STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Venetian Care & Rehabilitation Center, The	275 John T O'Leary Boulevard South Amboy, NJ 08879

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48423 Based on observation, interviews, and record review, it was determined that the facility failed to provide nail care to a resident who required extensive assistance from staff for Activities of Daily Living (ADL). This deficient practice was identified for 1 of 7 residents (Resident #13) reviewed for ADL care. The deficient practice was evidenced by the following: On 03/25/24 at 10:28 AM, during the initial tour of the facility, the surveyor observed Resident #13 in bed, with his/her right hand from middle finger to pinky finger closed into a fist and the index finger pointing out with an elongated thickened non-smooth nail. The surveyor was not able to observe the resident's right hand nails from the middle finger to pinky finger. Resident #13's left hand had long nails on the thumb, index finger and the pinky finger. The third and fourth fingernails had jagged appearance. The surveyor reviewed the medical records for Resident #13. A review of the Admission Record face sheet reflected Resident #13 was admitted to the facility with diagnoses which included, but were not limited to, Cerebrovascular Disease ([CVA] conditions that affect blood flow to your brain), Right leg above knee amputation (removal of a limb), and Atherosclerotic heart disease (buildup of plaque in arteries causing reduced blood flow). A review of the most recent Quarterly Minimum Data Set (MDS) an assessment tool to facilitate resident care dated 03/13/24 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognitively intact. Section GG Functional Abilities and Goals reflected that the resident had an impairment on one side in the upper extremity. The MDS revealed that the resident required extensive assistance and was dependent on staff for most ADLs and personal hygiene. Section E Behavior indicated that the resident did not exhibit rejection of care. A review of the resident's Care Plan (CP) did not reflect the Resident had a ADL self-care performance deficit and required assistance with ADLs. On 03/26/24 at 01:26 PM, the surveyor interviewed Certified Nursing Aide (CNA) #1, who stated that if she sees a resident with long nails and the residents were alert then she would ask the resident if she could trim their nails. (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: 315518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024

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Venetian Care & Rehabilitation Center, The	275 John T O'Leary Boulevard South Amboy, NJ 08879

