STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315523	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Care at Lantern Hill	537 Mountain Avenue New Providence, NJ 07974

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605 Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan (CP) that included the use splints (medical device that stabilizes a part of your body and holds it in place); a CP that included the use of anticoagulants (AC), and a CP that included pressure ulcer care. This deficient practice was identified for 5 of 15 residents (Resident #3, #5, #17, #11, and #29) reviewed for comprehensive person-centered CP. This deficient practice was evidenced by the following: 1. On 9/9/24 at 09:28 AM, the surveyor observed Resident #3 awake in bed. The surveyor also observed the resident had a left arm and left hand contracture. Resident #3 stated they wear a splint in the evening and the splint is removed in the morning. The surveyor reviewed Resident #3's medical records, which revealed that the resident was admitted to the facility with diagnoses that included but not limited to Hemiplegia (a condition characterized by paralysis of one side of the body) affecting left non-dominant side; Contracture left hand and muscle weakness. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 7/5/24 revealed a Brief Interview for Mental Status (BIMS) that could not be completed at the time of interview. The Quarterly MDS further revealed Resident #3 had been using a splint. A review of the August 2024 Physician Order Sheet revealed a Physician's Order (PO) dated 2/7/24, for Splint/Brace, apply onto left hand/arm in HS (bedtime) and remove in AM (morning). A review of the CP titled Holistic Care Plan/Continuing Services with a start date of 1/6/24 and a last reviewed date of 7/3/24, did not reflect the resident's use of the left hand/arm splint/brace. On 9/10/24 at 9:55 AM, the surveyor conducted an interview with Licensed Practical Nursing (LPN#1) who stated the residents CP are kept in a separate notebook inside the resident's room. LPN #1 added that the use of hand splint must be addressed in the resident's CP. LPN #1 was not able to locate a CP for Resident #3's use of splint/brace and could provide any information as to why there was no care plan initiated. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 9/9/24 at 10:47 AM, the surveyor observed Resident #17 in their room with eyes closed in bed. The surveyor reviewed Resident #17's medical records which revealed that the resident was admitted to the facility with diagnoses that included but were not limited to Nontraumatic intracerebral hemorrhage; Acute Embolism and thrombosis of the right femoral vein; and Atrial Fibrillation. A review of the Quarterly MDS, dated [DATE] revealed a BIMS score of 5 out of 15, which indicated that the resident had severely impaired cognition. The MDS further revealed under Section N. Medications that Resident #17 was taking an AC medication. A review of the September 2024 POS revealed a PO dated 12/22/23, Eliquis 2.5 milligram (mg) tablet (1 tab) Tablet oral. A review of Resident #17's CP which reflected a review date of 9/6/24, revealed under the medication's portion which did not reflect the resident's use of AC medication. 37791 3. On 09/09/24 at 9:59 AM, the surveyor observed the resident who was seated in a wheelchair in the dining room, eating breakfast with other residents. The surveyor reviewed Resident #5's medical records, which revealed that the resident was admitted to the facility with diagnoses that included but not limited to Hypertension (a condition in which the force of the blood against the artery walls is too high); Hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood); Hemiplegia following cerebral infarction (a condition that causes paralysis on one side of the body and is common result of a stroke and cerebral infarction); and Diabetes Mellitus (is a disorder in which the amount of sugar in the blood is elevated). A review of the Admission MDS dated [DATE], reflected the resident had a BIMS score of 15 out of 15, indicating the resident was cognitively intact. A review of the September 2024 POS revealed a PO dated 8/19/24 for Foam Boots to be applied at HS (bedtime) and removed in the morning. The September 2024 POS also reflected that Resident #5 had a PO dated 9/5/24 for soft splint to be applied to left hand at HS and removed in AM. A review of the comprehensive person-centered CP for Resident #5 did not reflect the resident's use of foam boots and splint to their left hand. On 9/11/24 at 11:15 AM, the surveyor requested documentation for Resident #5 from the Director of Nursing (DON). The surveyor informed the DON that the resident's foam boots, and splint did not reflect in the resident's CP. The DON told the surveyor that she was aware of the concern. 37175 4. On 09/10/24 at 11:54 AM, the surveyor observed Resident #29 in bed with a family member present at bed side. The resident was alert and stated that they had pressure wounds. