STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute at Woodbury Country Club	467 Cooper Street Woodbury, NJ 08096

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint#: NJ00173566 Based on interviews, record reviews, and a review of the facility's policy, it was determined that the facility failed to ensure residents code status was documented in the medical records, the Physician's Order for Life-Sustaining Treatment (POLST) reflected the residents' end of life wishes and the proper documentation was completed so that those end of life wishes were honored in the facility and/or during transport. The facility also failed to follow its policies titled Residents' Rights Regarding Treatment and Advance Directives and the Social Services Director Job Description for 8 of 28 residents (Resident (R)2, R10, R13, R17, R24, R25, R26, and R28) reviewed for code status. R17 was admitted to the facility from the hospital with documented evidence that he/she had chosen a Do Not Resuscitate (DNR) code status; however, the facility ordered a Full Code despite no documented evidence the facility verified with the resident and/or family that R17 wishes were not to be a DNR. On [DATE], this failure resulted in Cardiopulmonary Resuscitation (CPR) and Emergency Medical Services (EMS) being initiated when the resident became unresponsive. Additionally, R2, who had a DNR code status, was transferred to the hospital via ambulance; however, the facility failed to ensure the proper documentation was completed and provided to the ambulance transport company for the resident's code status of DNR to be honored. This failure resulted in psychosocial harm to R2 when the ambulance personnel informed the resident that CPR would be required if he/she became unresponsive during transport. Also, during R2's readmission to the facility on [DATE], a physician's order was obtained for a full code from [DATE] until [DATE] without verification if R2 had changed his/her end-of-life wishes from DNR to full code. These failures placed R2, R10, R13, R17, R24, R25, R26, R28, and all other residents who were admitted and/or readmitted to the facility in an Immediate Jeopardy (IJ) situation that the likelihood that their end-of-life code status would not be honored. An Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE], at §483.10 F578: Request/Refuse/Discontinue; Formulate Advance Directives. The Administrator was notified on [DATE] at 7:06 PM of the Immediate Jeopardy. . The IJ ran from [DATE] through [DATE] at 4:30 PM, when the facility submitted an acceptable removal plan. (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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], the Surveyors conducted a revisit to verify that the Removal Plan was implemented. The facility implemented the Removal Plan. So, the noncompliance remained on [DATE] as a level E for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. The facility implemented the removal plan, which included the following: The Regional Director of Clinical Services educated the Director of Nursing (DON) and the Assistant Director of Nursing (ADON)on the procedure, ensuring when residents are transferred from the facility to the hospital, the ambulance transportation company receives the required documents to honor a resident's end-of-life wishes/cold status. The DON and the ADON or Regional Nurse began re-educating, ensuring when residents are transferred from the facility to the hospital, the ambulance transportation company receives the required documents to honor a resident's end-of-life wishes/cold status. The DON or designee initiates audits of transfers to the hospital to ensure that when residents are transferred from the facility to the hospital, the ambulance transportation company receives the required documents to honor a resident's end-of-life wishes/code status. Findings include: 1. Review of R17's Face Sheet, located under the Profile tab of the electronic medical record (EMR), revealed that R17 was admitted to the facility on [DATE] from the hospital with diagnoses of osteomyelitis (bone infection), diabetes mellitus with foot ulcer, and heart failure. Review of R17's hospital History and Physical Report, electronically signed by a provider on [DATE], and uploaded on [DATE] into the Misc tab of R17's electronic medical record (EMR), revealed that R17 had a code status of DNR. Review of R17's New Jersey Universal Transfer Form, dated [DATE] and located in the paper chart, revealed that R17 came from the hospital to the facility with a DNR code status. Review of R17's Order Summary Report, located in the Orders tab of the EMR, revealed orders dated [DATE] and [DATE] for Full Code. The Medical Director signed both orders on [DATE] at 11:56 AM. Review of an Admission/readmission Note, dated [DATE] at 1:23 AM and located in the Prog Note tab of the EMR, revealed, Code Status: FULL CODE. Review of the note showed no documentation that R17 was asked what his/her wishes were regarding code status or to verify a change from a DNR to a Full Code. Review of R17's electronic and hard copy closed medical records revealed no documented evidence that the facility spoke with the resident or his/her family to verify his/her code status and end-of-life wishes after they were admitted to the facility. Review of a Progress Note, dated [DATE] at 8:30 AM, and located in the Prog Note tab of R17's EMR, revealed, At approx [approximately] [7:45 AM] resident was observed unresponsive to verbal and tactile stimuli. CPR was initiated. 911 called. CPR continued. The patient [resident] was transported to [the hospital]. