STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315515	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium at Navesink Harbor, The	40 Riverside Avenue Red Bank, NJ 07701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34421 Based on observation, interview, and record review it was determined that the facility failed to a.) maintain the dignity of an unsampled resident. This deficient practice was found with 1 of 2 Certified Nursing Aides (CNA) observed during a dining observation on the third floor, and b.) place a urine drainage collection bag in a privacy cover to ensure a resident's dignity for 1 of 2 residents (Resident #26) reviewed for urine catheters. The deficient practice was evidenced by the following: a.) On 9/17/24 at 12:40 PM, during a lunch meal dining observation on the 3rd floor in the main dining room, an unsampled resident asked the surveyor a question regarding wanting pineapple chunks with their meal. The CNA was next to the resident when the request was made, and the CNA did not say anything. The surveyor asked the CNA if she could help the resident with their request. The CNA looked at the surveyor and said, the resident knows that the dessert is not given until after the meal is served. The surveyor asked the CNA if she could speak directly to the resident about the concern. The CNA said, I am not telling the resident, the resident knows this. At that time, the CNA walked away from the resident and went to the other side of the dining room without speaking to the resident and without addressing the residents' request. On 9/17/24 at 1:20 PM, the above concerns were discussed with the Director of Nursing, who stated that this kind of interaction is unacceptable, and she will investigate the situation. A review of the Quality of Life- Dignity policy and procedure, dated 1/24/24, which revealed Residents shall be always treated with dignity and respect. and Staff shall always speak respectfully to residents 38079 b.) On 09/17/24 at 7:41 AM, Surveyor #2 observed Resident #26 lying in bed with an uncovered urinary catheter collection bag lying in direct contact with the floor and was visible from the hallway through the open door. The resident had a roommate, and the privacy curtain was not closed which allowed the roommate visualization of the urinary catheter collection bag. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/17/24 at 10:41 AM, Surveyor #2 observed Resident #26 sitting in a high back wheelchair in the third-floor activity day room. Resident #26 was with other residents and was participating in an exercise activity. Surveyor #2 was able to observe the urinary catheter collection bag only partially covered and in direct contact with the floor under the wheelchair. A review of the Resident #26's medical record revealed: The Face Sheet with diagnoses which included but were not limited to; obstructive and reflux uropathy, muscle weakness, and metabolic encephalopathy. A review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate resident care dated 07/19/2024, included but was not limited to; a Brief Interview for Mental Status of 07 out of 15 indicating severe cognitive impairment. At the time of the MDS, Resident #26 did not have a indwelling urinary catheters. A review of the Physician's Order Sheet documented an order dated 07/08/2024, for a [name redacted] urinary catheter 18 F (French - indicating the size) x 10 ml (milliliters) to straight drainage bag. A review of the resident-centered ongoing care plan included but was not limited to; a focus area of Enhanced Barrier Precautions due to suprapubic catheter inserted 09/12/2024, with a goal of no cross-contamination. On 09/17/24 at 10:44 AM, the direct care Licensed Practical Nurse (LPN) stated she had cared for the resident that morning. The LPN further stated that she has cared for the resident before, and that the urinary drainage collection bag must be below the level of the bladder and covered with a privacy bag. The LPN further stated it was important in order to prevent contamination and for dignity of the resident. On 09/17/24 at 11:03 AM, the Registered Nurse Infection Preventionist stated a urinary drainage collection bag needed to be kept off the floor to prevent infection and in a privacy bag for resident rights. A review of the facility provided policy, Quality of Life - Dignity revised 01/24/24, included but was not limited to; Policy: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Helping the resident to keep urinary catheter bags covered. NJAC 8:39-4.1(a)12, 12; 27.1 (a)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45208 Based on interviews, review of facility policy, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy to ensure a criminal background checks were completed prior to the start date of employment. This deficient