STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315483	A. Building B. Wing	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare & Rehabilitation Center	456 Rahway Avenue Elizabeth, NJ 07202

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46592 Based on record review, interviews, and facility policy review, the facility failed to inform the New Jersey Department of Health (NJDOH) of one of two abuse allegations reviewed for Resident (R)73 and R41 on 05/20/23 within the mandated two-hour period of 35 sample residents. Findings include: Review of the Investigation Summary provided by the facility, dated 05/23/23, revealed the incident occurred on 05/20/23. The residents were questioned on 05/22/23. R41 had no recollection of the event and stated, I can't fight anybody. How can I hit him? R73 stated he slammed the bathroom door shut, and R41 took offense and began yelling. R73 stated he [R73] opened the door and R41 hit him [R73] in the face. The investigation concluded there was not sufficient evidence to sustain the allegation stating, No visible injury to both residents, and no witness to this incident and therefore unable to determine that there was evidence of any physical altercation. The summary was signed by the then Director of Nursing (DON)2 [no longer employed] and the Administrator on 05/23/23 and faxed to the New Jersey Department of Health (NJDOH) on 05/25/23. During an interview on 01/24/24 at 11:40 AM, the Social Service Director (SSD) stated she began the abuse protocol on Monday, 05/22/24, after she heard about the incident. The SSD stated she could not say if anyone else was called within two hours after the nurse heard the allegation on Saturday the 20th, but she [SSD] began the investigation on the following Monday. During an interview on 01/24/24 at 12:15 PM, Licensed Practical Nurse (LPN)2 stated she called the Director of Nursing (DON)2 immediately after the incident between R41 and R73 had occurred. Review of the Reportable Event Record/Report provided by the facility, dated and faxed to the State on 05/22/23, indicated the alleged abuse occurred at 4:20 PM on 05/20/23. The report indicated the event was not significant and was not called in. The report indicated the Resident-to-Resident Abuse box was checked under the Type of Incident section. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/25/2024
NAME OF PROVIDER OR SUPPLIER: Plaza Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 456 Rahway Avenue Elizabeth, NJ 07202	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/24/24 at 1:50 PM, the Administrator stated he was not informed of the incident on the Saturday night of the incident. The Administrator stated he did not answer phones or other communications on the Saturday [NAME]. He found out about the incident on the following Monday and began the process. He agreed the DON2 was called the night of the incident, as LPN2 stated in an earlier interview. The Administrator agreed the NJDOH should have been informed within two hours of the accusation of physical contact between residents. Review of the facility's policy titled, Abuse and Neglect, with a revision date of December 2023, revealed It is the policy of this Center that procedures are in place to prevent any incidence of abuse, neglect, mistreatment, or misappropriation of resident's property. If any actual or alleged incidents occur there is a process in place for the reporting and investigation; pursuant to the instruction in Federal and Long-Term Care statutes. The policy further indicated for identifying abuse: a. All personnel will be instructed/educated on the importance of identifying events. Identifying events: i.e., bruising of unknown origin (Please refer to Types of Abuse at the end of this policy.) b. Anyone witnessing abuse and/or hearing an allegation of abuse must report the incident immediately to their immediate supervisor and the nursing supervisor. c. The supervisor will then report to the Administrator, Nursing Director, and Social Service Director. The policy indicated for initial reporting that all cases involving residents over sixty, alleged abuse, neglect, or exploitation will be reported to the Ombudsman Office, and all appropriate authorities will be notified, as directed in Federal and State statutes. NJAC 8:39-9.4(f)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on interview, record review, and facility policy review, the facility failed to ensure one of five residents (Residents (R) 46) reviewed for Pre-Admission Screening and Resident Review (PASARR) had a PASARR level one updated upon receipt of a new serious mental health diagnoses not previously identified of 35 sample residents. This failure placed residents at risk for unmet care needs and not receiving appropriate and necessary mental health support/services. Findings include: Review of R46's undated Admission Record from the electronic medical record (EMR) Profile tab showed a facility admitted [DATE] with medical diagnoses of bipolar disorder and acquired absence of limb. Review of R46's undated Admission Record from the EMR Diagnosis tab revealed a diagnosis of insomnia was added on 03/10/21; bipolar disorder in partial remission, most recent episode mixed was added on 01/23/23; the diagnosis unspecified