STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315471	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Catherine of Siena	7 Ryerson Avenue Caldwell, NJ 07006

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm 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. 37791 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. This deficient practice was identified for 1 of 1 resident, Resident #16, reviewed for hospitalization . On 12/31/24 at 8:15 AM, the surveyor observed Resident #16 during medication administration. The resident was seated in their wheelchair and was alert and oriented. A review of Resident #16's hybrid (paper and electronic) medical records revealed the following: 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), depression (mental health condition that causes low mood and loss of interest in activities for a prolonged period) and history of urinary tract infection. A review of the Discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 12/02/24, reflected that Resident #16 was discharged to the hospital with a return anticipated to the facility. A review of a Nurses progress note dated 12/02/24, revealed that Resident #16 was transferred to the hospital. A nurses note dated 12/03/24, revealed that the resident was admitted to the hospital. On 12/31/24 at 10:15 AM, the surveyor interviewed the Director of Nursing (DON), who stated she doesn't send a written notification to the resident's representative nor the Ombudsman Office for a letter of emergency transfer. The DON stated that the resident's representative was notified when a resident is sent out to the hospital. When the surveyor asked the DON which department was responsible for sending out the written emergency transfer notification, she stated she doesn't believe that anyone sends out those letters. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/24 at 10:30 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding who's the staff responsible for mailing out the emergency transfer letter to the resident's representatives and to the Ombudsman office. The LNHA stated that the facility doesn't send out these letters. On 12/31/24 at 1:00 PM, the surveyor discussed the above concerns with the LNHA and the DON. The LNHA stated that the facility had no policy related to sending out a written emergency letter to the resident's representative or the Ombudsman office when a resident will be transferred to the hospital. No further information was provided. NJAC 8:39-5.3; 5.4

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 37791 Based on interviews and record review, it was determined that the facility failed to provide the resident or resident representative appropriate written notification of the facility's bed hold and reserve payment policy upon transfer to the hospital for one of one residents (Resident #16) reviewed for hospitalization s. The deficient practice was evidenced by the following: On 12/31/24 at 8:15 AM, the surveyor observed Resident #16 during medication administration. The resident was seated in their wheelchair and was alert and oriented. A review of Resident #16's hybrid (combination of paper and electronic) medical record revealed the following: A 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 hypertension (elevated blood pressure), depression (mental health condition that causes low mood and loss of interest in activities for a prolonged period) and history of urinary tract infection. A review of the Discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 12/02/24, reflected that Resident #16 was discharged to the hospital with a return anticipated to the facility. A review of a Nurses progress note dated 12/02/24, revealed that the resident was transported to the hospital. A nurses note dated 12/03/24, revealed that the resident was admitted to the hospital. On 12/31/24 at 10:15 AM, the surveyor interviewed the Director of Nursing (DON), who stated that she doesn't send out a written letter of emergency transfer or a bed hold letter to the resident's representative or the Ombudsman Office. She stated that the resident's representative are notified when the residents are sent to the hospital. She also stated that the resident's room will always be held for the resident. When the surveyor asked the DON if she knows what department is responsible for sending out the emergency transfer letter, she stated that she doesn't believe that anybody sends out these letters. On 12/31/24 at 10:30 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding who's responsible for mailing out written emergency transfer letters and bed hold letters to the resident representatives and the ombudsman office. The LNHA stated that the facility is different from other facilities and that they don't send out these letters. Regarding bed holds, the residents are always guaranteed a bed. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/24 at 1:00 PM, the surveyor discussed the above concerns with the LNHA and the DON. The LNHA stated that the facility had no policy that address that a written emergency letters are sent out to the resident's representative or the Ombudsman office. The LNHA further stated that the residents are guarantee a bed upon return from an emergency transfer. She also stated that the facility has a bed hold policy. No further information was provided. A review of the facility policy titles Bed hold dated 04/30/24, and was provided by the DON which revealed the following: 1. All residents/representative are provided with written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave.) N.J.A.C. 8:39-5.1 (a); 5.2 (a)

