| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315467 | A. Building<br>B. Wing | 10/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Little Brook Nursing and Convalescent Home | 78 Sliker Road<br>Califon, NJ 07830 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>44605<br><br>Complaint #: NJ174200<br><br>Based on observation, interview, and record review, it was determined that the facility failed to maintain resident's dignity by, a. not providing an incontinent resident the correct size of incontinence briefs (IB) and b. standing over the resident while feeding during mealtime. This deficient practice was observed for 2 of 13 residents reviewed (Resident #21 and Resident #18) and was evidenced by the following:<br><br>1. On 10/28/24 at 9:00 AM, the surveyor observed Resident #21 in their room seated in an upward position in their bed. Resident #21 was observed eating their breakfast. The surveyor observed the Certified Nurse Aide (CNA #1) feeding Resident #21 while standing over them. The surveyor interviewed CNA #1, who stated they know they should be seated next to the resident during feeding assistance but could not provide an explanation why they were not seated.<br><br>A review of the Admission Record (AR) (an admission summary) for Resident #21 which revealed that the resident was admitted to the facility with diagnoses which included but were not limited to Dementia; Type 2 Diabetes Mellitus and Hyperlipidemia.<br><br>A review of Resident #21's Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated 7/21/24, reflected that Resident #21 was unable to complete a Brief Interview for Mental Status (BIMS) due to resident's cognitive status. The MDS further reflected that the resident was dependent of staff during eating.<br><br>A review of Resident #21 care plan (CP) with a reviewed date of 7/6/24 revealed under the nutrition portion of the CP a Focus titled, Fed by staff. A review of the interventions included, Assist with eating.<br><br>On 10/28/24 at 12:26 PM, the surveyor interviewed the Director of Nursing (DON) who stated all staff must be seated when feeding residents. The DON further stated that standing while feeding a resident was not a dignified manner.<br><br>(continued on next page) |

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

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/28/24 at 1:15 PM, the DON provided the surveyor with a facility policy titled, Assistance with meals with a reviewed date of October 2024. Under the policy interpretation and implementation indicated, 3. Residents Requiring Full Assistance .b. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: 1. Not standing over residents while assisting them with meals.<br><br>On 10/29/24 at 1:44 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and Business Office Manager (BOM) to discuss the above concern. There were no further information provided.<br><br>39399<br><br>2. On 10/22/24 at 11:30 AM, the surveyor investigated an anonymous complaint which stated that approximately around May 2024, the facility did not have an adequate supply of IB specifically the medium, large, XX Large and XXX Large sizes. The complaint also indicated for the residents who were wearing those specific sizes were provided to wear the small sized IB because it was the only size available due to inadequate supplies.<br><br>During the resident council meeting that was conducted on 10/24/24 at 11:01 AM attended by 7 alert and oriented facility residents which included Resident #18. Resident #18 stated to the surveyor, they recalled being provided a small sized IB or at times a size too big for them. Resident #18 added they wear medium sized IB. The resident further stated it didn't fit them good but it's better than nothing.<br><br>A review of the Resident #18's AR revealed that the resident was admitted to the facility with diagnosis which included but were not limited to Depression, Atrial Fibrillation and Hypertension.<br><br>A review of Resident #18's Q/MDS, an assessment tool used to facilitate the management of care, dated 8/11/24, reflected that Resident #18 had a BIMS score of 15 out of 15 indicating the resident was cognitively intact.<br><br>On 10/23/24 at 11:25 AM, the surveyor interviewed the facility's Director of Nursing (DON) who stated that around May 2024, the facility had shortage of IB due to a problem with shipment. The DON agreed that some residents were provided IB which was not their size.<br><br>The facility could not provide a policy for the use of IB.<br><br>On 10/29/24 at 1:44 PM, the survey team met with the LNHA, DON and BOM to review the above concern. No further information as provided.<br><br>N.J.A.C. 8:39-4.1(a)12 |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37175<br><br>Based on interview and record review, it was determined that the facility failed to issue the required Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) for 2 of 3 residents (Resident #14 and Resident #27) reviewed.<br><br>This deficient practice was evidenced by:<br><br>The SNF ABN provides information to beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. If the SNF provides the beneficiary with the SNF ABN, the facility has met its obligation to inform the beneficiary of his or her potential financial liability and related standard claim appeal rights.<br><br>On 10/22/24 at 10:27 AM, the facility provided the surveyor with a list of residents who were covered under Medicare A benefits, was discharged from the facility within the last 6 months from October 2022 and should have received the SNF ABN form. The surveyor reviewed Resident #14 and Resident #27 who were listed discharged from Medicare Part A coverage stay and were documented that they remained in the facility.<br><br>1. Resident #14 was admitted to the facility on [DATE]. The last documented covered day from Medicare Part A service was on 8/2/24. A review of the form titled, SNF Beneficiary Notification Review that was filled out by the facility's Director of Nursing (DON) indicated the SNF ABN was not provided to the resident. There was no additional documentation about the communication of these forms to the resident or the resident's representative.<br><br>2. Resident #27 was admitted to the facility on [DATE]. The last documented covered day from Medicare Part A service was on 10/9/24. A review of the form titled, SNF Beneficiary Notification Review that was filled out by the DON indicated the SNF ABN was not provided to the resident and or the representative prior to the last cover date. There was no additional documentation about the communication of these forms to the resident or the resident's representative.<br><br>On 10/28/24 at 1:10 PM, the surveyor interviewed the DON who stated that the beneficiary notifications were usually sent out by one of the staff at the facility. The DON stated that resident # 27 was sent on 10/24/24 and that Resident # 14 was not sent out.<br><br>On 10/24/24 at 12:49 PM, the surveyor discussed the above concerns with the facility's Licensed Nursing Home Administrator and the Director of Nursing. No additional information was provided.<br><br>NJAC 8:39-4.1(a)(8) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>37791<br><br>Complaint NJ#173220<br><br>Based on interview and record reviews, it was determined that the facility failed to report an allegation of Abuse/Neglect to the New Jersey Department of Health (NJ DOH) in the required timeframe for 2 of 2 sampled residents, (Residents #29 and Resident #81).<br><br>This deficient practice was evidenced by the following:<br><br>On 10/28/24 at 10:30 AM, the surveyor reviewed a Reportable Event Record/Report Form (RER/RF) provided by the facility. The form was dated 4/24/24 and documented an event that occurred on 4/20/24 at 3:30 PM involving Resident #81 and Resident #29. The report documented Resident #81 touched Resident #29's face and attempted to remove the resident's glasses from Resident #29's face. Resident #29 who was startled and reacted by swatting Resident #81's hand away. The facility's activity director was present during the time of the incident and was able to separate both residents and notified the nurse. Further review of the REF/RF form revealed an event date of 4/20/24 at 3:30 PM and the NJ DOH was notified by the facility via a phone call on 4/24/24 at 12:56PM.