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/01/24 at 12:07 PM, the surveyor asked the resident how he/she feels about his/her nails being that long or if the staff cleans their nails during care. The resident stated I don't like them (nails) too long. They don't clean the nails when they provide care. My hand is now contracted before I was able to use the right hand. On 04/02/24 at 11:47 AM, the surveyor interviewed CNA #2 who stated she was familiar with Resident #13. She stated that the resident was total dependence with care. CNA #2 stated that she cleans the nails when she provides care. I cut/trim residents nails if they need to be cut. The surveyor asked the CNA if they keep a log for nail care and the CNA stated, No log. On 04/02/24 at 12:17 PM, the surveyor interviewed the 3rd floor Unit Manager/Licensed Practical Nurse (UM/LPN), who stated that the CNA's are supposed to do basic nail care such as cutting and filing hand nails only. The UM/LPN stated, it was important to cut/trim nails because of an increased risk for infection, easy to scratch themselves or the staff, and for manipulations of utensils. The UM/LPN entered Resident #13's room with the surveyor. When asked about the resident's nail care, the UM/LPN stated, The resident has long nails and would benefit from having their nails cut and filed today. On 4/4/24 at 03:17 PM, the survey team met with LNHA, DON and Regional Nurse to present the above concerns. A review of the facility provided undated Position Title: Certified Nurse Aide document under responsibilities/ Accountabilities included: Bathes the resident in bed, tub or shower, combs hair, cleans and cuts fingernails and given shampoos. A review of the facility provided ADL Care policy revised on 09/2023 included: The level of assistance needed for any ADL activity will be included on the resident's plan of care. The care plan will describe potential distress triggers or behaviors as related to the completion of ADLs. A review of the facility provided Comprehensive Care Plan policy revised on 09/2023 included: The care planning process will include an assessment of the resident's strengths and needs and will incorporate the president's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlines by the comprehensive care plan, shall be culturally competent and trauma-informed. NJAC 8:39-27.2 (g)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41858 Based on observations, interviews, record review and other facility documentation, it was determined that the facility failed to complete weekly skin evaluations for 3 of 3 residents (Resident #5, #49 and #86) reviewed for pressure ulcers. This deficient practice was evidenced by the following: 1.On 03/25/24 at 11:10 AM, during initial tour of the 4th floor, the surveyor observed Resident #5 in bed. The surveyor attempted to interview the resident but he/she was unable to answer the surveyor's questions. A review of Resident #5's Electronic Medical Record (EMR) revealed the following: According to the Admission Record, Resident #5 was admitted to the facility with diagnoses that included but were not limited to: Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and Epilepsy, (a brain condition that causes recurring seizures) Unspecified, Not Intractable, without Status Epilepticus. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/29/24, indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a 9 out of 15 which indicated that the resident was moderately cognitively impaired. Further review of the MDS, revealed the resident had one Stage 3 (full thickness tissue loss. Slough may be present but does not obscure the depth of tissue loss) pressure ulcer. A review of the physician Order Summary Report (OSR) revealed an active physician's order (PO) for: Skin evaluation weekly every evening shift every Tue for Skin Evaluation. Complete COMS-Skin Only Evaluation (under Evaluation Tab). Report abnormal findings as per protocol. A review of the Treatment Administration Record (TAR) for January 2024 revealed that the above PO for Skin evaluation weekly was signed as completed for Eveni (evening) on 01/02/24, 01/16/24 and 01/23/24. The Eveni was left blank for 01/09/24 and 01/30/24. A review of the TAR for February 2024 revealed that the above PO for Skin evaluation weekly was signed as completed for Eveni on 02/06/24, 02/13/24 and 02/27/24. The Eveni was left blank for 02/20/24. A review of the TAR for March 2024 revealed that the above PO for Skin evaluation weekly was signed as completed for Eveni on 03/05/24, 03/12/24, 03/19/24, and 03/26/24. A review of the skin evaluations (under the Evaluations tab) revealed a N Adv - Skin Only Evaluation dated 2/19/2024. There were no other skin evaluations documented under the Evaluations tab for January, February, or March 2024. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's Care Plan revealed a Focus: potential for pressure ulcer development r/t (related to) Disease process, impaired mobility, incontinence. Lt (left) buttocks-stage 3 02/29/2024 seen by Heritage wound care- resolved. Intervention: Follow facility policies/protocols for the prevention/treatment of skin breakdown in [name redacted]. On 04/01/24 at 12:20 PM, the surveyor interviewed the Licensed Practical Nurse (LPN), who confirmed she was Resident #5's assigned nurse. She stated that skin assessments were usually done at least weekly on shower days. She then stated that the skin assessment should be documented under Evaluations in the EMR. On 04/02/24 at 09:42 AM, the surveyor interviewed the 4th floor LPN/Unit Manager (UM), who stated that resident's skin gets checked weekly and a skin check evaluation should be done in the EMR. He stated that skin evaluations were required if there was not a wound or if a wound was still there or if the wound was healing. The LPN/UM stated that the assessment was charted on the TAR and under the Evaluation tab. On 04/02/24 at 09:48 AM, the LPN/UM reviewed the EMR in the presence of the surveyor for Resident #5. He verified the above PO for weekly skin assessments. He confirmed that the 02/19/24 skin evaluation under the Evaluations tab was the only evaluation documented since 01/01/24. The LPN/UM confirmed no additional skin evaluations were completed since 2/19/2024. He stated the purpose of the evaluations was to check if skin was intact, to make sure the proper treatment was being done. He stated that the evaluations should be done even if a wound was already present because they still need to monitor the skin in addition to the wound to identify any new areas. He then stated that the Certified Nursing Assistant (CNA) would also identify new wounds. 2. On 03/27/24 at 11:33 AM, the surveyor observed Resident #49 sitting in a reclining chair in the common area on the 4th floor. The resident had their eyes closed. A review of Resident 49's EMR revealed the following: According to the Admission Record, Resident #49 was admitted to the facility with diagnoses that included but were not limited to: Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and Anxiety and a Pressure Ulcer of Sacral Region, Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle). The Quarterly MDS dated [DATE], indicated that the facility assessed the resident's cognitive status using a BIMS. The resident scored a 00 out of 15 which indicated that the resident was severely cognitively impaired. Further review of the MDS, revealed the resident had one Stage 3 pressure ulcer. A review of the physician OSR revealed an active PO for: Skin evaluation weekly every (Monday) on (11-7) evening shift every Mon for Skin Evaluation. Complete COMS-Skin Only Evaluation (under Evaluation Tab). Report abnormal findings as per protocol. A review of the TARs for January 2024 revealed that the above PO for skin evaluations weekly was signed as completed for Night on 01/08/24, 01/15/24 and 01/22/24 and 01/29/24. The Night was left blank for 01/01/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the TARs for February 2024 revealed that the above PO for skin evaluations weekly was signed as completed for Night on 02/05/24, 02/12/24, 02/19 /24 and 02/26/24. A review of the TARs for March 2024 revealed that the above PO for skin evaluations weekly was signed as completed for Night on 03/04/24, 03/11/24, and 03/25/24. The Night was left blank for 03/18/24. A review of the skin evaluations (under the Evaluations tab) revealed a N Adv - Skin Only Evaluation dated 2/19/2024. There were no other skin evaluations documented under the Evaluations tab for January, February, or March 2024. A review of the resident's Care Plan revealed a Focus: has a high risk for ulcer sacrum-pressure, rt (right) heel- pressure ulcer r/t Immobility, sacrum Date Initiated: 03/01/2022, Revision on: 03/22/2024. On 04/02/24 at 09:48 AM, the surveyor interviewed the 4th floor LPN/UM, who confirmed he was Resident #49's assigned nurse. He reviewed the EMR in the presence of the surveyor. He verified the above PO for weekly skin assessments. He then acknowledged that the only documented skin assessment under Evaluations from January to present was the N Adv - Skin Only Evaluation dated 02/19/2024. 3. On 03/25/24 at 11:17 AM, during the initial tour of the 3rd floor, Resident #86 was observed in a reclining chair in the activity area. A review of Resident 86's EMR revealed the following: According to the Admission Record, Resident #86 was admitted to the facility with diagnoses that included but were not limited to: Pneumonia, Unspecified Organism (An infection of the air sacs in one or both the lungs) and Dysphagia, Oropharyngeal Phase (difficulty swallowing food or water). The Quarterly MDS dated [DATE], indicated that the facility assessed the resident's cognitive status using a BIMS. The resident scored a 00 out of 15 which indicated that the resident was severely cognitively impaired. Further review of the MDS, revealed the resident's skin was intact. A review of the physician OSR revealed an active PO for: Skin evaluation weekly every Monday on evening shift. Every evening shift every Mon for Skin Evaluation. Complete COMS-Skin Only Evaluation (under Evaluation Tab). Report abnormal findings as per protocol. A review of the TARs for January 2024 revealed that the above PO for Skin evaluations weekly was signed as completed for Eveni on 01/01/24, 01/08/24, 01/15/24 and 01/29/24. The Eveni was left blank for 01/22/24. A review of the TARs for February 2024 revealed that the above PO for Skin evaluations weekly was signed as completed for Eveni on 02/05/24, 02/12/24, 02/19/24 and 02/26/24. A review of the TARs for March 2024 revealed that the above PO for Skin evaluations weekly was signed as completed for Eveni on 03/04/24, 03/11/24, and 03/25/24. The Eveni was left blank for 03/18/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the skin evaluations (under the Evaluations tab) revealed a N Adv - Skin Only Evaluation dated 01/16/24, 01/30/24, 02/13/24, and 3/12/24. There were no other skin evaluations documented under the Evaluations tab for January, February, or March 2024. A review of the residents Care Plan revealed a Focus: has sacral pressure ulcer -resolved Rt lateral thigh-surgical-3/28/24 infection to rt thigh rt arm-skin tear-resolved 8/31/23 skin tear lt hand-resolved r/t Immobility Date Initiated: 08/29/2022 Revision on: 03/28/2024. Intervention: Follow facility policies/protocols for the prevention/treatment of skin breakdown. On 04/02/24 at 10:07 AM, the surveyor interviewed the CNA, who stated that if new skin break down was identified, she would call the nurse in to see it. On 04/02/24 at 10:25 AM, the surveyor interviewed the 2nd floor Desk Nurse/Registered Nurse (DN/RN), who stated that skin assessment were done weekly in the evening and that it should be documented under the skin assessment under Evaluations tab. She stated the assessments should be signed off on the TAR as being completed and then document skin assessments. The DN/RN stated it (documentation) should be done regardless of skin breakdown or not. The DN/RN stated the purpose was to know if a wound was improving, if there was development of a wound, and to make sure there was nothing present that wasn't there before. On 04/02/24 at 10:30 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who stated that skin assessments were done weekly by the nurses. She then stated that the CNA's would notify the nurse if anything new comes up. The ADON stated that the assessment was documented on the Medication Administration Record (MAR) or TAR. She further stated that the skin assessment would be done weekly usually with the resident's shower and if anything, abnormal was found a skin evaluation would be done. On 04/03/24 at 12:17 PM, the surveyor interviewed the Regional Clinical Operations/Registered Nurse (RCO/RN) who state that skin should be assessed on admission, readmission, weekly and as needed. She stated that it (the skin assessment) should be documented in the EMR under the Evaluations tab. The RCO/RN stated that every resident should have a weekly skin assessment regardless of skin breakdown or not. She stated the purpose was to monitor skin abnormalities and to make sure interventions were put in place. At that time, the RCO/RN reviewed the facility provided OSR for Resident #5 and #49. She confirmed that the Complete COMS-Skin Only Evaluation (under Evaluation Tab) should be completed weekly as ordered. She reviewed the TARS and stated that if nurses are signing the TAR, they were acknowledging that the skin assessment was completed on skin assessment COMS tab. She further stated if they (nurses) don't sign it, it was not completed. If it is not documented, it is not done. She then reviewed the Evaluations tab in the EMR in the presence of the surveyor and verified that there was only a skin assessment documented on 02/19/24. On 04/03/24 at 12:45 PM, the surveyor made the Licensed Nursing Home Administrator, the DON and the RCO/RN were made aware of the above findings for Residents #5, #49, and #86. No additional information was provided. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy Pressure Ulcer Prevention & Management Policy revised 9/2023, revealed Policy: It is the policy of this facility to assess all resident upon admission; readmission and quarterly thereafter for risk factors associated with Pressure Ulcer development and the necessary precautions to prevent formation. Appropriate interventions will be utilized to prevent pressure ulcer development and to promote healing when pressure ulcer are present. Procedure: 1. All residents will be assessed on admission, re-admission, if noted with significant change in condition, and quarterly thereafter for the risk of PRESSURE ULCER formation using the BRADEN SCALE. 3. THE SKIN ONLY EVAL will be completed by the licensed nurse weekly to determine effectiveness of treatment. NJAC 8:39-25.2 (c), 27.1(e)

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F 0688

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48423

Based on observations, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to identify and prevent worsening of a contracture (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen) for one of four residents (Resident #13) reviewed for position and mobility.