practice was identified for 1 of 10 employee files reviewed (Employee #7) and was evidenced by the following: The surveyor reviewed ten employee files who had been hired since the last standard survey conducted on 7/7/23, which revealed the following incomplete pre-employment screening documents: Employee #7, Activities Aide, hired 5/13/24. The background check revealed a report date of 5/17/24. A review of the employee's position description, signed on 5/13/24, revealed a job summary to provide therapeutic activity programs to the residents. Essential Functions, as follows but not limited to; assist in organizing, developing, and directing therapeutic activities for groups or individuals to meet the needs of the residents. A review of Employee Acknowledgement Form was a signed document acknowledging receipt of employee badge to begin work, signed by Employee # 7, and the Director of Activities. It was dated on 5/13/24. A review of Employee # 7's timecard dated 5/1/24-5/31/24, revealed the following hours that the employee worked prior to the completion of the background check: - 32 hours of paid work on 5/13/24 - 2.0 hours - 5/14/24 - 7.5 hours; - 5/15/24 - 7.5 hours; - 5/16/24 - 7.5 hours; - 5/17/24 - 7.5 hours; On 09/18/24 at 10:48 AM, the surveyor reviewed the employee files with the Human Resource and Information System (HRIS) home office staff who acknowledged the missing documents. The HRIS stated, that the previous Human Resource Representative (HRR) at that time should have ensured the background check was completed prior to the employees being hired. On 09/18/24 at 11:21 AM, the surveyor interviewed the Director of Activities (DA) who stated, Human resources provides an email to the hiring department when the employee is all cleared and can start their employment. This email is sent once references, health check and background check are completed. Upon surveyor inquiry, the DA was unable to provide the email regarding the all clear for employment. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 11:38 AM, the surveyor interviewed the Director of Nursing (DON) on the hiring process. The DON stated, interview, prospect sent to HR (Human Resources) for contingency review on references, health evaluation, and background check. Once the prospect is cleared for all of that then the on-boarding starts. The DON stated, an email would go out from HR to the hiring supervisor informing that the prospect is good to go. The DON stated if the background check was not completed the prospect should not have been in the building or working. On 09/18/24 at 01:10 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated, background check should be done prior to hire. A review of the facility's undated Skilled Nursing Policy and Procedures, Title: Abuse (Elder Abuse) with an effective date 2/15/01, revised dates 10/12/2020, revealed: Policy: Employees have a unique position of trust with vulnerable elders. Their access to private information, as well as having elevated status and special relationships with elders, makes ethical and professional behavior essential. Springpoint is committed to ensuring that elders remain free from abuse. This includes, but not limited to facility staff. Procedures: The policies and procedures regarding abuse prevention addresses one of the seven key areas: the manner in which a prospective employee are screened. 1) New employee screening, E) New Jersey- as a condition of employment for the following job categories is a statewide criminal history check to be performed . Aide-Non-Certified and /or Activity department personnel. A review of the Hiring Policy: Employment Application and Pre-Employment Checks, dated 04/29/24 included, all offers of employment are contingent on satisfactory references and the candidate passing the mandatory drug screen and Criminal background check. NJAC 8:39-4.1(a)5

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain an Automated External Defibrillator (AED-equipment used for the purposes of immediate response for cardiac arrest) and other emergency items prior to their expiration date. This deficient practice was identified for 2 of 2 expired AED kits located on 2 of 2 resident units (2nd and 3rd floor), which contained expired defibrillator pads dated [DATE], and was evidenced by the following: On [DATE] at 11:01 AM, in the presence of the Licensed Practical Nurse (LPN), the surveyor observed an AED emergency response kit, mounted on the wall of the AED room on the Third floor. The surveyor observed the LPN, remove the AED kit from the wall mounting, opened it, and observed one defibrillator pad (AED electrode pad, an essential component of an AED to treat a sudden cardiac arrest emergency) attached to the AED machine, that expired on [DATE]. No other AED pads were observed inside the AED