<br><br>A review of Resident #81's Admission Record (AR) (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but not limited to, Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions); anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities, and altered mental status (a change in mental function, such as confusion, decreased alertness, or unusual behavior).<br><br>A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/6/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated that the resident's cognition was severely impaired.<br><br>A review of the progress notes (PN) revealed a nurse's note dated 4/20/24 at 4:07 PM (16:07) which documented that an incident occurred on 4/20/24 at 3:30 PM when a facility staff reported to the nurse that Resident #81 touched Resident #29's head before attempting to take Resident #29's glasses. The PN further revealed that Resident #29 swatted Resident #81's hand away. The PN also indicated both residents were assessed by the Director of Nursing (Director of Nursing) and the Medical Doctor (MD) was notified of the incident.<br><br>The surveyor reviewed the closed record for Resident #29.<br><br>A review of Resident #29's AR reflected that the resident was admitted to the facility with a diagnoses which included but not limited to spinal stenosis (the spaces inside the bones of the spine get too small and can put pressure on the spinal cord and the nerves); hypertension (a condition in which the force of the blood against the artery walls is too high), and diabetes mellitus (a group of diseases that result in too much sugar in the blood (high blood glucose).<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the quarterly MDS, an assessment tool used to facilitate the management of care, dated 6/30/24, reflected that the resident had a BIMS score of 14 out of 15, which indicated that the resident was cognitively intact.<br><br>A review of the PN revealed a nurse's note dated 4/20/24 at 7:16 PM, which documented when the nurse was alerted by a facility staff of an incident which involved both Resident #81 and Resident #29 on 4/20/24 at 3:30 PM.<br><br>On 10/29/24 at 11:10 AM, the surveyor interviewed the DON who acknowledged that the incident should have been reported to the NJ DOH within 24-hours. The DON also acknowledged that she reported the incident late but was unable provide a reason why it was not reported to the NJ DOH in a timely manner according to federal and state regulations. There was no further information provided by the facility.<br><br>A review of and undated facility's policy titled, Resident Abuse Prohibition Policy that was provided by the DON which did not indicate a time frame to report an incident or observation of an abuse including Resident to Resident abuse.<br><br>NJAC 8:39-4.1(a)(5)<br><br>NJAC 8:39-13.4(c)(2)(v) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>37175<br><br>Based on observation, interview, and record review, it was determined that the facility failed to notify the resident's representative and the Office of the Ombudsman in writing for an emergency transfer to the hospital.<br><br>This deficient practice was identified for 1 of 1 resident, Resident #9, reviewed for hospitalization .<br><br>On 10/23/24 at 9:28 AM, the surveyor reviewed the electronic medical record for Resident #9.<br><br>A review of the physician's progress note dated 4/20/24, revealed that the resident had a recent hospitalization .<br><br>A review of the Discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 4/15/24, reflected that Resident #9 was discharged to the hospital with a return anticipated to the facility.<br><br>On 10/23/24 at 12:06 PM, the surveyor interviewed the Director of Nursing (DON), who stated she reviewed the book of letters which contained a report to the Office of the Ombudsman and to the residents' representatives but was unable to find them. The DON further stated that in May 2024, she started to do the notification because there had not been a social worker in the facility for a while, so there were no notifications sent for the month of April 2024.<br><br>On 10/24/24 at 12:58 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the DON regarding the above concerns.<br><br>A review of the facility's policy titled Transfer, or Discharge, Emergency, with a review date of 2024, indicated that 1. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institutions, our facility will implement the following procedure . the facility will notify the representative (sponsor) or other family members, and others as appropriate or as necessary.<br><br>NJAC 8:39-5.3; 5.4 |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.<br><br>39399<br><br>Based on interview and record review, it was determined that the facility failed to accurately transmit the Minimum Data Set (MDS) for 20 of 32 residents reviewed, Residents #25, #3, #13, #10, #28, #1, #7, #17, #31, #231, #32, #33, #22, #27, #28 and was evidenced by the following:<br><br>On 10/23/24 at 10:44 AM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments.<br><br>The MDS is a comprehensive federal mandated process for clinical assessment of all residents that must be completed and submitted to the Quality Measure System. The facility must electronically transmit the MDS up to 14 days of the assessment being completed. After transmitting the MDS, it will generate a quality measure to enable a facility to monitor the residents decline and progress.<br><br>The following residents were identified that the MDS were not transmitted timely:<br><br>1. Resident #25 was triggered under the survey facility task as MDS record over 120 days old. Resident #25 was observed to have an Admission MDS with Assessment Reference Date (ARD) of 6/10/24 and was due to be transmitted no later than 6/30/24. The MDS was not transmitted until 7/24/24. Further review of Resident #25's completed MDS's revealed a Quarterly MDS (Q/MDS) with an ARD of 9/1/24 and was due to be transmitted no later than 9/29/24. The Q/MDS was not transmitted until 10/21/24.<br><br>2. Resident #3 was triggered under the survey facility task as MDS record over 120 days old. Resident #3 was observed to have a Q/MDS with an ARD of 6/16/24 and was due to be transmitted no later than 7/14/24. The Q/MDS was not transmitted until 7/24/24. Further review of Resident #3's completed MDS's revealed a Q/MDS with an ARD of 9/15/24 and was due to be submitted no later than 10/13/24. The Q/MDS was not transmitted until 10/21/24.<br><br>3. Resident #13 was triggered under the survey facility task as MDS record over 120 days old. Resident #13 was observed to have an Annual MDS with an ARD of 9/15/24 and was due to be transmitted no later than 10/13/24. The Q/MDS was not transmitted until 10/21/24.<br><br>4. Resident #10 was triggered under the survey facility task as MDS record over 120 days old. Resident #10 was observed to have an Annual MDS with an ARD of 6/9/24 and was due to be transmitted no later than 7/7/24. The Q/MDS was not transmitted until 7/24/24. Further review of Resident #3's completed MDS's revealed a Q/MDS with an ARD of 9/1/24 and was due to be submitted no later than 9/29/24. The Q/MDS was not transmitted until 10/21/24.<br><br>5. Resident #28 was triggered under the survey facility task as MDS record over 120 days old. Resident #28 was observed to have a Q/MDS with an ARD of 6/16/24 and was due to be transmitted no later than 7/14/24. The Q/MDS was not transmitted until 7/24/24. Further review of Resident #28's completed MDS's revealed an Annual MDS with an ARD of 9/8/24 and was due to be submitted no later than 10/6/24. The Q/MDS was not transmitted until 10/21/24.