This deficient practice was evidenced by:

On 03/25/24 at 10:28 AM, during the initial tour of the 3rd floor, the surveyor observed Resident #13 in bed. The resident's right hand was closed from the middle finger to the pinky finger and the index finger was pointing out. When asked by the surveyor, Resident #13 stated that they were not able to turn or open his/her right (R) hand/fist or extend his/her R arm. The surveyor observed that there was no a brace on the R arm or that there was nothing placed in the R hand.

On 03/26/24 at 1:26 PM, the surveyor interviewed Certified Nursing Aide (CNA #1) who stated that if she saw a resident with a contracture then she would perform range of motion exercises and inform the nurse to schedule the resident for therapy. She also stated that she would place a gauze or a wash rag in resident's hand.

On 03/27/24 at 12:00 PM, the surveyor observed Resident #13 in bed. The surveyor observed that there was no brace on the R arm and there was nothing placed in the R hand. Resident #13 stated that he/she was right-handed but was able to feed him/herself with their left hand. Resident #13 further stated, I learned how to eat with my left hand.

On 04/01/24 at 12:07 PM, the surveyor observed Resident #13 in bed and that there was no brace on the R arm and there was nothing placed in the R hand. The surveyor interviewed the resident about his/her hand. Resident #13 stated My hand is contracted now but before that I was able to use my right hand. Resident #13 stated; the staff does not give me anything in my right hand.

On 04/02/24 at 10:41 AM, the surveyor observed Resident #13 in a reclining chair in his/her room. The surveyor observed that there was not a brace on the R arm or that there was nothing placed in the R hand.

The surveyor reviewed the electronic medical records (EMR) for Resident #13.

A review of the Admission Record face sheet revealed Resident #13 was admitted to the facility with diagnoses which included but were not limited to; Cerebrovascular Disease (CVA) (conditions that affect blood flow to your brain), Right leg above knee amputation (removal of a limb), and Atherosclerotic heart disease (buildup of plaque in arteries causing reduced blood flow).

A review of the resident's diagnoses did not include a diagnosis for an upper extremity impairment.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	A review of the Quarterly Minimum Data Set (MDS), used to facilitate the management of care, dated 12/15/23, revealed that Resident #13 had a Brief Interview of Mental Status (BIMS), score of 14 out of 15, indicating the resident was cognitively intact. The MDS also identified that the resident had an impairment on one side, the upper extremity. A review of the most recent Quarterly MDS dated [DATE], revealed that Resident #13 had a BIMS score of 14 out of 15, indicating the resident was cognitively intact. The MDS also identified that the resident had an impairment on one side, the upper extremity. A review of Resident #13's ongoing Care Plan (CP) did not reveal a Focus or intervention for the resident's upper extremity impairment or the R hand contracture. A review of the readmission Physician's History & Physical dated 11/28/23 at 20:12 (08:12 PM) did not reveal documentation of the resident's upper extremity impairment or a contracture. Additional review of the Physician's Progress notes dated 09/1/2023, 09/21/23, 10/17/23, 12/28/23, 01/02/24, 01/16/24, 02/20/24, and 03/12/24 did not reveal documentation of the resident's upper extremity impairment or a contracture. A review of nursing Progress notes from 09/01/23 to 04/03/24 did not reveal any documentation of the resident's upper extremity impairment or a contracture. A review of the Order Summary Report (OSR) from 11/24/23, did not reveal physician's orders (PO) for a splint or brace to the right arm or hand. Further review of OSR did not reveal an order for restorative care for Range of Motion (ROM) to right arm/hand. A review of September 2023, October 2023, November 2023, December 2023, January 2024, February 2024, March 2024, and April 2024 Treatment Administration Record (TAR) did not reveal documentation of treatment to address any interventions for the resident's upper extremity impairment or contracture. On 04/02/24 at 11:47 AM, the surveyor interviewed CNA #2, who stated that she was familiar with Resident #13. When asked how long the resident had a contracture and what was being done, she stated, It's been a long time. Nothing new, I just wash it (the hand) and make sure it's clean and dry. CNA #2 further stated that Resident #13 does not get therapy and I don't know if there is a range of motion plan of care for the hand. On 04/02/24 at 12:47 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated that Resident #13 had a history of a CVA, and he thinks that the resident has had the contracture for long time but doesn't know when the traumatic event occurred. The UM/LPN further stated that if the CNA was providing care to the resident and noticed a new/acute (sudden onset) contracture then the CNA should come and notify the nurses. He then stated that his/her hand contracture seems to be chronic (persisting for a long time). The UM/LPN stated that the resident was not on a restorative program (A program of passive movement exercises to maintain flexibility and useful motion in the joints of the body). He further stated that if there was a decline in functional abilities, we discuss it during weekly meetings and if Physical Therapy (PT) can pick up the resident versus Restorative care. The UM/LPN was not sure if the resident was supposed to be wearing a splint to his/her right hand and could not speak to why he did not refer the resident to therapy for evaluation. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	On 04/03/24 at 12:54 PM, the surveyor interviewed the Occupational Therapist (OT) who stated that they have a restorative program for residents on Long Term Care (LTC) after the residents have completed their course of physical therapy or occupational therapy. The OT educates the nursing staff and aides about Range of Motion (ROM) exercises to prevent contractures. The OT stated the residents are screened quarterly, annually, on re-admission, after a fall or if the staff notices any acute changes. The OT stated the screening process included observation of the resident and interview of the resident if possible. She stated that she would also interview the CNAs and the licensed nursing staff. She stated that Resident #13 was screened within the last three months after he/she came back from the hospital and further stated, No contractures were reported to me when he/she was screened. The surveyor asked the OT if she knew about Resident #13's contractures, she stated she was Not aware of the resident having any contractures. The OT also stated I wasn't made aware that the resident had limited or a decrease in ROM. 04/03/24 02:10 PM, the surveyor requested a timeline of the upper extremity impairment for Resident #13 from the Licensed Nursing Home Administrator (LNHA). On 04/04/24 at 09:00 AM, the LNHA provided the survey team with a handwritten timeline and other documentation of Resident #13's upper extremity impairment. A review of the timeline revealed Resident #13 had an upper extremity impairment on the Annual MDS dated [DATE]. At this time, the surveyor interviewed the LNHA in the presence of the survey team. She acknowledged that there was no documentation or care planning for the resident's upper extremity impairment/contracture. She further acknowledged that the MDS identification of the upper extremity impairment did not include the location of the impairment. On 04/04/24 at 10:35 AM, the LNHA stated the resident was admitted to the hospital on 11/12/23, and was readmitted to the facility on [DATE]. The LNHA provided a copy of the hospital Progress Notes printed on 11/14/2023 17:11 (5:00PM). A review of the progress note revealed Physical Exam .Right arm contracted. A review of the Clinical Admission note dated 11/24/2023 at 22:50 (10:50 PM), revealed the resident was readmitted from the hospital. Further review revealed under Functional .Able to move all extremities. Upper extremity ROM: No impairment. A review of the Rehab (rehabilition) Screen dated 11/28/23, revealed: D. Primary Reason for Screen: check mark for b. Re-Admit; 3. PLOF (Prior Level of Function)/Specific Observations/Concerns: PT (patient) is a readmission to facility for hospitalization ,d+[DATE] (secondary) wound infection. PT was referred for concerns about feeding. Discussed with nurses as PT was listed in chart as needing assist with feeding. Staff reports PT can feed self if positioned properly .4. Therapy Evaluation Indicated: a. Physical Therapy, b. Occupational Therapy, c. Speech Therapy- All these were marked No. d. If no, please give reason: No evaluation indicated at this time. PT with no acute change in feeding status. Further review did not reveal documentation or evidence of an impairment/contracture to the RUE (right upper extremity). On 04/04/24 at 11:37 AM, the surveyors interviewed the Director of Rehabilitation, (DOR) who stated, I personally never worked with (the resident) and I don't think the resident received services. The DOR stated if the staff identified any decline in function or limitations with Activities of Daily Living (ADLs) then the staff makes referral to therapy. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Venetian Care & Rehabilitation Center, The	275 John T O'Leary Boulevard South Amboy, NJ 08879