psychosis was added on 10/30/23; and the diagnosis of schizoaffective disorder depressive type was added on 12/08/23. Review of R46's EMR Miscellaneous tab showed a PASARR level one completed on 01/18/21 that did not identify any serious mental health diagnosis. During an interview on 01/23/24 at 4:01 PM, in response to a request for a PASARR level two screening, the Administrator provided R46's PASARR level one screening, dated 01/18/21. When R46's EMR Diagnosis tab was reviewed, the Administrator stated, Oh, it should have been resubmitted. During an interview on 01/24/24 at 10:59 AM, the Social Services Director (SSD) stated R46's PASARR level one was received from the hospital on admission. When the PASARR level one was reviewed and no serious mental health diagnosis was identified, the (SSD) stated, That should have been corrected. When R46's EMR Diagnosis tab was reviewed and the SSD saw the psychosis and schizoaffective disorder diagnoses, SSD stated, Yes, it should have been updated with the correct diagnosis. Review of the facility's policy titled, PASARR, dated December 2023, showed: The purpose of the Preadmission Assessment and Annual Resident Review Program (PASARR) policy and procedure is to develop guidelines for admission related to those individuals with mental illness and intellectual disabilities to ensure they receive the care and services needed in the most appropriate setting . The policy did not address an incorrect admission screening or the screening resubmission if a serious mental health diagnosis was received after admission. NJAC 8:39-40.3(d)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, record review, and facility policy review, the facility failed to develop a comprehensive person-centered care plan with goals and approaches for three of three residents (Residents (R) 32, R33, and R71) reviewed for side rail use; and one of three residents (R71) reviewed for limited range of motion of 35 sample residents. Findings include: 1. Review of R32's undated Admission Record from the electronic medical record (EMR) under the Profile tab, showed a facility admitted [DATE], readmission on 09/13/23, with medical diagnoses that included bilateral below knee amputation, dementia, macular degeneration, peripheral vascular disease, and anxiety disorder. Review of R32's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/23, located in the MDS tab of the EMR, showed R32 was rarely or never understood and was totally dependent on staff for bed mobility. Review of R32's Care Plan from the EMR Care Plan tab, showed bed rails were not addressed in any area of the plan of care. During an observation on 01/22/24 at 12:17 PM, R32 was in bed, with an air mattress, being assisted during lunch with one full quarter rail up and one in down position where an aide was seated. During an observation on 01/25/24 at 8:08 AM and 9:15 AM, R32 was observed on an air mattress with bilateral full quarter upper rails in the up position. 2. Review of R33's undated Admission Record from the EMR Profile tab showed an admitted [DATE] with medical diagnoses that included cerebrovascular disease, seizures, hemiplegia, and hemiparesis following a subarachnoid hemorrhage, and dysphagia. Review of R33's quarterly MDS with an ARD of 12/28/23, located in the MDS tab of the EMR, showed R33 had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, indicative of being cognitively intact, and only required staff supervision for bed mobility. Review of R33's Care Plan from the EMR Care Plan tab showed the use of bed rails was not addressed in any area of the plan of care. During an observation and interview on 01/22/24 at 12:21 PM, R33 stated he had been in the facility for nine years. It was observed that he had bilateral upper full quarter bed rails. When asked, R33 stated he used them; when asked if anyone had advised him of the risks and benefits of side rails (an example of a risk of putting an arm through the rail and falling out of bed with the arm entrapped), R33 stated he had not been advised of any risks or benefits. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/25/24 at 8:10 AM and 9:15 AM, R33 was asleep in bed with bilateral upper full quarter rails in the up position. During an interview on 01/25/24 at 2:15 PM, the MDS Coordinator (MDSC) stated, The admission nurse starts the care plan and then all the departments do their own part. Then when I do the MDS I check out the care plan to make sure everything is in there. When asked if bed rails would/should be care planned, MDSC responded, They [bed rails] would be in ADLs [activities of daily living] for like bed mobility. MDSC reviewed R32's care plan at 2:22 PM and commented that the rails should be in one of those ADL areas, then confirmed bed rails were not present in R32's care plan. At 2:25 PM, MDSC reviewed R33's care plan and confirmed bed rails were not present. When queried why bed rails should be care planned, MDSC replied, For safety then clarified, from danger of like falling, or to help positioning in bed. 3. a. Review of R71's quarterly MDS with an ARD of 12/12/23, located in the MDS tab of the EMR, revealed R71 had an admitted [DATE]. R71 had no BIMS score, and cognition was severely impaired. R71 had impairment on one side to the upper extremity (shoulder, elbow, wrist, hand) and on the lower extremity (hip, knee, ankle, foot); was dependent with mobility when lying to sitting on the side of the bed; side rails not used and had diagnoses of epilepsy and cerebrovascular accident (CVA). Review of R71's care plan located in the EMR under the Care Plan tab, dated 07/08/22, revealed R71 has an ADL self-care performance deficit r/t [related to] Confusion, Impaired balance, Limited ROM [range of motion] r/t CVA and an intervention which included Side Rails: 2/half rails up as per Drs [doctor's] order for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Review of R71's side rail assessment provided by the facility, dated 07/07/22, revealed 3. Does the resident has [sic] alternation of safety awareness due to altered cognition? Yes, 5. Does the resident have difficulty moving in bed? Yes, 10. Does resident currently use side rails for independent positioning or to assist with positioning? (enabler) Yes. Alternatives included 2. Reminders to use call light for assistance and 3. Restorative care to enhance independence. Recommendations included 1. Side rails are indicated at the present time. a. They will b. promote independence. Side Rail Utilization included 5a. Sides, a. left, b. right, 5b. Rails b. Half. The assessment did not include the risk of entrapment or what condition the side rails were needed for. Review of R71's order located in the EMR under the Orders tab, dated 05/27/23, revealed Siderails - Half Side Rails. During an observation on 01/23/24 at 9:46 AM, R71 was observed in bed with the side rails in the up position on both sides of the bed. During an observation on 01/24/24 at 9:08 AM, R71 was observed in bed with side rails in the up position on both sides of the bed. During an observation on 01/25/24 at 8:01 AM, R71 was observed in bed with side rails in the up position on both sides of the bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/25/24 at 2:15 PM, the MDSC was asked about care plan development. MDS stated the admitting nurse started the care plans and the department heads developed their own care plans specific to their area. The MDSC stated when she reviewed the care plans, she would add interventions if she noticed they were missing. MDSC was asked about the side rail care plans. The MDSC stated the side rails were included only as an intervention and not a full care plan with goals and objectives saying, the side rails are just under ADLs and not as a problem. The MDSC was then asked should the side rails be fully care-planned if an assessment was conducted. The MDSC stated yes, for safety from danger of falling and repositioning. The MDSC was asked if side rails could present a danger should R71's care plan only address the side rails as only an intervention and not a full care plan with a focus area, goals, and interventions. The MDSC stated, yes it should be fully care planned. 3. b. Review of R71's quarterly MDS, with an ARD date of 12/12/23, located in the MDS tab of the EMR, revealed R71 had an admitted [DATE]; had no BIMS score, cognition was severely impaired; had impairment on one side to the upper extremity (shoulder, elbow, wrist, hand);and used a splint or brace assistance. Review of R71's care plan located in the EMR under the Care Plan tab, dated 07/08/22, revealed R71 has potential impairment to skin integrity r/t fragile skin, use of antiplatelets, impaired mobility, splint use, CVA, Incontinence and an intervention included Remove right hand/wrist splint before PM [evening] care or as tolerated. Check skin integrity after splint removal. every evening shift. Review of R71's order located in the EMR under the Orders tab, dated 09/20/23, revealed Apply right hand splint after AM [morning] care and remove before PM care or as tolerated. Check skin integrity before and after application. Review of R71's Medication Administration Review (MAR), dated 01/24, located in the EMR under the Orders tab, revealed 01/01/24 to 01/23/24 for day and evening shifts the right-hand splint was marked as applied. The only day the splint was not marked as applied was on 01/24/24 when the MAR was coded as 9 [Other / See Progress Notes]. Review of R71's progress notes located in the EMR under the Progress Notes tab revealed notes dated 01/24/23 to 01/23/24 did not include a note related to R71's right hand splint. No note dated 01/24/23 was found for the MAR related to the 9 code. During an observation on 01/23/24 at 10:32 AM, R71 was observed in her wheelchair in her room. R71 did not have a splint in place on her right hand. During an observation on 01/23/24 at 1:11 PM and at 1:36 PM, R71 was observed in her wheelchair in her room. R71 did not have a splint in place on her right hand. A splint was observed on the bed next to R71. During an observation on 01/24/24 at 10:32 AM, R71 was observed in her wheelchair in her room. R71 did not have a splint in place on her right hand. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/24/24 at 10:47AM, the Director of Rehabilitation (DOR) was asked about R71's hand splint. The DOR stated R71 was receiving occupational therapy to encourage R71 to wear the splint. The DOR went on to say R71 was noncompliant with it. The DOR stated R71 could take it off. The DOR was asked if R71 refused to wear the splint, should staff document her refusals. The DOR stated, yes, and let therapy know she refuses. The DOR stated the purpose of the splint was to prevent the contracture from getting worse. During an observation and interview on 01/25/24 at 10:30 AM, R71 was observed awake in her wheelchair in her room not wearing a hand splint on the right hand. Nurse Aide (NA)2 was observed in R71's room. At 10:32 AM, NA2 was asked if she cared for R71 and if she got R71 out of bed this morning. NA2 stated, yes. NA2 was then asked why R71 wasn't wearing the splint. NA2 stated because R71 refused it. NA2 went on to say R71 wouldn't let her put it on. NA2 stated when this happens, I report it to the nurse. NA2 stated she was R71's nurse aide on 1/23/24 and 1/24/24 and R71 refused to allow her to put it on. During an interview on 01/25/24 at 10:38 AM, the Director of Nursing (DON)1 was asked about R71's splint who confirmed her refusals. The DON1 was asked if R71's refusal to wear the splint was care planned. The DON1 stated she would have to check. During an interview on 01/25/24 at 10:40 AM, Licensed Practical Nurse (LPN)1 was asked why the January 2024 MAR reflected R71's splint was on when observations of R71 not wearing it and NA2 stated R71 refused to wear it. LPN1 stated because it's on and off all day long. LPN1 stated there was no other way to document it on the MAR. During an interview on 01/25/24 at 2:25 PM, the MDSC was asked about R71's refusal to wear the splint and if R71's refusal should be care planned. The MDSC stated, yes. Review of the facility's policy titled, Comprehensive Care Plans, revised 12/23, revealed Purpose: 1. To provide nursing care to the resident on a 24-hour basis to ensure that resident care and treatment is planned appropriately for the resident's needs. 2. A comprehensive care plan should be defined as person-centered and comprehensive, developed and implemented to meet individual preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. 3. To document the response to the prescribed plan of care to communicate the resident's condition to the health care team. 5. The Comprehensive Care Plan (CCP) will be reviewed and revised on a quarterly basis, with a significant change in condition, on re-admission from inpatient hospital stay, for any interim problems prior to CCP. Review of the facility's policy titled, Use of Side Rails, dated 12/23, revealed 11.) Care Planning: a.) Interdisciplinary team, once assessment determines appropriateness of side rails will implement interventions supportive of their assessment. b.) Interventions may reflect measures to enhance self-sufficiency or to minimize decline . d.) care Plan goal and interventions will be reflective of any changes in the resident's medical condition. NJAC 8:39-11.2(e) thru (i) NJAC 8:39- 27.1(a),(d) 28154

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Plaza Healthcare & Rehabilitation Center	456 Rahway Avenue Elizabeth, NJ 07202

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on observation, record review, interview, and facility policy review, the facility failed to ensure that three of three residents (Resident (R) 32, R33, and R71) reviewed for bed rail use of 35 sample residents had attempted alternatives documented, quarterly and annually side rail screen assessments completed according to facility policy, and the Resident or Resident Representative (RR) were advised of the risks and/or benefits of rail use with an informed consent signed prior to the installation of the bed rails. This failure had the potential for the resident, or the RR be uninformed of the risks associated with bed rail use and could put the residents at risk for injury or entrapment. Findings include: 1. Review of R32's undated Admission Record from the electronic medical record (EMR) Profile tab showed a facility admitted [DATE] and readmission on 09/13/23, with medical diagnoses that included bilateral below knee amputation, dementia, macular degeneration, peripheral vascular disease, and anxiety disorder. Review of R32's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/09/19, located in the MDS tab of the EMR, showed a Brief Interview for Mental Status (BIMS) score of three out of 15, indicative of severe cognitive impairment. During an observation on 01/22/24 at 12:17 PM, R32 was in bed, with an air mattress, being assisted during lunch with one full quarter rail up and one in down position where an aide was seated. During an observation on 01/25/24 at 8:08 AM and 9:15 AM, R32 was observed on an air mattress with bilateral full quarter upper rails in the up position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Side Rails form for R32 provided by the facility, dated 10/02/19, revealed the following: A. Factors 1. Is the resident ambulatory? No. 2. Is the resident lethargic or comatose? No. 3. Does the resident has [sic] alteration of safety awareness due to altered cognition? Yes. 4. Does the resident has [sic] history of falls? No. 5. Does the resident have difficulty moving in bed? Yes. 6. Does the resident have difficulty sitting on or moving to the side of the bed? Yes. 7. Does the resident have the [sic] difficulty with balance or poor control? Yes. 8. Does resident have difficulty of [sic] getting up / standing from sitting in a chair? Yes. 9. Does resident take any medication that would require safety precautions? No. 10. Does resident currently in use of [sic] side rails for independent positioning or to assist with positioning? (enabler) Yes. 11. Has the resident or family asked / requested to have side rails while on bed [sic]? Yes. B. Alternatives. 