<br><br>(continued on next page) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 6. Resident #1 was triggered under the survey facility task as MDS record over 120 days old. Resident #1 was observed to have a Q/MDS with an ARD of 6/16/24 and was due to be transmitted no later than 7/14/24. The Q/MDS was not transmitted until 7/24/24. Further review of Resident #1's completed MDS's revealed a Q/MDS with an ARD of 9/8/24 and was due to be submitted no later than 10/6/24. The Q/MDS was not transmitted until 10/21/24.<br><br>7. Resident #7 was observed to have an Admission MDS with ARD of 6/24/24 and was due to be transmitted no later than 7/14/24. The Admission MDS was not transmitted until 7/24/24. Further review of Resident #7's completed MDS's revealed a Q/MDS with an ARD of 9/22/24 and was due to be transmitted no later than 10/6/24. The Q/MDS was not transmitted until 10/21/24.<br><br>8. Resident #17 was observed to have an Admission MDS with ARD of 7/22/24 was due to be submitted no later than 8/11/24. The Admission MDS was not transmitted until 9/6/24. Further review of Resident #17's completed MDS's revealed a Discharge MDS with an ARD of 9/17/24 and was due to be submitted no later than 10/15/24. The Discharge MDS was noted to be open and was not transmitted.<br><br>9. Resident #31 was observed to have an Admission MDS with ARD of 10/2/24 was due to be submitted no later than 10/22/24. The Admission MDS was noted to be open and was not transmitted. Further review of Resident #31's completed MDS's revealed a Discharge MDS with an ARD of 9/22/24 and was due to be submitted no later than 10/20/24. The Discharge MDS was noted to be open and was not transmitted.<br><br>10. Resident #231 was observed to have an Admission MDS with ARD of 9/24/24 was due to be submitted no later than 10/14/24. The Admission MDS was noted to be open and was not transmitted.<br><br>11. Resident #32 was observed to have an Admission MDS with ARD of 9/26/24 was due to be submitted no later than 10/16/24. The Admission MDS was noted to be open and not transmitted.<br><br>12. Resident #33 was observed to have a Discharge MDS with ARD of 9/7/24 was due to be submitted no later than 10/5/24. The Discharge MDS was not transmitted until 10/21/24.<br><br>13. Resident #22 was observed to have a Q/MDS with ARD of 6/23/24 was due to be submitted no later than 7/21/24. The Q/MDS was not transmitted until 7/24/24. Further review of Resident #22's completed MDS's revealed another Q/MDS with an ARD of 9/22/24 and was due to be submitted no later than 10/20/24. The Q/MDS was not submitted until 10/21/24.<br><br>14. Resident #27 was observed to have a Significant Change in Status MDS (SCS/MDS) with ARD of 4/20/24 was due to be submitted no later than 5/17/24. The SCS/MDS was not transmitted until 5/23/24.<br><br>On 10/28/24, at 01:52 PM, the survey team interviewed the MDS Coordinator via phone who could not provide further information.<br><br>On 10/29/24 at 8:52 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON to discuss the concern. No additional information was provided.<br><br>46889<br><br>(continued on next page) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 20. Resident #28 was observed to have an Annual MDS with an ARD of 9/8/24 and was due to be transmitted no later than 9/22/24. The Annual MDS was not transmitted until 10/21/24. Further review of Resident #28's completed MDS's revealed another Q/MDS with an ARD of 6/16/24 and was due to be transmitted no later than 6/30/24. The Q/MDS was not submitted until 7/24/24. The surveyor observed another Q/MDS for Resident #28 with an ARD of 12/17/23 and was due to be transmitted no later than 12/31/23. The Q/MDS was not submitted until 1/1/24.<br><br>A review of the facility's policy and procedure titled: Electronic Transmission of the MDS with a review date in 2024 revealed under Policy Interpretation and Implementation that 5. MDS electronic submissions shall be conducted in accordance with current OBRA OBRA (Omnibus Budget Reconciliation Act) regulations governing the transmission of such data.<br><br>On 10/24/24 at 10:10 AM, the surveyor interviewed the DON who stated that the MDS Coordinator/Registered Nurse (MDSC/RN) was not a full-time employee and completed MDS's remotely. The DON further stated that she had not seen the MDSC/RN for a long time in the facility.<br><br>On 10/28/24, at 01:52 PM, the survey team conducted a telephone interview with the MDSC/RN regarding the above concern who stated that the MDS assessments were not completed and submitted in a timely manner due to other disciplines (Dietician, Social Worker, Activities) not completing their assigned sections. The MDSC/RN further stated that she worked remotely and was employed part-time in the facility.<br><br>On 10/29/24 at 8:52 AM, the survey team met with the LNHA and DON to discuss the above concern. Both acknowledged that the MDS's were submitted late according to the federal and state guidelines.<br><br>NJAC 8:39 - 11.2(e) |

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| Little Brook Nursing and Convalescent Home | 78 Sliker Road<br>Califon, NJ 07830 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889<br><br>Based on observation, interview, and record review, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) to reflect the resident status in accordance with federal guidelines. This deficient practice was identified for 1 of 12 residents (Resident #7) reviewed.<br><br>The deficient practice was evidenced by the following:<br><br>The MDS is a comprehensive tool that is federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System.<br><br>1. On 10/23/24 at 10:10 AM, the surveyor observed Resident #7 seated in the wheelchair inside the room, watching television. The resident was able to answer the surveyor's inquiry.<br><br>On 10/24/24 at 11:15 AM, the surveyor reviewed the hybrid (paper and electronic) medical record (HMR) of Resident #7, which revealed the following:<br><br>A review of the Admission Record (AR) (an admission summary) reflected that Resident #7 was admitted to the facility with diagnoses that included, but were not limited to, atrioventricular block (the heart beating slower than it should), second-degree.<br><br>A review of admission MDS (A/MDS), dated [DATE], reflected under Section O for Pneumococcal Vaccine (PV) which indicated as not offered.<br><br>A review of the recent quarterly Minimum Data Set (Q/MDS), dated [DATE], reflected that Resident #7 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderately impaired cognition. Further review of the Q/MDS under Section O for PV which indicated as not offered.<br><br>A review of the Immunization Consent Form provided by the Director of Nursing (DON) on 10/29/24. The form was signed and dated 6/24/24 by the resident's representative indicating Resident #7 received the PV.<br><br>According to the CMS (Centers for Medicare & Medicaid Services) MDS 3.0 RAI (Resident Assessment Instrument) Manual of October 2024, the RAI manual was revealed under Version 3.0 Manual, pages O-17. Coding Instructions O0300B, If Pneumococcal Vaccine Not Received, State Reason If the resident has not received a pneumococcal vaccine, code the reason from the following list: o Code 1, Not eligible: if the resident is not eligible due to medical contraindications, including a life-threatening allergic reaction to the pneumococcal vaccine or any vaccine component(s) or a physician order not to immunize. o Code 2, Offered and declined: resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine. o Code 3, Not offered: resident or responsible party/legal guardian not offered the pneumococcal vaccine.<br><br>A review of policies and procedures titled: Subject: MDS with a revision in 2024 revealed under Procedure that 1. r) .The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. 6. The assessment will accurately reflect the resident's status.