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F 0688 Level of Harm - Actual harm Residents Affected - Few	After surveyor inquiry, A review of OT (Occupation Therapy) Evaluation dated 4/4/24 reflected diagnosis: Contracture, unspecified joint. Prior Therapy . Pt refused last therapy attempts. Musculoskeletal-ROM: UE (upper extremity): RUE (right upper extremity) ROM=Impaired. Tone =abnormal; UE Muscle Tone=Rigid. RUE ROM: Shoulder=Impaired; Elbow/forearm=Impaired; Wrist=Impaired; Hand=Impaired (flexion contracture noted at digits (fingers) III (three)-V (five) with digits in 90 degrees of flexion at MCP [Manual Muslce Test for Metacarpophalangeal (knuckle) Flexion] and 65 degrees of flexion at PIP (proximal interphalangeal) joints (a hinge joint that connects the first two bones of the find, allowing it to benand extend). PT with swan neck deformity (an abnormal positioning of the joints in your fingers, with a curved appearance similar to the neck of a swan) at digit II (two). On 04/04/24 at 3:17 PM the survey team met with LNHA, DON and Regional Clinical Operations Registered Nurse to present the above concerns. On 04/08/24 at 11:31 AM, the LNHA stated she did not have anything additional from physical therapy or OT other than what she already provided due to the computer system change. A review of the undated facility provided Position Title: Certified Nurse Aide document revealed under responsibilities/Accountabilities included: Report any/all changes in resident's condition, any family concerns and resident's complaints to charge nurse and/or supervisor. A review of the undated facility provided Position Title: Licensed Practical Nurse document revealed under Responsibilities/ Accountabilities: Takes an active role in direct resident assessment and care; Formulates individualized nursing care plans utilizing the nursing process; Assesses each resident daily and implements a change in the course of action as needed. A review of the undated facility provided Position Title: Registered Nurse document revealed under Responsibilities/ Accountabilities: Takes an active role in direct resident assessment and care; Formulates individualized nursing care plans utilizing the nursing process; Assesses each resident daily and implements a change in the course of action as needed. A review of the facility policy Restorative Nursing- Active Range of Motion policy, revised on 09/2023, revealed: Unit Manager/Designee will: 7. Follow up with rehab when there are changes in resident condition including either an improvement or decline or unwilling to participate in the restorative program. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	A review of the facility provided Comprehensive Care Plans policy, revised on 09/2023 included: 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 7. The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative. A review of the facility provided ADL Care policy, revised on 09/2023, revealed Each resident's physical functioning will be assessed in accordance with the facility's assessment procedures. NJAC 8:39-27.1(a); 27.2(m)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 48423 Based on observation, interviews, record review and review of other relevant facility documentation, it was determined that the facility failed to obtain and carry out an order to discontinue a Peripheral Intravenous line (IV [In a vein]) and to maintain the site according to professional standards of practice. The deficient practice was identified for one of one residents (Resident #326) reviewed for IV therapy. The deficient practice was evidenced by the following: On 3/26/24 at 11:43 AM, the surveyor observed the resident's left forearm (region of the upper limb between the elbow and the wrist) with an IV line in place. The IV line was covered by a transparent dressing. The tape holding the dressing to the skin was peeling off. The surveyor noted the IV line was not dated or initialed. There were no medications or fluids infusing through the IV line during this observation. A review of the admission record (an admission summary) revealed that the Resident #326 was admitted to the facility with the follow diagnoses, which included but not limited to; Urinary tract infection (UTI [infection of any part of the urinary tract]), Fournier gangrene (a rare, life-threatening bacterial infection of your scrotum, penis or perineum [the area between your genitals and rectum]) and Type 2 Diabetes. Further review of Resident #326's admission record reflected that the resident was admitted to the facility with an IV access site. A review of the resident's admission Minimum Data Set (MDS), a tool used to facilitate the management of care, dated 3/12/24, revealed that the resident's Brief Interview for Mental Status (BIMS) score was 11 out of 15, which indicated the resident was moderately cognitively impaired. MDS section N and O reflected that the resident was on IV antibiotics within the past fourteen (14) days while at the facility. A review of the March 2024 Physician Orders (PO) revealed a PO dated 3/5/23 for the following: Ceftriaxone Sodium injection Solution Reconstituted 1 GM (gram). Use 100 ml intravenously one time a day for UTI for six (6) days. Further review of the PO did not reveal a PO to maintain or discontinue an IV line after the completion of IV antibiotics. Further review of the PO's did not reveal an order to assess or to discontinue the left forearm IV line. A review of the March 2024 Medication Administration Record (MAR) revealed that Resident #326 had received IV Ceftriaxone Sodium once a day for six (6) days from 3/6/2024 to 3/11/2024 for a UTI. The order was signed as given as ordered at 0630 (06:30 AM). Further review of the MAR and Treatment Administration Record (TAR) March 2024 did not reveal that the left foream IV line had been assessed or discontinued. A review of the Care Plan ([CP] a document that summarizes a person's health condition, specific care needs and health condition) did not reveal a focus for IV-line care or IV antibiotics. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Physician Progress Note dated 3/18/24 entered and signed by an Infectious Disease (ID) Advance Practice Nurse (APN) revealed: Recommendation: 4. Can d/c (discontinue) PIV (peripheral IV) from ID standpoint .case and care plan reviewed and discussed with Dr. [name redacted] and nurse. On 3/28/24 at 11:28 AM the surveyor interviewed the resident's Registered Nurse (RN). The RN stated, the resident is not on antibiotics now and stated, I don't know when his/her IV was inserted. On 3/28/24 at 11:40 AM the surveyor interviewed the RN/ Charge Nurse (RN/CN). The RN/CN stated that the resident came in with the IV line from the hospital and further stated, I don't know when it was inserted in the hospital, but I have to check his/her hospital records and get back to you. The RN/CN then reviewed Resident #326's progress notes dated from 3/6/2024, in the presence of the surveyor and stated, It (the note) says PICC line (is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart). The RN/CN reviewed the resident's paper chart/medical records from the hospital. The surveyor requested a copy of the Universal Transfer Sheet ([UTS] ensure that accurate communication of pertinent clinical patient care information is conveyed at the time of a transfer between healthcare facilities or programs). At 12:15 PM, the surveyor received and reviewed the copy of the UTS with the RN/CN which revealed: 17 IV Access which revealed the option for Saline lock (which is referred to IV line also) was checked off. At 12:48 PM, the RN/CN and the surveyor went to the resident's room to confirm the access site. The RN/CN acknowledged, It's an IV line and it was unacceptable that it was still there. During a follow up interview with the RN/CN in regard to the purpose of removing an IV line, the RN/CN stated Infection is definitely a major one. Infection can lead to causing other things like sepsis. The RN/CN further stated that any nurse can get PO to discontinue an IV line after the completion of antibiotics. The surveyor reviewed the CP with the RN/CN and asked if IV-line care or antibiotics should have been care planned for and RN/CN stated, it might be that they (the MDS coordinator) removed it since he/she (the resident) completed his/her IV antibiotics. On 3/28/24 at 01:01 PM, the surveyor interviewd the MDS coordinator, who acknowledged that the focus CP for IV-line care or antibiotics use was not there. On 3/28/24 at 02:17 PM, the surveyor interviewed the Director of Nursing (DON) in regard to her expectation of staff if a resident was admitted with an IV line. The DON stated, the IV line should be changed every 3 days but As a nurse, I will follow the policy. The DON also acknowledged that the IV line should have been care planned. On 4/02/24 at 09:48 AM, the DON provided the surveyor a timeline for Resident #326's IV line. A review of the time line revealed: Hospital records state PICC line, upon admission assessment, resident had IV peripheral (IVP) line to left forearm. Resident was receiving antibiotics from admission to 3/11/24. On 3/13/24, ID phyiscian assess resident and recommened IVP to be removed. No order was written for removal. Staff continued to maintian IVP and on 3/18, the ID physician recommended removing the line-no order was written. Order received on 3/28/24 (after surveyor inquiry) to remove the line and nurse removed with no issues. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/03/24 at 11:43 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who stated that upon admission, the staff should document the kind of access the resident had and when it was inserted. She further stated it should all be documented in the admission assessments and also in progress notes. The ADON stated, the IV line is changed every 3 days to prevent infection and for Resident # 326, the IV line should have been removed after the completion of IV antibiotics. The ADON acknowledged that the CP should have been initiated for IV line and stated, No, it is not acceptable that the IV-line CP wasn't initiated. On 4/04/24 at 3:17 PM, the survey team met with the LNHA, DON and Regional Nurse to present the above concerns. No additional infomration was provided. A review of the facility's policy Catheter insertion and care with an effective date 8/1/2018, revealed: Policy: Peripheral IV dressings will be changed when needed to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. General Guidelines: 2. Change the dressing if it becomes dampl, loosened or visibly soiled and at least every 5 to 7 days. Change dressing and perform site care if signs and symptoms of site infection are present. A review of the facility plociy Comprehensive Care Plans policy, revised on 09/2023 revealed: 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. NJAC 8:39-25.2(c)5

