STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Brook Rehabilitation and Healthcare Center	3718 Church Road Mount Laurel, NJ 08054

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41260 Complaint #: NJ177765; NJ177069 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the resident environment, equipment and living areas in a safe, sanitary, and homelike manner. This deficient practice was identified on 5 of 5 resident units (East, West, Central, North 1, and North 2) and was evidenced by the following: 1.) During the initial tour of the facility on 10/8/24 at 11:31 AM of the East Unit, the surveyor observed the following: -room [ROOM NUMBER]-A: the air conditioner (AC) unit had unidentified black discolorations on the vent grill and the front of the AC unit had an accumulation of dust. During an interview with the surveyor on 10/15/24 at 4:14 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) stated that housekeeping and maintenance should ensure the AC units were cleaned and remained dust free weekly. 41072 2.) During a tour on 10/9/24 at 8:34 AM of the North 2 Unit, the surveyor observed the following: -room [ROOM NUMBER]: dust on the front cover of the window AC unit -room [ROOM NUMBER]: the inside of the bathroom door had brown paint peeling off. -room [ROOM NUMBER]: dust on the front cover of the window AC unit -room [ROOM NUMBER]: the inside of the bathroom door had brown paint peeling off. -room [ROOM NUMBER]: dust on the front cover of the window air conditioner (AC) unit. -room [ROOM NUMBER]: dust on the front cover of the window AC unit (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-room [ROOM NUMBER]: dust on the front cover of the window AC unit, napkins stuffed into open area on the side of the Window AC unit to prevent outside air from coming into the room. -room [ROOM NUMBER]: observed an uncovered mattress propped against the wall and a cabinet with visible red colored spots on the mattress -room [ROOM NUMBER]: the inside of the bathroom door had brown paint peeling off. -room [ROOM NUMBER]: dust on the front cover of the window AC unit During an interviw with the surveyor on 10/15/24 at 2:36 PM, the Maintenance Director (MDR), in the presence of the survey team stated that he will check if any maintenance orders were placed for the peeling paint. The MDR did not bring any additional information regarding the paint. On 10/15/24 at 3:06 PM, the surveyor interviewed the Director of Housekeeping (DHK) and the Regional DHK (RDHK) in the presence of the survey team. The DHK stated that floor mats and mattresses should be cleaned. 40041 3). During the initial tour on 10/8/24 at 10:35 AM of the North 1 Unit, the surveyor observed the following: -Yellow tape on the hallway floor in multiple areas. -A strip of the flooring was partially raised off of the floor. On 10/9/24 at 2:19 PM, during a surveyor visit to room [ROOM NUMBER], a resident occupied room, the following was observed: -a hardened brown substance on the resident's floor. During an interview with the surveyor, the resident in room [ROOM NUMBER] stated, my room has not been cleaned in a couple weeks. On 10/10/24 at 12:33 PM, the surveyor returned to room [ROOM NUMBER] and the hardened brown substance was still on the resident's floor. An empty clear manufacture packaging, an empty carboard juice wrapping, and small debris were noted on the floor near the resident's bed. On 10/15/24 at 3:06 PM during an interview with the surveyor in the presence of the Director of Houskeeping (DHK) and the survey team, the Regional Director of Housekeeping (RDHK) stated that the resident rooms were cleaned daily which included, the tray tables, high touch areas, door knobs, furniture, and floors. When asked about the hardened substance stuck on the floor, the DHK replied, we usually spray, then we have scrappers for anything that is stuck to the floor. 