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/24/24 at 10:10 AM, the surveyor interviewed the DON who stated that the MDS Coordinator/Registered Nurse (MDSC/RN) was not a full-time employee and completed MDS's remotely. The DON further stated that she had not seen the MDSC/RN for a long time in the facility.<br><br>On 10/24/24 at 12:49 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON to discuss the concern. The DON acknowledged that Resident #7 was offered a PV but refused them because the resident received them previously. The DON further stated it should be coded accordingly in their MDS assessment.<br><br>On 10/28/24, at 01:52 PM, the survey team conducted a telephone interview with the MDSC/RN regarding the above concern<br><br>NJAC 8:39-33.2(d) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39399<br><br>Part A<br><br>Based on observation, interview, record review and review of pertinent documentation, it was determined that the facility failed to ensure a cognitively impaired resident with a PO (physician's order) for NTL (nectar thick liquid, liquid thickened with an agent for a nectar like consistency) to prevent aspiration (accidental breathing in of fluid or food into the lungs). This deficient practice was identified for 1 of 18 residents reviewed for modified liquid diet consistency.<br><br>On 10/23/24 at 12:28 PM, during lunch observation, the surveyor observed Resident #19 coughing while the Licensed Practical Nurse (LPN #1) was assisting Resident#19 with their meal. LPN #1 informed the surveyor that the resident started coughing after LPN #1 fed Resident #19 whole mandarin oranges in its own thin juice. LPN #1 stated that Resident #19 was on nectar thickened liquid. The surveyor observed thickened water, thickened coffee, and mandarin oranges in thin liquid juice on the resident's meal tray. The surveyor checked the meal card which revealed a plain yellow dot, and no specialized diet was identified. The surveyor asked LPN #1 what the yellow dot meant; LPN #1 did not know what the yellow dot meant and stated that the resident was on a mechanical soft diet (texture modified diet).<br><br>The surveyor interviewed the Food Service Director (FSD) who stated that the kitchen staff plated the resident's meal tray, and that a yellow dot indicated a chopped diet (texture-modified). The FSD stated that a yellow dot with a N indicated NTL. Resident #19's meal card did not have a yellow dot with a N.<br><br>The surveyor interviewed the MD [medical doctor] who confirmed that Resident #19 had a medical diagnosis of Parkinson's Disease (a movement disorder of the nervous system) and had a high risk of aspiration that could lead to pneumonia and death.<br><br>The surveyor interviewed the Speech Language Pathologist (SLP), who revealed that the resident was on NTL and could not be served mandarin oranges in its own juice because the resident's vocal cords would not be able to close in time and the liquid would go into their lungs and cause aspiration.<br><br>The facility's failure to ensure a cognitively impaired resident with a PO for NTL was provided the appropriate consistency diet posed a likelihood of choking and aspiration which could result in serious harm, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation.<br><br>The IJ began on 10/23/24 at 12:28 PM, when Resident#19 was observed choking after being served whole mandarin oranges in thin liquid. The facility's Administration was notified of the IJ on 10/23/24 at 5:00 PM. The facility submitted an acceptable removal plan (RP) on 10/24/24 at 2:11 PM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 10/23/24.<br><br>The evidence was as follows:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of the facility Food Labels for Dietary Consistency policy with a review date of 2024, included food diets are marked by colored labels . yellow labels are soft chopped . yellow dot with N is nectar thick liquids . the colored dots are placed on the name cards and the tray cart . the color is changed if the diet is changed .<br><br>On 10/23/24 at 12:28 PM, during the lunch observation, the surveyor observed Resident #19 coughing while LPN #1 was assisting the resident with their meal. LPN #1 informed the surveyor that the resident started coughing after LPN #1 fed Resident #19 whole mandarin oranges in its own thin juice. LPN #1 stated that Resident #19 was on nectar thickened liquid. The surveyor observed thickened water, thickened coffee, and mandarin oranges in thin liquid juice on the resident's meal tray. The surveyor checked the meal card which revealed a plain yellow dot and no specialized diet. LPN #1 stated they did not know what a yellow dot meant and added the resident was on a mechanical soft diet.<br><br>On 10/23/24 at 12:35 PM, the surveyor interviewed the FSD who stated they plated Resident #19's meal tray and a plain yellow dot indicated a chopped diet and a yellow dot with a N indicated nectar thickened liquid. The surveyor did not observe a N on the resident's meal card.<br><br>On 10/23/24 at 12:45 PM, the surveyor interviewed LPN #1 and LPN #2 who both stated they did not receive education regarding diet consistencies.<br><br>On 10/23/24 at 1:19 PM, the surveyor interviewed the facility's MD, who was also Resident #19's primary care physician. The MD stated that the resident had a medical diagnosis which included Parkinson's Disease which contributed to a high risk of aspiration that could lead to pneumonia and death as a result.<br><br>On 10/23/24 at 2:39 PM, the surveyor conducted a telephone interview with the Registered Dietician (RD) who confirmed that Resident#19 had a PO for NTL, and it was not appropriate for the resident to be served the whole mandarin orange in its own juice as it could lead to aspiration.<br><br>On 10/23/34 at 3:24 PM, the surveyor interviewed the facility's SLP who stated the mandarin orange in its own juice cannot be served to a resident who was on NTL because the vocal cords would not be able to close in time and the liquid could go down their lungs and cause aspiration.<br><br>On 10/23/24 at 1:10 PM, the surveyor reviewed Resident #19's electronic medical record.<br><br>A review of the quarterly Minimum Data Set, an assessment tool used to facilitate the management of care dated 7/21/24, reflected Resident#19 had a brief interview for mental status (BIMS) score of 3 out of 15, indicating that the resident had severe impaired cognition. A review of Section K revealed the resident received a mechanically altered diet.<br><br>A review of the Admission Record face sheet (an admission summary) revealed that Resident #19 was admitted to the facility with diagnoses which included but were not limited to: Parkinson's Disease, unspecified abnormal involuntary movements, and unspecified dementia.<br><br>A review of a PO dated 5/1/23, revealed a diet order for regular diet. mechanical soft texture, nectar/mildly thick consistency, chopped.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of the individualized comprehensive care plan included a focus area dated 5/31/22, that the resident had a potential nutrition risk due to a mechanically altered diet. The goal included that the resident would tolerate their diet order without signs and symptoms (s/s) of aspiration. Interventions included to provide mechanical soft diet with nectar thickened liquids.<br><br>A review of the key information section located in the electronic medical record revealed Special Instructions, Takes medications whole with nectar thickened liquids.<br><br>A Review of the Physician's progress notes dated 8/3/24 at 3:02 PM, included the resident was seen and examined while seated in a chair. The resident was awake but confused with tremors and head movements.<br><br>A review of the Speech Therapy (ST) Progress Notes (PN) documented by the SLP on 10/7/24 at 12:53 PM, included the resident was seen in their wheelchair in the dining room for dysphagia (difficulty swallowing) evaluation due to reported coughing during meals. The resident was currently on chopped diet with NTL with a recommendation to continue current diet. The recommendation was reviewed with nursing.