kit. The LPN searched for another AED pad and acknowledged that the AED pad in the machine should not have been expired in the event of an emergency. The LPN confirmed that was the only AED machine located on the third floor. At that time, the surveyor and the LPN reviewed the Emergency Cart Daily Check List for [DATE]. The checklist included AED and was initialed and marked checked, daily until [DATE], except for: Oxygen was not marked as checked on [DATE] which revealed all items including the AED were checked and initialed on [DATE]. The LPN stated that the ,d+[DATE] shift nurse was responsible for checking and ensuring the emergency supplies were available and were not expired. A further review of the AED machine reflected a sticker Approved for use by the Biomedical Engineering Department and was inspected on [DATE]. Further review of the emergency kit located inside the AED room revealed the following: - one sealed Ultra Trak test strips quantity of 50, that expired on [DATE]. - one Insta glucose that expired on ,d+[DATE]. - two Adult manual pulmonary resuscitator bag that expired on ,d+[DATE]. At that time, the LPN confirmed observing the same expired items within the AED room. On [DATE] at 11:26 AM, in the presence of LPN #1 and the Registered Nurse/Infection Preventionist (RN/IP), the surveyor discussed the concerns regarding the equipment for the purposes of immediate response to potential life-threatening, cardiac emergencies and the associated supply in the AED room. The RN/IP stated she would inform the Director of Nursing (DON), remove, and replace the expired items immediately. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:30 AM, the surveyor and the Registered Nurse/ Charge Nurse (RN/CN) began the inspection of the AED room located on the Second Floor. The AED machine had an AED pad that expired on [DATE]. The RN/CN looked through the kit and could not provide another AED pad from the AED kit. At that time, the RN/CN stated that the AED pads should have not been expired because the AED machine won't work properly with an expired AED pad. At that time, the surveyor and the RN/CN reviewed the Emergency Cart Daily Checklist dated [DATE]. The checklist reflected that it was checked daily, until [DATE]. The RN/CN stated that the ,d+[DATE] PM shift nurse checked the list that included the AED. The RN/CN informed the surveyor that the check list was to ensure all the items on the list were in the emergency kit and were not expired. At that time, the surveyor discussed the concern the expired AED pads with the RN/CN who oversaw both floors. The RN/CN stated she would inform the DON, remove, and replace the expired items. On [DATE] at 12:15 PM, in the presence of the survey team, the Licensed Nursing Home Administrator stated that the AED pads were not part of the check list and was uncertain if the nurses checked the dating on the AED pads. On [DATE] at 12:19 PM, the regional nurse and the surveyor re-inspected the AED machines on the second and third floor. The regional nurse confirmed that, after surveyor inquiry, the AED pads were replaced with an in-date AED pad paired with a back-up AED pad that was also not expired. The regional nurse confirmed picking-up the pads from a separate entity other than the facility, and also provided a copy of a purchase order for the new AED pads. A review of the facility provided policy, Automatic External Defibrillation (AED) Program dated/revised on [DATE], under Maintaining AED Unit in a State of Readiness included the following: Monthly check of an AED unit will be conducted by authorized Security/Nursing Department Personnel to Community to include: 3. Completion of the maintenance check list including the pad expiration date. NJAC 8:,d+[DATE].3(a) (b)1

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 38079 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure a urinary drainage collection bag and drainage tubing were not in direct contact with the floor to prevent potential contamination. This deficient practice was identified for 1 of 2 residents (Resident #26) reviewed for urinary catheter use and was evidenced by the following: A review of the facility provided policy, Indwelling Urinary Catheter Insertion/Maintenance (Male/Female) revised 01/29/24, included but was not limited to; 5. Both the drainage tubing and bag must be kept from touching the floor. On 09/17/2024 at 7:41 AM, the surveyor observed Resident #26 lying in bed with part of the urinary drainage tube and urinary drainage bag lying in direct contact with the floor. On 09/17/2024 at 10:41 AM, the surveyor observed Resident #26 in a high-backed wheelchair in the third-floor activity day room. The surveyor observed part of the urinary drainage tube and the urinary collection bag lying directly on the floor under the wheelchair. Resident #26 was participating in exercise and as their knee hit the over bed table, the activity staff moved the table and the collection bag on floor was even more obvious. A review of Resident #26's medical record revealed: A Face Sheet with diagnoses which included but were not limited to; chronic kidney disease, unspecified mood disorder; and urinary retention. A review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate resident care dated 07/08/2024, included but was not limited to; a Brief Interview for mental status (BIMS) of 07 out of 15 indicating severe cognitive impairment. Section H: Bladder and Bowel documented no urinary catheter at that time. A review of the Physician Order Sheet included an order dated 07/08/2024, Foley Catheter 18 F (French - the size) x 10 ml (milliliter) to straight drainage bag. A review of the assessment note dated 07/12/2024, revealed the resident had a suprapubic catheter insertion completed. A review of the resident-centered on-going care plan included but was not limited to; a goal of there will be no cross contamination due to my suprapubic catheter with myself or staff for my length of stay. On 09/17/24 at 10:44 AM, the direct care Licensed Practical Nurse (LPN) stated she cares for Resident #24 including suprapubic care. The LPN stated that the urine collection bag must be placed below the level of the bladder and covered by a privacy bag. The LPN stated she checked the urine collection bag at 9:30 AM. The LPN was informed about the observation of the urine collection bag and tubing on the floor and was then shown the urine collection bag and tubing that was lying on the floor. The LPN went into the activity room and acknowledged. The LPN asked the Certified Nursing Assistant (CNA) to bring the resident to their room to correctly place the urine collection bag. On 09/17/24 at 10:52 AM, the CNA stated she was responsible to drain and keep the urine drainage bag clean. She stated the urine drainage bag should be hooked on the side and off the floor because of contamination. The CNA stated she was off the floor that morning and someone else must have cared for Resident #24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/17/24 at 11:03 AM, the Registered Nurse Infection Preventionist (RN/IP) was asked about the observations of the urine drainage bag and tubing. The RN/IP stated that the urine drainage bag and tubing must be off the floor to prevent infection. NJAC 8:39-19.4 (a)5; 27.1 (a)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure a resident who received pain management: a.) had a comprehensive patient-centered care plan for pain, and b.) the pain management physician recommendation was acted upon in a timely manner. This deficient practice was identified for 1 of 1 resident, reviewed for pain management (Resident #15) and was evidenced by the following: On 9/17/24 at 7:43 AM, a surveyor observed Resident #15 in bed who complained of pain. The resident stated that the pain medication would be administered after breakfast. On 9/17/24 at 11:11 AM, a surveyor observed the resident in the rehabilitation room. At that time, during an interview with the surveyor, the Physical Therapist (PT) stated that they would provide a hot pad for the resident's back pain. The surveyor then interviewed the Registered Nurse/Charge Nurse (RN/CN) who informed the surveyor that they charted the resident's pain by exception (documenting only when pain was reported or observed). On 9/18/24 at 10:47 AM, during an interview with the surveyor, the RN/CN stated the resident had a fall on 6/4/24, while going to the bathroom. The surveyor reviewed the hybrid (electronic and paper) medical record for Resident #15. According to the Face Sheet, Resident #15 was admitted to the facility with diagnoses that included unspecified dementia, generalized muscle weakness and nondisplaced intertrochanteric fracture of the left femur (a type of hip fracture that occurs in the upper thigh bone, between the greater and lesser trochanters). Review of the Quarterly Minimum Data Set (qMDS), an assessment tool dated 7/18/24, reflected a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated that the resident had moderate cognitive impairment. Further review of the qMDS dated [DATE], under section J. Pain Management indicated the resident received PRN (as needed) pain medication, a pain assessment interview should be conducted, and that the resident had not experienced pain or hurting in the last five (5) days. A review of the September 2024 Physician Order (PO) sheet included the following orders: Acetaminophen 325 milligram (mg), two (2) tablets every 6 hours as needed for mild pain (scale of 1 to 3). The order was started on 5/28/24. Tramadol 50 mg, one (1) tablet every 6 hours as needed for moderate to severe pain (scale of 4 to 10). The order