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility-provided, CPR/Code Blue Documentation, dated [DATE], revealed CPR was initiated on R17 at 7:45 AM. At 7:53 AM, R17 was suctioned. EMS arrived at 8:00 AM, took over CPR, and intubated [tube inserted into the windpipe to provide oxygen via a ventilator] R17 at 8:02 AM. Review of R17's Progress Note, dated [DATE] at 5:02 PM, and located in the Prog Note tab of the EMR, documented a follow up call to the hospital revealed R17 had expired. During an interview on [DATE] at 3:43 PM, R17's Family Member (FM17) revealed that the resident was a DNR in the hospital and wore a DNR wristband from the hospital during his/her stay at the facility. FM17 stated that if the facility had asked R17 what his/her end-of-life wishes were, R17 would have been verified and chosen to be a DNR. During an interview on [DATE] at 1:38 PM, Licensed Practical Nurse (LPN) 1 stated that the facility received code status orders from the provider when a resident was admitted . According to LPN1, the nursing staff verbally spoke to residents about their wishes and relayed them to the provider. Nurses were not allowed to have the resident sign a POLST (Practitioners Orders for Life Sustaining Treatment). LPN1 stated, Someone else did that. However, LPN1 was uncertain about who ensured the POLST forms were signed. During an interview on [DATE] at 2:10 PM, Unit Manager (UM)1 stated the Nurses reviewed the admitting resident's hospital papers to determine what their code status was in the hospital. UM1 stated that nurses did not ask the residents what their wishes were regarding code status. Instead, they relayed the resident's code status in the hospital to the physician and obtained the same orders. During a concurrent interview with the DON and Administrator on [DATE] at 2:48 PM, they stated the following facility's process: if the hospital records clearly indicate DNR or full code, these were the orders the Nurses asked for from the physician when residents were admitted to the facility. On admission or the day after, nursing asked residents if they wanted a consultation with the palliative nurse practitioner to discuss code status. When asked what the expectation was regarding the discussion of code status, the DON and Administrator stated the expectation was that residents were asked what their wishes were regarding code status. It was expected that a nurse practitioner or physician had a conversation with residents regarding code status and that the nurses followed the physician's orders. If residents did not want a discussion about code status, then their code status was whatever the doctor confirmed based on hospital records. In the same interview, the DON stated she expected a conversation to be documented in EMR for code status changes. The Administrator stated if code status changed from the hospital to the facility, she expected documentation of that either in a nurse's assessment, a progress note, or verification with the physician's order. When asked for documentation that R17 had changed her code status from DNR to Full Code, a social service progress note was provided as documentation. Review of the social service progress note, Social Services Assessment and Documentation, dated [DATE], revealed no documentation that code status was discussed with R17 or that R17 had changed her code status from DNR to Full Code. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 8:20 PM, the Certified Social Worker/Social Services Director (SSD) stated social services did not ask residents what their wishes for code status were when they were admitted . According to the SSD, within 72 hours of the resident's admission, social services asked residents if they had any advanced directive or living will and provided information regarding filling out an advanced directive or POLST if they wished. If a resident expressed interest in filling out a POLST, the SSD assisted but did not otherwise ask residents what their wishes were. During an interview on [DATE] at 6:44 PM, LPN2, the nurse who entered R17's admission orders for a Full Code into the EMR, stated she was agency staff and worked the night shift. LPN2 stated that she had not been trained concerning the facility's code status policy. LPN2 stated that other nurses instructed her to review the hospital records and request orders from the physician for the code status the resident had in the hospital. If the records were unclear or did not mention the code status, full code orders were requested and entered into the EMR. LPN2 stated she was told by other nursing staff that the facility did not want the nurses asking residents for their code status, so she did not ask about their end-of-life wishes. During an interview on [DATE] at 12:26 PM, the Medical Director stated he expected the admitting nurse to attempt to talk to the resident or family about their code status wishes before calling the provider for orders. If unable to obtain their input, the Universal Transfer Form could be used for code status until current wishes were verified. The Medical Director stated there were many opportunities to discuss code status with the resident by the admitting provider, the palliative nurse practitioner, nursing, or a social worker. In addition, the Medical Director further stated, We [the facility] need to make sure we close the loop. The Medical Director further stated he expected code status to be clarified within 48 to 72 hours after admission to the facility but was uncertain who ensured this was done. 2. Review of R2's undated admission Record, located in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] and most recently readmitted on [DATE]. The undated admission Record also documented under the Advance Directive section, R2 was DNR-DO NOT RESUSCITATE/DNI-DO NOT INTUBATE [insertion of a tube into the windpipe to provide oxygen through a ventilator]. A review of R2's untitled hospital record dated [DATE] and located in the resident's EMR under the Misc [Miscellaneous] tab revealed on the second-page order of DNR/DNI. The order documented, .I am attending, or I conferred with the attending physician prior to placing this order .Discussed with Patient . The print date of the document was [DATE] at 4:40 PM. Review of R2's