAC 8:39-27.1(a), 29.2 (d)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45208 Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to provide wound care in accordance with the facility's policy and professional standards of clinical practice for one (1) of one (1) resident reviewed and observed for wound care observation, Resident #56. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and COVID-19, page last reviewed 01/08/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. In addition, wear gloves, according to Standard Precautions, when it can be anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment could occur; gloves are not a substitute for hand hygiene; if your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment, and after removing gloves. Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. On 02/05/24 at 10:47 AM, the state surveyor observed wound care performed for Resident #56 in the presence of a federal surveyor. The Wound Care Registered Nurse (WCRN) was scheduled to perform wound treatment on the left heel. During the wound treatment observation, the surveyors observed that the WCRN did not perform hand hygiene on 12 of 17 opportunities. This was observed by the surveyors between 10:47 AM and 11:29 AM. Upon entry to the Resident #56's room, the WCRN identified herself to the resident and asked if the resident had any pain and she proceeded to check the resident's name bracelet to identify them. ~WCRN then washed her hands at the sink. ~WCRN gloved, cleaned the bedside table, removed her gloves, and did not perform hand hygiene. ~WCRN proceeded to take the supplies from the wound care cart. (Blue prep pad, saline, plastic cups, iodine, island 4 x 4, tape, left heel, trash bag, gloves, Foley catheter insertion tray being used for sterile gloves, tongue depressors, wound tape, trash bag). ~WCRN gloved and did not perform hand hygiene. ~WCRN was observed dropping the plastic cups she took out for supplies; she picked them up, removed gloves during the entire procedure (including removing her gloves because she forgot gauze dressing) but did not perform hand hygiene prior to starting wound care and removed the soiled dressing. (continued on next page)

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	315458	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Nursing & Rehabilitation Ctr	300 Broadway Newark, NJ 07104

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~WCRN proceeded to redress the residents wound with bare hands and did not perform hand hygiene. ~WCRN gloved to reapply the residents heel protectors prior to walking away to get the gauze and did not perform hand hygiene. At this point the surveyor interrupted the process and asked the WCRN to wash her hands prior to going into the wound care cart. After washing her hands and getting her supplies, the WCRN gloved and proceeded with the wound care. ~WCRN removed the residents heel protectors as well as the dressing, measured the wound, took off her gloves and did not perform hand hygiene. ~With bare hands WCRN opened the foley kit to get the white prep pad on the cleaned bedside table covered with a barrier, then proceeded to open five (5) 4 x 4 inch gauze pads onto the prep pad. She got a plastic cup and poured normal saline (NS) in it and prepared another cup with iodine in it. She dated and signed the NS with an opening date. ~ Without performing hand hygiene, WCRN put on gloves, and placed the blue prep pad under the resident's foot. ~ Without performing hand hygiene, WCRN applied sterile gloves. She performed wound care on the heel with soaked gauze in NS and Iodine. Without performing hand hygiene, WCRN removed her gloves. She reached in her pocket to get a pen and proceeded to initial and date the resident's 4 x 4 dressing. to cover the resident's heel. ~ Without performing hand hygiene or changing her gloves, WCRN proceeded to complete the left plantar wound care (a different area) with the same gloves. ~WCRN then removed her sterile gloves, without performing hand hygiene changed gloves and proceeded to apply the heel boots on the resident. ~WCRN then proceeded with the same gloves to clean up the room, bedside table, pulled the trash and brought the trash to the dirty utility room. ~WCRN was observed returning to the room, without gloves using hand foam sanitizer in the hallway. ~WCRN applied gloves to clean bedside table and inserted a new trash bag. ~WCRN then removed her gloves and properly washed her hands at the sink. The surveyor reviewed the medical record for Resident #56. The resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility with a diagnosis that included but were not limited to type 2 diabetes mellitus (DM) (is a condition that happens when blood sugar (glucose) is too high, it develops when pancreas doesn't make enough insulin), and chronic obstructive pulmonary disease (COPD) (a chronic inflammatory lung disease that causes obstructed airflow from the lung). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 11/17/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident's cognition was intact. A review of the facility provided personalized care plan initiated on 8/10/23 and revised on 12/28/23, with a focus of risk for pressure ulcer development related to related to (r/t) immobility and non-adherence to care plan. Patient is at risk for worsening r/t immobility and comorbidities and non-wound healing. A review of the order summary report (OSR) revealed an order for Povidone/Iodine (or betadine, a topical antiseptic that provides infection protection against a variety of germs for minor cuts, scrapes, and burns) external solution 5%, apply to left heel, topically cover every 8 hours as needed for pressure. Apply betadine then cover to protect. A review of the Skin and weekly note dated 01/24/24 indicated: a.) Left heel: pressure ulcer 1.5 centimeters (cm) length (L) x1.0cm width (W) x 0cm depth (D), b.) Left plantar foot: blood blister 5.4cm/ L x 1.8cm/ W x 0 cm /D. On 02/05/24 at 11:45 AM, the surveyor interviewed the WCRN, and asked what the wound care process for the facility was. She responded, introduce yourself, tell them what is happening, check pain and their identification band, clean your table, place a patient bib down. WCRN stated, I didn't use the bibs, because they are not sterile. When the surveyor inquired about the facility wound care policy, WCRN responded, I don't know if the policy is the same or not, at this moment there is no infection preventionist in the building, the Director of Nursing (DON) is covering that role. The surveyor reviewed the 13 opportunities out of 17 for handwashing. with the WCRN that was observed during the wound care. She responded, I didn't realize that. Once the surveyor reviewed the observation with WCRN, she stated, I agree I should have washed my hands for those instances and could have used a bottle of hand sanitizer on the top of the bedside table to perform hand hygiene more appropriately and frequently during the wound care. On 02/05/24 at 01:15 PM, in the presence of the survey team, the surveyor interviewed the DON who stated, hand washing is essential during wound care and having a clean environment while performing the wound care to protect against infection and the spread of germs. A review of the facilities handwashing policy, dated 2001, revised 2009 documented: #1 All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#2 All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. #8 The use of gloves does not replace handwashing/hand hygiene. A review of the facility's Wound Care Policy, dated 2001, revised 2010 provided by the Licensed Nursing Home Administrator (LNHA) indicated the purpose of the policy is to provide guidelines for the care of wounds to promote healing. Under the section steps in the procedure hand hygiene and gloves were instructed throughout the wound care process . On 02/06/24 at 01:30 PM, the survey team met with the LNHA and DON. There was no additional information provided by the facility. NJAC 8:39-11.2(b), 19.4(a), 27.1(a), 29.2(d)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39399 Based on observation, interview and record review, it was determined that the facility failed to ensure that the urinary output of resident's with indwelling catheters (IC) were monitored to ensure patency to further prevent any infections. This deficient practice was noted to two (2) of two (2) resident's reviewed with IC, Resident #242 and Resident #266. This deficient practice was evidenced by the following: 1. On 01/31/24 at 10:10 AM, the surveyor observed Resident #242 in the room lying in bed. The surveyor reviewed Resident #242's hybrid (combination of paper and electronic) medical records. The resident was admitted to the facility with diagnosis that included but not limited to cerebral Infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), type II diabetes mellitus, hypertension (elevated blood pressure), and hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood). A review of the quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 01/12/24 reflected that the resident had a Brief Interview for Mental Status (BIMS) score 6 out of 15 indicating that the resident had severe cognitive impairment. A review of the Progress Notes (PN) dated 01/30/24 at 01:53 PM reflected that Resident #242 was transferred to the hospital due to complaints of stomach pain and were unable to urinate. Further review of the PN dated 01/30/24 at 11:09 PM reflected that Resident #242 came back from the hospital at 10:50 PM with a new IC. A review of the active physician orders (PO) did not reflect that Resident #242 had a PO to monitor the urinary output of the resident. On 02/01/24 at 12:05 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to the resident who stated that for any resident with an IC, the urinary output must be documented every shift in the electronic Medication Administration Record (eMAR). A review of the January 2024 and February 2024 eMAR did not reflect any documentation for the urinary output of the resident. On 02/01/24 at 01:49 PM, the surveyor discussed the above concern to the facility's Director of Nursing (DON) who stated that any residents with an IC, the urinary output must be documented in the eMAR to ensure patency including the urine characteristics which could indicate any infection. (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 facility's policy and procedure (P&P) titled, Emptying a Urinary Collection Bag revealed under General Guidelines 1. Empty the urinary collection bag at least every eight (8) hours or more often if needed to keep the bag from becoming full. Further review of the P&P revealed under Documentation The following information should be recorded in the resident's medical record: 2. The amount of urine emptied from the drainage bag On 02/05/24 at 01:15 PM, the above concerns were discussed to the facility's Licensed Nursing Home Administrator (LNHA) and DON. There were no further information provided. 39885 2. On 01/29/24 at 10:45 AM, the surveyor observed Resident #266 seated up in bed. The surveyor observed Resident #266 had a catheter that was draining clear yellow urine into a drainage bag that was hung on the side of the bed. Resident #266 stated that the catheter had been placed because he/she had trouble urinating. Resident #266's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to urinary tract infection (an illness in any part of the urinary tract, the system of organs that makes urine), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and benign prostatic hyperplasia (a benign (not cancer) condition in which an overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine). A review of Resident #266's most comprehensive MDS, dated [DATE], reflected that the resident had a BIMS score 15 out of 15 indicating that the resident's cognition was intact. A review of the active PO did not reflect that Resident #266 had a PO to monitor the urinary output of the resident. A review of the January 2024 eMAR and electronic Treatment Administration Record (eTAR) did not reflect any documentation for the urinary output of the resident. On 02/01/24 at 9:31 AM, the surveyor interviewed the Certified Nursing Assistant #1 (CNA#1) regarding the documentation of Resident #266's urinary output. CNA#1 stated that the facility had placed the output in the computer system but that they did not have the computer system now and that they documented it in an ADL (Activities of Daily Living) binder. She added that she was not assigned to Resident #266. On 02/01/24 at 09:34 AM, the surveyor interviewed Resident #266's assigned CNA#2. CNA#2 stated that she emptied the drainage bag, measured the amount, documented the amount and gave it to the nurse. She added that it used to be in the computer and that now it was in the ADL binder. A review of Resident #266's ADL sheet for January 2024 did not include any amounts of urine output. On 02/01/24 at 9:41 AM, the surveyor interviewed the Registered Nurse (RN) who stated that the catheter is monitored to see if was draining but that the amount of output was not recorded anymore. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/24 at 01:01 PM, the surveyor interviewed the DON regarding output. The DON stated that it depended on the policy. The DON stated that the facility did not document the output. She added that for quality improvement would want it to be done. On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor notified the LNHA and DON the concern that Resident #266 did not have their output of the catheter measured, documented and monitored. The facility did not provide any additional information. NJAC 8:39-33.2(c)5