<br><br>A review of the Nutrition/Dietary quarterly note dated 10/19/24 at 8:11 AM, documented by the RD included the resident continued on a mechanical soft/chopped diet with NTL. The resident was seen by the SLP on 10/7/24, with no new diet orders, but it was recommended the resident be fed.<br><br>On 10/23/24 at 5:00 PM, the survey team interviewed the LNHA, DON and Business Office Manager (BOM) who all confirmed Resident #19 should not have been fed the mandarin orange in thin juice since the resident was on a NTL diet. No further information was provided to the survey team.<br><br>The acceptable RP on 10/24/24 at 2:11 PM, indicated the action the facility will have to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: Resident #19 was assessed by the Registered Nurse and MD; all nursing and kitchen staff were in-serviced on facility's consistency and added diet policy; any food with liquid consistency added such as sauce, gravies, natural juices and syrups will have added thickener for appropriate diet consistency and any diet changes will be communicated to the Charge Nurse who will communicate to the kitchen. The survey team verified the implementation of the RP during the continuation of the on-site survey on 10/24/24.<br><br>44605<br><br>Part B<br><br>Based on observation, interview, record review, it was determined that the facility failed to accurately investigate the cause of a fall incident for 1 of 3 residents (Resident #15) reviewed for falls, and was evidenced by the following:<br><br>On 10/22/24 at 10:45 AM, the surveyor observed Resident #15 seated in their wheelchair in their room with family present. Resident #15's family stated that the resident had a recent fall in the bathroom. The family member also stated that the facility notified them via telephone on the day of the fall incident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of Resident #15's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to; dementia, low back pain, and retention of urine.<br><br>A review of a Quarterly Minimum Data Set, dated dated dated [DATE], revealed that the resident was unable to complete a Brief Interview for Mental Status (BIMS) due to severe memory impairment.<br><br>A review of the progress note (PN) dated 9/25/24 at 5:28 AM, revealed that Resident #15 was found lying in the bathroom. The PN also indicated the nursing staff assessed the resident and obtained vital signs.<br><br>A review of the Fall risk evaluation completed on 6/17/24, revealed that Resident #15 was at a moderate risk for falls.<br><br>A review of the Physician Orders (PO) dated 9/25/24 revealed a PO for Right hip x-ray stat rule out (r/o) fracture.<br><br>A review of Resident #15's comprehensive Care Plan (CP) revealed under focus with a revision date of 9/28/24 titled, The resident is at risk for falls r/t confusion, and had an unwitnessed fall with no injury. Further review of the CP included an intervention dated 9/28/24, to encourage resident to use call bell for help.<br><br>On 10/24/24 at 9:46 AM, the surveyor interviewed the Director of Nursing (DON), who stated the facility does not complete fall investigation reports and any information regarding a fall incident would be documented under the nursing progress note found in the electronic medical record. The DON further added that there were no witness statements obtained after the fall.<br><br>On 10/24/24 at 9:55 AM, the DON provided the surveyor a facility policy titled Falls, with an implementation date of 6/2024, under the policy section which revealed, All falls are to be investigated and monitored. The facility will maintain a record that contains a list of all incidents and falls. Under the program steps of the policy included, F . Complete Incident/Event Report. G. Start Investigation Report. H. Obtain detailed statements from any witnessed. Statements must be signed with the correct date and time for fall with serious injuries.<br><br>On 10/24/24 at 12:21 PM, the survey team met with the Licensed Nursing Home Administrator (LHNA), DON and Business Office Manager (BOM) to review the above concern. The DON stated a complete fall investigation that included statements from witnesses was not completed for Resident #15's fall incident that occurred on 9/25/24.<br><br>On 10/31/24 at 11:15 AM, the survey team met with the LHNA, DON, BOM and the Operator of the facility to discuss the above concern. There was no additional information provided.<br><br>NJAC 8:39-27.1(a); 31.4(a); 33.1(d)<br><br>NJAC 8:39-17.4 (a)1-2; 27.1(a) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>44605<br><br>Based on observation, interview, and record review it was determined that the facility failed to ensure residents with significant weight changes (a weight change of 5% in 30 days and/or 10% in 180 days) were addressed by the Registered Dietitian (RD) in a timely fashion. This deficient practice was identified for 2 of 2 residents reviewed for significant weights changes (Resident #3 and #14), and was evidenced by the following:<br><br>1. On 10/22/24 at 10:30 AM, the surveyor observed Resident #3 seated in their wheelchair on the outside deck of the facility. Resident #3 stated they had weight gains and losses but was not sure of their current weight.<br><br>A review of Resident #3' Admission Record (AR) (admission summary) revealed that the resident was admitted to the facility with diagnosis that included but were not limited to paranoid schizophrenia, gastro-esophageal reflux disease, and muscle wasting and atrophy.<br><br>A review of the Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated 9/15/24 reflected a Brief Interview for Mental Status (BIMS) was not assessed/completed.<br><br>A review of the weights documented in the electronic medical record (EMR) revealed that on 9/2/24 and 10/1/24, Resident #3's weight was 135.4 pounds (lb.) and on 10/2/24, the resident's weight was 146.2 lb. which indicated a 10.8 lb. gain or 7.98% significant weight change in the last 30 days.<br><br>A review of the nutrition progress notes in the EMR revealed the last nutrition note documented for Resident #3 was dated 9/9/2024.<br><br>37791<br><br>2. On 10/22/24 at 11:58 PM, the surveyor observed Resident #14 who was seated in a wheelchair while organizing personal items on their dresser. The resident was unable to respond to the surveyor during the interview.<br><br>A review of Resident #14's AR revealed that the resident was admitted to the facility with diagnosis that included but not limited to; hypertension (a condition in which the force of the blood against the artery walls is too high), type II diabetes(a long-term condition in which the body has trouble controlling blood sugar and using it for energy), depression (a mental health condition that involves a prolonged low mood and a loss in interest in activities, that were previously enjoyable), and anxiety disorder ( a mental health disorder characterized by feeling worry, anxiety, or fear).<br><br>A review of the Q/MDS, an assessment tool used to facilitate the management of care, dated 6/16/24, reflected a BIMS score of 11 out of 15, which indicated that the resident had a moderate cognitive impairment.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the weights documented in the EMR revealed that on 9/30/24 and 10/1/24, Resident #14's weight was 171 lb. and on 10/14/24, the resident's weight was 161.4 lb. which indicated a 9.6 lb. loss or 5. 0% significant weight change since 9/23/24.<br><br>A review of the nutrition progress notes documented in the EMR revealed the last nutrition note documented for Resident #14 was on 9/21/2024.