physician Order Summary Report (POS), dated [DATE] through [DATE] and provided by the facility, revealed an order dated [DATE] of DNR/DNI. The order summary report did not have any physician signatures, nor did it have what provider gave the order. Review of R2's admission Agreement, dated [DATE] (four days after the resident was admitted to the facility), revealed . Facility Representative Documentation on Advance Directives: Resident has executed a Living Will [marked 'Yes'] . Resident has executed a Medical Order for Life Sustaining Treatment [nothing marked] .Resident has executed a Do Not Resuscitate (DNR) [nothing marked] . (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R2's nursing Progress Note, dated [DATE] and located in the resident's EMR under the Progress Notes tab., revealed .at 1700 [5:00 PM], patient's son and his/her daughter .requested that [the] patient [be] transferred out to the hospital. 1810 [6:10 PM] Patient transferred to hospital via stretcher by [name of ambulance transport company] . Review of R2's New Jersey Universal Transfer Form, dated [DATE] and provided by the facility, revealed . CODE STATUS: DNR [marked], DNI [marked] .19. Attached Documents: .Code Status [marked] . The New Jersey Universal Transfer Form, dated [DATE], was completed by Licensed Practical Nurse (LPN) 3. No documents were attached to the facility provided New Jersey Universal Transfer Form, dated [DATE]. R2 was readmitted to the facility on [DATE] and even though the facility was aware the resident was a DNR, R2 was ordered a Full Code status until the next day. Review of the admission Record for R2 readmission with a print date of [DATE], provided by LPN1 and located in the resident's Paper Medical Record adjacent to the 200 nurses' station, revealed that R2 was readmitted to the facility on [DATE] and under the Advance Directive section it was documented Full Code. Review of R2's nursing Progress Note, dated [DATE] and located in the resident's EMR under the Progress Notes tab, revealed an admission/readmission note of [R2's Name] arrived at the facility on 11/15/ [at] 6:15 PM from a hospital via stretcher .Code Status: FULL CODE . Review of R2's Order Recap Report, revealed an order dated [DATE] of Full Code. The order for the resident to have a Full Code status ended on [DATE] when the order was changed to DNR Do Not Resuscitate. A review of R2's physician's Progress Note, dated [DATE] as a late entry and located in the resident's EMR under the Progress Notes tab, revealed .plan of care discussion had with family and patient's CODE STATUS was changed to DNR/DNI . During an interview on [DATE] at 6:13 PM, R2 stated that during the transfer to the hospital on [DATE], prior to leaving the facility, the ambulance transport staff informed him/her that the facility could not find the correct paperwork for them to take with them to verify that he/she was a DNR. The resident stated he/she, and the nurse told the ambulance staff he/she was a DNR code status. The resident stated that he/she had been a DNR since admission to the facility. According to the resident, the ambulance staff told him/her that if he/she was to code during transfer to the hospital, they would be required to perform CPR. The resident stated this made him/her very upset. During an interview on [DATE] at 9:23 AM, LPN3 stated on [DATE] that he was the nurse who had completed R2's transfer to the hospital. When asked if there were any concerns with R2's transfer to the hospital, LPN3 stated he could not locate R2's Practitioner Orders for Life-Sustaining Treatment (POLST) form. LPN3 stated the POLST had R2's code status on it and was supposed to go with the resident to the hospital. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LPN3 revealed that because he could not locate R2's POLST, the ambulance transport company told him and the resident they would have to make her a Full Code while being transported. LPN3 also stated he and R2 both verbally told the ambulance personnel that R2 was a DNR; however, the ambulance personnel stated they needed either a copy of the POLST form or a copy of a signed physician's order for the DNR. LPN3 further stated he completed the New Jersey Universal Transfer Form, dated [DATE], and indicated the resident was a DNR on the form. In addition, LPN3 stated he sent a copy of R2's Order Summary Report, which indicated the resident had a physician's order for a DNR code status. When asked if R2's Order Summary Report had either a physician's signature or a physician's electronic signature on the report, LPN3 stated it did not. During a record review on [DATE] at 2:00 PM, LPN1 reviewed R2's Paper Medical Record, located adjacent to the nurses' station, and verified the resident's medical record did not contain a signed physician's order for a DNR status or a POLST form. During an interview on [DATE] at 2:55 PM with the DON and the Administrator, the DON stated when a resident was transferred to the hospital from the facility, the facility sends, at a minimum, the resident's order summary report and verbal report of the resident's code status is given to the ambulance company. The Administrator stated a POLST form was not required to be completed; they (the facility) just recommended that it be completed to ensure the residents' wishes are honored. The DON stated it was her expectation for residents to be offered a POLST form, and if the resident declined to complete a POLST form, the declination should be documented in the record. During a subsequent interview on [DATE] at 11:54 AM, R2 was further asked about his/her transfer to the hospital on [DATE]. R2 stated when the ambulance staff told him/her since the facility did not have the required document (completed POLST or signed physician's order) for his/her DNR status and if he/she coded on the way to the hospital, they would be required to do CPR, he/she became very upset and started crying. R2 stated all he/she