1. Toileting Schedule. 2. Reminders to use call light for assistance [this was marked]. 3. Restorative care to enhance independence. C. Recommendations. 1. Side rails are indicated at the present time. a. They will. a. [sic] Provide Safety. b. Promote Independence [this was marked]. c. Carry out request. 2. Side rails not indicated at the present time. 3. Evaluation will continue to determine appropriateness. 4. Notes. Side Rail Utilization. 5a. Sides a. Left b. Right c. Both [marked] d. Neither. 5b. Rails a. Full b. Half [marked]. (Left Right Both). The last part of the form was a place for a signature (signed by a nurse) and a signature date. No other side rail assessments were provided by the facility. Review of R32's care plan tab, Medication Administration Record (MAR)/ Treatment Administration Record (TAR), miscellaneous tab, and evaluation/ assessments in the EMR revealed no documentation related to the use of alternative measures utilized prior to the use of side rails. 2. Review of R33's undated Admission Record from the EMR Profile tab showed an admitted [DATE] with medical diagnoses that included cerebrovascular disease, seizures, hemiplegia, and hemiparesis following a subarachnoid hemorrhage, and dysphagia. Review of R33's quarterly MDS, with an ARD of 12/28/23, located in the MDS tab of the EMR, showed R33 had a BIMS score of 14 out of 15, indicative of being cognitively intact, and required staff supervision for bed mobility. During an observation and interview on 01/22/24 at 12:21 PM, R33 stated he had been in the facility for nine years and it was observed that he had bilateral upper full quarter bed rails. When asked, R33 stated he used them; when asked if anyone had advised him of the risks and benefits of side rails (an example of a risk of putting an arm through the rail and falling out of bed with the arm entrapped), R33 stated he had not been advised of any risks or benefits. During an observation on 01/25/24 at 8:10 AM and 9:15 AM, R33 was asleep in bed with bilateral upper full quarter rails in the up position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Side Rails form for R33 provided by the facility, dated 08/14/15, revealed the following: A. Factors. 1. Is the resident ambulatory? No. 2. Is the resident lethargic or comatose? No. 3. Does the resident has [sic] alteration of safety awareness due to altered cognition? Yes. 4. Does the resident has [sic] history of falls? No. 5. Does the resident have difficulty moving in bed? Yes. 6. Does the resident have difficulty sitting on or moving to the side of the bed? Yes. 7. Does the resident have the [sic] difficulty with balance or poor control? Yes. 8. Does resident have difficulty of [sic] getting up / standing from sitting in a chair? Yes. 9. Does resident take any medication that would require safety precautions? No. 10. Does resident currently in use of [sic] side rails for independent positioning or to assist with positioning? (enabler) Yes. 11. Has the resident or family asked / requested to have side rails while on bed [sic]? Yes. B. Alternatives. 1. Toileting Schedule. 2. Reminders to use call light for assistance [this was marked]. 3. Restorative care to enhance independence. C. Recommendations. 1. Side rails are indicated at the present time. a. They will. a. [sic] Provide Safety. b. Promote Independence [this was marked]. c. Carry out request. 2. Side rails not indicated at the present time. 3. Evaluation will continue to determine appropriateness. 4. Notes. Side Rail Utilization. 5a. Sides a. Left [this was marked] b. Right [this was marked] c. Both d. Neither. 5b. Rails a. Full b. Half [this was marked] (Left Right Both). The last part of the form was a place for a signature and a signature date. No other side rail assessments were provided by the facility. Review of R33's care plan tab, MAR/ TAR, miscellaneous tab, and evaluation/ assessments in the EMR revealed no documentation related to the use of alternative measures utilized prior to the use of side rails. On 01/24/24 at 2:55 PM, the Administrator and Director of Nursing (DON)1 provided the Side Rails form for R32 and R33 and the DON stated there was no risk/benefit statement or consent. 