<br><br>A review of Resident #14's comprehensive care plan revealed the following nutrition care area with a focus titled, The resident has nutritional problem or potential nutritional problem appetite and weight change. A review of the goal included, The resident will maintain adequate nutritional status as evidenced by maintaining weight with +/- of calculated body weight (CBW), no sign and symptoms of malnutrition, and consuming at least 75% of at least 2 meals daily.<br><br>On 10/23/23 at 11:45 AM, the survey team conducted a telephone interview with the RD who stated, resident's weights were done monthly by the 5th of the month and will be documented in the EMR. The RD further stated for any resident with a significant weight change, they will be immediately re-weighed to confirm the weight change. The RD also stated, after the resident would be re-weighed, the RD will document a nutrition weight change immediately to address the possible reasons for the weight change and would add interventions if needed. The RD further stated that not all the residents with significant weight change have been addressed at this time. The RD could not provide an information why the residents with significant weight change have not been addressed.<br><br>On 10/24/24 at 9:00 AM, the Director of Nursing (DON) provided the surveyor with a facility policy titled, Resident Rights - Weight Management with a reviewed date of 10/2024. Under the procedure section of the policy, it stated, 3. Monthly weights will be completed by the fifth (5th) of each month. 4. Dietary will evaluate all weights by the seventh (7th) of each month. 5. A reweight will be obtained for any weight change of +/- three (3) lbs. (pounds) from the previous weight unless other parameters have been ordered by the physician.<br><br>On 10/24/24 at 12:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and the Business Office Manager (BOM) to review concerns. The LHNA stated the RD comes in twice a week but could not provide an explanation why the residents with significant weight changes had not been addressed.<br><br>On 10/30/24 at 11:15 AM, the survey team met with the LHNA, DON, BOM and the Operator of the facility to conduct the exit interview. There was no further information provided.<br><br>NJAC 8:39 - 11.2(e)(1)(f), 17.1(c), 17.2(c)(d), 27.1(a) |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observe each nurse aide's job performance and give regular training.<br><br>39399<br><br>Based on observation, interview and review of facility provided documentation, it was determined that the facility failed to ensure that the Certified Nursing Aide (CNA) received a performance review for one (1) of five (5) CNA files reviewed.<br><br>This deficient practice was evidenced by the following:<br><br>On 10/22/24 at 10:27 AM, the surveyor requested from the facility's Director of Nursing (DON) and Business Office Manager (the annual education, competencies, and performance reviews for five randomly selected CNAs.<br><br>The facility provided a copy for each of the five CNA's records which contained their post tests for the education they received. The facility did not provide performance reviews for the five CNAs.<br><br>On 10/29/24 at 12:02 PM, the surveyor interviewed the DON regarding performance reviews who stated that she did not complete all the required annual performance review for everyone who was hired within the last year except for 1 CNA. The DON confirmed that the other 4 CNAs did not have performance reviews.<br><br>A review of the facility's policy titled, Job Descriptions - Written with a 2024 review date revealed under #4. Department Directors are responsible for reviewing the job description with the employee during the employee's orientation process, when changes are made in the job description, and during annual performance and comptency evaluations.<br><br>On 10/29/24 at 01:44 PM, the survey team met with the Licensed Nursing Home Administrator, DON and BOM and discussed the above concern that the four CNAs did not have an annual performance review. The DON stated the facility was working on the performance reviews. The facility did not provide any additional information.<br><br>FACILITY POLICY<br><br>N.J.A.C. 8:39-43.17 (b) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>37791<br><br>Based on observation, interview, and record review, it was determined that the facility failed to follow acceptable standards of clinical practice for accurately administering medications according to the physician's order (PO). This deficient practice was identified in 1 (one) of 12 (twelve) residents (Resident #20) observed during the medication observation pass.<br><br>The deficient practice was evidenced by the following:<br><br>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.<br><br>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.<br><br>On 10/28/24 at 9:10 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse #1 (LPN#1) in the room of Resident #20. The surveyor observed LPN #1 checked the resident's identification bracelet prior to administering Resident #20's medications.<br><br>On 10/28/24 at 9:15 AM, the surveyor observed LPN #1 prepared to administer six (6) medications to Resident #20 which included Norvasc 10 mg tablet (medication for lowering blood pressure), Cyanocobalamin 1000 mcg tablet (supplement), Ferrous Sulfate 325 mg (supplement), Januvia 50 mg (medication for) blood sugar, Depakote 125 mg sprinkles (medication for mood disorder) and Colace 100 mg tablet (medication for constipation). The surveyor observed LPN #1 crushed Norvasc, Cyanocobalamin, Ferrous Sulfate, Januvia, and Colace then added the crushed medications into a medication cup and then mixed with apple sauce. The surveyor then observed LPN #1 opened the Depakote 125 mg sprinkle capsule and emptying the contents of the capsule into the apple sauce that contained all the other crush medications. The surveyor then observed LPN#1 administered the medications to Resident #20.<br><br>A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to hypertension (elevated blood pressure), type II diabetes mellitus(a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315467 | A. Building<br>B. Wing | 10/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Little Brook Nursing and Convalescent Home | 78 Sliker Road<br>Califon, NJ 07830 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the Annual Minimum Data Set, an assessment tool used to facilitate the management of care, dated 8/11/24, reflected that the resident's cognitive skills for daily decision-making score was 0 (zero) out of 15, which indicated that the resident's cognition was severely impaired.<br><br>A review of the October 2024 Order Summary Report revealed a PO dated 3/1/23, for Ferrous Sulfate oral tablet 325 mg (65 FE)Mg (Ferrous Sulfate) give 1 tablet by mouth one time a day for supplement.<br><br>A review of the September 2024 electronic Medication Administration Record revealed a PO dated 3/1/23, for Ferrous Sulfate oral tablet (65 FE) Mg (Ferrous Sulfate) give 1 tablet by mouth one time a day for supplement.<br><br>A review of the manufacturer's specification for the medication Ferrous Sulfate revealed to, Swallow the tablets, film-coated tablets, and extended-release tablets whole; do not split, chew or crush them.<br><br>On 10/29/24 at 12:00 PM, the surveyor interviewed LPN#1 who acknowledged that Ferrous Sulfate should have not been crushed. LPN #1 further stated that if the resident was unable to swallow the Ferrous Sulfate tablet, she would obtain a PO for Ferrous Sulfate liquid.<br><br>A review of the facility's policy titled, Administering Medication with a review date of 12/31/12 provided by the DON revealed, Medications must be administered in accordance with the orders, including the required time frames.<br><br>On 10/29/24 at 1:00 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above concerns. There was no additional information provided.<br><br>NJAC 8:39-11.2 (b), 29.2 (d) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37791<br><br>Based on observation, interview, and record review, it was determined that the facility failed to properly label, store, and dispose medications in one (1) of two (2) medication carts inspected.