could think about was the conversation his/her granddaughter had with him/her related to not being a full code at his/her age. The resident stated he/she pictured in his/her mind the tears coming down his/her granddaughter's face when he/she was having this conversation with him/her. R2 stated he/she did not want to be a vegetable and feared that it would happen if he/she coded on the way to the hospital. R2 stated even though his/her transfer to the hospital was not an emergency; the ambulance driver knew he/she was upset and transported him/her with the lights and siren on like it was an emergency to get there quicker. R2 was teary while relaying the incident to the surveyor. During an interview on [DATE] at 4:36 PM, when asked if there were documents that were required to be attached to the New Jersey Universal Transfer Form, the DON stated the Medication Administration Record/Treatment Administration Record (MAR/TAR), physician order summary (POS), face sheet, labs, and if the resident had a POLST. The continued interview revealed that when the POS (order summary report) was printed out for a transfer, the orders had been approved by the physician, whether verbal or signed. The DON verified that the POS did not have a physician's signature/electronic signature (which was required by the EMS to be a valid order). 3. Review of R10's undated admission Record, provided by the facility, revealed the resident was admitted on [DATE] and most recently readmitted on [DATE]. The admission Record documented the resident's code status as DNR/DNI. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R10's EMR and paper medical record revealed no documented evidence that the resident's record included a POLST form or a copy of a signed physician's order for DNR/DNI, which EMS required. 4. Review of R13's undated admission Record, provided by the facility, revealed the resident was admitted on [DATE] and most recently readmitted on [DATE]. The admission Record documented the resident's code status as DNR/DNI. Review of R13's EMR and Paper Medical Record revealed no documented evidence the resident's record included a POLST form or a copy of a signed physician's order for DNR/DNI, which EMS required. 5. Review of R24's undated admission Record, provided by the facility revealed the resident was admitted to the facility on [DATE] and documented the resident's code status as DNR/DNI. Review of R24's EMR and Paper Medical Record revealed no documented evidence that the resident's record included a POLST form to document the code status of DNR/DNI, so that the resident's end of life wishes would be honored by the ambulance staff during transport. During a record review and interview on [DATE] at 2:00 PM, LPN4 verified that R24's medical records did not contain a POLST form or a copy of a signed physician's order for DNR/DNI, which EMS required. 6. Review of R25's undated admission Record, provided by the facility, revealed the resident was admitted on [DATE] and most recently readmitted on [DATE]. The admission Record documented the resident's code status as DNR/DNI. Review of R25's EMR and Paper Medical Record revealed no documented evidence that the resident's record included a POLST form or a copy of a signed physician's order for DNR/DNI, which EMS required. 7. Review of R26's undated admission Record, provided by the facility revealed the resident was admitted to the facility on [DATE] and documented the resident's code status as DNR/DNI. Review of R26's EMR and Paper Medical Record revealed no documented evidence the resident's record included a POLST form or a copy of a signed physician's order for DNR/DNI, which EMS required. 8. Review of R28's undated admission Record, provided by the facility revealed the resident was admitted to the facility on [DATE] and documented the resident's code status as DNR/DNI. Review of R28's EMR and Paper Medical Record revealed no documented evidence the resident's record included a POLST form or a copy of a signed physician's order for DNR/DNI, which EMS required. During a record review and interview on [DATE] at 2:08 PM, Unit Manager (UM) 1 stated a POLST form should be completed and placed in the residents' chart. UM1 verified that R10, R13, R24, R25, R26, and R28's Paper Medical Record and EMR did not include a POLST form or a copy of a signed physician's order for DNR/DNI, which EMS required. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's Social Services Director Job Description, updated [DATE], revealed, The Social Services Director will oversee the process of Advance Care Planning for each resident upon admission, and make sure that any Advance Directives are reviewed with the resident/resident representative on a regular basis. The Director will ensure that staff members are made aware of the resident's code status and end-of-life wishes and will assist with informing and educating residents and their representatives about health care options and ramifications. Review of the facility's policy titled, Residents' Rights Regarding Treatment and Advance Directives, revised [DATE] revealed Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate and advance directive .Policy Explanation and Compliance Guidelines: .9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care . A review of the NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST), form dated [DATE] revealed DIRECTIONS FOR HEALTHCARE PROFESSIONAL .POLST orders are actual orders that transfer with the person and are valid in all settings in New Jersey. It is recommended that POLST be reviewed periodically, especially when: The person is transferred from one care setting or care level to another .Any incomplete section of POLST implies full treatment for that section .Section D. Make a selection for the person's preferences regarding CPR . Review of Section D revealed a selection of Attempt CPR or Do not attempt resuscitation/DNAR Allow Natural Death . Continued review of the POLST revealed on the front page at the bottom is a signature line for the resident/representative to sign confirming I have discussed this information with my physician/APN/PA [advanced practice nurse/physician assistant]. The POLST also had a signature line for the physician/APN/PA to sign, making the POLST document an order. NJAC: 8:39-9.6