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49173 Based on observations, interviews, record review, and review of facility documentation, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure that a.) staff followed a Physician Orders (PO) for the administration of an insulin medication for 1 of 1 resident (Resident #96) reviewed for the management of insulin, b.) medications were observed as accurately and timely administered to one (1) of five (5) residents, (Resident #54) reviewed for medication administration, and c.) to ensure an accurate inventory of controlled medications (narcotic medications) dispensed from the facility's automated medication dispensing system (AMDS) located on the 2nd floor nursing unit. The deficient practices were evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. A.) On 03/26/24 11:49 AM, Resident #96 was observed in the room. The resident was in bed and watching television. The resident was alert and verbalized no issues or concerns to the surveyor. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to the following: diabetes mellitus (DM) type 2(the pancreas does not make enough insulin), cerebral infarction due to occlusion(blockage which prevents blood flow to the brain), and occlusion and stenosis of left carotid artery (narrowing of the blood vessel that prevents blood flow). A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's Brief Interview for Mental Status (BIMS) was 13 out of 15, which indicated that the resident's cognition was intact. A review of the Order Summary Report (OSR) revealed a PO dated 2/16/24, for insulin Glargine subcutaneous (under the skin) solution 100 unit/ml (insulin Glargine) inject 14 unit subcutaneously in the evening for DM Hold if BS (blood sugar) is less than 100. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the February 2024 electronic Medication Administration Record (eMAR) revealed the above PO for the insulin Glargine had been signed as administered as ordered from 2/16/24 to 2/29/24 at 2000 (08:00 PM). Further review of the eMAR, did not reveal documentation that a blood sugar was obtained prior to the administration of medication. A review of the March 2024 eMAR revealed the above PO for the insulin Glargine had been signed as administered as ordered from 3/1/24 to 3/25/24 at 2000. Further review of the eMAR did not reveal documentation that a blood sugar was obtained prior to the administration of medication. On 3/26/24 at 12:40PM, the surveyor interviewed the Assisted Director of Nursing (ADON). The ADON informed the surveyor that she was the nurse taking care of the resident. The ADON stated that the blood sugar should have been obtained first and then given if the blood sugar was above the parameters or held according to the parameters. She further stated that if the insulin was held it should be documented in the supplemental section of the eMAR. At that time, the ADON reviewed Resident #96's March 2024 eMAR in the presence of the surveyor for the order dated 2/16/24, for insulin Glargine subcutaneous solution 100 unit/ml (insulin Glargine) inject 14 unit subcutaneously in the evening for DM (diabetes mellitus) Hold if BS is less than 100. The ADON confirmed she was unable to verify that the blood sugar had been obtained prior to the administration of the evening insulin. On 3/26/24 at 12:56 PM, the surveyor interviewed the Registered Nurse (RN)/Unit Manager (UM,) in the presence of the ADON, in reference to the insulin parameters. The RN/UM reviewed the March 2024 eMAR, for the order dated 2/16/24, for insulin Glargine subcutaneous solution 100 unit/ml (insulin Glargine) inject 14 unit subcutaneously in the evening for DM Hold if BS is less than 100. She acknowledged that the blood sugars were not documented on the eMAR. She then reviewed the weights and vital sign section of the eMAR which revealed one blood sugar obtained on 3/25/24 at 20:15 (08:15 PM) which was 229. She further acknowledged that the blood sugars should have been obtained and documented on the eMAR. The RN/UM stated the purpose of the parameters on insulin was to monitor for hypoglycemia (low blood sugar). On 3/27/24 at 2:30 PM, the surveyor presented the above concerns to the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and the Regional Clinical Nurse. There was no additional information provided. On 03/28/24 at 11:10AM, during a follow up interview with the RN/UM and in the presence of the surveyor, the RN/UM reviewed the February 2024 eMAR and acknowledged that the BS was not documented for the order for the insulin Glargine subcutaneous solution 100 unit/ml (insulin Glargine) inject 14 unit subcutaneously in the evening for DM Hold if BS is less than 100. 37791 B). On 4/03/24 at 10:48 AM, the surveyor was touring the 4th floor nursing unit and noted Resident #54 in bed with his/her head slump down. The surveyor knocked on the door and greeted the resident. The resident picked up their head and said hello. At that time, the surveyor noted a medication cup that was turned over on their overbed table that contained 4 tablets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, the surveyor called the Registered Nurse/Unit Manager (RN/UM) into the resident's room, who acknowledged that there was a medication cup that contained four (4) tablets on the resident's overbed table. The RN/UM stated that he doesn't know how the medication were left on the overbed table and stated it was the nurse's responsibility to assure that medication was not left unattended and to assure that all medication is consumed by the resident. The RN/UM identified the 4 tablets as being a Multivitamin with minerals (a supplement), Coreg (blood pressure/heart medication), Eliquis (heart medication and blood thinner), and Lasix (a water pill). The RN/UM also acknowledged that he was the nurse that administered the resident's medication that morning and that he assured that the resident consumed all their medications. The RN/UM was unable to answered how the medication ended up on the resident's overbed table. The surveyor reviewed the medical record for Resident #54 The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), acute pulmonary edema (shortness of breath, cough, decreased exercise tolerance and chest pain), adjustment disorder with depression (excessive reaction to stress that involve negative thoughts, strong emotions and changes in behaviors) and hypertension (a condition in which the force of blood against the artery walls is to high). A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/12/24, reflected that the resident had a brief interview for mental status (BIMS) score of 8 out of 15, indicating that the resident is moderately impaired. A review of the active interdisciplinary care plan revealed that there was no focus area that indicated that the resident could self-administer their medications. A review of the April 2024 Order Summary Report (OSR) and the Electric Medication Administration Record (e-MAR) revealed the following physician's orders (PO): 1. Carvedilol (Coreg) oral tablet 3.125 milligrams (mg) dated 1/5/24, give 1 tablet by mouth every 12 hours for dysfunction of left ventricle of the heart. Give with food to reduce risk of orthostatic hypotension. Advise resident to arise slowly to reduce possibility of following and hold for Systolic blood pressure (SBP) less than 100. The eMAR also revealed that Coreg had an administration time of 0900 (9:00AM) and 2100 (9:00 PM) that showed that the medication was signed off as being given at 0900 on 4/3/24. 2. Eliquis oral tablet 2.5 mg (Apixaban) dated 1/5/24, give 1 tablet by mouth two times a day for DVT (Deep Vein Thrombosis) prophylaxis. Monitor for bruising, dark urine and black tarry stools. The eMAR also revealed that Eliquis had an administration time of 0900 (9:00AM) and 1700 (5:00 PM) that showed that the medication was signed off as being given at 0900 on 4/3/24. 3. Multivitamins-Minerals tablet dated 1/5/24, give 1 tablet by mouth one time a day for supplement. The eMAR also revealed that Multivitamins had an administration time of 0900 (9:00AM) and was signed off as being given on 4/3/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Lasix Oral Tablet 20 MG (Furosemide) dated 3/24/24, give 1 tablet by mouth in the morning for congestive heart failure (CHF). The eMAR revealed that Lasix had an administration time of 0900 (9:00AM) and was signed off as being given on 4/3/24. On 04/03/24 at 11:20 AM, the surveyor interviewed the Director of Nursing (DON) who acknowledge that medications should never be left unattended and that a nurse should assure that the resident consumed their medication. On 4/05/24 at 2:30 PM, the surveyor presented the above concerns to the Licensed Nursing Home Administrator and the Director of Nursing (DON). There was no additional information provided. A review of the facility's policy for Medication Administration dated 09/30/23, which was provided by the DON included the following: 15. Observe resident consumption of medication. C). On 4/02/24 at 10:20 AM, the surveyor inspected the 2nd floor medication room which contained the facility's AMDS machine. The surveyor interviewed the second floor Registered Nurse/Desk Nurse (RN/DN) who stated that the AMDS counts were checked once a day between the 7-3 (7AM-3PM) shift and the 3-11(3PM-11PM) shift. She showed the surveyor the AMDS April 2024 daily count narcotic back-up sheet. The sheet revealed that the narcotic count was performed on 4/1/24. The surveyor requested the daily count narcotic back-up sheets for March and February 2024. The RN/DN stated that the DON had the daily count sheets from March and February. On 4/02/24 at 10:30 AM, the surveyor reviewed the facility's DEA 222 forms and asked the DON if she could provide the surveyor with signed off logs showing that narcotics were being accounted for in the facility's AMDS. On 4/02/24 at 12:15 PM, the surveyor went to the License Nursing Home Administrator (LNHA) office where the DON was seated. The surveyor requested the facility daily count narcotic back-up sheets. The DON was only able to show that the AMDS narcotic counts were performed on 3/28/24 and 3/29/24. The DON was unable to provide any accountability and narcotic counts for the AMDS machine prior to 3/28/24. At that time, the surveyor interviewed the LNHA who stated that the facility just created a new form on 4/1/24 for daily counts of narcotics and controlled substances in the AMDS machine. On 4/8/24 at 9:00AM, the surveyor interviewed the DON who stated that it's important to perform a daily inventory counts for controlled substances which includes narcotic because it assures accountability, and that medication is not being diverted. On 4/05/24 at 2:30 PM, the surveyor presented the above concerns to the Licensed Nursing Home Administrator and the Director of Nursing (DON). There was no additional information provided. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Venetian Care & Rehabilitation Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 275 John T O'Leary Boulevard South Amboy, NJ 08879	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy for BLOOD GLUCOSE MONITORING reviewed on 10/2023, revealed the following: 1.Check physician's order for blood glucose testing frequency and coverage if needed. 10. Monitor resident for signs of hypo-or hyper-glycemia. 11. Record findings in the Medication Administration Record. Report any abnormal findings to the MD. A review of the facility's policy for Controlled Substances Policy dated 08/31/23, which was provided by the DON included the following: Accounting for Back-up stock Controlled Substances. 