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 38327 REPEAT DEFICIENCY Based on observation, interview, and review of other pertinent provided facility documents, it was determined that the facility failed to ensure that oxygen care and services were provided according to the standard of clinical practice and physician's order for three (3) of five (5) residents, (Residents #19, #145, and #235 reviewed for respiratory care. This deficient practice was evidenced by the following: 1. On 02/01/24 at 8:48 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) who informed the surveyor that Resident #19 was cognitively impaired and required total care with activities of daily living (ADL). He further stated that the resident was recently hospitalized and came back three weeks ago for pneumonia (an infection that affects one or both lungs). On that same date and time, LPN#1 stated that it was the responsibility of the Unit Manager (UM) to initiate and update the care plan of the resident including the care plan for oxygen (O2) use. He further stated that there was no UM for one and a half (1 1/2) years and he did not know who does the care plan now. On 02/01/24 at 8:51 AM, the surveyor observed the resident laying in bed asleep with O2 at 5 LPM (five liters per minute) via nasal cannula (N/C, device that delivers extra O2 through a tube and into the resident's nose) attached to a concentrator (a medical device that produces O2). At that same time, the surveyor notified LPN#1 regarding the resident's O2. The LPN stated that the resident's O2 should be at 3 LPM. Then, the LPN went inside the resident's room, assessed the resident, and adjusted the O2. The surveyor reviewed the hybrid (a combination of paper-based and electronic health records that primarily involves tracking and storing a resident's health records in several formats and places) medical records of Resident #19 as follows: Resident's Admission Record (AR, admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; other cerebrovascular diseases (a group of conditions that affect blood flow and the blood vessels in the brain), hemiplegia unspecified affecting unspecified side (indicates partial paralysis), aphasia (a language disorder that affects a person's ability to communicate), heart failure, and essential hypertension (occurs when a resident have abnormally high blood pressure that's not the result of a medical condition). The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care with assessment reference date (ARD) 01/22/24 showed in Section C Cognitive Skills for Daily Decision Making that the resident's cognition was severely impaired. Section O Special Treatments, Procedures, and Programs revealed that the resident was not on O2 while a resident of the facility for 14 days. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Progress Notes (PN) showed that on 01/13/24 at 12:28 PM, 01/21/24 at 6:30 AM, and 01/22/24 at 10:06 PM, there was documentation that the resident had used the O2. A review of the January 2024 orders revealed that there was a physician's order (PO) created on 01/10/24 for O2 at 2 LPM via N/C every eight hours as needed (PRN) for shortness of breath (SOB). The order for O2 at 2 LPM was discontinued (d/c) on 01/14/24 and the reason for d/c was because the resident was hospitalized . The February 2024 Order Summary Report (OSR) showed that there was no order for O2 use. The personalized care plan did not include O2 use, goals, and interventions. Further review of the above information showed that the MDS did not capture the use of O2 in the resident's qMDS ARD of 01/22/24. On 02/05/24 at 8:23 AM, both the surveyor and LPN#1 went inside the resident's room and observed the resident was on 2 LPM via N/C attached to a concentrator and the resident was asleep. Outside the resident's room, the surveyor asked the LPN what was the order for O2 and he said that the order should be continuous at 2 LPM. Then the surveyor notified the LPN of the above concerns. The LPN checked the electronic medical records and confirmed that there was no order, he stated that he would call the doctor to obtain an order. He further stated that the admitting nurse should have obtained an order for O2, and it was missed when the resident came back from a recent hospitalization . He further stated that it was his fault too. He claimed that he should have seen that there was no order because he was taking care of the resident. On 02/05/24 at 10:55 AM, the surveyor interviewed the Director of Nursing (DON) regarding the above observations and findings. The surveyor asked the DON if there should be an order and care plan for O2 use, and she stated yes. On 02/06/24 at 11:30 AM, the survey team met with the DON and Licensed Nursing Home Administrator (LNHA). The DON stated that O2 should be part of a PO and the O2 care plan should be developed and initiated. 46049 2. On 01/29/24 at 11:06 AM, the surveyor observed Resident #145, resting in bed in their room. Resident #145 was awake, alert, and verbally responsive. Resident #145 was receiving O2 via a NC which was attached to a concentrator. The surveyor observed there was no indicator visible on the concentrator to show the LPM of O2 the resident was receiving. Resident #145 was not aware of the LPM of O2 that they should be receiving and stated that the nurses took care of it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/29/24 at 11:15 AM, the surveyor interviewed LPN#2 about Resident #145's O2 therapy. LPN#2 stated the resident was ordered to receive O2 at 2 LPM continuously. The LPN accompanied the surveyor to the resident's bedside to check the resident's O2 setting on the concentrator. The LPN was unable to read the LPM of O2 the resident was currently receiving and acknowledged the setting of LPM could not be read on the concentrator. LPN#2 did not provide a verbal response as to when the O2 setting, or the concentrator was last checked. LPN#2 called central supply to replace the concentrator for the resident. The surveyor reviewed the hybrid medical records of Resident #145 which revealed the following: The resident's AR reflected that Resident #145 was admitted with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease (COPD, group of lung diseases that block airflow and make it difficult to breathe). The comprehensive MDS (cMDS) with an ARD 10/23/23, indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a 12 out of 15 which indicated that the resident's had moderate cognitive impairment. A PO dated 8/17/23 read, O2 at 2L/MIN [LPM].VNC[via nasal cannula] FOR COPD every shift for COPD. A review of the January 2024 electronic Treatment Administration Record (eTAR) revealed there were five (5) of 85 entries were not signed by the nurses for O2 therapy order. On 01/31/24 at 01:12 PM, the surveyor informed the DON about observation of O2 concentrator in use by Resident #145 and the January 2024 TAR with five entries not signed. The DON acknowledged eTAR should be signed by the nurses and would follow up to provide further information. On 02/05/24 at 01:35 PM, the surveyor informed the LNHA and DON about the above concern for the observation of Resident #145's O2 concentrator. The DON stated the nurse changed the concentrator right away for the resident. There was no further verbal response by the facility. A review of the undated facility policy with the subject of O2 THERAPY under Policy read, O2 therapy is administered only as ordered only by a physician or as an emergency measure until an order can be obtained. The policy did not further address O2 concentrator setting or checking O2 settings. 3. On 01/29/24 at 10:54 AM and 01/30/24 at 11:58 AM, the surveyor observed resident #235, out of bed in a wheelchair. The resident's N/C tubing was not properly labeled with a date and the nebulizer equipment was not labeled. The face mask was sitting on the bedside table face down not in a bag or labeled with date and time. The residents' respirations were not labored. The N/C tubing the resident was wearing was attached to an O2 concentrator with the O2 liters set at 3 LPM. The surveyor reviewed the hybrid medical records for resident #235. The AR reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to COPD, acute respiratory failure (ARF) with hypoxia (ARF is a condition in which your blood does not have enough O2 or has too much carbon dioxide). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The qMDS with an ARD 9/22/23, reflected a BIMS score of 15 of 15 which revealed that resident #235's cognitive status was intact. A review of the January 2024 Active OSR showed a PO dated 6/15/23 at 11 PM Oxygen via N/C continuous every shift at 3 L/min. There was another PO dated 6/21/23 at 6 AM change O2 cannula weekly, one time a day every Wednesday. Further review of the January 2024 Active OSR revealed a PO dated 6/16/23 at 6 AM, AR formoterol Tartrate Inhalation Nebulization Solution 15 MCG/2ML (microgram/milliliter), one (1) vial inhale orally via nebulizer every 12 hours related to COPD. The above orders for weekly change of O2 cannula was transcribed and signed by nurses. On 01/24/24, the nurse signed the eTAR as the O2 cannula was changed but the observation of the surveyor did not reflect that the O2 tubing was dated and labeled. The surveyor interviewed LPN#3, the assigned nurse on 01/30/24 at 12:02 PM. LPN#3 stated, my practice is to check the resident and their O2 level prior to giving any treatments. The night shift is assigned to change the tubing weekly. When the tubing is changed it should be dated and labeled. If the equipment is not in use, it should be in a bag that is labeled and dated. Storage is to prevent infection until next use. The surveyor asked if it is the assigned nurse's responsibility to labeled and date the tubing if they found it not appropriate. The LPN stated, yes, it should be done as needed not just the assigned day. On 02/01/24 at 10:00 AM, the surveyor interviewed the DON in the presence of the survey team. The DON stated, The O2 should be administer based on the doctor order. The nursing staff is supposed to check the O2 concentrator for volume flow correctness. They are to follow the schedule for changing the tubing and placing other O2 and nebulizer equipment into a bag that is labeled. It is to prevent contamination or infection. If there is an issue, they are supposed to inform me of it and write a note in the electronic medical record (eMR). A review of the undated policy titled, Oxygen Administration Policy provided by the DON indicated, Purpose: The purpose of this policy and procedure is to provide guidelines for safe oxygen administration. 1. Verify that there is a physician order. 2. Review residents care plan to assess for any special needs of the resident. A review of policy titled, Nebulizer Therapy Policy provided by the DON on indicated, Policy: It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions. Care of equipment: #7 Once completely dry, store nebulizer cup, mouthpiece, mask, in a plastic bag. #8 Change the nebulizer tubing every seventy-two hours or per facility policy. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/06/24 at 01:35 PM, the survey team met with the LNHA, Business Office Personnel, and DON for an exit conference, and there was no additional information provided by the facility management. NJAC 8:39-11.2(b); 25.2(c)3; 27.1(a) 45208

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 39399 Based on observation, interview, and record review, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face to face visits at least once every sixty days and wrote progress notes to address nutritional issues for a resident with weight loss for one (1) of 10 residents, Resident #77 reviewed for nutrition, and was evidenced by the following: On 02/05/24 at 10:15 AM, the surveyor observed Resident #77 lying in bed with eyes closed. The surveyor reviewed Resident #77's hybrid (both paper and electronic) medical records. The Admission Record (an admission summary) reflected that Resident #77 was admitted to the facility with medical diagnoses which included but not limited to dementia; hypertension (elevated blood pressure), type II diabetes mellitus; and anxiety disorder. The quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated 01/15/24 reflected that the resident had a Brief Interview for Mental Status score 03 of 15 indicating that the resident had severely impaired cognition. A review of the interdisciplinary progress notes (PN) dated 01/16/24 documented by the facility's dietician reflected that Resident #77 had a 5.2 % significant weight loss over the past one month. Further review of the PN indicated the resident will be referred to the physician. A review of the interdisciplinary PN revealed that the most recent physician visit to Resident #77 was on 11/19/23. There was no additional documentation that the resident was seen and examined by the primary physician. On 02/06/24 at 10:30 AM, the surveyor interviewed the facility's dietician who was responsible for Resident #77 who stated that for any resident who had weight loss, she would refer them to the primary physician. On 02/05/24 at 01:15 PM, the above concerns were discussed to the facility's Licensed Nursing Home Administrator and Director of Nursing. There were no further information provided. On 02/06/24 at 01:31 PM, the surveyor attempted to contact the physician but was unavailable for interview. NJAC 8:39-27.1 (b)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 39885 Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure a) a non-certified Nurse Aide (NA) did not continue to work as an NA after the specified 120 days for one (1) of three (3) NAs reviewed during the Sufficient and Competent Nurse Staffing task (NA #1) and b) there was a delineated policy and/or program in place for the hiring, staffing, and assignments of non-certified NAs. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health memo dated April 21, 2023 sent to Nursing Homes included the following: On February 27, 2023, the Centers for Medicare and Medicaid Services (CMS) announced that all nurse aide emergency training waivers will terminate at the end of the Federal Public Health Emergency (PHE). The PHE is expected to end on May 11, 2023. At that time, all Temporary Nurse Aides (TNAs) hired prior to the end of the PHE and who have enrolled in a NATCEP (Long Term Care Facilities Training and Competency Evaluation Program) program and completed the first 16 hours of training prior to May 11, 2023, must complete the NATCEP and pass the nurse aide written exam and the clinical skills competency exam by September 10, 2023. Nurse aides hired after the end of the PHE will have four months to complete a NATCEP program and pass the exams, as required by N.J.A.C. 8:39-43.1. The New Jersey Department of Health issues this memorandum to update facilities on the interpretation of the CMS guidance, P.L. 2021, c. 326, c. 368 and Executive Directive (ED) 20-004 (Revised July 6, 2022). Facilities are advised as follows: I. TNAs A. Individuals who are working as TNAs must pass the nurse-aide written or oral exam and the State-approved clinical skills competency exam by May 11, 2023, or the end of the federal PHE, whichever comes first. B. If a TNA does not pass the exams by the end of the federal PHE, the TNA may not work after May 11, 2023, unless the TNA meets the requirements of Paragraph C below. C. In order to work beyond May 11, 2023, TNAs must, by May 11, 2023: 1. Be enrolled in a NATCEP CNA training program, and 2. Have completed the first 16 hours of training, and 3. Be working in a facility before May 11, 2023. 4. Note that the TNA only has until September 10, 2023 to complete the NATCEP program and pass the exams. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Nurse Aides Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C. 8:39-43.1. After completing the first 16 hours of training, the nurse aide may work in a nursing home while completing the training and testing. On 01/29/24 at 10:22 AM, in the presence of a federal surveyor, the survey Team Coordinator met with the Licensed Nursing Home Administrator (LNHA) for an entrance conference and requested a list of the facility's CNAs with their date of hire and license numbers listed. On 01/30/24 at 9:10 AM, the surveyor asked the LNHA and Director of Nursing (DON) for the list of the facility's CNAs with their date of hire and license numbers listed. On 01/30/24 at 01:48 PM, the surveyor asked the LNHA if he had the previously requested facility CNA list. The LNHA stated that he had the list but that the license numbers were not on it and that someone was working on placing the license numbers on the list. On 02/01/24 at 11:02 AM, the LNHA informed the survey Team Coordinator that some of the CNAs that were on the list provided no longer worked at the facility. The LNHA provided the survey team a new list of CNAs with the date of hire and license numbers listed. A review of the list revealed that some of the CNAs listed did not have a license number listed next to their name and that certificate was listed in lieu of a license number. On 02/01/24 at 11:13 AM, in the presence of another surveyor, the surveyor interviewed the Staffing Coordinator (SC) regarding the staffing schedule of non-certified NAs. The SC stated that she did not identify whether the staff was a CNA or a NA on the schedule and that the nurses on the floor knew who was not certified. On 02/01/24 at 11:26 AM, the surveyor interviewed the Human Resources Clerk (HRC) regarding the process of hiring CNAs. The HRC stated that she was new and that the Human Resources Manager (HRM) was not in. The HRC stated that the process was to perform a background check and a license verification. The surveyor asked what if the person did not have a license The HRC stated that they cannot work until they get a license. The surveyor asked if the facility had any NAs working. The HRC stated that it was her understanding that they did not have any NAs. She added that the Director of Activities (DoA) who worked previously in the Human Resources (HR) department would know. The surveyor requested NA #1's employee file. On 02/01/24 at 11:34 AM, the surveyor interviewed the DoA regarding NAs. The DoA stated that she worked in HR from October 2021 until October 2023. The DoA stated that the facility had NAs and that as long as the NA was in school, passed the skills test and was observed by a Registered Nurse that the NA could continue to be on the schedule. She added that the NA was just waiting to take the written exam. At that time, the DoA stated that she would get proof of their school and that they passed the skills test. The surveyor asked if there was a certain time frame that they had to take the test and continue to work for. The DoA stated that we tell them to take the written test as soon as possible. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the facility provided employee file which revealed the following: NA #1, hired 9/15/23, had a photo copy of a document from the NJ DOH which included the following: Exam Date: 5/01/23 Exam Name: NJ CNA Written Exam Result: Pass You MUST complete a CBI (New Jersey requires all new nurse aide candidates, new personal care assistant candidates, and nurse aides applying for recertification or reciprocity, and homemaker/home health aides to undergo a Criminal Background Investigation (CBI) application and schedule a fingerprint appointment before being considered for permanent certification in New Jersey. Please note that a passing examination score is not a license. There was no verification printout that NA #1 was licensed. There was no documentation that NA #1 was enrolled in school during their employment. The NA #1 was working at the facility for more than 120 days. It was eight months since NA #1 passed the written exam. On 02/01/24 at 12:35 PM, in the presence of another surveyor and the DON, the surveyor interviewed the LNHA regarding NAs. The LNHA stated that he thought the NAs were CNAs and that they passed the skills test, had a certificate and were just waiting to take the written test. He added that he reviewed it with the Department of Health and that the NA could work for a year as long as there was a Registered Nurse in the facility. On that same date and time, the surveyor asked who verified the NA had the required schooling and passed the skills test before the NA was hired on worked on the unit. The DON stated that she did not verify the information. The LNHA stated that HR verified the information. The surveyor asked about NA #1 who had CNA listed on their employee file but did not appear on the NJDOH online Public Registry license verification website as having a license. The DON stated that NA #1 had a date of hire of 9/15/23 and that during her interview she told me she was a CNA. She then stated that if they do not have a license then they are not a CNA. The LNHA stated that HR checked everyone that was hired. On 02/01/24 at 12:46 PM, in the presence of another surveyor and the LNHA, the surveyor interviewed NA #1 via telephone on speaker setting. NA #1 stated that she was waiting for her license to be mailed to her. NA #1 stated that she completed CNA school November 2022. She further stated that she had been working as a TNA at two other Nursing Home (NH) facilities. She stated that she worked at NH #1 from 2021 September 2022 and NH #2 from September 2022 to April 2023. NA #1 stated that she sent in the required application to get her license in September 2023. On 02/01/24 at 01:02 PM, in the presence of another surveyor and LNHA, the surveyor interviewed the Human Resources Manager (HRM) via telephone on speaker setting. The HRM stated that the NAs are required to submit certificate from school that they completed their clinicals and passed the skills test and that they are waiting to take the written state test. She added that the facility had some TNAs in the past that that they had to enroll in school to continue to use them. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, the surveyor asked how long after they finished school and waiting to take test could the NA work. The HRM stated that she believed it was a year. She added that if they fail the test then they could not use them anymore. The surveyor asked if they were following a facility policy or a regulation. The HRM stated that they followed the state regulation regarding the Temporary Nurse Aide. She added that if they were not in school then they could not use them. On 02/05/24 at 11:01 AM, in the presence of the LNHA, the DoA stated that she thought they could accept anyone that was in enrolled in school and that they had one year to pass the written test. On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor notified the LNHA and DON the concern that there was a NA that was working past the 120 days since their date of hire. On 02/06/24 at 9:26 AM, the LNHA stated that the facility did not have a policy regarding NAs. On 02/06/24 at 12:06 PM, the LNHA stated that they started a QAPI (Quality Assurance and Performance Improvement). The facility did not provide any additional information. N.J.A.C. 8:39-43.1

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 39885 Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure that the facility Certified Nursing Aides (CNA) received annual performance reviews for five (5) of five (5) CNA files reviewed. This deficient practice was evidenced by the following: On 1/29/24 at 10:22 AM, in the presence of a federal surveyor, the survey Team Coordinator met with the Licensed Nursing Home Administrator (LNHA) for an entrance conference and requested a list of the facility's CNAs with their date of hire and license numbers listed. On 2/1/24 at 11:02 AM, the LNHA provided the survey Team Coordinator an updated list of CNAs. The surveyor randomly chose five CNAs from the updated facility list and requested the education provided, annual performance reviews and competencies done for the five CNAs. On 2/5/24 at 11:16 AM, the surveyor still had not received the annual performance reviews for the selected 5 CNAs and once again requested them from the LNHA. The facility did not provide the requested performance reviews. There was no documented evidence that a performance review was conducted for the five CNAs randomly reviewed. On 2/5/24 at 1:53 PM, in the presence of the survey team and two federal surveyors, the surveyor discussed the concern related to the five CNAs who did not receive annual performance reviews, with the LNHA and Director of Nursing. The facility did not provide any additional information. The facility did not provide a policy referring to the CNA annual performance review. N.J.A.C. 8:39-43.17 (b)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 39885 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the 24-hour staffing report was posted in a prominent place within the facility and readily accessible to the residents and the visitors. This deficient practice was evidenced by the following: On 1/29/24 at 9:18 AM, the survey team entered the facility and observed that there was no Nursing Home Resident Care Staffing Report (NHRCSR) posted at the entrance area or elevator area. On 1/30/24 at 9:25 AM, after the surveyor did not observe a NHRCSR posted, the surveyor interviewed the Security staff in the front lobby regarding the posting of the NHRCSR. The Security staff stated that the Administration staff usually place the posting on the bulletin board that was behind the wall near the elevators. The Security staff confirmed that there was no NHRCSR posted on the bulletin board. On 1/30/24 at 9:31 AM, the surveyor interviewed the Staffing Coordinator (SC) regarding the posting of the NHRCSR. The SC stated that she usually posted the NHRCSR in the lobby. She added that she did not post it today because she was running late. The surveyor told the SC that the NHRCSR was not posted the previous day. The SC confirmed that she had not posted the NHRCSR on 1/29/24 and 1/30/24. On 2/5/24 at 1:53 PM, in the presence of the survey team and two federal surveyors, the surveyor discussed with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) their concern that the 24-hour staffing report was not posted for two days in a prominent place within the facility readily accessible to the residents and the visitors. On 2/6/24 at 12:07 PM, in the presence of the survey team, two federal surveyors and the DON, the LNHA stated that the person who usually posted the report had a medical emergency and came in late each day, 1/29/24 and 1/30/24. The LNHA added that the facility recognizes that where the NHRCSR was usually posted was not a readily visible location. The facility did not have a policy on posting staffing. The facility did not provide any additional information. N.J.A.C. 8:39-41.2 (a)(b)(c)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure, a) labeling of medication with an expiration date, b) expired medication was removed from active inventory, c) beyond use date was in accordance with standard of practice, and d) discontinued medications were removed from active inventory. The deficient practice was identified for two (2) of six (6) medication carts, and (one) 1 of three (3) medication rooms and was evidenced by the following: Reference: USP Compounding Standards and Beyond-Use-Dates (BUDs; the date or time after which a compounded sterile preparation may not be stored or transported and is calculated from the date and time of compounding). According to the revised <795> -Non-preserved aqueous had a BUD of 14 days. 1) On [DATE] at 9:58 AM, in the presence of the Registered Nurse #1 (RN#1), the surveyor began the inspection of Cart A on the west wing of the fifth floor. The surveyor observed an open, and undated multiple-dose vial (MDV) of Lantus for Unsampled Resident #104. The MDV vial reflected a received date of [DATE], without a date of when the bottle was opened and/or removed from the refrigerator. At 10:22 AM, during an interview with the surveyor, RN#1 stated that the MDV vial should have been dated once removed from the refrigerator for use. RN#1 informed the surveyor that she had not administered the medication (med) to the resident since the order was for bedtime. A review of the manufacturer's specification for Lantus indicated that a multiple-dose vial, opened, and in-use bottle that is refrigerated or at room temperature were in date for 28 days. 2.) On [DATE] at 11:53 AM, in the presence of the Licensed Practical Nurse (LPN), the surveyor began the inspection of the med room on the East side of the third floor. The surveyor observed an amber bottle of Omeprazole (used to treat certain conditions where there is too much acid in the stomach) 2 milligram (mg)/1 milliliter(ml) solution, with a use by date of [DATE] for Resident #47. At that time, the LPN reviewed the bottle of Omeprazole and stated that the label on the bottle indicated the Omeprazole expired on [DATE]. The LPN also stated that Resident #47 was assigned to med cart A, and the resident was a G-tube resident (gastrostomy; a tube inserted through the belly that allows air, fluid to leave the stomach and can be used to administer food, liquid, and meds). The LPN informed the surveyor that she was assigned to cart B on that day. The surveyor reviewed the hybrid medical record for Resident #47. A review of the Admission Record (AR, an admission summary) for Resident #47 revealed the resident was admitted with diagnoses that included heart failure, blindness in the left eye, normal vision on the right eye, unspecified dementia without behavioral disturbance, psychotic disturbance, and type 2 diabetes mellitus (an impairment in the way the body regulates glucose (sugar)). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the annual Minimum Data Set (aMDS), an assessment tool used to facilitate the management of care, dated [DATE] under section C0500 for Brief Interview for Mental Status (BIMS) revealed a score of 6 out of 15 which indicated the resident had a severely impaired cognition. A review of the active Order Summary Report (OSR) as of [DATE] reflected an order for Omeprazole 2 mg/1 ml solution, give 20 ml via G-tube one time a day for GERD (gastroesophageal reflux disease) with an order date of [DATE]. A review of the electronic Medication Administration Record (eMAR) from [DATE] to [DATE] reflected the nurses signed the administration of Omeprazole every day from the use by date of [DATE] to [DATE]. On [DATE] at 12:12 PM, during an interview with the surveyor, RN #2 stated she had administered the med to Resident #47 on that day. At that time, RN#2 stated she should have looked at the expiration date on the bottle prior to administration. At that time, RN #2 stated that all nurses on all shifts were responsible for ensuring that expired meds were not with the active inventory. On [DATE] at 2:52 PM, the surveyor observed the Director of Nursing (DON) assessed the resident. A review of RN #2's med pass competency performed by the facility's employed Registered Nurse, dated [DATE], revealed RN#2 was coached to check the external feeding tubes (nasogastric (NG) or G-tubes) with one error out of 20 medications passed. 3.) On [DATE] at 9:26 AM, the surveyor received an email correspondence between the pharmacy provider and the Licensed Nursing Home Administrator (LNHA). The letter reflected that the expiration date for the Omeprazole would be 30 days thereafter and that the pharmacy had randomly pick an earlier date for the use by just to give the facility some extra runway, not to come to close to the expiration. On [DATE] at 10:31 AM, during an interview with the surveyor, the pharmacist from the provider pharmacy stated that Omeprazole suspension had a shelf life of 14 days. The pharmacist had informed the surveyor that the compounded Omeprazole (Prilosec) for G-tube consisted of Prilosec capsules with sodium bicarbonate powder and diluted in sterile water. A review of the Omeprazole bottle revealed the med had a label from the pharmacy with a beyond use date (BUD) of 21 days. 4.) On [DATE] at 11:53 AM, during the med storage and labeling observation of the med room located on the east wing of the third floor, the surveyor observed the following: - A Pneumococcal syringe labeled for Resident #100, dated [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Nursing & Rehabilitation Ctr	300 Broadway Newark, NJ 07104

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A Pneumococcal syringe labeled for Resident #127, dated [DATE]. The surveyor reviewed the hybrid medical record for Resident #100. A review of the AR for Resident #100 revealed the resident was admitted with diagnoses that included type 2 diabetes mellitus, end stage renal disease ((condition in which a person's kidneys permanently stop functioning), and cerebral infarction (a result of decreased blood flow to the brain) without residual deficits. A review of the OSR from [DATE] to [DATE] revealed the Pneumococcal Vaccine (Pneumovax 23) had an order date of [DATE] and an end date of [discontinued on] [DATE]. A review of the eMAR from [DATE] to [DATE] reflected that on [DATE] the nurse documented a number nine (9) which indicated, refer to the nurses' progress notes (PN). A review of the nurses' PN for [DATE] did not reveal a documentation that the resident refused the administration of the Pneumococcal vaccine or that the vaccine was administered. The surveyor reviewed hybrid medical record for Resident #127. A review of the AR for Resident #127 revealed the resident was admitted with diagnoses that included cerebral infarction, and hypertension (high blood pressure). A review of the OSR from [DATE] to [DATE] revealed the Pneumococcal vaccine (Pneumovax 23) had an order date of [DATE] and an end date of [discontinued on] [DATE]. A review of the eMAR from [DATE] to [DATE] reflected that on [DATE] the nurse documented a number nine (9) which indicated, refer to the nurses' PN. A review of the nurses' PN for [DATE] did not reveal a documentation that the resident refused the administration of the Pneumococcal vaccine or that the vaccine was administered. On [DATE] at 01:06 PM, in the presence of RN #2, the surveyor began the inspection of cart A on the west side of the third floor. The surveyor observed a box of Ipratropium/Albuterol 0.5 -3 mg/3 ml nebules for inhalation. The box was labeled for Unsampled Resident #172 with a date of [DATE]. At 01:16 PM, the surveyor and RN #2 reviewed the electronic Medical Record which indicated the Ipratropium/Albuterol for Resident #172 was discontinued (d/c) and was not included in the active electronic Administration Record for [DATE]. At that time, RN #2 stated that all nurses on all shifts were responsible for ensuring that d/c meds were not with the active inventory. On [DATE] at 02:24 PM, the surveyor discussed the concerns with the DON. On [DATE] at 01:21 PM, in the presence of the survey team, the federal surveyors, the DON and the LNHA, the surveyor discussed the concerns regarding the facility's failure to label with a date an opened biological, remove from active inventory expired and d/c meds. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the provided facility policy [DATE] included the following: Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 3. The drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 4. The facility shall not use d/c, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 9. Meds requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location .Med must be stored separately from food and must be labeled accordingly. A review of the provided facility policy, Administering Meds, dated/revised on ,d+[DATE], included under, Policy Interpretation and Implementation section 8. The expiration date on the med label must be checked prior to administering. When opening a multi-dose container, the date shall be recorded on the container. A review of the provided facility policy provided, Med Administration via Enteral Tube, included under Policy; It is the policy of this facility to ensure the safe and effective administration of meds via enteral feeding tubes by utilizing best practice guidelines. NJAC 8:,d+[DATE].2(b), 27.1(a), 29.4(a)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Complaint #: NJ 167957 REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of hot foods served to the residents. This deficient practice was identified for one (1) of one (1) resident complaint, Resident #107, and confirmed during the lunchtime meal service on 01/31/24 for one (1) of three (3) nursing units tested for food temperatures and was evidenced by the following: A review of a complaint in-take form indicated the food is not received on time. 1. On 01/29/24 at 10:41 AM, during the initial tour, the surveyor observed Resident #107 sitting on his/her bed. The resident was pleasant and stated, the food is bad here. At 12:05 PM, the surveyor interviewed Certified Nursing Assistant #1 (CNA #1) who stated there were four of them assigned to the west side of the fourth floor, at that time. The surveyor visually saw four CNA's adjacent to the dining area. At 12:12 PM, the surveyor entered the main dining area on the west side of the fourth floor, and observed eight residents seated in the main dining area. Their lunch had not arrived. At 12:34 PM, the surveyor observed CNA #1 pass sanitary wipes to the residents to wipe their hands. At that time, the surveyor observed the first meal truck arrive. The meal truck was an open system, covered by a clear plastic. Each plate had a plate cover on the tray. Two of the CNAs (CNA #2 and CNA#3) began passing the trays to the resident rooms which started at room [ROOM NUMBER]. The CNAs passed the tray in sequence by room number. At 12:38 PM, the second meal truck arrived, and CNA #4, and CNA #1 began passing the trays to the other rooms of the west side. At that time, the first meal truck included the meal trays for the main dining area. CNA #1, CNA #2, and CNA #3 began passing the meal trays to the residents seated in the main dining area. The residents who received their lunch began to eat. At 12:46 PM, CNA #1, CNA #2 and CNA #3 continued to pass the lunch trays into the other rooms conjoined with the main dining area. 44605 2. On 01/31/24 at 11:30 AM, the surveyor calibrated a state issued digital thermometer via the ice bath method to 32 degrees Fahrenheit (F) in the presence of the survey team. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:06 PM, the surveyor, Food Service Director (FSD) and two Federal Surveyors (FS) observed the first food truck arrived at the 4th floor East unit. A regular diet consistency tray was identified by the surveyor and Licensed Practical Nurse (LPN). This tray was removed from the food truck and placed at the nurse's station in the presence of the surveyor, FSD and two FS. The FSD replaced the resident's tray from the kitchen. At 12:08 PM, the nursing staff began delivering the resident's food trays. At 12:33 PM, the last tray was delivered to the residents' and the surveyor tested the food temperatures with the reserved tray in the presence of the FSD and two FS. The temperatures were as follows: Beef Stew: 121.9 degrees Fahrenheit (F) Boiled Potatoes: 125.5 degrees F Peas and Carrots: 119.2 degrees F Apple Juice: 55.2 degrees F Hot Dog: 121.8 degree F Milk: 55 degrees F At 12:37 PM, the surveyor interviewed the FSD in the presence of two FS. The FSD stated that their kitchen equipment to maintain meal temperatures were working adequately and all the items on the lunch tray were within normal temperatures limits prior to leaving the kitchen, but the passing out of the lunch trays took entirely too long which caused the food items to lose their temperature. On 02/05/24 at 01:23 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director or Nursing (DON). The LNHA acknowledged the food temperatures were below the recommended 135 degrees F for hot foods and below 40 degrees F for cold food and beverages. The LHNA further stated, the facility is exploring options to pass out the meal trays in a timelier fashion. On 02/06/24 the LNHA provided the surveyor with multiple facility policies which included, Food: Quality and Palatability and Meal Distribution. Neither facility policy had a created or revised dated available. Under the policy statement for the Food: Quality and Palatability policy it states, Food will be palatable, attractive and served at a safe and appetizing temperature. Under the policy statement for the Meal Distribution facility policy it states, Meals are transported to the dining location in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner. Under the procedure section of the same policy it states, 2. All food items will be transported promptly for appropriate temperature maintenance .4. The nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to residents/patients. No further comments made by the LHNA and/or DON prior to exiting the facility. NJAC 8:39-17.2(a) 2, (e)