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** Complaint#: NJ00173566 Based on interviews, record reviews, and a review of the facility's policy titled Residents' Rights Regarding Treatment and Advance Directives, it was determined that the facility failed to ensure the physician's orders matched the resident's documented end-of-life wishes, which resulted in cardiopulmonary resuscitation (CPR) being done on a resident (Resident (R) 17) reviewed for code status out of a total sample of 22 residents. While in the hospital, R17 chose to be a do-not-resuscitate (DNR). However, the facility was unable to provide evidence that they implemented their policy for R17 for Advance Directives upon R17 admission to the facility. On [DATE], when R17 was found unresponsive, the facility performed approximately five rounds of chest compressions on the resident before the emergency medical services (EMS) arrived. EMS intubated [inserted a tube into the windpipe to provide oxygen via ventilator] R17 when they arrived on site and continued CPR via an automatic machine as they departed the facility for the hospital. R17 expired after leaving the facility. This failure resulted in an Immediate Jeopardy identified on [DATE] and was determined to exist on [DATE] at F678: Cardio-Pulmonary Resuscitation (CPR) at a Scope and Severity (S/S) of J. The Administrator was notified of the Immediate Jeopardy on [DATE] at 9:54 PM. The facility submitted an acceptable removal plan on [DATE]. On [DATE], the Surveyors conducted a revisit to verify that the Removal Plan was implemented. The facility implemented the Removal Plan. So, the noncompliance remained on [DATE] as a level D for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. The facility implemented the removal plan, which included the following: The Regional Director of Clinical Services educated the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on the procedure: ensuring the resident's wishes regarding code status are reflected in the resident's chart, communicating the correct code status to the physician, and interviewing the resident or responsible party regarding completing a POLST form upon admission to the facility. The DON and the ADON or Regional Nurse began re-educating, all nursing and social services staff on ensuring residents wishes regarding code status are reflected in the resident's chart communicating the correct code status to the physician, and interviewing the resident or responsible party regarding completing a POLST form upon admission to the facility. to the hospital, the ambulance transportation company receives the required documents to honor a resident's end-of-life wishes/cold status. The DON or designee initiates audits of new admission and readmission to ensure the nurse(s) completing the admission have reviewed: residents hospital records are reviewed, if they exist the resident's advanced directives is reviewed, the resident's POLST is reviewed, the resident's Living Will is reviewed, and the wishes regarding code status are reviewed with the resident or responsible party and are reflected accurately in the chart and communicated to the physician and that a POLST was offered if one wasn't already in place. Findings include: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Atlas Post Acute at Woodbury Country Club		STREET ADDRESS, CITY, STATE, ZIP CODE 467 Cooper Street Woodbury, NJ 08096	

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R17's hospital History and Physical Report, electronically signed by a provider on [DATE], and uploaded on [DATE] into the Misc tab of R17's electronic medical record (EMR), revealed that R17 had a code status of DNR. Review of R17's New Jersey Universal Transfer Form, from the hospital to the facility dated [DATE], and located in the resident's paper chart, revealed R17 came from the hospital to the facility with a DNR code status. Review of R17's Face Sheet, located under the Profile tab of the electronic medical record (EMR), revealed R17 was admitted to the facility on [DATE] from the hospital with diagnoses of Osteomyelitis (bone infection), diabetes mellitus with foot ulcer, and heart failure. Review of an Admission/readmission Note, dated [DATE] at 1:23 AM, and located in the Prog Note tab of the EMR, revealed, Code Status: FULL CODE. Further review of the note revealed no documentation that R17 was asked what his/her wishes were regarding code status or to verify whether R17 had changed his/her code status to a Full Code. Review of R17's Order Summary Report, located in the Orders tab of the EMR, revealed orders dated [DATE] and [DATE] for Full Code. The Medical Director signed both orders on [DATE] at 11:56 AM. Review of the R17's electronic and hard copy closed medical records revealed no documented evidence that the resident or his/her family changed R17's code status from DNR to a Full Code status after he/she was admitted to the facility. Review of a Progress Note, dated [DATE] at 8:30 AM, and located in the Prog Note tab of R17's EMR, revealed, At approx [approximately] [7:45 AM] resident was observed unresponsive to verbal and tactile stimuli. CPR was initiated. 