1. Back-up Controlled Substances will be counted daily by incoming and outgoing unit manager/nurse supervisor/designee for accuracy of number of doses currently on hand. 2. An immediate investigation will be initiated to resolve any discrepancy. The DON and the Administrator will be notified of all unresolves discrepancies immediately. A review of the facility's policy for CUBEX Station Medication Policies and Procedures that was undated which was provided by the DON included the following: J. Discrepancy Reporting and Documentation 9. A narcotic activities report will be printed daily according to established facility procedures that will track access of medications from the CUBEX station for E-Kit/Starter doses purposes. The report will include the name of the patient, nurse's name, prescriber name, medication, dose, quantity, date, and time of removal. The reports representing these activities will be retained per Federal Regulations for ten (10) years at the facility and pharmacy. NJAC 8:39-11.2 (b), 29.2 (d) (n)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41858 NJ #159787 Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of foods served to the residents. This deficient practice was identified for 5 of 5 residents interviewed during the Resident Council meeting and confirmed during the lunchtime meal service on 04/05/24 for 1 of 3 nursing units (2nd Floor unit) tested for food temperatures and was evidenced by the following: On 03/27/24 at 10:51 AM, the surveyor met with five residents for a resident council meeting. Three out of five residents resided on the 3rd floor. Two out of five residents resided on the 4th floor. Five of five residents agreed that the food trays were not warm. On 04/05/24 at 11:14 AM, the surveyor calibrated a state issued digital thermometer via the ice bath method to 32 degrees Fahrenheit (F) in the presence of the survey team. On 04/05/24 at 12:24 PM, the surveyor observed the lunch truck arrive to the 2nd floor. The Assistant Director of Nursing (ADON) met the food truck. A regular diet consistency tray (Resident #120) was removed and verified by the surveyor and the ADON. The tray was placed at the nurse's station. At 12:25 PM, the Unit Clerk called the kitchen and ordered a replacement tray for Resident #120. The nursing staff began delivering the resident's food trays. At 12:35 PM, the last tray was delivered. The surveyor tested the food temperatures on the reserved tray in the presence of the ADON. The temperatures were as follows: Roast Beef 3 oz & gravy 2 oz: 122.5 degrees F roasted potatoes 4 oz.: 121.0 degrees F Capri veg blend 1/2 cup:115.9 degrees F cream of tomato 6 oz: 144.0 degrees F fruit cup 1/2 cup (watermelon): 53.3 degrees F 1% milk 8oz: 54.3 degrees F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/05/24 at12:45 PM, the surveyor interviewed the Food Service Director (FSD), who stated that the lunch tray line was set up at approximately 10:55 AM-11:00 AM. He then stated that food temps were taken just prior to the first tray being pulled at approximately 11:00 AM to 11:10 AM. The FSD stated the 4th floor gets delivered first, then the 2nd floor and then the 3rd floor. The FSD provided the surveyor with the Service Line Checklist which revealed that at the time of service the temperaturyes were as follows: Roast Beef was 176 degrees F, roasted potatoes was 178 degrees F, Broc/Caulif (broccoli/cauliflower) was 178 degrees F, watermelon was 34 degrees f, and the tomato soup was 181 degrees F. On 04/05/24 at 01:52 PM, during a follow up interview with the FSD, in the presence of the survey team, he stated that the 2 cooks verify the food temperatures. He verified that yes, everything (in the kitchen) was functioning properly today. The surveyor reviewed the above mentioned temperatures observed on the 2nd floor with the FSD. He stated he takes temperatures of the food that has been on the truck the longest before the truck is ready to leave the kitchen, but he does not record it. The FSD stated that they use pellets (keeps hot food at safe temperatures) on their trays. He stated the purpose of taking the food temperatures were to ensure the food was palatable and consistent. On 04/05/24 at 02:56 PM, the above findings were presented to the Licensed Nursing Home Administrator, the Director of Nursing, and the Region Clinical Operations/Registered Nurse in the presence of the survey team. A review of the undated facility's policy Cold Food Policy revealed Policy: The kitchen will receive and deliver cold foods to residents at a temperature of 41 degrees Fahrenheit or lower. 6. Food will be delivered to residents at a temperature of 41 degrees or lower. A review of the undated facility's policy Hot Food Policy revealed Policy: All managers are responsible for training dietary staff on how to take and monitor food temperatures on a daily basis. For quality assurance. Food temperature will be monitored, and test tray temperature will be monitored. 7. The Food Service Director .will monitor test tray temperatures. NJAC 8:39-17.2(g);17.2 (a)(2)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40042 Based on observations, interviews, record review and review of pertinent facility documents, it was determined that the facility failed to ensure foods were provided in accordance with physician's orders and resident preferences identified in their plan of care. This deficient practice was identified for 2 of 4 residents reviewed for nutrition (Resident #114 and #120). This deficient practice was evidenced by the following: 1. On 3/27/24 at 10:57 AM, the surveyor observed Resident #114 seated in a wheelchair at a table in the dining area drinking water. On 3/28/24 at 12:18 PM, the surveyor observed the resident's lunch tray. The meal ticket indicated the tray items should have included four ounces (oz.) of red bean chili, a creamy peanut butter and jelly sandwich, a 1/2 cup of Fortified mashed potatoes, a 1/2 cup of green peas, one piece of cornbread, six oz. chicken orzo soup, one serving of a low-sugar house shake, 1/2 cup of fruit cup, one vanilla ice cream, a four oz. cranberry juice, eight oz. of whole milk and six oz. of tea. There was no evidence of a low-sugar house shake, the Fortified mashed potatoes and there was a chocolate ice cream (not vanilla) on initial observation. On 3/28/24 at 12:35 PM, the surveyor reviewed the meal ticket versus items on the lunch meal tray with the Licensed Practical Nurse (LPN)/Unit Manager (UM) who acknowledged there were no Fortified mashed potatoes (white rice was served), no low-sugar house shake and a chocolate ice cream instead of vanilla on the tray. On 4/1/24 at 12:15 PM, the surveyor observed the resident seated in the dining area. The surveyor observed his/her tray placed on the table and the LPN/UM sat next to the resident to assist. Prior to that, the surveyor observed an opened empty container of health shake in his/her room. Review of Resident #114's Admission Record (an admission summary) reflected the resident had diagnoses which included but were not limited to; Alzheimer's Disease, malignant (cancer) . tumors, and cachexia (unintentional weight loss). Review of the residents Admission Minimum Data Set (MDS), a tool to facilitate the management of care, dated 12/29/23 reflected the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated his/her cognition was severely impaired. It also reflected the resident received a therapeutic diet (a meal plan that is modified or tailored to fit the nutrition needs of a particular person). Review of the April 2024 Order Summary Report (OSR) reflected physician's orders (PO) for a four oz. Health Shake with lunch and dinner and Super Mashed with meals, both with a start date of 1/5/24. Review of the electronic Medication Administration Record's (eMAR) for January 2024 through April 2024, reflected the PO's noted above. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nutrition Care Plan initiated 12/27/23, reflected the above PO's as interventions. Review of the Registered Dietitian's (RD) initial evaluation dated 12/26/23, reflected that the resident enjoyed vanilla ice cream and it would be provided with lunch and dinner. Review of the RD's Nutrition Note dated 1/5/23, reflected that super mashed potatoes would be provided with lunch and dinner. On 3/28/24 at 12:35 PM, the surveyor interviewed the LPN/UM who acknowledged that the missing tray items on the lunch tray were nutritional interventions that were part of the resident's plan of care to promote weight gain. On 3/28/24 at 12:43 PM, the surveyor interviewed RD #1 and reviewed the items that were not provided on Resident #114's lunch tray. She acknowledged that the house shake and fortified foods were part of the resident's plan of care which provided extra nourishment to promote weight gain. She could not speak to why these items were not provided and that there should have been an employee in the kitchen that checked the tray for accuracy before delivery to the resident. On 3/28/24 at 1:16 PM, the surveyor interviewed the Food Service Director (FSD). He acknowledged that there were no low-sugar health shakes in the facility. On 4/05/24 at 12:45 PM, the surveyor interviewed Regional RD #2 (RRD) in the presence of the survey team. She stated that super mashed potatoes were one of the fortified foods available. And that these foods were nutritional interventions to promote weight gain or prevent weight loss because they were nutrient dense. The RRD further stated that this was part of the resident's individualized plan of care. She stated that there would have been a PO and there was accountability on the eMAR. She could not speak to which kitchen employee was responsible to ensure tray accuracy but acknowledged that someone should have been responsible. 2. On 03/25/24 at 11:23 AM, the surveyor observed Resident #120, who was groomed and offered no concerns. On 4/05/24 at 12:35 PM, the surveyor observed the residents lunch tray and reviewed the meal ticket versus items on the tray with the Assistant Director of Nursing (ADON). The meal ticket indicated the resident should have received two large portions of protein, however there was three oz. on the plate; there should have been a dinner roll, however a slice of bread was provided; eight oz. of whole milk should have been provided instead the resident received one percent milk; and there was supposed to be a four oz. juice and eight oz. of coffee on the tray, neither of which were provided. Review of resident #120's Admission Record, reflected the resident had diagnoses that included but were not limited to; type 2 diabetes and Parkinson's Disease (a progressive disease of the nervous system). Review of the residents Admission MDS dated [DATE], reflected a BIMS score of 15 out of 15 which indicated the resident had an intact cognition. It also reflected the resident was on a therapeutic diet. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nutrition Care Plan initiated 3/4/24, included the intervention Provide me with my food/beverage preferences as available. Review of the Registered Dietitian's (RD) initial evaluation dated 3/4/24, reflected that the resident had a history of unplanned weight loss and would be provided large protein portions at meals as per his/her preference. On 4/05/24 at 12:45 PM, the surveyor interviewed the FSD who stated that the cook or the caller position checked the meal trays to ensure accuracy and that if an item was not available, he should have been notified. He stated that if the meal ticket indicated coffee, whole milk and a dinner roll that is what should have been provided. The FSD then stated he was aware that the facility was out of whole milk. On 04/05/24 at 1:05 PM, the surveyor interviewed the RRD who stated she should have been notified if there was no whole milk available. She further stated that a protein portion was three oz. and if the meal ticket indicated two (2) portions, the resident should have received six oz. On 4/05/24 at 1:52 PM, the surveyor interviewed the FSD who stated that if a meal ticket indicated a large portion of protein, the resident should have received eight oz. He stated that one of the cooks should have checked the trays for accuracy today and could not state whether or not any employee ensured lunch tray accuracy for the lunch meal service. He acknowledged he had not assigned anyone this task. On 4/05/24 at 2:56 PM, the Licensed Nursing Home Administrator (LNHA) acknowledged the concerns regarding tray accuracy. On 4/08/24 at 11:30 AM, the LNHA stated there was no additional information to present for above mentioned concerns. Review of the undated facility policy Medical Nutrition Therapy Documentation included that medical nutrition therapy for each individual was the responsibility of the RD and the FSD. Review of the undated facility policy Therapeutic Diets included that all residents would be given foods based on their diet order which was prescribed by the physician. In addition, the policy included that the purpose of a therapeutic diet was to eliminate or decrease specific nutrients in the diet or provide food that a resident is able to consume. Review of the undated facility policy Fortified Foods and Supplements included Fortified foods and supplements will be given inn accordance with the orders of a physician or registered or licensed dietitian. In addition, the policy included that The supplement or fortified food item is then added to the resident's meal tray card ticket to be prepared, served and delivered accordingly. Review of the undated facility policy Dining and Food Preferences included Individual dining, food and beverage preferences will be identified, accommodated, and followed for all residents. It further included that all preferences will be added to the meal tray card ticket. Review of the undated facility policy Tray Accuracy included the following: (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Each residents individual meal tray will be set up and made according to the resident's personal meal tray card ticket. All items described on this ticket will be present on the tray. The defined diet and the individual needs and food preferences will be present on the tray including likes and dislikes in accordance with the compliance guidelines. - All trays will be checked by the Dietary representative calling the tray line and setting up each tray. Each tray will then be checked by a Dietary management team member prior to being sent to the unit. - Once received on the unit, the healthcare professional will check the tray prior to serving it to the resident. Review of a signed and undated Cook job description included that the cook was responsible and accountable for following menus and special diet instructions. Review of a signed Dining Services Director job description dated 2/27/24, included the following responsibilities: - Prepare food for regular and therapeutic diets according to the planned menu and written doctor's orders. - Purchase food, supplies, and equipment, as required to meet the needs of the department. - Ensure that a stock of staple/non-staple food, supplies, equipment, etc., is maintained at adequate levels at all times to perform departmental functions. NJAC 8:39-17.4(a)(1)