<br><br>This deficient practice was evidenced by the following:<br><br>On [DATE] at 11:35 AM, the surveyor inspected medication cart #1 in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed an opened vial of Fiasp insulin with an opened date of [DATE] and was expired. The surveyor also observed two opened bottles of Pro-Stat AWC (protein supplement), one bottle had an opened date of [DATE] and a second bottle with an opened date of [DATE]. Both bottles of Pro-Stat AWC were expired.<br><br>At that time, the surveyor interviewed LPN#1 who acknowledged that both the Fiasp insulin vial and the two bottles of Pro-Stat AWC were expired and should have been removed from the medication cart.<br><br>A review of the manufacturer's specifications for the following medications revealed that the Fiasp insulin had an expiration date of 28 days once opened and Pro-Stat AWC had an expiration date of 90 days once the bottle was opened.<br><br>A review of the facility's policy titled Storage of Medications that was undated and provided by the Director of Nursing (DON) revealed the following: 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.<br><br>On [DATE] at 1:00PM, the survey team met with the Licensed Nursing Home Administrator and DON to discuss the above concerns. There was no additional information provided.<br><br>NJAC: 8:,d+[DATE].4 (a) (h) (d) |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.<br><br>44605<br><br>Based on observation, interview, record review, and review of facility policy, it was determined that the facility staff failed to ensure a resident received liquids in the appropriate consistency at meals in accordance with physician orders for 1 of 1 resident (Resident #1).<br><br>This deficient practice was evidenced by the following:<br><br>On 12/26/24 at 11:37 AM, during the kitchen inspection, the surveyor observed Resident #1's lunch tray with tray card listing the resident's diet, diet consistency and liquid consistency. The surveyor further observed Resident #1's tray card which revealed the current diet order was Regular diet, mechanical soft consistency (mechanical soft diet consists of any foods that can be blended, mashed, pureed, or chopped using a kitchen tool such as a knife, a grinder, a blender, or a food processor) and nectar thick liquids (nectar thick liquids are thicker than water, fall slowly from a spoon, and are sipped through a straw or from a cup). The surveyor observed a cup with a clear liquid labeled nectar on Resident #1's tray.<br><br>A review of the Resident Face Sheet (an admission summary) reflected that Resident #1 was admitted to the facility with diagnoses that included but were not limited to Covid-19, severe protein-calorie malnutrition, and type 2 diabetes mellitus without complications.<br><br>A review of the Admission Minimum Data Set (an assessment tool used to facilitate care management) dated 10/11/24, reflected that the resident had a Brief Interview for Mental Status (BIMS), which revealed that the BIMS score was not assessed.<br><br>A review of the Physician Order's (PO) reflected an order dated 12/16/24, for NCS (No Concentrated Sweets) diet, Mechanical Soft Texture, Regular/Thin consistency liquids.<br><br>On 12/26/24 at 12:15 PM, the surveyor interviewed Dietary Aide #1 (DA#1), who stated they were not aware the Resident #1's liquid consistency had changed. DA#1 further stated to the surveyor the nurses on the unit would alert the dietary staff for any diet changes.<br><br>On 12/26/24 at 12:30 PM, the Director of Nursing (DON) provided the surveyor with a facility policy titled, Following Physician Orders with a revised date of 5/2024, Under the procedure section of the chart revealed, All staff are required to follow physician orders without question. Another facility policy provided titled, Food and Nutrition Service with a revised date of 5/20204 stated under the procedure section, 9 . The dietary staff will change the diet texture, liquid consistency, and therapeutic diet order from the physician.<br><br>On 12/26/24 at 1:00 PM, the survey team met the Licensed Nursing Home Administrator and DON to review the above concern. No further comments provided.<br><br>NJAC 8:39-17.4(a)(1) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>44605<br><br>Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness.<br><br>This deficient practice was observed and evidenced by the following:<br><br>On 10/22/24 9:07 AM, the surveyor in the presence of the Food Service Director (FSD) observed the following during the kitchen tour:<br><br>1. The surveyor observed three dented cans (6 lb. peaches, 6 lb. potatoes, and 6 lb. shredded potatoes) stored with all intact canned goods. FSD stated those cans should have been removed and placed in the dented can area.<br><br>2. The surveyor observed the canned goods stored on the top of the storage unit were warm to the touch with a heat vent observed on ceiling next to the canned goods.<br><br>3. The surveyor observed three portable window air conditioning units (AC). All three AC units were observed with a blackish dust like build up on the vents. The AC unit located next to the 3 compartment sink and food prep area was also noted with a brown colored sticky substance on the left vent. The FSD stated the maintenance department was in charge of cleaning the AC units.<br><br>4. The surveyor observed the FSD tested the sanitizing solution on the low temperature dish machine (LTDM). The FSD recorded the sanitizer concentration at zero parts per million (PPM). The surveyor further observed the LTDM log which was used to record the daily temperatures of the LTDM and the sanitizing solution. The daily temperatures were recorded except the sanitizer PPM. The FSD stated sanitizer PPM test must be recorded. The FSD could not provide an explanation why the sanitizer PPM has not been recorder. The surveyor observed an empty bottle of sanitizing solution connected to the dish machine.<br><br>On 10/24/24 at 9:00 AM, the Business Office Manager (BOM) provided the surveyor with facility policies titled, Food Storage, Equipment with a revision date of 5/2024 and revealed under the procedure section, 8. Dented cans are removed to a separate area and returned to sender. The equipment policy with a revision date of 10/2024, states under the procedures section, 1 . All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions .4. All non-foods contact equipment will be cleaned and free of debris. A review of the policy titled, Dishwashing Machine Use with a revision date of 10/2024 under the procedures section, 4. Dishwashing machine chemical sanitizer concentrations and contact times will be as followed, Chlorine 50-100 PPM for 10 seconds. 5. A supervisor will check the dishwashing machine for proper concentrations of sanitizer solution. Concentrations will be recorded in a facility approved log. 6. Corrective actions will be taken immediately of sanitizer concentration are too low.<br><br>On 10/24/24 at 12:21 PM, the survey team met with the Licensed Nurse Home Administrator (LNHA), Director of Nursing and BOM to review the above concerns. No further comments provided.<br><br>(continued on next page) |

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| | 315467 | A. Building<br>B. Wing | 10/30/2024 |

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| Little Brook Nursing and Convalescent Home | 78 Sliker Road<br>Califon, NJ 07830 |