37547 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4.) During the initial tour on 10/8/24 from 10:55 AM to 1:11 PM of Central Unit, the surveyor observed the following: -room [ROOM NUMBER]-A: There was a hole in the ceiling that was covered with clear plastic surrounded by black electrical tape. There was a dried substance noted in the center of the plastic that covered the hole in the ceiling. A PTAC (packaged terminal air conditioner unit) had a visibly dented and damaged front cover, and a portable air conditioner unit that was vented out of the resident's window were both in the room. Resident #81 and his/her spouse were present and stated, the ceiling should not be that way, and it has been that way since around Christmas. They put the plastic up in the early part of the year. I would think it would have been fixed by now. The resident's spouse stated that he/she mentioned it to maintenance previously, who stated that they would come back and fix it. -Room: 15-B: A wall unit air conditioner had a thick coating of dust on the outside of the vent cover. During an interview with the surveyor on 10/9/24 at 12:20 PM, Certified Nursing Assistant (CNA) #8 stated that if she noted anything in need of repair she told the nurse and put a maintenance request into the system. CNA #8 further stated that she noticed the hole in the ceiling and saw the tape in room [ROOM NUMBER]-A and figured that it was being taken care of. During an interview with the surveyor on 10/9/24 at 12:25 PM, Licensed Practical Nurse (LPN) #9 stated that when she noted something in need of repair, she placed a maintenance call and they responded within thirty minutes. LPN #9 further stated, I think that they may have taken a vent out of room [ROOM NUMBER]-A. LPN #9 stated that she would follow-up with maintenance. During an interview with the surveyor on 10/9/24 at 12:32 PM, Licensed Practical Nurse/Unit Manager (LPN/UM) #4 stated, I honestly did not notice the air conditioner units. It has to be cleaned. LPN/UM #4 stated that he would notify maintenance or housekeeping. During an interview with the surveyor on 10/9/24 at 12:35 PM, Resident #123 stated that he/she had not seen the air conditioner unit filter changed or cleaned since he/she was admitted to the facility. During a later interview with the surveyor on 10/9/24 at 1:07 PM, LPN/UM #4 stated that he did not see a hole in the ceiling in room [ROOM NUMBER]-A. He stated, It was not acceptable. They probably attempted to fix it, but had to see how to resolve it. LPN/UM #4 further stated, It was not acceptable for it to be like that since January. LPN/UM #4 stated that he would inform maintenance. During an interview with the surveyor on 10/10/24 at 11:24 AM, the Maintenance Director (MDR) stated that he had worked at the facility since 1997. He stated that he was not sure how long room [ROOM NUMBER]-A had been like that, but it was brought to his attention yesterday by the LPN/UM, and was being patched now. The MDR stated that we do weekly walk throughs. The MDR stated that he did not think that the plastic should have been there and the repairs should have been made immediately or ASAP. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 11:33 AM, the surveyor asked the MDR about the condition of the air conditioning unit in room [ROOM NUMBER]-B on Central Unit. The MDR stated that housekeeping was responsible to clean the outside of the air conditioning units and maintenance cleaned the filters. During an interview with the surveyor on 10/10/24 at 12:00 PM, Housekeeper (HK) #3 stated that she was responsible to dust the air conditioning units. HK #3 stated that her boss brought it to her attention today and the vent was wiped with an all purpose cleaner. HK #3 stated that it was important to clean the outside of the air conditioner vents because the resident's had to breathe air from it. The surveyor noted that there was still dust that remained on the air conditioner vent after it was reportedly cleaned. During an interview with the surveyor on 10/15/24 at 2:37 PM, the MDR stated when an AC unit went bad, they placed a portable window unit. When asked if the maintenance department did walking rounds for preventative maintenance he stated, We do more of a visual rounding, they take notes, and make repairs. The MDR described the maintenance notes as personal notes and stated that there was no official form that staff were required to turn in. During an interview with the surveyor on 10/15/24 at 3:07 PM in the presence of the survey team, the Director of Housekeeping (DHK) stated that air conditioner vents were supposed to be wiped daily and deep cleaned weekly. The DHK stated that she did not expect to see a thick coating of dust on the outside of the air-conditioning units. The DHK further stated that it could cause health issues in residents with respiratory problems. At that time, the surveyor showed the DHK photos of the air conditioner unit in room [ROOM NUMBER]-B, both before and after it was reportedly cleaned. The DHK stated, They can do better than that. 5.) During a tour of East Unit on 10/10/24 at 10:29 AM, the surveyor observed the following: -room [ROOM NUMBER]-A: The surveyor observed