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough backup water supply for essential areas of the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49173 Based on observations, interviews, and pertinent facility documents it was determined that the facility failed to maintain the designated emergency supply of water needed for residents in the event of a loss of normal water supply. This deficient practice was evidenced by the following: On [DATE] at 09:00 AM, the survey team entered the facility and was made aware by the Licensed Nursing Home Administrator (LNHA) that the facility was licensed for 180 beds and the facility census was 123 (the number of residents who currently resided at the facility). On [DATE] at 10:10 AM, the surveyor toured the kitchen with the facility's Food Service Director (FSD) and the Regional FSD. During the initial tour, the surveyor was escorted to a storage room which contained the emergency water and food supply. In the presence of the surveyor and the facility's FSD, the regional FSD stated that he had 22 cases of emergency water which contained 6 gallons of water per case. He stated that there was a total of 132 gallons of emergency water in the facility available in the event of an emergency. The surveyor inquired how much water should he have based on today's census, and he stated that there should be a water supply of 1 gallon per resident for 3 days. He further stated that he had to throw some water out because it had expired, and that he had already placed an order to replenish the water that was discarded. He informed the surveyor that the previously ordered emergency water supply would be delivered to the facility on [DATE]. The surveyor requested an invoice that showed that the emergency water supply had been ordered prior to surveyor inquiry. On [DATE] at 09:36 AM, in the presence of the survey team and the senior corporate FSD. The regional FSD provided the surveyor with an invoice order dated [DATE] from [name redacted]and an invoice from [name redacted] dated [DATE]. Review of both invoices did not reveal that water had been ordered. The surveyor inquired again about the emergency water supply that was observed on [DATE]. The regional food service director acknowledged that the emergency water supply that was in the facility on [DATE] was not enough based on the resident census of 123. The regional FSD also stated that the first time he saw the emergency water supply was with the surveyor on [DATE]. On [DATE] at 10:11 AM, in the presence of the survey team, the surveyor interviewed LNHA. The surveyor inquired about the invoice dated [DATE] from [name redacted]. The LNHA clarified that the invoice date of [DATE] was the delivery date. She confirmed that an order was placed on [DATE] at 12:25pm by phone and was scheduled to be delivered on [DATE]. She also acknowledged that she approved the purchase order for additional emergency items. On [DATE] at 02:07 PM, in the presence of the survey team, the surveyor interviewed the facility's FSD. The facility's FSD stated that he had knowledge of emergency preparedness. He stated that the purpose of the emergency water and food supply was so that if there was a situation that the facility was unable to obtain food and water, the facility had a supply of emergency food and water in storage at the facility. The FSD stated that the facility was required to have 1 gallon of water per resident for three days. He stated that he was responsible for ensuring that there was enough food and water for emergency use. (continued on next page)