3. Review of R71's quarterly MDS, with an ARD of 12/12/23, located in the MDS tab of the EMR, revealed R71 had an admitted [DATE]. R71 had no BIMS score, and cognition was severely impaired. R71 had impairment on one side to the upper extremity (shoulder, elbow, wrist, hand) and on the lower extremity (hip, knee, ankle, foot); was dependent with mobility when lying to sitting on the side of the bed; side rails not used and had diagnoses of epilepsy and cerebrovascular accident (CVA). Review of R71's care plan located in the EMR under the Care Plan tab, dated 07/08/22, revealed R71 has an ADL [activities of daily living] self-care performance deficit r/t [related to] Confusion, Impaired balance, Limited ROM [range of motion] r/t CVA and an intervention included Side Rails: 2/half rails up as per Drs [doctor's] order for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Review of R71's side rail assessment provided by the facility, dated 07/07/22, revealed 3. Does the resident has [sic] alternation of safety awareness due to altered cognition? Yes, 5. Does the resident have difficulty moving in bed? Yes, 10. Does resident currently use side rails for independent positioning or to assist with positioning? (enabler) Yes. Alternatives included 2. Reminders to use call light for assistance and 3. Restorative care to enhance independence. Recommendations included 1. Side rails are indicated at the present time. a. They will b. promote independence. Side Rail Utilization included 5a. Sides, a. left, b. right, 5b. Rails b. Half. The assessment did not include the risk of entrapment or what condition the side rails were being used for. No other side rail assessments were provided by the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/25/2024
NAME OF PROVIDER OR SUPPLIER: Plaza Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 456 Rahway Avenue Elizabeth, NJ 07202	

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R71's order located in the EMR under the Orders tab, dated 05/27/23, revealed Siderails - Half Side Rails. Review of R71's EMR and hard chart revealed no informed consent. Review of R71's care plan tab, MAR/TAR, miscellaneous tab, and evaluation/ assessments in the EMR revealed no documentation related to the use of alternative measures utilized prior to the use of side rails. During an observation on 01/22/24 at 2:50 PM, R71 was in a wheelchair next to her bed. R71's bed was noted to have one silver side rail up on the side closest to the door that was loose and slightly leaning away from the bed. A hand size gap was present between the mattress and side rail. During an observation on 01/23/24 at 9:38 AM, R71 was observed in bed with the side rails up on both sides of the bed as Nurse Aide (NA)2 used bed remote to bring R71's head of bed up. At 9:46 AM, R71 was again observed in bed with the side rails in the up position. The side rail on the side of the bed closest to the door was noted to be loose and leaning away from the bed. During an interview on 01/23/24 at 1:25 PM, Licensed Practical Nurse (LPN) 4 was asked why R71 had side rails on her bed. LPN4 stated the side rails were enablers for R71 during care. LPN4 was asked if the side rails were only up during care and LPN4 stated, yes. LPN4 was then asked if it was okay for R71 to have the side rails in the up position while in bed after R71 was provided care and LPN4 stated, yes. During an observation on 01/24/24 at 9:08 AM, R71 was in bed asleep with side rails on both sides of the bed in the up position. During an interview on 01/24/24 at 10:51 AM, the Director of Rehabilitation (DOR) was asked if therapy got involved with side rails. DOR stated, no. The DOR was asked if R71 had the capacity to use side rails and the DOR stated, yes, with assistance. The DOR stated R71's right hand was contracted, and she couldn't use the side rail with her right hand. The DOR went on to say R71 could use her left hand. The DOR was asked if R71 needed assistance when using the side rail and should the side rail remain up after R71 had been assisted. The DOR stated, yes because R71 could move herself some and could reposition herself using the left-side rail with assistance. During an interview on 01/24/24 at 2:10 PM, DON1 was asked why R71 had side rails and was informed consent obtained. The DON1 stated R71 had side rails for repositioning with one hand. The DON was asked if the side rail use was for only one hand, why did R71 have two side rails and could she get trapped on the other side. The DON stated she would have to look at the report. The DON was asked if there were any more recent side rail assessments for R71 than the 07/07/22 she had provided. The DON stated not that she was aware of. The DON was asked why the assessment didn't include entrapment. The DON stated she started in September of 2023, and she had recently recreated a new form for the side rail assessment that included more details including informed consent. During an observation on 01/25/24 at 8:01 AM, R71 was asleep in bed with side rails up on both sides of the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/25/2024
NAME OF PROVIDER OR SUPPLIER: Plaza Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 456 Rahway Avenue Elizabeth, NJ 07202	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/25/24 at 2:15 PM, the MDS Coordinator (MDSC) was asked about R71's side rails. The MDSC stated R71 could use the side rails with her good hand to reposition herself. The MDSC was asked if there was a risk for entrapment if R71 could only move one side and the MDSC stated, yes. The MDSC stated R71 used the side rails when the NAs reposition her during care. The MDSC was asked should both side rails remain up after care and the MDSC stated, no. Review of the facility's policy titled, Use of Side Rails, effective December 2023, showed: Policy: It is the policy of this facility to ensure the safety and psychosocial well-being of its Residents while avoiding the use of side rails as a physical restraint. However, in review of resident's medical symptoms, the Physician and the Interdisciplinary team will review and determine through assessment the appropriateness of side rails. Procedure: 1.) Upon admission/readmission the resident will have a side rail screen assessment to evaluate the individual need for side rails. 