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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. 44605 REPEAT DEFICIENCY Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices as well as store and discard potentially hazardous foods in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 01/29/234 at 9:24 AM, the surveyor in the presence of the Food Service Director (FSD) and a Federal Surveyor (FS) observed the following during the kitchen tour: 1. On a tray cart, the surveyor observed multiple 6 ounce (oz) disposable individual cups that the FSD stated the contained rice crispy cereal. No labels with made or use by dates noted. FSD stated the cereal cups were put together yesterday but could not state why they were not labeled. 2. The juice machine was observed with a clear tubing from orange juice with brown colored spots on the tubing. FSD unable to state what the brown spots were but would call the service company to change the tubing. 3. Dietary aide (DA #1) was observed preparing salads with lettuce, cucumbers, and carrots. The Surveyor further observed DA #1 unwrapping the lettuce from plastic wrapper and not washing lettuce prior to chopping lettuce for salad. Both DA #1 and FSD both stated the lettuce does not need to be washed prior to prepping. Surveyor further observed manufactures plastic wrap for the lettuce that stated, wash before eating. The FSD instructed DA #1 to wash all lettuce that was being used for today's salads. FSD stated the lettuce they normally are delivered in ready to use straight from the bag, but the lettuce they were delivered was different from their normal delivery. 4. Surveyor observed nine (9) individually wrapped loafs of white bread, all not labeled. The FSD stated all bread came from single box that was labeled with a delivery date, but unable to produce that box or state if individual breads should be labeled. 5. In dry pots and pans area, the surveyor observed 2, 1/4 tray pans with wet nesting, FSD stated all pots and pans in that area should be dry. 6. Surveyor observed the FSD perform hand hygiene. The FSD failed to scrub hands with soap for 20 seconds before rinsing as well as turning off the faucet with contaminated paper towels that the FSD used to dry their hands. FSD stated she used contaminated paper towel because the towel dispenser did not have any clean towels. Surveyor observed paper towels next to dispenser. FSD acknowledged hand washing was completed incorrectly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Surveyor observed multiple packages of opened hamburger buns, not labeled with open or use by date. The FSD stated they do not label individualized packages of bread or buns, all bread products are labeled on the box they are delivered in, but unable to produce the box the hamburger buns were delivered in. 8. In the chef preparation area. The surveyor observed crumb-like debris in-between the upper and lower ovens of the dual standing oven. The FSD stated the ovens should be clean and wiped down after each use and when visibly soiled. 9. Surveyor observed a dual oven with six (6) range stove top and griddle. The FSD stated both ovens were not currently working. Inside the right side oven, surveyor observed two boxes of Adobo seasoning. FSD stated, sorry that should be in there, they staff likes to take that home. In the left oven, surveyor observed two pots with a handle, the first contained partially melted butter with brown colored spots on non-melted area and second pot had used cooking grease/oil. Both pots were covered with plastic wrap and was dated 01/28/24. FSD stated, nothing should be stored inside those ovens, the butter and oil must have been left over from yesterday and not properly disposed of. The FSD had the Chef dispose of the butter and oil. 10. On top of the flat top griddle was a removable cast iron flat top griddle that was observed with black debris. The FSD stated, the cast iron griddle should be cleaned after each use. 11. In the walk-in refrigerator #1, the surveyor observed multiple items stored 18 inches from top of ceiling as well as a black dust-like debris on light bulb and connected wiring. The FSD stated they had a food delivery was today and that was the reason for items being stored 18 inches from ceiling but could not explain the dust-like debris. 12. In walk-in refrigerator #2, the surveyor observed multiple items stored 18 inches from ceiling. The FSD could not state why the food items were stored that high. 13. In the walk-in freezers. Surveyor observed multiple items stored 18 inches from ceiling. The FSD could not state why the food items were stored that high. 14. In the dry storage area, all opened seasonings were observed with open dates, but no use by/discard dates noted. The FSD stated once the seasoning are opened, they are good for one year. 15. In the dry storage area, the air conditioning unit (AC) was observed with a thick layer of black colored debris on the vent. The FSD stated, they would call maintenance to clean the AC unit immediately. The FSD unable to state when the AC unit vent was last cleaned because the AC unit is cleaned by the maintenance department. 16. In the dry storage area, the surveyor observed multiple broken, partial moved, and missing ceiling tiles. The FSD stated the facility had been doing some repairs in the dry storage area but could not state why the ceiling tiles had not been replaced or put back. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/31/24 at 9:40 AM, the FSD provided the surveyor with multiple facility policies. The policies were titled; dating and Labeling Policy with a revised date 1/24/2017, Pot Washing Policy with created date 1/1/2017, Handwashing/Hand Hygiene with a revised date December 2009, and Food Storage, no date available. The policy for dating and labeling states under the procedure section, 2. Label products in storage with date the package was opened .7. Keep all storage areas clean and dry. The pot washing policy states under the procedures section, 10. Air dry all clean and sanitized pots and wares. The hand washing and hand hygiene policy states under the procedures section, 3. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least fifteen (15) seconds under moderate stream of running water, at a comfortable temperature .4. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. The food storage policy states under the storage section of the policy, Dry and staple foods must be stores on shelving at least 6 (inches) from the floor and 18 from the sprinkler heads in clean well-ventilated rooms .All fruits and vegetables upon receive shall be stored properly and must be wash before using for food preparation. On 02/05/24 at 01:23 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of nursing (DON). The LNHA stated all the kitchen issues will be addressed and corrected by the FSD immediately. No further comments made. NJAC 8:39-17.2(g)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 44605 Based on observation, interviews, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage compactor and dumpster free of garbage and debris. On 1/29/24 at 9:56 AM, the surveyor, in the presence of the Food Service Director (FSD) and a Federal Surveyor toured the kitchen and the designated garbage area observing the following: There was garbage debris that included food, cups, bottles, gloves, paper products, and brown paper bags, surrounding the garbage compactor and dumpster. The FSD stated that the area should have been cleaned by the maintenance and dietary departments. On 2/5/24 at 1:23 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) of the debris findings. The LNHA clarified that the garbage disposal area is shared with another facility on the same property but admitted that the facility maintenance department is responsible for keeping the area clean and free of debris. On 2/6/24 at 12:54 PM, the LNHA provided the surveyor with a copy of the facility policy titled, Food-Related Garbage and Rubbish Disposal, with a revised date of December 2008. Under the policy interpretation and implementation section of the policy it states, 7. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. No further information was provided by the LNHA or DON prior to exiting the facility. NJAC 8:39-19.7

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46049 Complaint NJ#162723, 162811 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for two (2) of 38 residents reviewed (Residents #470 and #269). This deficient practice was evidenced by the following: 1. On 02/05/24 at 11:20 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) about where Certified Nurse Assistants (CNAs) documented resident care. The LPN showed the surveyor an ADL [Activities of Daily Living] binder at the nurses station. The ADL binder consisted of monthly forms which the CNAs would document CNA and ADL care for residents. The LPN stated the CNAs used to document electronically but now it was paper based. The LPN could not recall exactly when the change occurred and stated sometime last year. On 02/05/24 at 12:25 PM, the surveyor reviewed the closed hybrid (paper and electronic) medical records of Resident #470. The Admission Record (AR, admission summary) reflected that Resident #470 had diagnoses that included but were not limited to: chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe), epilepsy (convulsion), type 2 diabetes mellitus, acute kidney failure, unspecified protein-calorie malnutrition, and muscle weakness. A quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) 3/27/23, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test, Resident #470 scored 6 out of 15, which indicated the resident had severe cognitive impairment. Under Section G Functional Status, the resident was documented as needing extensive assistance with personal hygiene and toilet use. Under Section H Bowel and Bladder, the resident was documented as having occasional incontinent episodes. Further review of the hybrid medical records revealed no documentation related to CNA documentation of ADL care which included incontinence and hygiene care. On 02/05/24 at 12:45 PM, the surveyor requested from the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA), CNA documentation for ADL care of Resident #470 for 2023. On 02/06/24 at 08:55 AM, the surveyor asked the LNHA regarding the documentation requested for Resident #470. The LNHA stated the DON would have further information. On 02/06/24 at 10:45 AM, the DON informed the surveyor that she was still looking to provide requested documentation for Resident #470. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/24 at 12:40 PM, the DON did not provide any CNA or ADL care documentation for Resident #470. The DON was made aware of the concern that the documentation was not available. The DON could not provide a response as to why the documentation for Resident #470 was not available in the electronic and paper medical record of the resident. 38327 2. On 01/30/24 at 8:25 AM, the surveyor asked the DON for closed records that included Resident #269, and the DON stated that she would get back to the surveyor. The surveyor reviewed the hybrid medical records of Resident #269 as follows: Resident's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; unspecified convulsions (epilepsy), fluid overload unspecified, anemia in chronic kidney disease (kidneys cannot make enough erythropoietin which causes their red blood cells to drop and anemia), and dependence on renal dialysis (type of treatment that helps body remove extra fluid and waste products from blood when the kidneys are not able to). A review of the most recent discharge MDS (dMDS) Section A2105 Discharge status revealed that the resident had an unplanned discharge (d/c) from the facility to the community. A review of the Progress Notes (PN), a late entry alert note that was electronically documented and signed by the DON on 12/19/23 at 7:53 PM (created date) for an effective date on 10/31/23 at 01:44 AM included that the resident was d/c AMA (against medical advice). On 01/31/24 at 02:15 PM, the surveyor reviewed the hybrid medical records again of the resident and revealed that there was no Discharge Summary from the physician when the resident was d/c AMA. On 01/31/24 at 02:40 PM, the surveyor interviewed the DON regarding the Discharge Summary, and she stated that the physician was responsible for the physician discharge summary. The DON further stated that she was not sure what was the regulation on when they should do the discharge summary. She further stated that the discharge summary should be in the hard medical chart and not in the computer. On that same date and time, the surveyor then asked the DON to check the resident's medical records if there was a discharge summary of the physician. The DON in the presence of the survey team checked and confirmed that there was no physician discharge summary. The DON did not provide additional information as to why there was no discharge summary from the physician. On 01/31/24 at 3:02 PM, the surveyor asked the LNHA for the facility's policy regarding physician discharge summary and he stated that he would get back to the surveyor. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/01/24 at 9:08 AM, the LNHA provided a copy of a policy that he stated was their facility's policy regarding transfer and discharge. The Policy had no date. The policy included that to ensure that residents being transferred or discharged are subject to a standardized process that ensures regulatory compliance and ethics as well as maintenance of the resident's quality of care. When the facility transfers or discharges a resident under any of the circumstances specified in Section I. (A-F), the facility shall ensure that the transfer or discharge is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider. B. The documentation must be made by: a. the resident's physician when transfer or discharge is necessary under section I. A or section I. B of this policy; and b. a physician when transfer or discharge is necessary under Section I.C or section I.D of this policy F. All other necessary information, including a copy of the resident's discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care X Residents that sign out of the Facility or leave Against Medical Advice (AMA); A. The facility shall not force, pressure, or intimidate a resident or resident representative into leaving AMA, which would be considered to be a facility-initiated discharge. On 02/05/24 at 01:21 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above concerns. On 02/06/24 at 11:30 AM, the survey team met with the DON and LNHA. The LNHA stated that the physician had sent the note that included the discharge summary of the resident that was kept on file. The LNHA provided a copy of the PN and Certification paper dated 11/01/23 for a Discharge Summary. The PN and Certification paper had a piece of fax information from the physician and included a date of 02/04/24 10:47p (10:47 PM). The surveyor asked why it was not on the file that the surveyor had reviewed and why the information was faxed on 02/05/24 after the surveyor's inquiry. Both the LNHA and the DON had no response. On 02/06/24 at 01:35 PM, the survey team met with the LNHA, Business Office Personnel, and DON for an exit conference, and there was no additional information provided by the facility management. NJAC 8:39-35.2 (d)(12)(15)(16), (e)