911 called. CPR continued. Patient was transported to [hospital]. Review of the facility-provided, CPR/Code Blue Documentation, dated [DATE], revealed CPR was initiated on R17 at 7:45 AM. At 7:53 AM, R17 was suctioned (fluid removed from the oral cavity via vacuum suction). EMS arrived at 8:00 AM, took over CPR, and intubated R17 at 8:02 AM. Review of R17's Progress Note, dated [DATE] at 5:02 PM, and located in the Prog Note tab of the EMR, documented a follow up call to the hospital revealed R17 had expired. During an interview on [DATE] at 3:43 PM, Family Member (FM)17 revealed that R17 was a DNR in the hospital and wore a DNR wristband from the hospital during his/her stay at the facility. FM17 stated if the facility had asked R17 what his/her end-of-life wishes were, R17 he/she would have chosen to continue to be a DNR. During an interview on [DATE] at 1:22 PM, the Director of Nursing (DON) stated that when a resident was admitted to the facility, the admitting nurse relayed the code status the resident had at the hospital to the Doctor to obtain an order. If there was a discrepancy in the hospital records, the Doctor was likely to order a full code. During a concurrent interview with the DON and Administrator on [DATE] at 2:48 PM, they stated if the hospital records clearly indicated DNR or full code, these were the orders the nurses asked for from the physician when residents were admitted to the facility. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 6:44 PM, LPN2, the nurse who entered R17's admission orders of a Full Code into the EMR, stated she was agency staff and worked the night shift. LPN2 stated she was not provided with the facility's code status policy. She further stated that other nurses she had worked with instructed her to review the hospital records and request orders from the physician for the code status of the resident in the hospital. LPN2 no longer worked at the facility and could not remember why she entered Full Code as R17's code status. During an interview on [DATE] at 12:26 PM, the Medical Director stated he expected the admitting nurse to attempt to talk to the resident or family about their wishes regarding code status prior to calling the provider for orders. If unable to obtain their input, the Universal Transfer Form could be used for code status until current wishes were verified within 48 to 72 hours after admission to the facility. When asked if he verified what code status R17 wanted before signing the orders, the Medical Director stated he could not remember R17 but that physicians and Nurse Practitioners had an area in the progress notes to document any discussions with the resident or family about code status. Review of the facility's policy titled, Residents' Rights Regarding Treatment and Advance Directives reviewed/revised [DATE], included the following: Under Policy: revealed It is the policy of the facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Under Definitions: showed Advance directive is a a written instruction, such as a living will or a durable power of attorney for health care . Under: Policy Explanation and Compliance Guidelines: included 1. On, admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, . 9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. NJAC: 8:39-4.1(a)2 NJAC: 8;39-9.6 (b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** C#'s: NJ00177015 and NJ00180017. Based on interviews, record review, and review of the facility's policy, the facility failed to ensure documentation of controlled substance medications accurately reflected disposition and administration times in 3 of 28 residents (Resident (R)4, R23, and R24). The facility's failure placed residents who were ordered and administered controlled medications at risk of their controlled medications being misappropriated/diverted. This provided inaccurate documented evidence during the investigation of misappropriation/diversion events and/or allegations. Findings include: 1. Review of R4's undated admission Record, located in the resident's EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE]. Review of R4's physician Orders, located in the resident's EMR under the Orders tab revealed the resident was ordered alprazolam (a benzodiazepine used to treat anxiety and is a schedule 4 controlled medication) 2 MG [milligram] twice a day. Review of R4's untitled and undated document provided by the facility revealed R4 was administered alprazolam 2 MG on 12/08/24 at 12:53 PM. The medication was scheduled to be administered at 12:00 PM. Review of R4's Individual Patient Controlled Substance Administration Record-30 dose, for alprazolam, with a received date of 11/27/24 revealed it was documented on 12/08/24 under the Time column, that the alprazolam was removed from the narcotic lock box at 1200 (53 minutes before the medication was administered to the resident). 2. Review of R23's undated admission Record, provided by the facility, revealed the resident was admitted on [DATE]. Review of R23's physician Order Summary Report, provided by the facility revealed the resident was ordered pregabalin (Lyrica) 75 MG for pain on 09/12/24. Review of R23's untitled and undated document provided by the facility revealed that R23 was administered Lyrica 75 MG capsule on 12/10/24 at 8:04 AM. The medication was scheduled to be administered at 9:00 AM. Review of R23's Individual Patient Controlled Substance Administration Record-30 dose, for Lyrica, with a received date of 11/30/24 revealed it was documented on 12/10/24 under the Time column, that the Lyrica was removed from the narcotic lock box at 0900 [9:00 AM] (56 minutes after the medication was administered to the resident). 