was started on 5/28/24. Diclofenac 1% topical gel, 4 grams (gr) to the left hip three (3) times daily for pain management. The order was started on 6/27/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bengay Ultra 4% - 30% - 10% topical cream, apply a small amount topically to back, every 6 hours as needed for back pain. 1. A review of the resident's comprehensive person -centered care plan dated 9/18/24, reflected that there was no goal or interventions to monitor or manage pain, including the resident's preferences for management of their pain, pain triggers, medications, and any non-pharmacological interventions. On 9/18/24 at 11:15 PM, during an interview with the surveyor, the RN/CN stated that the standard of practice was when a resident had pain, the resident would request for the PRN (as needed) pain medication or was offered and declined. The surveyor then asked the RN/CN what should have been the standard of practice of Resident #15's comprehensive person-centered care plan, a resident who had unspecified dementia, admitted with a hip fracture involving the thigh bone, with a documented nonverbal observation during admission assessment of moaning/yelling with admitted pain when turning with assistance. At that time, the RN/CN confirmed that the patient should have had a care plan for pain. A review of the admission assessment for pain dated 4/11/24, included that at the time of the interview Resident had not reported pain at admission, was able to report pain, and had been treated for pain in the past. During assessment, the nurse documented that the resident was observed moaning in [their] the left hip/leg when turning with two (2) persons assist for care and was unable to rate their pain scale. On 9/18/24 at 10:58 AM, the surveyor and the RN/CN reviewed the September 2024 electronic Administration Record (eMAR) and the electronic Treatment Administration Record (eTAR) together. The eMAR and the eTAR did not reveal a shift-to-shift pain monitoring for Resident #15. At that time, the RN/CN stated that the shift-to-shift pain assessment was on the eMAR/eTAR from 4/10/24 prior to the addition of Tramadol on 4/11/24. The surveyor asked how Resident #15's pain was monitored without a care plan and a shift-to-shift monitoring of pain. The RN/CN stated that the shift-to shift pain assessment continued to be documented until 7/11/24, and was stopped, based on the Consultant Pharmacist's (CP) recommendation to discontinue, the pain scale on 6/27/24. The RN/CN also stated that monitoring a resident's pain included patient's self-reporting of pain and observations of the resident's facial expression which was monitored by staff but did not mention the resident's pain triggers and the non-pharmacological interventions used to address the resident's pain. At that time, the RN/UM who did not carry out the order to discontinue the shift-shift pain assessment stated that discontinuation of the shift-to-shift pain assessment was inappropriate, and the failure to develop a care plan for pain was improper because Resident #15 might not have received enough pain medication, ensuring that Resident #15 was living their best life and the resident's pain was well managed. On 9/18/24 at 11:37 AM, during an interview with the surveyor, the Certified Nursing Assistant (CNA) stated she was familiar with Resident #15 and was assigned to the resident that day. The CNA stated she monitored the resident for falls, although the resident was able to do things by them self. The CNA stated, no, I don't monitor [gender redacted] for pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 11:39 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) stated that Resident #15 was asked every shift about their pain, when the resident was having pain, it followed with a discussion with the physician to see if a routine medication would be needed, or an adjustment of medication, and a consult for the resident may be ordered. The LPN also stated that a family meeting was also completed along with a care plan for pain. At that time, there was no evidence a care plan for pain existed for Resident #15. 