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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** 44605 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 3 of 12 residents, (Resident #23, Resident #28 and Resident #17) reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: 1. On 12/27/24 at 10:08 AM, the surveyor observed Resident #23 in their bed with their eyes closed. On 12/27/24 at 10:10 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who was the nurse providing care for Resident #23. LPN #1 stated Resident #23 was transitioning off a tube feeding (Enteral nutrition (EN), also called tube feeding, is a way of providing nutrition and fluids directly into the gastrointestinal (GI) tract through an enteral access device (feeding tube) that is placed with its tip in the stomach or small intestine) and is only receiving water flushes at this time. Review of Resident #23's Face Sheet (FS) (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but was not limited to gastrostomy, hemiplegia(one-sided paralysis) and hemiparesis (weakmess to one side of the body) following cerebral infarction (blood flow in the brain is blocked), and aphasia (difficult to understand and express language). Review of the K section of the 10/16/24 Quarterly MDS for Resident #23 revealed that section K0520 Nutritional Approaches documented under subsection B. Feeding tube (e.g., nasogatric or abdominal PEG) While a resident was listed No, indicating Resident was receiving nutrition or water via PEG. A review of the January 2025 Physician Orders (PO) revealed a PO dated 7/25/24 to Flush G tube with 60 ml of water every shift for Patency. On 12/30/24 at 10:31 AM, the surveyor interviewed the Registered Dietitian (RD) who stated they entered the dietary information in Section K of the MDS, and the tube feeding fluid section of section K was entered incorrectly as Resident #23 is currently receiving water flushes. According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2024) on page K-11-18 . According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2024). This item documents to review the medical record to determine if any of the listed nutritional approaches were performed during the look-back period. If none apply, check K0520Z. None of the above . Nutritional approaches that vary from the normal (e.g., mechanically altered food) or that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating. The resident's clinical condition may potentially benefit from the various nutritional approaches included here. It (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is important to work with the resident and family members to establish nutritional support goals that balance the resident's preferences and overall clinical goals. Coding Tip for K0520B Only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period is coded in K0520B. K0710B, Average Fluid Intake per Day by IV or Tube Feeding Steps for Assessment 1. Review intake records from the last 7 days. 2. Add up the total amount of fluid received each day by IV and/or tube feedings only. 3. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day. 4. Divide by 7 even if the resident did not receive IV fluids and/or tube feeding on each of the 7 days. Coding Instructions Code for the average number of cc per day of fluid the resident received via IV or tube feeding. Record what was received by the resident, not what was ordered. Code 1: 500 cc/day or less. Code 2: 501 cc/day or more. On 12/30/24 at 11:33 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a facility policy, Electronic Signature MDS with a revised date of 12/2024. The policy stated under the assessment section to, Ensure documentation of the Interdisciplinary Team's participation coordination of a resident's assessment and to attest to the accuracy of the section of MDS 3.0. On 12/30/24 at 12:30 PM, the surveyor met with the LHNA and Director of Nursing (DON) to review the above concern. The LNHA stated they were aware of the concern and would review all tube feeding residents. 39885 2. On 12/27/24 at 9:45 AM, the surveyor observed Resident #28 seated in a recliner. The surveyor observed Resident #28's bed did not have any side rails engaged in the upright position. The surveyor interviewed Resident #28 regarding the use of side rails for the bed. Resident #28 stated that the side rail was able to go up and down and that he/she used the side rail to help him/her get out of bed. A review of Resident #28's FS which reflected that the resident was admitted to the facility with diagnoses which included but were not limited to dementia (a general term for a group of brain disorders that cause a decline in cognitive function, including memory, thinking, reasoning, language, and judgment), hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone) and hypertension (high blood pressure) A review of Resident #28's Admission MDS, an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated that Resident #28 cognition was moderately impaired. Further review of the MDS indicated under Section P that the bed rail was used less than daily as a physical restraint. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #28's care plan reflected a focus area that the resident used 2 half side rails which could be considered as restraints however the resident used them to assist with turning and repositioning in bed and helped to pull self up. A review of Resident #28's paper medical record reflected a Side Rail Utilization assessment dated [DATE] which indicated that a Partial rail was indicated to provide safety and serve as an enabler to promote independence. The use of the side rail was not used as a restraint. On 12/30/24 at 11:13 AM, the surveyor observed Resident #28 seated in the recliner. The surveyor observed that Resident #28's bed did not have any side rails engaged in the upright position. On 12/30/24 at 11:20 AM, the surveyor interviewed the Registered Nurse (RN) regarding Resident #28 and the use of restraints. The RN stated to the surveyor that the resident had a wander guard bracelet and that she did not know if the side rail was the restraint. The RN added that the resident did not have side rails. On 12/30/24 at 11:53 