2.) In addition, a side rail screen assessment will also be completed with each quarterly and annual assessment to determine the continued need for side rails. 3.) The side rail screen assessment will also be completed when deemed necessary and appropriate between regular assessments. 4.) Side rails will be used for safety when assessed as appropriate and documented as necessary: a. documented medical diagnosis, i.e., Seizure Disorder, Multiple Sclerosis, Parkinson disease, Hypotensive episodes. b. behavioral symptoms may include repetitive physical movements. c. Psychiatric diagnosis requiring psychoactive medications which may have the potential to cause disturbance in balance or vertigo. d. Severe cognitive loss as associated with the end stages of Dementia where safety awareness is absent. 5.) Staff may utilize side rails while care is provided to enable the resident to assist in their ADL's. 6.) Half side rails or one (1) side rail may be utilized for residents who require/request an assist device in promoting bed mobility or enhance a resident's ability to be more self-sufficient. An example, half rails may assist a resident to enter or to exit their bed independently. 7.) A resident may request a side rail to facilitate their capability of entering or exiting their bed, self-positioning in a safe and independent manner. 8). The Resident and/or Responsible representative will be informed: a. Their medical condition, the potential risks and benefits considered in utilizing a restraint, not using a restraint, and alternatives to restraint use. b. It will be explained to the resident and/or their responsible representative how the restraint would benefit the resident's medical symptoms and assist in attaining or maintaining their present physical well-being, c. Also, the negative outcomes of side rail use may contribute to a decline in muscle condition, incontinence, agitation. d. Once the resident and/or responsible representative has had a discussion with the Interdisciplinary team in regard to the resident's assessment, the determined appropriate use of side rails and their care planning decision the resident and/or the responsible representative will be asked to sign an informed consent .10.) Assessment for use of side rails. a. bed mobility. b. ability to transfer between positions, does the raised side rail enable the resident to transfer. safely or does it pose a potential risk. c. restorative care to enhance and maintain abilities to stand, transfer and walk safely. d. trapeze to enhance resident's mobility while in bed. e. exercise, encouragement of active ROM, or restorative passive ROM. NJAC 8:39-27.1(a) NJAC 8:39-31.8(c)1 36190

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare & Rehabilitation Center	456 Rahway Avenue Elizabeth, NJ 07202

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, record review, and facility policy review, the facility failed to have an ongoing monitoring of bed side rails as part of their routine maintenance program for one of one resident (Resident (R)71) of 35 sample residents and 86 of 87 occupied beds reviewed for side rails. Findings include: 1. Review of R71's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/23, located in the MDS tab of the electronic medical report (EMR), revealed R71 had an admitted [DATE]. There was no Brief Interview for Mental Status (BIMS) score conducted and R71 had severely impaired cognition, R71 had impairment on one side to the upper extremity (shoulder, elbow, wrist, hand) and on the lower extremity (hip, knee, ankle, foot) R71 was dependent with mobility when lying to sitting on the side of the bed. Side rails were not used and R71 had diagnoses of epilepsy and cerebrovascular accident (CVA). Review of R71's side rail assessment provided by the facility, dated 07/07/22, revealed 3. Does the resident has [sic] alternation of safety awareness due to altered cognition? Yes, 5. Does the resident have difficulty moving in bed? Yes, 10. Does resident currently in use of side rails for independent positioning or to assist with positioning? (enabler) Yes. Alternatives included 2. Reminders to use call light for assistance and 3. Restorative care to enhance independence. Recommendations included 1. Side rails are indicated at the present time. a. They will b. promote independence. Side Rail Utilization included 5a. Sides, a. left, b. right, 5b. Rails b. Half. The assessment did not include the risk of entrapment or what condition the side rails were needed for. Review of R71's care plan located in the EMR under the Care Plan tab, dated 07/08/22, revealed R71 has an ADL [activities of daily living] self-care performance deficit r/t [related to] Confusion, Impaired balance, Limited ROM [range of motion] r/t CVA and an intervention included Side Rails: 2/half rails up as per Drs [doctor's] order for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Review of R71's order located in the EMR under the Orders tab, dated 05/27/23, revealed Siderails - Half Side Rails. Review of the 200-hall maintenance log for January 2024, did not include an entry for bed rail maintenance. During an observation on 01/22/24 at 2:50 PM, R71 was in a wheelchair next to her bed. R71's bed was noted to have one silver side rail up that was loose and slightly leaning away from the bed. A hand size gap was present between the mattress and side rail. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Plaza Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 456 Rahway Avenue Elizabeth, NJ 07202	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 01/23/24 at 9:38 AM, R71 was in bed with silver side rails in the up position as Nurse Aide (NA)2 used the bed remote to bring R71 up to a seated position. At 9:46 AM, R71 was again observed in bed with the side rails in the up position. The side rail on the right side of the bed was noted to be severely loose and leaning away from the bed. During an interview on 01/23/24 at 1:11 PM, the Maintenance Supervisor (MS) was asked about bed inspections. The MS stated he didn't conduct bed checks. The MS stated the staff would log problems for him to address in a maintenance notebook located at the nurse's station. The MS was asked if he conducted side rail inspections. The MS stated every morning he checked the side rails but didn't document the inspections. The MS then demonstrated what he checked for on an empty bed. The MS stated the only gap he checked was the gap between the top of the side rail and the headboard but didn't check for gaps between the side rail and mattress. The MS was shown R71's side rail on the right side of her bed. The side rail was observed, and the MS confirmed the rail was severely loose, causing it to wobble back and forth. The side rail was noted to have hand size (five inch) gap. The MS stated, it's loose because the nurse aides put them up and down and the bolt gets loose. The MS then tightened the bolt. The MS then stated the silver side rails were the old ones and he would replace R71's side rails with new ones that were black. The MS went on to say he had new side rails that worked better on their beds. 2. Review of a resident roster with occupied beds highlighted with side rails, dated 01/25/24, provided by the facility revealed 86 (101-1, 101-2, 102-2, 103-1, 103-2, 104-1, 104-3, 105-2, 106-2, 107-1, 107-2, 108-1, 108-2, 109-1, 109-2, 110-3, 110-4, 111-2, 119-1, 119-2, 120-1, 121-1, 122-1, 122-2, 123-1, 124-1, 125-1, 126-1, 127-1, 127-2, 128-1, 129-2, 201-1, 202-1, 203-1, 204-1, 204-2, 205-2, 206-1, 206-3, 206-4, 207-1, 208-2, 209-1, 210-2, 211-1, 211-2, 212-1, 212-2, 212-3, 212-4, 213-1, 213-4, 214-1, 214-2, 215-1, 215-2, 216-1, 216-2, 217-1, 217-2, 218-1, 218-2, 219-1, 219-2, 220-1, 221-1, 221-2, 222-1, 222-2, 223-1, 223-2, 224-1, 224-2, 225-1, 225-2, 226-1, 227-1, 228-1, 228-2, 229-1, 230-1, 230-2, 231-1, 231-2, 232-1, and 232-3) of 87 occupied beds had side rails in use. During an interview on 01/24/24 at 1:46 PM, the Administrator was asked for the bed maintenance/manufacture instructions, and he stated they only had the parts catalog. Review of the 2009 on-line manual titled, Owner's Operator and Maintenance Manual - Invacare Continuing Care, Inc. [incorporated] [NAME](R)DLX Series Long Term Care Beds IH820DLX, IH820-3MDLX, SC900DLX https://www.1800wheelchair.com/media/manuals/invacare_dlx_bed_manual.pdf, included on page nine, Entrapment Warning that revealed Proper patient assessment and monitoring, and proper maintenance and use of equipment is required to reduce the risk of entrapment. Variations in bed rail dimensions, and mattress thickness, size or density could increase the risk of entrapment. Visit the FDA website at http://www.fda.gov to learn about the risks of entrapment. Review A Guide to Bed Safety, published by the Hospital Bed Safety Workgroup. Refer to the individual instruction sheet included with the bed rails and/or positioning device for additional product and safety information. After any adjustments, repair, or service and before use, make sure all attaching hardware is tightened securely. Assist rails with dimensions different from the original equipment supplied or specified by the bed manufacturer may not be interchangeable and may result in entrapment or other injury. Mattress must fit bed frame, assist rails and/or positioning device snugly to reduce the risk of entrapment. On 01/25/24 at 2:05 PM, the Administrator was asked for a bed maintenance/inspection policy. None was provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315483	A. Building B. Wing	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare & Rehabilitation Center	456 Rahway Avenue Elizabeth, NJ 07202

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Use of Side Rails, dated 12/23, revealed It is the policy of this facility to ensure the safety and psychosocial well-being of its Residents while avoiding the use of side rails as a physical restraint. However, in review of resident's medical symptoms, the Physician and the Interdisciplinary team will review and determine through assessment the appropriateness of side rails . 10.) Assessment for use of side rails . h.) frequent monitoring by staff. The policy did not address the risk of entrapment. NJAC 8:39- 31.4(c) NJAC 8:39-31.8(c)1