2. A review of the the Pain Management Consultant report dated 9/13/24, included the following: Consider adjusting pain medication for better pain control. On 9/18/24 at 11:15 AM, during an interview with the surveyor, the RN/UM stated the consult for adjusting pain medication for better pain control should have been acted upon within 24 hours of the recommendation. The RN/CN could not explain how the consult was missed and was unsure if the attending physician was notified. At that time, after surveyor inquiry, the RN/UM stated she would contact the physician, conduct a pain assessment, and inform the Director of Nursing. On 9/18/24 at 11:59 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concerns regarding Resident #15's comprehensive patient centered care plan failed to include a focus on pain, the pain assessment/ monitoring that was discontinued on 7/11/24, and the inaction with the pain management physician's recommendation to adjust the resident's pain medication for better pain control. On 9/19/24 at 10:14 AM, during a telephonic interview with the surveyor, the CP clarified that the discontinuation of vitals and pain scale was only to remove the documentation from the eMAR and/or the eTAR, and not to discontinue the pain assessment altogether. On 9/19/24 at 10:58 AM, during a meeting with the survey team, and the LNHA, the DON stated that Resident #15 complained of hip pain more consistently and was sent to a pain management physician. At that time, the DON acknowledged that the pain management physician's consult from 9/13/24, should have been followed. At that time, the DON stated that the facility policy was to monitor a resident when they had pain and thought it was appropriate to remove the shift-to-shift pain monitoring on the eMAR/eTAR because the resident was able to self-report. A review of the provided facility policy for Pain Management dated/revised 6/13/23 included the following: It is the policy of [facility name redacted] to ensure that the care planning process is systematic, comprehensive, interdisciplinary, and timely and directed toward achieving and maintaining each resident's optimal physical, psychosocial, and functional status. Procedure: 4. Pain Monitoring and evaluation will be specific to each resident based on the outcome of the pain assessment. (continued on next page)

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	315515	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium at Navesink Harbor, The	40 Riverside Avenue Red Bank, NJ 07701

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. The pain management program will be addressed on the Resident Care Plan. It will include the medical/pathological basis of pain, triggers of pain, medications, modalities, non-pharmacological interventions, and how to evaluate the resident's response. Resident Care Plans will be specific, tailored to their individual needs and responses. A review of the provided facility policy for Resident Care Plan dated/revised 6/29/23, included It is the policy of [facility name redacted] to ensure that the care planning process is systematic, comprehensive, interdisciplinary, and timely and directed toward achieving and maintaining each resident's optimal physical, psychosocial, and functional status. NJAC 8:39-27.1(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 45449 Based on observation, interview, and record review, it was determined that the facility failed to appropriately administer medications used to manage low blood pressure in accordance with physician orders. The deficient practice was identified for one (1) of five (5) residents reviewed for unnecessary medications (Resident #15) and was evidenced by the following: On 9/17/24 at 7:43 AM, a surveyor observed Resident #15 in bed who complained of pain. The resident stated that the pain medication would be administered after breakfast. On 9/17/24 at 11:11 AM, a surveyor observed the resident in the rehabilitation room. At that time, during an interview with the surveyor, the Physical Therapist (PT). The surveyor then interviewed the Registered Nurse/Charge Nurse who informed the surveyor that they charted the resident's pain by exception. On 9/18/24 at 10:47 AM, during an interview with the surveyor, the Registered Nurse/Charge Nurse (RN) stated the resident had a fall on 6/4/24 while going to the bathroom and a risk assessment was conducted. The surveyor reviewed the hybrid medical record for Resident #15. According to the Face Sheet, Resident #15 was admitted to the facility with diagnoses that included unspecified dementia, generalized muscle weakness and nondisplaced intertrochanteric fracture of the left femur (a type of hip fracture that occurs in the upper thigh bone, between the greater and lesser trochanters). Review of the Quarterly Minimum Data Set (qMDS), an assessment tool dated 7/18/24, reflected a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated that the resident had moderate cognitive impairment. A review of the September 2024, Physician Order (PO) sheet included the following orders: Midodrine 5 milligram (mg; medication use to treat low blood pressure) tablet, one (1) tablet oral two times day, scheduled for administration at 9:00 AM and 13:00 (1:00 PM). Under notes, included parameters that reflected, hold for systolic blood pressure greater than (>) 120. The order date was started on 4/11/24. Midodrine 5 mg tablet, half (1/2 = 2.5 mg) tablet one time daily, schedule for administration at 17:00 (5:00 PM). Under notes, incorporated