AM, in the presence of the survey team, the surveyor, via phone call, interviewed the MDS Coordinator (MDS/C) regarding the MDS coding for restraints under Section P. The MDS/C stated that the previous Director of Nursing stated the siderails were used as enabler. The MDS/C also stated that she visited the facility and had a discussion with the current Director of Nursing (DON) and when they looked at the siderails, they felt that some of the siderails were not falling into the category of enabler bars by definition and their measurements. She added they were considered restraints and we decided to code the side rails as restraints. The MDS/C stated they note that the side rails were for mobility and helping the residents and the care plan also stated it was used for mobility. She acknowledged that in the MDS, the side rails were coded as restraints. The MDS/C explained that the siderails were considered as restraints even though they were used for mobility. The MDS/C also stated that she followed the RAI manual and went to the State Operations Manual for additional informatio but could not find the exact definition that determined the difference between an enabler and a restraint. On 12/30/24 at 12:59 PM, the surveyor interviewed the DON regarding the process for side rails. The DON stated that almost everyone used side rails as an enabler to stand up or to position themselves. The DON stated that the MDS/C suggested the quarter siderails were listed as a restraint in the care plan. The DON stated that in her opinion there was no one in the facility that had a restraint. The surveyor asked the DON why Resident #28's MDS was coded as having a restraint. The DON stated that the MDS/C insisted that anyone with a side rail be coded as a restraint. The DON stated that Resident #28 did not have a restraint and that the resident did not use the side rails all the time. On 12/31/24 at 10:49 AM, in the presence of the survey team, the surveyor told the LNHA and DON the concern that Resident #28's MDS was not coded accurately and the MDS indicated that the Resident #28's quarter side rail was a restraint and not used as an enabler. The DON stated that she did not agree that the quarter siderail was a restraint. She added that an assessment of the side rail was done quarterly and indicated that it was used as an enabler. 46889 3. On 12/27/24, at 09:56 AM, the surveyor observed Resident #17 seated in their wheelchair with eyes closed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/24 at 9:57 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #17, which revealed the following: According to the FS, Resident #17 was admitted to the facility with diagnoses that included but were not limited to Dementia (loss of memory). A review of the quarterly MDS (Q/MDS), an assessment tool used to facilitate the management of care, dated 11/18/24, reflected that the resident had a BIMS score of 6 out of 15, indicating that the resident had severe cognitive impairment. Further review of the Q/MDS dated [DATE] Section P. Physical Restraints Used in Bed A. Bed rail 1. Used less than daily. A review of the December 2024 Order Summary Report (OSR) revealed there was no physician's order (PO) for bed rail use. A review of the comprehensive care plan revealed no care plan for bed rail used. On 12/31/24 at 11:22 AM, the surveyor interviewed the MDS/C regarding the above concern. The MDS/C did not provide further information and added that the facility followed the RAI (Resident Assessment Instrument - a tool that helps gather information about a resident's strengths and needs, which is used to create an individualized care plan) manual. The surveyor reviewed the Centers for Medicare and Medicaid Services (CMS) RAI Version 3.0 Manual, updated October 2024. The RAI manual is revealed under Chapter 3, page P-3, Steps for Assessment 1. Review the resident's medical record (e.g., physician's orders, nurses' notes, nursing assistant documentation) to determine if physical restraints were used during the 7-day look-back period. On 12/31/24 at 11:35 AM, the surveyor interviewed the Director of Nursing (DON), who confirmed that there is no restraint in the building and that Resident #17 had no order for bed rails. NJAC 8:39-11.1, 11.2(e)(1) NJAC 8:39-33.2(d)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46889 Based on observation, interview, and record review, it was determined that the facility failed to administer oxygen (O2) therapy according to the physician's order for 1 (one) of 2 residents (Resident #22) reviewed for respiratory care. This deficient practice was evidenced by the following: On 12/27/24 at 10:05 AM, the surveyor observed Resident #22 in bed asleep, wearing a nasal cannula (a medical device to provide supplemental oxygen therapy to people who have lower oxygen levels) (NC) connected to an oxygen (O2) concentrator at four (4) liters per minute (lpm) on the regulator. On 12/27/24 at 10:25 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #22, which revealed the following: A review of the Admission Record (an admission summary) (AR) reflected that Resident #22 was admitted with diagnoses that included but were not limited to malignant neoplasm (abnormal mass of tissue) of unspecified part of unspecified bronchus or lung. A review of the Admission Minimum Data Set (A/MDS), an assessment tool used to facilitate the management of care with an assessment reference date (ARD) (the last day of the observation period) of 11/27/24, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident had an intact cognition. Further review of the A/MDS Section O - Special Treatments, Procedures, and Programs, C1. Oxygen therapy, B. While a Resident was coded Yes. A review of the December 2024 Order Summary Report (OSR) revealed an active physician's order (PO) with an order date of 11/20/2024 for oxygen at three (3) lpm via NC for sob (shortness of breath) as needed. The above PO for O2 was transcribed to the December 2024 electronic Treatment Administration Record (eTAR) and failed to be signed by a nurse, indicating that O2 was administered to Resident #22 on 12/27/24. On 12/27/24 at 10:10 AM, the surveyor, in the presence of the Certified Nurse Assistant (CNA), checked and confirmed that the O2 was set at 4 lpm via NC from the concentrator regulator. On 12/27/24 at 10:15 AM, the surveyor interviewed the Registered Nurse (RN), who confirmed that Resident #22's is currently on continuous O2 at 4 lpm via NC. On 12/30/24 at 12:15 PM, the surveyor team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The DON did not provide further information. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/24 at 1:49 PM, the LNHA provided a policy titled Oxygen Administration, effective December 2023 under Purpose: Administer oxygen therapy in accordance with the attending physician's orders. When an order is written for PRN (as needed), the oxygen will be administered according to the liters prescribed by the Attending Physician. NJAC 8:39-25.2(c)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 39885 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 an annual performance review for 5 of 5 CNA files reviewed. The deficient practice was evidenced by the following: On 12/27/24 at 12:08 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) the annual performance reviews that were done for 5 randomly selected CNAs. On 12/30/24 at 9:17 AM, the LNHA stated that the facility did not have any performance reviews for the 5 CNAs. She added that the Director of Nursing (DON) had the forms that were to be used but that she had not done the reviews yet. The facility did not provide any documented evidence that the 5 CNAs received an annual performance review. On 12/30/24 at 12:36 PM, in the presence of the survey team, the surveyor told the LNHA and DON the concern that the 5 CNAs did not have an annual performance review. On 12/31/24 at 10:44 AM, in the presence of the survey team and the LNHA, the DON stated that she had been at the facility for 7 months and that she had not conducted any performance reviews since she had started. The LNHA stated that they would have to get up to speed on that. The facility did not provide any additional information. A review of the facility provided policy titled, Employee Evaluation Performance with an effective date of 3/2018, included the following: Policy: Our facility's employee evaluation of performance may be scheduled annually. The purpose of effective performance management is for employees to have a clear understanding of the work expected from them, a. To receive ongoing feedback regarding how they are performing relative to the facility's expectations b. Distribute rewards accordingly c. Identify development opportunities, d. And to address performance that does not meet expectations (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procedure: A facility standard evaluation form is used to guide the performance evaluation process. Employees are scheduled for an evaluation. The employee's review of performance may receive constructive feedback and recommendations for improvement. -Frequency: The policy specifies how often reviews will be conducted, such as annually, bi-annually, or quarterly . -Rewards and training: The policy outlines guidelines for rewards and training N.J.A.C. 8:39-43.17 (b)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. 39885 Based on observation, interview and review of pertinent facility documentation, the facility failed to ensure facility staff that were utilized to assist residents that needed to be fed were appropriately trained and evaluated as competent to be a paid feeding assistant. This deficient practice was evidenced by the following: On 12/27/24 at 10:01 AM, the surveyor entered Resident #12's room. The surveyor observed a staff member (SM) wearing gloves, holding a bowl and a spoon standing next to Resident #12's bed. After the surveyor introduced herself to Resident #12, the SM put down the bowl and spoon on the tray that was on the resident's over the bed table and wiped Resident #12's mouth with a napkin. The surveyor observed that the bedside table was next to the resident's bed and it was not positioned in front of the resident for the resident to feed himself/herself. The surveyor observed that the resident did not have any utensil in his/her hand. The surveyor observed the SM's badge which indicated the SM was a HHA (Home Health Aide). The surveyor asked the SM what she was doing and what her title was. The SM stated that she was feeding the resident and that she was a HHA and also a nursing student that finished her first year. The surveyor interviewed Resident #12 who stated that he/she had a stroke recently but that he/she was doing better. On 12/27/24 at 10:11 AM, the surveyor interviewed Resident #12's Registered Nurse #1 (RN #1) regarding the SM and Resident #12. RN #1 stated that Resident #12 recently was placed on hospice services. RN #1 stated that the SM was a nursing student and that SM helped feed residents. The surveyor asked RN #1 if the SM had a competency done for feeding. RN #1 stated that the SM had a competency for feeding. A review of Resident #12's Admission Record face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to cerebral infarction (also known as an ischemic stroke, is a serious condition that occurs when blood flow to the brain is blocked, causing brain tissue to die) and hypertension (high blood pressure). A review of Resident #12's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that Resident #12 was cognitively intact. On 12/27/24 at 12:42 PM, in the presence of the survey team and Director of Nursing (DON), the surveyor asked the Licensed Nursing Home Administrator (LNHA) for information regarding the SM. The LNHA stated that the SM was in her second year as a nursing student and had a CNA (Certified Nurse's Aide) license in the state of Florida. The LNHA stated that the SM was hired for clerical work. The surveyor asked the LNHA if the SM had a signed job description. The LNHA stated that she did not. The LNHA stated that the SM came to the facility to help when the SM was on break from school. The LNHA stated that the SM received minimal pay and that she thought that the SM only set up residents for meals. The surveyor requested the SM's personnel file. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Catherine of Siena	7 Ryerson Avenue Caldwell, NJ 07006