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | NJAC 8:39-17.2(g) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>46889<br><br>Based on observation, interview, record review, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for (1) one of (5) five residents (Resident #28) reviewed for unnecessary medication.<br><br>This deficient practice was evidenced by the following:<br><br>On 10/23/24 at 10:15 AM, the surveyor observed Resident #28 in bed, awake, covered with a blanket, and unable to answer the surveyor's inquiry.<br><br>On 10/23/24 at 11:23 AM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #28, which revealed the following:<br><br>A review of the Admission Record (an admission summary) reflected that Resident #28 was admitted to the facility with diagnoses that included but were not limited to unspecified dementia (memory loss), unspecified severity, with other behavioral disturbances.<br><br>A review of the recent annual Minimum Data Set (An/MDS), an assessment tool used to facilitate the management of care, dated 9/8/24, reflected that Resident #28 had a Brief Interview for Mental Status score (BIMS) score of 0 (zero) out of 15, indicating severely impaired cognition.<br><br>A review of the September 2024 Order Summary Report (OSR) included a physician's order (PO) dated 9/15/23 for Risperidone 0.5 mg (milligrams) to be administered one tablet by mouth one time a day.<br><br>A review of the September 2024 electronic Medication Administration Record revealed the above PO for Risperidone that was signed by the nurses which indicated that the medication was administered from 9/16/23 through 9/30/24.<br><br>A review of the form Initial Consultation/Evaluation revealed Resident #28 was seen by [Name Redacted] Behavioral Service on 12/3/23.<br><br>Further review of the hybrid medical records revealed no other Psychiatric consults (PC) sheets after 12/3/23.<br><br>On 10/24/24 at 9:58 AM, the surveyor interviewed the Director of Nursing (DON), who confirmed that there were no PC sheets found in the hybrid medical record. The DON stated that she was waiting for the psychiatrist to send it to the facility.<br><br>The facility did not provide a policy regarding medical record keeping.<br><br>On 10/29/24 at 8:52 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON, who acknowledged that the psychiatric notes were not in the chart. The DON stated that the psychiatrist had it with him in his possession.<br><br>(continued on next page) |

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| | 315467 | A. Building<br>B. Wing | 10/30/2024 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | NJAC 8:39-35.2(a)(d)4 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39399<br><br>Based on observation, interview and record review, it was determined that the facility failed to 1. ensure the sharps container (SC) that were filled with contaminated sharps/needles were disposed properly, 2. ensure the used COVID19 Ag test card was discarded after use, 3.ensure the clean linen room was free from soiled device and 4. ensure the Personal Protective Equipment (PPE) cart was cleaned to prevent the spread of infection. This deficient practice was evidenced by the following:<br><br>1. On 10/22/24 at 9:00 AM, two surveyors observed a used COVID19 Ag test card exposed laying on the table right by the entrance door where all the visitors and staff enter the facility. The surveyor further observed that the COVID19 Ag test card showed a one red line indicating the results was negative (-). The surveyor also observed a red bio hazard bin next to the table where the test card was observed.<br><br>On 10/22/24 at 9:15 AM, the surveyor interviewed the Business Office Manager (BOM) who stated the facility provided COVID19 test kits to all the visitors and staff who wish to test themselves. The unused test kits were observed inside the basket by the entrance door. The BOM also added the used COVID19 Ag test card was supposed to be discarded in the red bio hazard bin after the results are revealed.<br><br>On 10/22/24 at 11:25 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the COVID19 Ag test card was supposed to be discarded after use.<br><br>A review of the facility's policy titled, Used Covid Test Cards revealed under Procedure: Upon administrating a COVID PRC test the recipient must wait, read the results of the test and place the exposed Covid Card in the Stericycle container next to the testing area . At the beginning of each shift the Charge Nurse will ensure all used COVID cards are placed in the Stericycle container.<br><br>On 10/24/24 at 12:49 PM, the surveyor discussed the above concerns with the facility's Licensed Nursing Home Administrator and the DON. No additional information was provided.<br><br>2. On 10/23/24 at 11:25 AM, the surveyor together with the facility's Director of Nursing (DON) toured the clean storage room located in a shed adjacent to the facility. Upon entering the locked storage room, the surveyor observed several SC boxes piled up in a bio-hazard bag that were overflowing in a bin next to the clean incontinence briefs and toilet papers. The surveyor further observed that the bin had a lock that wasn't secured. The DON stated they were unable to secure the lock since the SC overflowed the bin. The DON added that the SC box were filled with contaminated needles.<br><br>The surveyor interviewed the DON who stated it was the Maintenance Director's responsibility to call the company who will then come and pick up the SC bins. The DON further stated to the surveyor that the SC was overflowing and it was long overdue to be picked up by the licensed vendor.<br><br>On 10/23/24 at 12:30 PM, the surveyor interviewed the Business Office Manager (BOM) who stated the last time their SC were picked up was in January 2024.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A review of the facility's policy titled, Medical Waste, Handling of with a review date of 2024 revealed under General Guidelines #2. All sharps must be handled as medical waste, placed in approved sharps containers, and sent for eventual incineration. The DON provided the surveyor another policy titled, Needle Handling and/or Disposal with a review date of 2024 and revealed under Safety Precautions #2. Place used needles in the needle disposal box. Do not bedm break, or cut needles. When the disposal box is three-quarter filled or at fill line seal the box and store it in a closed, puncture-resistant container marked Biohazard until incinerated or picked up by a licensed vendor for proper disposal.<br><br>On 10/29/24 at 1:44 PM, the survey team discussed the above concern to the facility's Licensed Nursing Home Administrator, DON and BOM. No further information was provided.<br><br>46889<br><br>3. On 10/23/24 at 10:18 AM, the surveyor toured the clean linen room in the presence of the Director of Nursing/Infection Preventionist (DON/IP). The surveyor observed a dark blue colored heel elevator device ([NAME]) with a white stain on the side and was placed on top of the clean gown. The DON/IP acknowledged that the device does not belong to the clean linen room. The DON/IP could not provide an explanation why the [NAME] was inside the clean linen room that was placed on top of the clean gown.<br><br>4. On 10/23/24 at 10:23 AM, the surveyor observed a 3 drawer cart during the tour with the DON/IP in the hallway. The surveyor observed the cart with a splatter of dark brown substances on the right side from the first drawer to the third drawer of the cart. The DON/IP stated that it was a PPE cart that was inactively used. The DON/IP acknowledged that the PPE cart should not placed be in the hallway if not in use and a housekeeping staff should clean it before putting them away.<br><br>A review of the policy and procedure titled Cleaning and Disinfection of Resident-Care Items and Equipment, with a review date in 2024, stated that under Policy Interpretation and Implementation 2. Critical and semi-critical items will be sterilized/disinfected in a central processing location and stored appropriately until use .<br><br>On 10/24/24 at 1:10 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON/IP regarding the above concern. The DON/IP acknowledged that any therapy devices should not be inside the clean linen room and that the unused PPE cart should not be in the hallway.<br><br>NJAC 8:39-19.3(a);19.4(l);21.1(a) |