parameters that reflected hold for systolic blood pressure (SBP) greater than (>) 120. The order date was started on 4/11/24. A review of the August 2024 electronic Medication Administration Record (eMAR) revealed Midodrine was administered to Resident #15 outside the hold parameters on the following: 8/11/24 at 17:00 (5:00 PM) SBP of 132 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/18/24 at 17:00 (5:00 PM) SBP of 136 8/20/24 at 17:00 (5:00 PM) SBP of 122 8/26/24 at 13:00 (1:00 PM) SBP of 137 A review of the September 2024 electronic Medication Administration Record (eMAR) revealed Midodrine was administered outside the hold parameters on the following: 9/3/24 at 17:00 (5:00 PM) SBP of 122 9/15/24 at 13:00 (1:00 PM) SBP of 136 A review of the resident's individualized comprehensive care plan dated 9/18/24, reflected that there was no intervention to monitor the blood pressure. On 9/19/24 at 10:14 AM, during an interview with the surveyor, the Consultant Pharmacist admitted to missing the irregularities that occurred in August 2024 for the administration of Midodrine outside the hold parameter. In missing the irregularity, a recommendation to the facility was not made. On 9/19/24 at 10:58 AM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concern regarding the administration of Midodrine outside the parameters for August 2024, and September 2024. The DON stated that she would educate the nurses on administration of Midodrine and its parameters. The LNHA stated that the facility had no policy on administration of medication with parameters. A review of the facility provided medication administration pass observation for the five (5) nurses that administered the Midodrine outside of the prescribed parameters revealed only two (2) of the (3) nurses received a graded medication pass observation. No further information was provided. NJAC 8:39-27.1(a), 29.2(d)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31654 Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) store food in a manner to prevent food-borne illness and, b.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: 1. On 09/17/24 at 7:30 AM, an initial brief tour of the kitchen was conducted in the presence of the Food Service Director (FSD), and the surveyor observed the following: - The large commercial food processor was stored on the metal table with the lid, and when the FSD lifted the lid the inside was wet. The FSD stated it should not have been left wet. - Various crumb type debris was observed on the bins which stored bulk flour and sugar. - The base of the can opener, affixed to the stainless steal table debris on the base and around - A large meat slicer was observed on the corner of the metal steam table, covered in plastic, and was identified as clean by the FSD. The FSD removed the cover and there was various debris by the slicer blade, on the base of the slicer, and a blue handled food scoop was stored on the base of the slicer. 2. A follow up observation in the kitchen at 9:25 AM, in the presence of the FSD, the surveyor observed the following: In the server kitchen area, the surveyor observed the following: - A dried brown substance on 2 of the 4 dispensing tubes which came from the soda drink dispensers. - A brown substance on the floor beneath the 4 drink dispenser boxes. - Inside the box ice cream freezer, the surveyor observed 6 of 10 lids on the ice cream containers opened. The FSD stated that the server kitchen area should be clean and the ice cream lids should have been closed. NJAC 8:39-17.2(g)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19106 Based on interview, medical record review, and review of other pertinent facility documentation, it was determined the facility failed to consistently offer residents a pneumococcal vaccine. The deficient practice was identified for 2 of 5 residents (#2, #18) reviewed for immunizations and was evidenced by the following. Reference: A review of the CDC's Advisory Committee on Immunization Practices (ACIP) for Pneumococcal Vaccine Recommendations dated/last reviewed on 2/13/23, included the following. The CDC recommends routine administration of pneumococcal conjugate vaccine (PCV15 or PCV20) for all adults [AGE] years or older who have never received any pneumococcal conjugate vaccine or whose previous vaccination history is unknown . 1. The surveyor reviewed Resident #12's immunization history on the hybrid (paper and electronic) medical record on 9/18/24. Documentation supporting the administration of pneumococcal immunization could not be located on the paper or electronic sections of the record. In an interview with the unit Registered Nurse (RN) on 9/18/24, the RN indicated all immunization documentation should be located on the electronic medical record. A review of Section O of the 9/9/24 Comprehensive Minimum Data Set (MDS) assessment tool revealed the resident's pneumococcal vaccination was not up to date. Additionally, no reason was indicated of why the vaccination was not given. On 9/19/24 at 11:11 AM the Administrator and Director of Nursing stated they could not provide evidence of pneumococcal vaccination for Resident #12. 