Resident #191 who was seated in a wheel chair directly beneath a patched area on the ceiling that had a white coating over it with a visible crack through the patched area that ran along the ceiling. Licensed Practical Nurse (LPN) #10 was present at the bedside and stated that she had not noticed the condition of the ceiling before. During an interview with the surveyor on 10/10/24 at 10:59 AM, the Registered Nurse/Unit Manager (RN/UM) and the surveyor went into room [ROOM NUMBER]-A together to see the condition of the ceiling. At that time, the RN/UM stated, Oh my God. When the surveyor asked her to clarify what she meant, she stated, I want to see if it were previously addressed. During an interview with the surveyor on 10/10/24 at 11:30 AM, the surveyor and the MDR went to room [ROOM NUMBER]-A to view the ceiling together. The MDR stated, I see buckling here and we have to immediately address it and get the resident out of the room. The Regional Director of Maintenance (RDM) was present and stated that the area looked like it was previously patched. The RDM stated, It was very concerning to me. We cannot let it go on. During an interview with the surveyor on 10/15/24 at 2:37 PM, the MDR stated that he was unsure of the cause of the ceiling damage in room [ROOM NUMBER]. 43308 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6.) During the initial tour on 10/8/24 at 10:34 AM of the [NAME] Unit, the surveyor observed the following: In room [ROOM NUMBER]-B, the resident's intravenous (IV) pole (a stand that holds enteral feeding pumps - a device that delivers hydration and nutrition) had hardened, dried, spillage on it. The wheels of the IV pole had dust and debris on it. At 1:07 PM the surveyor observed the following in the [NAME] Unit: -In the hallway, there were three (3) geriatric chairs (geri-chair - used for those with mobility issues and have difficulty sitting upright) that had debris on the back of the chairs. One (1) of the geri-chairs had a tear on the right arm rest. -In the same hallway there was a linen cart with a black net covering that had white spatter on it and was torn. -In the activities/dining room, there was an air conditioning (AC) unit in the back of the room that had a brown color noted on the vents with visible debris. There was no cover over on AC unit vents. The middle window was partially opened and had dust, debris, and cobwebs noted on the windowsill. The AC unit in the window in the front of the room had dust and cobwebs on it. During an interview with the surveyor on 10/9/24 at 11:54 AM, LPN #9 stated the overnight nursing staff was responsible for cleaning the IV poles and pump machines. She further stated it was documented on the Treatment Administration Record (TAR) that the machine was cleaned. During an interview with the surveyor on 10/9/24 at 11:58 AM, LPN #8 stated that both nursing and housekeeping were responsible for cleaning the enteral feeding pumps and the IV poles. She stated they were cleaned weekly and as needed. She further stated that the housekeeper wiped it daily, but was not sure if there was a cleaning schedule or where it would be documented. During an interview with the surveyor on 10/9/24 at 12:05 PM, CNA #9 stated the nurses were responsible for cleaning the enteral feeding pumps and IV poles. She stated that maintenance was responsible for checking the air conditioners. During an interview with the surveyor on 10/9/24 at 12:07 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) #2 stated that if there was spillage in the resident's room then the nurses would clean it, but then they would call housekeeping to follow up and disinfect it. LPN/UM #2 stated that she did not know if there was a cleaning schedule. She then stated if she had seen it, then she would notify housekeeping. At 12:10 PM, the surveyor continued to interview LPN/UM #2, who stated she was not sure if there was a cleaning schedule for the cleaning of the wheelchairs and geri-chairs. She stated that she knew they were cleaned but was unsure of how often they were cleaned. On 10/9/24 at 12:13 PM, LPN/UM #2 and the surveyor went to room [ROOM NUMBER]-B and at that time LPN/UM #2 confirmed there was spillage and drippings of the enteral feeding on the machine, the IV pole, and on the wheels of the pole. She stated that she would get housekeeping to clean it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/9/24 at 12:15 PM, LPN/UM #2 and the surveyor toured the hallway were the geri-chairs where located. LPN/UM #2 stated that the geri-chairs and