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the SM's personnel file included an Employee Action Form which indicated she was a new hire on 5/21/24 and that the Current Position was blank. The form did not indicate what position the SM was hired for. Further review of the SM's personnel file included an Employee File Checklist which indicated the hire date was 5/28/24 and the Position was blank. The form did not indicate what position the SM was hired for. There was no documented evidence in the file that indicated the SM had completed a paid feeding assistant course or a competency for feeding a resident was performed. On 12/27/24 at 12:54 PM, the surveyor verified that the SM was licensed as a CNA in Florida. On 12/30/24 at 11:46 AM, the surveyor interviewed RN #2 regarding the SM. RN #2 stated that the SM was a nursing student and was a great help. RN #2 stated that in the summer the SM answered phones and transported residents. She added that last Monday the SM was feeding residents and the nurses were supervising her. The surveyor asked RN #2 how she knew what the SM could do. RN #2 stated that the DON had told them what the SM could do. On 12/31/24 at 9:18 AM, the surveyor interviewed the DON regarding the process for residents that needed to be fed. The DON stated that the CNAs did the feeding typically or the nurses. The DON stated that they did not have paid feeding assistants but that she had taken the course to be a trainer. The surveyor asked the DON about the SM. The DON stated that the SM was here in the summer as an intern a couple days and last week while on college break. The DON stated that the SM worked under her supervision. The DON stated that Resident #12 mostly feeds himself/herself and that Resident #12 had a recent CVA (cerebral vascular accident or stroke) and was on hospice. The DON stated that the SM was just holding the cup for the resident. The DON stated that the LNHA asked the SM to help. The surveyor asked the DON if the SM should be helping feed residents. The DON stated that the SM should not be helping to feed according to her title. The DON added that the SM had training in Florida and was a second year student nurse. The surveyor asked the DON if the SM had a competency done for feeding by the facility. The DON stated no. On 12/31/24 at 10:49 AM, in the presence of the survey team, the surveyor told the LNHA and DON the concern that the SM fed Resident #12 and was not trained to be a paid feeding assistant. On 01/02/25 at 10:49 AM, in the presence of the survey team, the LNHA stated that she did not have any further responses related to the concern. The facility did not provide any additional information. A review of the facility provided policy titled, Paid Feeding Assistance with an effective date of 10/2024, included the following: Policy Paid Feeding Assistant Procedure: 1. In the event of a resident requires assistance with their meals; (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Residents only need encouragement or minimal assistance, which does not require nursing training. b. Properly trained non-nursing personnel could provide this type of assistance. 2. Nurse aides and other nursing staff receive training so that they are able to feed residents with all kinds of feeding problems. 3. A higher level of training is required of nurse aides because nurse aides need to be able to deal with complicated feeding problems. 4. After proper basic training in feeding techniques and working with the elderly, are able to feed residents who do not have complicated feeding problems. 5. in the event of a nurse aide shortage, it is often the case that residents without complicated feeding problems receive little or no assistance at mealtimes with eating or drinking, while the nursing staff focuses on feeding residents with complicated problems. N.J.A.C. 8:39-17.3(c)