45449 2. On 9/18/24 at 9:28 AM, a surveyor observed the Resident #18 sleeping in bed; the head of the bed was elevated. The resident was wearing a nasal cannula (a device used to deliver supplemental oxygen) infusing at 2 liters per minute (lpm). The surveyor reviewed the hybrid medical record for Resident #18. According to the Face Sheet (an admission record), Resident #18 was admitted to the facility with diagnoses which included acute and chronic respiratory failure with hypercapnia ((too much carbon dioxide (CO2) in your blood). Further review of the Face Sheet, under notes, reflected Resident #18's immunization record, that did not include information about the resident's Pneumococcal vaccination. Review of the Quarterly Minimum Data Set (qMDS), an assessment tool dated 6/3/24, reflected a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated that the resident was cognitively intact. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the qMDS dated [DATE], under section O0300 A. Was the resident's Pneumococcal vaccine to date? The response was marked one (1), which indicated Yes. Section B. If Pneumococcal vaccine not received, and the reason was blank. A review of the admission assessment dated [DATE], indicated the resident received the Pneumococcal vaccine and the date was unknown. On 9/18/24 at 10:27 AM, during an interview with the surveyor, the Registered Nurse/Charge Nurse (RN/CN) stated that during admission the resident was asked if, or when they received the Pneumococcal vaccine. At the time of admission four years ago, Resident #18 was cognitively intact, and was able to inform the facility staff of having received the Pneumococcal vaccine but could not recall which type and when. At that time, in the presence of the surveyor and the RN/CN, the RN/MDS-Coordinator (RN/MDSC) was asked about the qMDS information that reflected the resident's Pneumococcal vaccination was up to date. The RN/MDSC stated that she received the information from the nurses during her interview with them for the qMDS dated [DATE]. On 9/18/23 at 12:43 PM, during an interview with the surveyor, the RN/Infection Preventionist (RN/IP) stated she did not have documentation that showed the resident was offered or declined the Pneumococcal vaccination and was not able to provide proof that an education was provided. At that time, the RN/IP acknowledged that based on the missing consent, declination, education, the historical data provided by the resident, and a review of the hybrid medical record, Resident #18's Pneumococcal vaccination status was not up to date. At that time, the RN/IP was asked how the inaccuracy of the qMDS occurred. The RN/IP stated she could not answer for the RN/MDSC who conducted the resident's assessments for the Pneumococcal immunization. At that time, the RN/IP stated that in the spring of 2024, she began to update the Pneumococcal immunization surveillance for the long-term care residents to determine who was current against who was not. The RN/IP also stated that moving forward the documentation of when a vaccination was received, offered, declined, and when the resident was educated would be documented. On 9/18/24 at 12:24 PM, in the presence of the survey team, the Licensed Nursing Home Administrator, and the Director of Nursing, the surveyor discussed the concerns regarding Resident #18's qMDS that reflected the resident had a current Pneumococcal vaccination while the hybrid medical record did not reflect the resident was offered, or declined and was educated on the Pneumococcal vaccination. On 9/19/24 at 9:00 AM, the surveyor reviewed the facility's response to the concern that revealed, after surveyor inquiry, the resident's family member was contacted by the facility, then asked for a consent to administer the Pneumococcal vaccine to Resident #18. A verbal consent was given by the family member, and was informed that the administration would occur when the physician advised. A review of the provided facility policy, Pneumonia Prevention and Control dated 9/18/24, under Procedure included the following: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. 5. The resident or the resident's legal representative may refuse vaccination for any reason. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the Pneumococcal vaccination. 7. Initiation of the Pneumococcal vaccine or revaccinations will be made in accordance with current Center for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. NJAC 8:39-19.4 (i)