high back wheelchair in the hallway were from the hospice company. She stated that the hospice company was supposed to come pick them up but did not come yet. During an interview with the surveyor on 10/9/24 at 12:26 PM, the Housekeeper (HK #1) stated that housekeeping would wipe the poles if we have time after doing everything we are supposed to do. HK #1 stated that he mainly cleaned the main areas and not the resident's rooms. HK #1 explained if he cleaned the resident's room he would clean the bathroom, sweep, and mop the floor. During an interview with the surveyor on 10/9/24 at 12:29 PM, the Director of Nursing (DON) stated housekeeping and nursing were responsible for cleaning the enteral feeding pump and the IV poles. He stated that he would have to research to see if there was a cleaning schedule since he had only been the DON at the facility for three (3) months. The DON stated that even if the geri-chairs are from hospice the facility was still responsible for cleaning them. He stated that housekeeping was responsible to clean out any visible cobwebs and debris on the windowsill. He further stated housekeeping was also responsible for cleaning the air conditioners to ensure there was no dust and to ensure everything was clean. The DON stated it was important to keep the equipment and areas clean to prevent infection and to create a homelike environment. On 10/9/24 at 12:36 PM, the DON and the surveyor conducted an environmental tour on the [NAME] Unit. At that time, the DON stated the geri-chairs in the hallway were not being used, but he could see the areas that needed to be cleaned. At 12:37 PM, the DON and the surveyor entered room [ROOM NUMBER]-B. The DON confirmed there were drippings and spillage from the enteral feeding on both the pump and IV pole. He stated he would have to check the frequency that equipment was cleaned but would expect it to be clean. At 12:39 PM, the surveyor showed the DON the linen cart in the hallway. He stated he was aware of the linen cart and had ordered replacement covers but was waiting on a shipment. At 12:41 PM, the surveyor and the DON entered the activities/dining room. At that time, the DON confirmed the AC unit in the back of the room needed to be fixed, and the cobwebs and the dust on and by the air conditioner and in the windowsill needed to be cleaned. He stated it was the expectation for it to be cleaned to prevent allergens. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the surveyor on 10/10/24 at 10:41 AM, HK #2 stated that he was mainly on the [NAME] Unit. He stated that he was responsible for cleaning the resident's rooms, dining room, medication room, oxygen room, the unit manager's room, the spa/shower room, the pantry, and the supply room. He further stated in the resident's room, he cleaned the toilets, windowsills, handrails, soap dispenser, paper towel dispenser, swept and mopped the floors, the nightstands, IV poles and mirrors. HK #2 stated that he tried to clean the IV poles daily because they got dirty quick. He further stated, it looks like I did not even clean it. He explained there was no documentation, but that it was done daily. HK #2 stated housekeeping was responsible for cleaning the wheelchair and geri-chairs and that he did them today, 10/10/24. When asked how often they are cleaned, HK #2 stated I am not going to lie, I am not sure how often they were supposed to get cleaned. He further stated he was not sure if there was a log to track the wheelchairs and geri-chairs. HK #2 stated we was unsure if the chairs in the hallway were from the hospice company but that he cleaned anything he saw which would include the geri-chairs in the hallway. At 10:48 PM, the surveyor showed HK #2 the pictures that were taken on 10/8/24 and 10/9/24. At that time, HK #2 stated the drippings were hard to get off the IV pole and machine. He acknowledged they should have been cleaned. On 10/10/24 at 11:50 AM, the surveyor interviewed the Maintenance Director (MDR) in the presence of the survey team. The MDR stated the maintenance department was responsible for changing the AC filters and the housekeeping cleaned the exterior. On 10/15/24 at 2:36 PM, the surveyor conducted a follow up interview with the MDR in the presence of the survey team. The MDR stated that for the AC units, the maintenance department was responsible for preventive maintenance, to clean the filters, and if any issues were found to address them immediately. He stated that the filters were cleaned monthly and that housekeeping generally wiped the