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F 0947

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39885

Based on observation, interview and review of facility documentation, it was determined that the facility failed to ensure that a) Certified Nurses Aides (CNA) received 12 hours of mandatory in-service training for 5 of 5 CNAs reviewed (CNA #1, CNA #2, CNA #3, CNA #4 and CNA #5); and b) CNA education included abuse and resident rights for 1 of 5 CNAs reviewed (CNA #1).

This deficient practice was evidenced by the following:

On [DATE] at 12:08 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) the annual education that was provided to 5 randomly selected CNAs.

On [DATE] at 8:41 AM, the LNHA stated that the facility had a book of the education provided which were in person sessions with sign in sheets but that not everyone signed that they attended. She added that the facility did not use a computer-based education system and did not have an educator.

On [DATE] at 9:11 AM, the LNHA provided the binder of inservice sign in sheets that the facility had done. The LNHA stated that capturing everyone was difficult. She added that if the staff did not attend the in person in-service then the staff were to take the material to read and then sign that they done it. She then stated that they all did not sign. The surveyor asked the LNHA if she could provide 12 hours of education for the 5 CNAs that included the mandatory trainings. The LNHA stated she could not provide 12 hours of education for each of the 5 CNAs but that she would check about the mandatory trainings. The LNHA stated that we provided the in-services but that it does not help if the staff did not come.

On [DATE] at 10:58 AM, the LNHA provided the surveyor a document titled Mandatory Inservice's 2024 for each of the 5 CNAs which did not include any indication to how long each of the in-services listed were conducted for and included the following:

CNA #1 with a date of hire (doh) of [DATE] had one in-service listed which was Understanding Dementia. There was no documented evidence that CNA #1 had abuse or resident rights training.

CNA #2 with a doh of [DATE] had 9 in-services listed which included the mandatory trainings of dementia, abuse, and resident rights.

CNA #3 with a doh of [DATE] had 8 in-services listed which included the mandatory trainings of dementia, abuse, and resident rights.

CNA #4 with a doh of [DATE] had 3 in-services listed which included the mandatory trainings of dementia, abuse, and resident rights.

CNA #5 with a doh of [DATE] had 4 in-services listed which included the mandatory trainings of dementia, abuse, and resident rights.

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NAME OF PROVIDER OR SUPPLIER St Catherine of Siena		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Ryerson Avenue Caldwell, NJ 07006	

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the staff sign in sheets provided indicated that the in-services were one hour or one hour and 10 minutes in length. The facility did not provide documented evidence that the 5 CNAs had annual 12 hours of in-service education. On [DATE] at 12:36 PM, in the presence of the survey team, the surveyor told the LNHA and DON the concern that the 5 CNAs did not have 12 hours of education and that CNA #1 did not have abuse and resident rights training. On [DATE] at 10:42 AM, in the presence of the survey team and the DON, the LNHA stated that she was going to hire a health educator. She added that the facility did provide education but that they had to track the education better. The LNHA confirmed that the 5 CNAs did not have the 12 hours of education and that CNA #1 did not have all the required mandatory trainings. The facility did not provide any additional information. A review of the facility provided policy titled Education Nursing Staff with a review date of 2023, included the following: Our facility has yearly required scheduled education for our nursing staff. To promote quality of life and quality of care of resident, Staff will be informed in advance of the required staff education. The following are the required staff education to be completed yearly. 1. Abuse/Neglect . 3. Alzheimer's Disease . 7. Infection Control (each quarter) 8. Resident Rights . 12. CPR The policy did not include any information regarding the amount of hours required for CNAs. N.J.A.C. 8:,d+[DATE].17 (b)