3. Review of R24's undated admission Record, provided by the facility, revealed the resident was admitted to the facility on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R24's physician Orders, located in the resident's electronic medical record (EMR) under the Orders tab, revealed the resident was ordered Lyrica (schedule 5 controlled medication used to treat nerve and muscle pain) on 11/01/24. Review of R24's untitled and undated document provided by the facility revealed R24 was administered a Lyrica 25 milligram (MG) capsule on 12/10/24 at 8:31 AM. The medication was scheduled to be administered at 9:00 AM. Review of R24's Individual Patient Controlled Substance Administration Record-30 dose, for Lyrica, with a received date of 12/05/24 revealed on 12/10/24 under the Time column, that the Lyrica was removed from the narcotic lock box at 0900 [9:00 AM] (31 minutes after the medication had been administered to the resident). During record reviews and interview on 12/12/24 at 9:28 AM, the Director of Nursing (DON) reviewed the Individual Patient Controlled Substance Administration Records (controlled drug records) and medication administration records (MAR) for R4, R23, and R24. The DON stated the nurses were documenting the scheduled administration time for the controlled medications because they (nurses) knew it would be time-stamped on the MAR when the medication was administered. When asked about the Individual Patient Controlled Substance Administration Records for the residents having documentation of the scheduled administration times for the controlled medications and not reflecting the time the nurse retrieved the controlled medication from the narcotic lock box, the DON stated it was her expectation the nurse would document the scheduled medication administration time on the residents' Individual Patient Controlled Substance Administration Record. The DON stated the facility's current practice of completing the Individual Patient Controlled Substance Administration Records was acceptable since the MAR documents the actual time of administration. During an interview on 12/12/24 at 11:13 AM, when asked about how residents' Individual Patient Controlled Substance Administration Records should be completed, the Regional Director of Operations stated as a nurse, she would document the Individual Patient Controlled Substance Administration Record the times she pulled the controlled medication from the controlled medication lock box. During an interview on 12/12/24 at 4:45 PM, Licensed Practical Nurse (LPN) 6 stated when she administered a controlled medication to a resident, she recorded the time she administered the medication on the Individual Patient Controlled Substance Administration Record. During an interview on 12/12/24 at 4:48 PM, Registered Nurse (RN)2 stated he documented the time the controlled medication was scheduled to be administered to the resident and not the time he punched the controlled medication out. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/24 at 5:54 PM, when asked what the expected procedure was for signing out controlled medications, the facility's Consultant Pharmacist (CP) stated the facility used declining inventory sheets (Individual Patient Controlled Substance Administration Record). The CP also stated as soon as the nurse pops the medication out from the mediation card, they sign the declining inventory sheet. The CP further stated that if the controlled medication was routinely scheduled, the nurses were to document the medication administration time. When asked, was she indicating the declining inventory sheet was not a reflection of when the scheduled controlled medications were punched (removed from the lockbox/medication card) but a reflection of when the controlled medications were scheduled, the CP stated, Yes, that's correct. Review of the facility's policy titled Controlled Substances, revised November 2022, revealed The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Scheduled II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) .4 .an individual resident controlled substance record is made for each resident who will be receiving a controlled substance .This record contains: .a. name of resident; b. name and strength of the medication; c. quantity received; d. number on hand; e. name of the prescriber .h. date and time received; i. time of administration .Storing Controlled Substances. 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing, and disposition of controlled substances includes the following: a. records of personnel access and usage; b. Medication administration records . NJAC: 8:39-29.3 NJAC: 8:39-29.4

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** C#'s: NJ00177015 and NJ00180017. Based on observations, interviews, and record review, it was determined that the facility failed to utilize the proper personal protective equipment (PPE) for residents on special droplet/contact precautions for 4 of 22 residents (Residents (R) 10, R11, R12, and R13) reviewed for COVID-19 out of a sample of 22 residents. The facility also failed to follow its COVID-19 Prevention, Response, and Reporting policy. This created the potential for the transmission of infection to staff and other residents. Findings include: 1. Review of R10's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with a diagnosis of urinary tract infection. On 12/07/24, COVID-19 was added as a diagnosis. Review of R10's Prog Note tab revealed a Skilled Note, dated 12/07/24 at 10:34 PM, During the first shift, resident tested positive for covid. All isolation precautions put in place . A review of R10's Care Plan, located in the Care Plan tab of the EMR, revealed a focus area, I am COVID-19+ and exhibiting symptoms consistent with COVID-19, initiated 12/07/24. Interventions included contact/droplet isolation precautions and instruct staff to wear PPE when entering the room. In addition, the Care Plan revealed a focus area, I require droplet isolation precautions R/T [related to] Covid-19, initiated 12/07/24. Under: Interventions included Place protective equipment/isolation station at the entrance of the room. During an observation on 12/08/24 at 6:21 PM, Certified Nurse Aide (CNA) 1 walked into R10's room wearing a surgical mask over an N95 mask, gown, and gloves. No eye protection was worn. The Special Droplet/ Contact Precautions sign on R10's door staged to wear gloves, gown, a mask, fit tested N95 if doing aerosolizing procedures, and eye protection. A three-drawer cart with PPE was in the hall outside the room. During an interview on 12/08/24 at 6:23 PM, when CNA1 exited R10's room and was asked about wearing eye protection, she opened the PPE cart, pointed to a face shield, and asked if it was the eye protection being referred to. CNA1 then walked down the hall to speak to another staff member. 