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 09:04 AM, the LNHA provided the surveyor with invoices from the contracted vendor [name redacted] that additional water had been delivered for the emergency water supply. On [DATE] at -2:30 PM, the surveyor presented the above concerns to the LNHA, Director of Nursing (DON) and the Regional Clinical Nurse in the presence of the survey team. The LNHA stated that it was the responsibility of the facility's FSD to ensure that the emergency supply is sufficient based on the census. She further stated that she and the regional FSD were responsible for approving food orders and that there was no delay in approval or delivery. She stated, I get emails regarding food ordering and orders come to my phone if I am not here. She stated that if there was an emergency, the requirement was that the facility had 1 gallon of water per resident for 3 days in storage. There was no additional information provided to the surveyor. Review of an undated facility policy VENETIAN EMERGENCY WATER POLICY AND PROCEDURE under PROCEDURE revealed the following: - The Venetian will have 3 gallons of water per resident for 3 days time according to current census. - If more water is needed, our contracted vendor will deliver water within 24 hours or sooner in case of an emergency. Review of an undated facility policy EMERGENCY AND DISASTER PLANNING POLICY, included under PROCEDURE revealed the following: 2. The Food Service Director will be responsible for ensuring 3-day emergency supply (as per emergency supplies list attached) is located in the facility with Inventory List, noting expiration date of items. 4. The Food Service Director will maintain Inventory Check List monthly to check that all documentation is completed correctly, and all stock is accounted for. NJAC 8:,d+[DATE].6 (n)