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor reviewed Resident #29's medical records, which revealed that the resident was admitted to the facility with diagnoses that included but not limited to Cerebral Infarction (lack of blow flow in the brain), Hemiplegia (paralysis on one side of the body), and Malignant Neoplasm (cancer) of urinary organ. A review of the Quarterly MDS, dated [DATE], revealed that the resident had a BIMS score of 9 out of 15, indicating moderate cognitive impairment. Further review of the MDS revealed the resident had a stage 4 pressure ulcer (PU) and 2 different sites of unstageable PU's. A review of the September 2024 POS revealed a PO dated 08/29/24 for antibacterial foam wound dressing 4x4 bandage with an indication for the left heel pressure injury to cleanse with normal saline, apply the antibacterial foam wound dressing soaked in sterile water then cover with a foam island dressing. Further review of the September 2024 POS revealed a PO dated 08/29/24 for 4x4 bandage with an indication for the right heel pressure injury to cleanse with normal saline, apply antibacterial foam wound dressing soaked in sterile water then cover with a foam island dressing. A review of Resident #29's CP titled Holistic Care Plan did not reflect a CP that addressed the resident's right heel and left heel PU's. On 09/12/24 at 09:56 AM, the surveyor interviewed and reviewed the CP's that were provided by the DON, who stated to the surveyor the CP's that were provided were the residents CP's and there were no CP's for the pressure wounds that had developed. A review of the facility's policy titled Skin Integrity Program dated 01/24 revealed that if a new wound is identified during skin checks the care/service plan will address approaches for wound care. 46889 5. On 9/09/24 at 10:13 AM, the surveyor observed Resident #11 seated in their wheelchair inside the main dining room. The resident was able to answer the surveyor's inquiry and stated they were not in any pain. The surveyor reviewed Resident #11's medical records, which revealed that the resident was admitted to the facility with diagnoses that included but not limited to Atrial Fibrillation (irregular heartbeat). A review of the Quarterly MDS, dated [DATE], revealed that the resident had a BIMS score of 3 out of 15, indicating severely impaired cognition. Further review of the MDS under Section N. Medications indicated that the resident was taking AC. A review of the form titled, August 2024 Medications for Resident #11 reflected a PO for Eliquis 2.5 mg (milligram) tablet (1 tab) tablet oral two times daily started on 8/10/24. A review of Resident #11's CP which reflected an initiated date of 9/9/24, revealed under the medication's portion which did not reflect the resident's use of AC medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/10/24 at 9:59 AM, the survey team interviewed the DON, who stated holistic assessment included the CP. The DON further stated that the CP were kept in a notebook inside each resident's room. The DON added that the CP's were updated as needed and for any immediacy on the CP's would be handwritten. The DON agreed that the hand splints; use of AC medications; PU's and pressure relieving devices must be addressed in the CP. The DON did not provide any further information as to why the above concerns were not reflected in each of the resident's CP's. On 9/10/24 at 11:30 AM, the DON provided the survey team with a facility policy, Care/Service Plans with a revision date of 5/2021. Under the procedure section of the policy it states, 1. Guest/residents admitted to Post Acute/Long Term Care will have .b, The interim care plan will reflect the resident's goals and include interventions that address his or her current needs .c. The interim care plan will include healthcare information necessary to care for resident including, but not limited to .ii. Physician orders (list of medications) 4. Any changes identified in the comprehensive care plan in the resident's goals, physical, mental, or psychosocial function, that was not identified in the interim care plan will be provided in to the resident and/or responsible party .8. Care plans will be reviewed, revised if applicable, on an ongoing basis by the interdisciplinary team with any changes in condition and after each assessment, including both comprehensive and quarterly review assessments. On 9/11/24 at 2:00 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON. There were no further information provided. NJAC 8:39-11.2(e)(2) thru (i); 27.1(a), (d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 Based on observation, interview, and record review, it was determined that the facility failed to maintain the nursing professional standard of clinical practices by not accurately 1. documenting the pain management assessment and 2. Documenting the time and use of each as-needed (PRN) pain medication for 1 of 12 residents (Resident #11) reviewed for unnecessary medications. 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. The deficient practice was evidenced by the following: On 9/09/24, at 10:13 AM, the surveyor observed Resident #11 seated in their wheelchair in the main dining room. The resident was able to answer the surveyor's inquiry and stated that they were not in pain. On 9/11/24, at 10:42 AM, the surveyor reviewed Resident #11's electronic medical record and revealed the following information: According to the Admission Record (an admission summary), Resident #11 was admitted to the facility with diagnoses that included but were not limited to left closed Femur fracture with routine healing. The Quarterly Minimum Data Set (MDS), dated [DATE], indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored 3 out of 15, which indicates that resident had severe cognitive impairment. Further review of the MDS under Section J. Pain Management Pain Presence was answered as 0. No. A review of Resident #11's August 2024 Medications revealed the following Physician Orders: Acetaminophen 325 mg tablet (2 tablets = 650 mg) oral PRN every 6 (six) hours. Notes: Indication: Pain, with an order date of 8/09/24. Tramadol 100 mg tablet two (2) times daily. Notes: Indication: Pain management Give (1) tablet PO BID (twice daily). with an order date of 8/28/24. Further review of the form titled August 2024 Medications reflected a medication with an order date of 8/20/24 for Tramadol 100 mg 1 tablet as needed every six hours that were administered on the following dates: 8/16/24 at 20:00 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/21/24 at 08:02 8/23/24 at 08:21 8/24/24 at 13:04 8/25/24 at 07:40 8/26/24 at 09:46 The surveyor could not locate in the medical records regarding any pain assessment documentation before and after the pain medication was administered to the resident. A further review of the clinical notes from August 9 through August 28, 2024, did not reflect any documented pain assessment; the time when the medication was administered and the indication of use for Tylenol 650 mg every 6 hours PRN. A review of the form titled Holistic Care Plan initiated on 9/09/24 revealed under 6. Pain, under Goal(s), which revealed to, Please monitor for action and expression of pain as well as asked. On 09/11/24, at 09:35 AM, the surveyor interviewed the Certified Nursing Assistant who stated that when the resident complained of pain, they would report it to the nurse. On 09/11/24 at 9:45 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that Resident #11's medical record had no pain assessment monitoring that was ordered by the Physician. On 9/11/24 at 01:50 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The DON stated that the nursing staff does not complete any pain assessment documentation. A review of the policy titled Pain Management, updated in May 2021 under Procedure: revealed that 3. Nurse uses the numerical Pain Intensity Scale and/or physical observations to identify the presence of pain, 5. Nurse will notify provider of existing pain and/or history of pain presently relieved or not relieved by medications and non-medicinal approaches, and 7. Pain level will be assessed before and after administration of analgesic and documented in the Physical Monitors in the eMAR. There were no further information provided by the LNHA and the DON regarding the concern above. NJAC 8:39-27.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44605 Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 9/9/24 at 8:29 AM, the surveyor in the presence of the General Manager of Dining Services (GMDS) observed the following during the kitchen tour: 1. In the walk-in refrigerator, the surveyor observed a 2 gallon container with Bechamel sauce with a use by date of 9/8/24, cooked bacon with a use by date of 9/7/24, a full tray pan of shrimp defrosting not covered or labeled, a 1 gallon tub of an unidentified white liquid with no date, and a full sheet pan of raw asparagus not labeled. The GMDS stated all items were past the use by date and should have been discarded by the evening supervisor. The GMDS also confirmed that all items need to be labeled with prepared date and use by dates. 2. In the walk-in freezer, the surveyor observed multiple items stored higher than 18 inches from the ceiling. 3. In the dry storage area, the surveyor observed an open bag of sourdough bread with a use by date 9/7/24, an open bag of 160 ounce (oz) pasta not properly wrapped or labeled, and a 1 gallon container Worcestershire 8/14/24 use by date. The GMDS stated all items were past the use by date and should have been discarded by the evening supervisor and all items need to be labeled with open and use by dates. 4. In the cooking area of the kitchen, the surveyor observed the two, two door standing ovens. The inside of oven #2 had black colored cooked on debris and oven #1 had a sticky white colored substance on lower oven door handles. On 9/9/24 at 9:12 AM, the surveyor while on dining observations observed the following: 5. Surveyor observed an open container of cranberry juice labeled with a use by date of 9/8/24. The dietary aide (DA#1) stated that the cranberry juice should have been discarded. DA#1 could not provide any information on how the cranberry juice was in the dining room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/10/24 at 9:50 AM, the GMDS provided the surveyor with three facility policies: Labeling and Dating with a revised date of 4/2024, Cleaning and Sanitizing Major Cooking Equipment with a revised date of 1/2024, and Food/Non-Food Storage with a revised date of 4/2024. The labeling and dating policy states under the procedure section, 2. All items will have a received date. 3. All opened items or items not in original containers will be covered, clearly and properly labeled. 4. Leftover food will be in appropriate containers or wrapped and dated. Leftover food is checked daily to determine its usage. If it cannot be used within 72 hours of production, it is labeled, dated, and frozen for future use. The cleaning and sanitizing major cooking equipment policy states under the procedure section, 1. All Food Service Equipment and preparation Equipment will be cleaned and sanitized after each use and maintained in a clean and sanitized condition. The food/non-food storage policy states under its procedure section, 3. All food and supplies will be stored six (6) inches above the floor, and 18 inches from the ceiling. On 9/10/24 at 1:49 PM, the survey team met with the Licensed Nursing Home Administrator (LHNA) and Director of Nursing to discuss the above concerns. There were no further information provided. NJAC 8:39-17.2(g)