2. Review of R11's admission Record located in the Profile tab of the EMR revealed she was admitted to the facility on [DATE] with a diagnosis of wedge compression fracture of first lumbar vertebra. On 12/07/24, COVID-19 was added as a diagnosis. Review of R11's Prog Note tab revealed a Nurses Note, dated 12/07/24 at 4:02 PM, Rapid Covid-19 test completed on a patient [resident] with positive results. [Provider] made aware and notified. Patient symptomatic stated cough . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R11's Care Plan, located in the Care Plan tab of the EMR, revealed a focus area, I am COVID-19+ and exhibiting symptoms consistent with COVID-19, initiated 12/07/24. Under: Interventions included contact/droplet isolation precautions and instruct staff to wear PPE when entering the room. In addition, the Care Plan revealed a focus area, I require droplet isolation precautions R/T [related to] Covid-19, initiated 12/07/24. Interventions included Place protective equipment/isolation station at the entrance of the room. During an observation on 12/08/24 at 6:18 PM, the Licensed Practical Nurse (LPN)5 was observed in F11's room with the door open. LPN5 wore a gown, N95 mask, and gloves but had no eye protection other than her glasses. The Special Droplet/ Contact Precautions sign on R11's door staged to wear gloves, gown, a mask, fit tested N95 if doing aerosolizing procedures, and eye protection. A three-drawer cart with PPE was in the hall outside the room. During an interview on 12/08/24 at 6:24 PM, LPN5 stated the facility had face shields, but she did not wear them unless the resident was having symptoms such as cough or diarrhea. She stated that R11 had no symptoms. LPN5 reported nurses and CNAs care for both COVID-positive and COVID-negative residents in the hall during their shifts. 3. Review of R12's admission Record located in the Profile tab of the EMR revealed she was admitted to the facility on [DATE] with a diagnosis of diabetes. On 12/07/24, COVID-19 was added as a diagnosis. Review of R12's Prog Note tab revealed a Nurses Note, dated 12/07/24 at 4:21 PM, Rapid Covid-19 test completed on patient with positive results. [Practitioner] made aware and notified. Patient symptomatic stated cough and flu-like symptoms at this time . Review of R12's Care Plan, located in the Care Plan tab of the EMR, revealed a focus area, I am COVID-19+ and exhibiting symptoms consistent with COVID-19, initiated 12/07/24. Under: Interventions included contact/droplet isolation precautions and instruct staff to wear PPE when entering the room. In addition, the Care Plan revealed a focus area, I require droplet isolation precautions R/T [related to] Covid-19, initiated 12/05/24. Interventions included Place protective equipment/isolation station at the entrance of the room. During an observation on 12/08/24 at 6:15 PM, CNA2 entered R12's room after donning a gown, gloves, and a surgical mask over the surgical mask already worn. She wore glasses but no additional eye protection. The Special Droplet/ Contact Precautions sign on R12's door staged to wear gloves, gown, a mask, fit tested N95 if doing aerosolizing procedures, and eye protection. A three-drawer cart with PPE was in the hall outside the room. During an interview on 12/08/24 at 7:15 PM, CNA2 stated the caddy did not have an N95 mask, so she put on two surgical masks. It also had no eye protection, so she used her glasses. 4. Review of R13's admission Record in the Profile tab of the EMR revealed she was re-admitted to the facility on [DATE] with a diagnosis of urinary tract infection. On 12/07/24, COVID-19 was added as a diagnosis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R13's Prog Note tab revealed a Skilled Note, dated 12/07/24 at 2:20 PM, Earlier during this shift, resident was seen lying quietly in bed c/o [complaining of] not feeling so well . Resident tested positive for covid and was immediately put on isolation precautions . Review of R13's Care Plan, located in the Care Plan tab of the EMR, revealed a focus area, I am COVID-19+, initiated 12/06/24. Under: Interventions included contact/droplet isolation precautions and instruct staff to wear PPE when entering the room. In addition, the Care Plan revealed a focus area, I require droplet isolation precautions R/T [related to] Covid-19, initiated 12/06/24. Interventions included Place protective equipment/isolation station at the entrance of the room. During an observation on 12/08/24 at 6:45 PM, Registered Nurse (RN) 1 went into R13's room after donning a gown, gloves, and N95 mask but no eye protection. The Special Droplet/ Contact Precautions sign on R13's door staged to wear gloves, gown, a mask, fit tested N95 if doing aerosolizing procedures, and eye protection. A three-drawer cart with PPE was in the hall outside the room. During an interview on 12/08/24 at 7:15 PM, RN1 verified he had not worn eye protection. RN1 stated the expectation was to wear eye protection, but R13 did not have the correct PPE set up. During an interview on 12/09/24 at 4:22 PM, the Infection Preventionist (IP) stated she expected staff to wear a gown, goggles or face shield, gloves, and an N95 mask when entering a room of a resident who has COVID-19. Failure to wear the correct PPE could spread COVID-19 to the staff or others in the facility. During an interview on 12/09/24 at 4:25 PM, the Director of Nursing (DON) stated she expected staff to wear a gown, goggles or face shield, gloves, and an N95 mask when entering a room of a resident who has COVID-19. Review of the facility's COVID-19 Prevention, Response, and Reporting policy, dated 05/29/24, revealed, HCP [health care personnel] who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection. NJAC: 8:39-19.4(a)