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	315458	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Nursing & Rehabilitation Ctr	300 Broadway Newark, NJ 07104

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 38327 Based on interviews, and review of pertinent facility provided documents, it was determined that the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee developed and implemented appropriate plans of action to correct identified quality deficiencies. This failure had the potential to affect all 273 residents who currently live in the facility. Refer to F607E, F728E, F730E, F804D, F883E, and S0560 The deficient practice was evidenced by the following: On 01/29/24 at 10:22 AM, during the entrance conference held with the facility's Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor in the presence of another surveyor requested information regarding the QAA (Quality assessment and assurance) committee, last three quarters sign in sheets for QAPI meetings, and QAPI plan. On 02/05/24 at 01:09 PM, the surveyor reviewed the facility provided QAA (a committee composition and frequency of meetings in nursing facilities requires facilities to develop and implement appropriate plans of action to correct identified quality deficiencies) Committee Information did not include the Infection Preventionist as members. Further review of the provided documents, the facility's QAPI Policy was last reviewed in December 2021. The listed QAPI procedure included that the QAPI will be reviewed annually and upon any significant change at the facility. In addition, the QAPI Program did not have a review date. The QAPI Plan included departments: Social Services (SS), Housekeeping/Maintenance (H/M), Nursing: All 2019 POCs (plan of corrections), Infection Control (IC), MDS (Minimum Data Set), Admissions, Food Services (FS), Dietician, Rehab and Recreation. The goal descriptions for departments: SS, H/M, IC, and FS were on December 31, 2019. The goal descriptions for departments: Nursing, MDS, and Admissions were in 2019. The goal description for the Dietician was to be completed by the 10th of each month in 2019 and Recreation was each month in 2019. There was no documented evidence in the minutes and the documents that were provided to the surveyor to confirm plans of action, developed and implemented appropriate plans of action to correct identified quality deficiencies for the last four years. A review of the above information showed that the last QAPI Plan was for 2019. On 02/06/24 at 10:07 AM, the surveyors met with the LNHA and discussed the QAPI and QAA. The surveyor asked the LNHA how often the facility reviews the QAPI plan, QAA, and Program. The LNHA stated that I review every quarterly before the upcoming QAPI. The surveyor showed the LNHA the provided QAPI Plan, QAA Committee Information, QAPI Program, and QAPI Plan. The surveyor then notified the LNHA of the above findings and concerns. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At that same date and time, the LNHA had no answer when asked by the surveyor why the QAPI plan was for 2019. Later on, the LNHA showed a piece of paper with no title and not dated. The LNHA stated that the untitled and undated paper was the facility's QAPI plan. The surveyor reviewed the paper in the presence of another surveyor, then asked the LNHA if that was the QAPI plan and why there was no goals determined in each department: Human Resources, MDS, Rehab, Activities, SS, Dietitian, FS, and Maintenance. Also, the surveyor asked why Nursing and Infection Control were not included, and the LNHA did not respond. The heading statement that was documented in the provided piece of paper of the LNHA included: QAPI all documents uploaded in [electronic medical record]. Appointments. I will help them set up an audit. The document was not reflective of a comprehensive QAPI plan as stipulated in the facility's previously submitted QAPI plan for 2019. On that same date and time, the surveyor asked the LNHA based on the back and forth communications between the facility management and the survey team, what were the areas of concerns that the survey team had identified that the facility were not able to identify in their QAPI. The LNHA stated that the surveyor's identified concerns about employee files, non certified Nursing Aides, staffing, vaccinations of staff and residents, and other areas of concerns with food temperature. On 02/06/24 at 11:30 AM, the survey team met with the DON and LNHA, and the surveyor notified the facility management of the above concerns. The LNHA further stated that there was no additional information that the facility could provide and the survey team could proceed with the decision-making. A review of the facility's QAPI Policy dated 12/2021 included that it is the policy of the facility to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life, and residents' choice. The QAPI Plan will be reviewed annually and upon any significant change at the facility. On 02/06/24 at 01:35 PM, the survey team met with the LNHA, the DON, and the Business Office Personnel for an exit conference, and there was no additional information provided by the facility management. N.J.A.C. 8:39-33.1(a)(b); 33.2(b)(d); 34.1(a)(b)(d)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 38327 Based on the interview and review of pertinent facility documentation, the facility failed to have the Infection Preventionist present for three (3) of three (3) quarterly Quality Assurance Performance Improvement (QAPI) meetings. This failure had the potential to affect all 273 residents who currently live in the facility. The deficient practice was evidenced by the following: On 02/05/24 at 8:45 AM, the surveyor in the presence of the Social Services Director interviewed the Licensed Nursing Home Administrator (LNHA) regarding the submitted QAPI Attendance for the last three quarters: 5/11/23, 9/07/23, and 11/30/23. The surveyor asked the LNHA to confirm who attended the last three quarters of QAPI because the 5/11/23 QAPI Attendance did not include the title and department for some attendees. During an interview, the LNHA confirmed that on 5/11/23, 9/07/23, and 11/30/23 there was no Infection Preventionist (IP) who attended the quarterly QAPI meetings. The LNHA acknowledged that IP was part of the key members of the QAPI team that should be present in the QAPI meetings. A review of the facility's provided QAA (Quality Assessment and Assurance, a committee composition, and frequency of meetings in nursing facilities requires facilities to develop and implement appropriate plans of action to correct identified quality deficiencies) Committee Information that was provided by the Nursing Clerk showed that the QAPI Meetings are held quarterly in the 2nd-floor conference room. Also, according to the QAA Committee Information, the members included the Medical Director (MD), Administrator (or LNHA), Director of Nursing (DON), Admissions Director, FSD (Food Service Director), Director of Building Services, Director of Recreation, Director of Social Services, Director of Rehabilitation, MDS Supervisor, Dietician, Pharmacy Consultant, and [company name] Pharmacy. Further review of the QAA Committee Information above revealed that the IP was not included in the list of members. On 02/05/24 at 01:21 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above concerns. 02/06/24 at 10:07 AM, the two surveyors met with the LNHA and discussed the QAPI and QAA. The LNHA again confirmed that no IP attended the last three quarters of QAPI meetings. The LNHA also confirmed that the QAA Committee Information that was submitted above did not include the IP as part of the committee list and the LNHA had no answer why the IP was not listed. On that same date and time, the surveyor asked the LNHA what were the areas that the survey team had identified as concerns during the survey period and the facility did not identify. The LNHA stated a few concerns that the survey team identified as concerns were testing for COVID-19 and vaccinations for both residents and staff. The LNHA confirmed that they were all important parts of infection control which is the Infection Preventionist's responsibility. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's QAPI Policy dated 12/2021 included that it is the policy of the facility to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life, and residents' choice. The Quality Assessment and Assurance Committee consists at a minimum of: The Administrator, DON, Medical Director, or his/her designee; at least three other members of the facility's staff. On 02/06/24 at 01:35 PM, the survey team met with the LNHA, the DON, and the Business Office Personnel for an exit conference, and there was no additional information provided by the facility management. NJAC 8:39-33.1 (b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain infection control standards and procedures to address the risk of infection transmission by failing to: a) conduct COVID-19 testing and to conduct appropriate surveillance for COVID-19 (a deadly, highly transmissible infectious disease) during an outbreak, for three (3) of three (3) residents (Residents #62, #121 and #155) and three (3) of (3) staff members reviewed for unit-based testing, b) follow appropriate storage of PPE (personal protective equipment) for one (1) of one (1) nurse (Licensed Practical Nurse #1 [LPN#1]), and c) follow appropriate hand hygiene practices for two (2) of three (3) staff (LPN#2 and Certified Nursing Aide #3), in accordance with the facility's policies and Centers for Disease Control and Prevention (CDC) guidelines for infection control. The deficient practice was evidenced by the following: According to the CDC guidance titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic with an updated date of Sept. 23, 2022, included the following: Perform SARS-CoV-2 Viral Testing Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 . Nursing Homes . Responding to a newly identified SARS-CoV-2-infected HCP (Health Care Personnel) or resident When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority. A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 . According to the CDC Hand Hygiene in Healthcare Settings, Healthcare Providers, last reviewed: January 8, 2021, . When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers . 1. On 01/31/24 at 01:12 PM, the surveyor interviewed the Director of Nursing (DON) who stated the facility's most recent COVID-19 outbreak started in December 2023. The DON further explained contact tracing was initiated when there was a positive COVID-19 case in the facility and if unable to conduct contact tracing wider based testing would be conducted. The surveyor requested the line list for the December 2023 COVID-19 outbreak and any contact tracing conducted. On 02/01/24 at 10:00 AM, the DON provided the surveyor a line list for the most recent COVID-19 outbreak. The DON to provide further documentation on the contact tracing and testing at onset of the COVID-19 outbreak. A review of the line list indicated on 12/17/23 Resident #252 tested positive for COVID-19. A review of the electronic medical record for Resident #252 indicated the resident presented on 12/17/23 with symptoms that included cough, fatigue, and a sore throat. The resident was given a rapid antigen test, which resulted as positive, and the resident was placed on transmission-based isolation precautions (TBP, are infection control measures designed to interrupt pathogen transmission). The physician was made aware, and the physician ordered Paxlovid (oral antiviral pill used to treat COVID-19) medication treatment for Resident #252. The resident remained on TBP for 10 days. On 02/01/24 at 10:57 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated the facility's infection control practice was based on the facility policies, along with CDC guidance, state, and federal regulations. On 02/05/24 at 9:28 AM, the Minimum Data Set (MDS) coordinator provided resident and staff testing documentation for the COVID-19 outbreak from the DON. A sample of three residents and three staff members were reviewed for the positive case of COVID-19 on 12/17/23. Residents #62, 121, and 155 were tested on [DATE] and 12/21/23. Staff members, Certified Nursing Aide #1 (CNA#1), CNA#2, and Registered Nurse #1 (RN#1) were tested on [DATE] and 12/21/23. The residents and staff members were tested on Day 1 and Day 4. They were not tested on Day 1, 3, and 5 as indicated by CDC guidance and facility policy. On 02/05/24 at 10:13 AM, the surveyor interviewed the DON who stated COVID testing for potentially exposed individuals through contact tracing or unit based tested should be performed day 1, then day 3, and day 5. The surveyor discussed the concern with the COVID-19 testing reviewed. The DON believed that the testing conducted followed the testing policy of Day 1,3, and 5. On 02/05/24 at 01:35 PM, the surveyor informed the LNHA and the DON about the above concerns of COVID-19 testing not following facility policy and national standards. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/06/24 at 8:34 AM, the surveyor interviewed RN#2 who worked during COVID-19 outbreak. RN#2 stated residents and staff were being tested twice a week. RN#2 further stated that the nurse supervisor performed COVID-19 testing. On 02/06/24 at 10:53 AM, the surveyor interviewed the RN Supervisor (RNS) over the phone. The RNS stated the facility policy for COVID-19 testing when there was a COVID-19 positive case in the facility was day 1, day 3, and day 5. The RNS further stated that she conducted testing for residents and staff at the time of the positive case on 12/17/23. The RNS also stated the DON and previous Infection Preventionist (IP) would oversee COVID-19 testing. On that same date and time, the surveyor discussed testing documentation on 12/18/23 and 12/21/23. The RNS stated she thought she did the testing, and that she did tests on 12/19/23. The RNS acknowledged the testing dates were not on day 1, 3 and 5. The RNS further stated she did a lot of testing at the time and all staff would come to get tests done. The RNS stated nurses would also perform testing for residents on the unit. On 02/06/24 at 11:30 AM, the survey team met with the LNHA and DON. No additional information was provided by the facility. A review of the provided facility policy Outbreak Plan with an updated date of 02/12/2023 read under Testing Procotol- COVID-19: .Testing of all residents and HCP will be conducted as directed by federal, state, or local governing bodies, or facility medical directorship . A review of the provided facility policy titled Coronavirus Disease (COVID-19)- Testing Residents with a revised date of September 2022 read under Broad-Based Testing: 12. When utilizing broad-based testing, all residents and staff identified as close contacts or on the affected unit (s) are tested , regardless of vaccination status . 13. Testing is done immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 . 38327 2. On 01/30/24 at 8:12 AM, the surveyor observed CNA#3 for an incontinence check of Resident #107. Afterward, the CNA performed handwashing inside the resident's room for 11 seconds. On that same date, outside the resident's room, the surveyor interviewed CNA#3 regarding handwashing. The CNA notified the surveyor that it was the IP Nurse (IPN) whom she forgot the name was, who provided education and training about hand hygiene. CNA#3 stated that handwashing should be at least 20 seconds by singing a Happy Birthday song. The surveyor then asked the CNA if she did follow the protocol for handwashing, and CNA#3 stated that she probably did not because she was hurrying up, and she claimed that she did handwashing for 10 seconds. 3. On 01/30/24 at 02:06 PM, the surveyor asked LPN#1, the assigned nurse of the resident to go to the resident's room. The LPN took a surgical mask from her uniform pocket and used it and donned (put) a pair of gloves from the PPE box outside the room before entering the resident's room. The LPN informed the surveyor that the resident was not in isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 01/31/24 at 8:36 AM, the surveyor observed LPN#2 administered the medications to Resident #179. The surveyor observed the LPN performed handwashing inside the resident's toilet room for 11 seconds. There was no garbage can inside the toilet room and the LPN placed the used paper towels on top of the sink and stated that he would let the housekeeper know later about the missing garbage can. On 02/01/24 at 8:34 AM, the surveyor interviewed LPN#2 regarding hand hygiene. The LPN stated that handwashing should be at least 40 seconds. The surveyor notified the LPN of the above concerns and the LPN stated that he believed the surveyor for 11 seconds observations of handwashing during medications administration because he was not counting at that time. He further stated that he was hurrying up. On 02/05/24 at 10:41 AM, the surveyor interviewed the DON regarding the above concerns for infection control. The DON informed the surveyor that the infection control education including hand hygiene, PPE use, and the like was a collaborative effort between the IP, 3-11, and 11-7 shift Supervisors. The DON stated that for the use of sanitizer, at least 15 seconds until dry. The DON further stated that handwashing the whole process is 40 seconds, scrubbing both hands for 20 seconds under the water. The surveyor then asked the DON if that was the facility's protocol and policy, the DON stated that the policy was at least 15 seconds of hand scrubbing. The surveyor then asked the DON what should the facility staff follow, the DON stated it should be the policy for 15 seconds. On that same date and time, the surveyor also asked if it was appropriate for the staff to store their surgical mask inside their uniform pocket. The DON responded that no, because of the bacteria on the mask that will go to the uniform pocket, and it will be considered contaminated. At this time, the surveyor notified the DON of the concerns regarding CNA#3, LPN#1, and LPN#2. On 02/05/24 at 01:21 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above concerns. On 02/06/24 at 11:30 AM, the survey team met with the DON and LNHA. The LNHA stated that there should be one garbage can inside Resident #179's toilet room. A review of the provided Handwashing/Hand Hygiene Policy that was provided by the LNHA with a revised date of December 2009 included that this facility considers hand hygiene the primary means to prevent the spread of infections. Employees must wash their hands for at least 15 seconds using antimicrobial or non-microbial soap and water under the following conditions: when coming on duty; when hands are visibly soiled and before and after direct resident contact. On 02/06/24 at 01:35 PM, the survey team met with the LNHA, Business Office Personnel, and DON for an exit conference, and there was no additional information provided by the facility management. NJAC 8:39-5.1(a), 19.4 (a)

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F 0881 Level of Harm - Potential for minimal harm Residents Affected - Many	Implement a program that monitors antibiotic use. 46049 Based on interview and review of other pertinent facility documentation, it was determined that the facility failed to ensure facility-wide implementation of the Antibiotic Stewardship program, which included a system for routine feedback reports and tracking measures of outcome surveillance related to antibiotic use was followed, as per facility policy and national standards. This deficient practice was evidenced by the following: On 01/31/24 at 01:12 PM, the surveyor interviewed the Director of Nursing (DON) who stated the Infection Preventionist (IP) was responsible for Antibiotic (ABT)Stewardship. The DON further explained the newly hired IP was still in training and that the facility was in contact with the previous IP who left approximately two weeks ago. The DON stated the facility had access to the former IP's reports and antibiotic tracking documentation. The surveyor requested for the DON to provide the facility's antibiotic stewardship policy, reports, and documentation. On 02/01/24 at 9:40 AM, the DON informed the surveyor she was still gathering the requested documents. On 02/01/24 at 10:37 AM, the surveyor interviewed the former IP over the phone. The former IP stated her last day of work was on 01/16/24. The IP stated she was responsible for antibiotic review and infection surveillance during her time in the facility. The IP stated she reported to the Licensed Nursing Home Administrator (LNHA) and the DON, who would have all the documentation related to ABT stewardship and ABT tracking reports. On 02/01/24 at 10:57 AM, the surveyor interviewed the LNHA who stated infection control was discussed in QAPI meetings and on an as needed basis. The LNHA confirmed the IP would report to him and the DON. The LNHA stated he and the DON would provide documentation of ABT stewardship including ABT tracking, surveillance and trend reports completed by the IP. On 02/05/24 at 9:20 AM, the LNHA provided the surveyor with the facility's policy titled Antibiotic Stewardship Program. On 02/05/24 at 10:13 AM, the surveyor interviewed the DON about ABT stewardship. The DON stated the former IP reviewed residents who were prescribed antibiotics using the Mcgreer's criteria (a set of guidelines used to assess the appropriateness of ABT initiation) to determine the reason for the ABT treatment and to ensure an appropriate treatment was carried out. The DON further explained that there was no standardized assessment form used in the facility for ABT use assessment. The DON acknowledged she was responsible for overseeing infection control processes and ensuring IP duties were being completed. The surveyor requested the DON to provide any documentation for ABT stewardship recently conducted. On 02/05/24 at 10:35 AM, the DON provided the surveyor with an untitled and undated document that she stated was the ABT tracking for December 2023 that was completed by the IP. No additional information was provided at this time. (continued on next page)

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F 0881 Level of Harm - Potential for minimal harm Residents Affected - Many	A review of the untitled document consisted of a list of residents, the start date of their prescribed ABT, the stop date for their ABT and their diagnosis. There was no information documented regarding diagnostic testing, type of organism if any identified, and signs/symptoms of the residents. On 02/05/24 at 01:35 PM, the surveyor informed the LNHA and the DON regarding the concern for ABT stewardship as there was no documentation of comprehensive assessment of prescribed antibiotics, no documentation of feedback reports, trend reports, and surveillance provided. There was no verbal response by the facility at this time. On 02/06/24 at 8:34 AM, the surveyor interviewed a staff Registered Nurse (RN) about ABT stewardship. The RN stated it was to ensure appropriate ABT use. The RN further explained the nurses ensure to follow up with physicians for the order of appropriate diagnostic tests, such as cultures, and to review results to ensure the ABT ordered by the physician was appropriate. The RN stated it was also important for the ABT order to include a stop date to establish the duration of the ABT treatment. On 02/06/24 at 11:25 AM, the LNHA provided an email documentation of a summary for 3rd quarter QAPI for infection control review sent by the former IP to the DON and LNHA on 11/29/23. No additional information was provided by the facility. A review of the provided email documentation included a list of residents (identified by number) who were on antibiotics in July, August, and September. For each resident, the category of infection (such as CAI [catheter acquired infection] or soft tissue infection) was documented, whether the resident received an ABT, and whether the resident met McGreers criteria. There was no detailed information on the specific ABT prescribed, diagnosis, or microorganism of infection identified. The document did not indicate further why a resident met or did not meet McGreers criteria. The email documentation did not detail the tracking ofABT resistant microorganisms and infections. There was no trend report or QAPI report for October, November, and December 2023 provided. No additional information was provided by the facility. A review of the facility's policy titled, Antibiotic Stewardship Program with effective date of March 2018, under Policy it read: New Vista Nursing and Rehabilitation c Center ASP [Antibiotic Stewardship Program] activities should, at a minimum, include these basic elements: leadership, accountability, drug expertise, action to implement recommended policies or practices, tracking measures, reporting data, education for clinicians, nursing staff, residents and families about ABT resistance and opportunities for improvement . Under Procedure, 2. Accountability it read, .The ASP [Antibiotic Stewardship Program] Team may consist of: ASP Physician Champion and/or Medical Director, Administrator, Director of Nursing, Infection Preventionist (IP), pharmacy consultant, and laboratory representative. As a team they will: i. Review infections and monitor ABT usage patterns on a regular basis .ii. Obtain and review antibiograms for institutional trends of resistance .iii. Monitor ABT resistance patterns (MRSA, VRE, ESBL, CRE, etc.) and Clostridium difficile infections .iv. Report on number of antibiotics prescribed (e g. days of therapy) and the number of residents treated each month .v. Include a separate report on the number of residents on antibiotics that did not meet criteria for active infection . NJAC 8:39-19.4(d)(g)

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	315458	A. Building B. Wing	02/06/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, interview, and record review, it was determined that the facility failed to ensure: a) that the resident's medical record included documentation that indicated the consent for administration or refusal of the Influenza Annual Vaccination for four (4) of six (6) residents (Resident #7, #132, #149, and #214) reviewed for influenza immunizations, and b) the Pneumococcal vaccine was administered to the residents, (Residents #100 and #127) identified during the medication storage and labeling observation for one (1) of three (3) medication rooms. This deficient practice was evidenced by the following: Reference: A review of the Centers for Disease and Control Prevention (CDC) guidelines for Pneumococcal vaccination included: For adults who only received the Pneumococcal polysaccharide vaccine (Pneumovax/PPSV 23) regardless of risk and condition, should received one (1) dose of Pneumococcal conjugate vaccine (PCV 15 or PCV20) at least one year after the most recent PPSV23. 1. On 02/1/24 at 9:55 AM, the surveyor reviewed the hybrid (paper and electronic record) medical records of Resident #7. The resident's Admission Record (AR, an admission summary) reflected that Resident #7 had diagnoses that included but were not limited to, malignant neoplasm [cancer] of genitourinary organ, schizoaffective disorder, dysphagia, muscle weakness, and cognitive communication deficit. A quarterly Minimum Data Set (qMDS), assessment tool used to facilitate the management of care, with an assessment reference date (ARD) 11/26/23, indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a 3 out of 15 which indicated that the resident's had severe cognitive impairment. Section O Special Treatments, Procedures, and Programs indicated last influenza vaccination received on 9/16/22. A review of the resident's paper chart on the unit, revealed there was no documentation for influenza vaccination for this season. There was no documentation to indicate administration or declination of the vaccine. The paper chart also indicated the resident had a resident representative who was involved in the resident's care planning and was the responsible party for the resident. A review of immunizations listed in the electronic medical record (EMR) documented an influenza vaccine for Resident #7 completed on 9/16/22. There was no documentation for 2023 to indicate administration or declination of the influenza vaccine. A review of physician orders (PO) revealed there was no PO for influenza vaccination administration from September 2023 to January 2024. On 02/01/24 at 01:15 PM, the surveyor informed the Director of Nursing (DON) of the above concerns that no 2023/2024 influenza vaccination status for Resident #7 found in the hybrid medical records. The DON stated she would follow up to provide further information. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/05/24 at 10:13 AM, the surveyor interviewed the DON regarding influenza vaccination status for Resident #7. There was no information provided at this time. The DON stated she had not been able to follow up yet. The DON stated immunizations were assessed upon admission and as needed. The DON further explained for influenza vaccination it was offered to residents every flu season, beginning end of October. A consent form would be completed by the resident or resident representative. The DON stated the infection preventionist would be responsible for keeping track of resident influenza vaccination. On 02/05/24 at 01:35 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and DON about the concerns that there was no documentation found regarding Resident #7's influenza vaccination status. There was no verbal response at this time. On 02/06/24 at 11:30 AM, the survey team met with the LNHA and the DON. The DON provided an influenza vaccination declination form for Resident #7. A review of the untitled document regarding Resident #7's influenza vaccination status. The form was dated 11/18/23 and indicated with a check mark Do not consent to an annual flu vaccination. On the form written in ink it read [resident representative] said no. There was a line with at the bottom with the name of Resident #7 and there was a signature line with an unknown signature. On 02/06/24 at 12:30 PM, the surveyor interviewed the DON about the provided form. The DON stated the signature was from a nurse who completed the form. The DON stated the form was found in separate binder and did not specify which binder. The DON provided no verbal response as to why the form would not be found in the resident's paper chart. The surveyor asked the DON if the documentation on the form was appropriate for obtaining consent. There was no documentation in the EMR to confirm vaccination discussion with the resident's representative and no documentation found in the resident's paper chart. The DON provided no further verbal response. 38327 2. The surveyor reviewed the hybrid medical records of Resident #132 as follows: The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to dysphagia oropharyngeal phase (difficulty swallowing), gastrostomy status (resident with TF), altered mental status unspecified, and need for assistance with personal care. The qMDS with an ARD of 12/23/23, and Section C Cognitive Skills for Daily Decision Making showed that the resident was severely impaired. Section O Special Treatments, Procedures, and Programs indicated the last influenza vaccination was received on 10/21/22. A review of the resident's paper chart on the unit revealed there was no documentation for influenza vaccination for this season. There was no documentation to indicate administration or declination of the vaccine. The paper chart also indicated the resident had a resident representative who was involved in the resident's care planning and was the responsible party for the resident. A review of immunizations listed in the EMR documented an influenza vaccine for Resident #132 completed on 10/21/22. There was no documentation for 2023 to indicate the administration or declination of the influenza vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of PO revealed there were no PO for influenza vaccination administration from September 2023 to January 2024. 02/01/24 08:46 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the resident's influenza vaccination for 2023. The LPN confirmed that if the resident's electronic record in immunization did not have the 2023 influenza vaccination and nothing in the chart, then the resident did not receive the vaccine. 3. On 01/30/24 at 12:30 PM, the surveyor reviewed the hybrid medical records of Resident #149 as follows: The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to dysphagia (difficulty swallowing), gastrostomy status (alternate means of feeding through the stomach), heart failure, chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys), bipolar disorder (causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression), and anxiety disorder. The qMDS with an ARD of 12/08/23, and Section C Cognitive Skills for Daily Decision Making showed that the resident was severely impaired. Section O Special Treatments, Procedures, and Programs indicated the last influenza vaccination was received on 10/21/22. A review of the resident's paper chart on the unit revealed there was no documentation for influenza vaccination for this season. There was no documentation to indicate administration or declination of the vaccine. The paper chart also indicated the resident had a resident representative who was involved in the resident's care planning and was the responsible party for the resident. A review of immunizations listed in the EMR documented an influenza vaccine for Resident #149 completed on 10/21/22. There was no documentation for 2023 to indicate the administration or declination of the influenza vaccine. A review of PO revealed there were no PO for influenza vaccination administration from September 2023 to January 2024. On 02/01/24 at 10:57 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN) in the presence of the survey team. The MDSC/RN informed the surveyor that the MDS for immunization section, I checked the EMR immunization record. She stated that if a resident is a new admit, the hospital record will be checked, and then I reflect it in MDS. She further stated that if she did not see record of immunization it will be reflected in the MDS. On that same date and time, the surveyor asked the MDSC/RN if she asked nursing if she did not find any record for immunization, and the MDSC/RN did not respond. The surveyor then notified the MDSC/RN of the above concerns regarding Residents #132 and #149's that the influenza vaccine last received according to MDS documentation was from 10/21/22. The surveyor also notified the MDSC/RN that there was no documentation that it was offered and declined. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, the MDSC/RN confirmed that the influenza vaccine was not given and that there was no documentation that showed that it was offered and declined that was why she documented in MDS Section that the influenza vaccine last received on 10/21/22 for both residents. 31656 4. On 02/05/24 at 9:23 AM, the surveyor reviewed the hybrid medical records for Resident #214. The AR for Resident #214 revealed that they were admitted to the facility with diagnoses included but not limited to dementia with other behavioral disturbance, generalized muscle weakness, and encephalopathy (a broad term for any brain disease that alters brain function or structure). The comprehensive MDS (cMDS) with an ARD of 11/10/23, and Section C Cognitive Patterns with a BIMS score of 3 out of 15 which reflected that the resident's cognitive status was severely impaired. Section O Special Treatments, Procedures, and Programs indicated the last influenza vaccination was received on 10/14/22. Review of the POs from 9/2023 to 02/2024 lacked any orders for administering the Influenza Vaccine to Resident #214. A review of the provided facility policy titled, Immunization: Influenza/Pneumococcal with a revised date of July 2020 under Procedure 1b. it read: .Influenza vaccine is offered in the fall of each year according to Influenza management Program . Under Procedure #4 it read: .Document: a. Immunizations given and date in resident's Medical Records .b. Immunizations given on Medication Administration Record (MAR) .c. If Immunization refused, document resident's or decision maker's refusal of immunization and education and counseling given regarding the benefit of immunization in the resident's Medical records (interdisciplinary progress notes) A review of the provided, undated facility policy titled, Infection Control Policy and Procedure under Procedure IV it read: .a. Before offering the influenza immunization each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; b. Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated, or the resident has already been immunized during this time period; c. The resident or the resident's representative has the opportunity to refuse immunization; and d. The resident's medical record includes documentation that indicates at a minimum, the following: i. That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and ii. That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal . A review of the provided, undated policy titled, Influenza Vaccine under Policy Interpretation and Implementation it read: .6. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record . On 02/05/24 at 10:30 AM, the surveyor interviewed the DON, and requested any information related to the administration or refusal of the Influenza Vaccination for this year's Influenza Vaccination season (2024). No further information was provided. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45449 5. On 01/31/24 at 11:53 AM, during the medication storage and labeling observation of the medication room located on the east wing of the third floor, the surveyor observed the following: -A Pneumococcal syringe labeled for Resident #100, dated 7/04/23. -A Pneumococcal syringe labeled for Resident #127, dated 9/11/23. The surveyor reviewed the hybrid medical records for Resident #100. The AR for Resident #100 revealed the resident was admitted with diagnoses that included type 2 diabetes mellitus (an impairment in the way the body regulates glucose (sugar)), end stage renal disease ((condition in which a person's kidneys permanently stop functioning), and cerebral infarction (a result of decreased blood flow to the brain) without residual deficits. The qMDS with an ARD of 12/19/23, and Section C Cognitive Patterns with a BIMS score of 15 out of 15 which reflected that the resident was cognitively intact. Further review of the qMDS dated [DATE], under section O0300 A. Was the resident's Pneumococcal vaccine to date? The response was marked zero, which reflected a non-responsive answer to the yes or no question. Section B. indicated the Pneumococcal vaccine was offered and declined. The active PO for February 2024 did not include an order for the Pneumococcal vaccine. Review of the EMR under immunization for the resident under Pneumococcal 23 reflected an undated documentation of consent refused. The surveyor reviewed the resident's physical medical record which included a New Jersey Immunization Information System that indicated Pneumonia vaccine was due now 6/9/2011. Further review of the physical chart did not include a Pneumococcal/Influenza informed consent form or a refusal form. 6. The surveyor reviewed the hybrid medical records for Resident #127. The AR for Resident #127 revealed the resident was admitted with diagnoses that included cerebral infarction, and hypertension (high blood pressure). The cMDS with an ARD of 11/21/23, and Section C Cognitive Patterns with a BIMS score of 13 out of 15 which reflected that the resident was cognitively intact. Further review of the cMDS dated [DATE], under section O0300 A. indicated the resident's Pneumococcal vaccine was up to date. The active PO for February 2024 did not include an order for the Pneumococcal vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the electronic medical record under immunization for the resident under Pneumococcal 23 reflected the resident received Pneumovax on 11//16/17. Review of the physical chart did not include a Pneumococcal/Influenza informed consent form or a refusal form. On 02/05/24 at 12:48 PM, during an interview with the surveyor, the MDS Coordinator/Registered Nurse (MDSC/RN) stated that when she completed the MDS for the resident she reviewed the progress notes from the nurse and the immunization record on the hybrid medical record. The MDSC/RN informed the surveyor that she did not check for the immunization consent/refusal form when answering section O0300 of the MDS. On 02/05/24 at 01:21 PM, in the presence of the survey team, DON and the LNHA, the surveyor discussed the concern regarding the Pneumococcal vaccine. At 2:30 PM, during a follow-up interview with the surveyor, the DON stated the nurse who placed the order for the Pneumococcal vaccine should have obtained the informed consent/refusal form from the resident. The DON also stated the nurse who received the refusal from the resident should have obtained the informed refusal form [which included the benefit versus risk of the refusal]. On 02/06/23 at 12:27 PM, during a meeting with the survey team, the LNHA and the DON, did not provide an additional information regarding the concerns discussed yesterday. A review of the provide facility policy Immunization: Influenza/Pneumococcal reviewed/revised 7/2020 under Procedure section 1. Upon admission, request permission from resident or healthcare decision maker for pneumovax and annual influenza vaccine. Use Pneumococcal/ Influenza informed consent form. On 02/06/24 at 01:35 PM, the survey team met with the LNHA, the DON, and the Business Office Personnel for an exit conference, and there was no additional information provided by the facility management. NJAC 8:39-19.4 (h), (i)