AC units down, but if maintenance saw them dusty, we do not mind cleaning them. At 2:40 PM, the surveyor showed the MDR the pictures of the AC unit in the [NAME] Unit activities/dining room. He stated that he noticed it today, 10/15/24, and placed a cover over it immediately. He further stated he generally toured each unit once a week. The MDR stated the last time he rounded on the [NAME] Unit was last Monday, 10/7/24 or Tuesday, 10/8/24. He stated that it stuck out today [10/15/24] and jumped right on it. He further stated that no one brought it to his attention. The MDR stated the cover was temporary because the vents needed to be replaced. He stated that when the maintenance department inspected the AC units, they checked to ensure they were in place and if they needed to get replaced, it was done immediately. The MDR stated that he generally conducted visual rounds, but there was no official documentation for the environmental rounds. On 10/15/24 at 3:06 PM, the surveyor interviewed the Director of Housekeeping (DHK) and the Regional DHK (RDHK) in the presence of the survey team. The DOK stated the housekeepers (HK) were responsible for cleaning the resident's rooms, the wheelchairs, equipment, and the spa/shower rooms daily. She stated the HK had a check list on their cart on what to clean, but that there was nothing official to check off daily. She further stated that her and the Assistant DHK conducted weekly and monthly audits. The DHK stated that housekeeping was responsible for cleaning the windowsill and the front of the AC unit daily. She further stated that the maintenance department was responsible for changing the filters. The DHK stated that the AC units should be cleaned because it could cause effects for residents with respiratory issues. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37547 Based on interviews, record review and review of other pertinent documentation, it was determined that the facility failed to report timely an allegation of staff to resident abuse to the facility administrator and the New Jersey Department of Health (NJDOH). This deficient practice was identified for 1 of 3 residents (Resident #173) reviewed for an allegation of abuse. This deficient practice was evidenced by the following: During the initial tour of the facility on 10/08/24 at 1:36 PM, Resident #173 was observed seated on the side of their bed. When interviewed, the resident was tearful at times as they described how they were spoken to by the Nurse Practitioner (NP). The resident stated that the NP told them that they would die if they did not take their potassium. The resident stated that he/she did not want care forced upon them. The resident stated that they preferred to take a more natural approach like eating bananas instead of taking medication such as potassium. The resident stated that they had declined the medication and that was what the NP was mad about. The resident stated that they were most upset about the fact that the NP took away his/her diuretics (water pill) and the resident feared getting fluid build up in their lungs and limbs. The resident stated that they had spoken with both the Social Worker (SW) and psychiatry about the incident. A review of Resident #173's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to; chronic kidney disease, unspecified, major depressive disorder, heart failure, unspecified, essential (primary) hypertension (high blood pressure), pleural effusion (a build up of fluid between the tissues that line the lungs and chest), and traumatic subarachnoid hemorrhage (results from a medical aneurysmal (an enlargement of an artery caused by a weakening artery wall) rupture or traumatic head injury resulting in bleeding between the subarachnoid (area in the brain) space). A review of Resident #173's quarterly Minimum Data Set (MDS), an assessment tool, dated 09/23/24 revealed that the resident's Brief Interview for Mental Status (BIMS) score was 15 out of 15, which indicated that the resident was fully cognitively intact. The remainder of the assessment remained in progress. A review of Resident #173's Care Plan included an entry dated 5/7/24 with a Focus of: I have fluid deficit and/or potential fluid deficit related to diuretic use. Fluid restriction. The Goal included: I will be free from s/s/x (signs and symptoms) of fluid deficit by/through the review. Interventions included: Administer medications as ordered. Monitor for side effects and effectiveness. Educate me/RP (responsible party) on the importance of adequate fluid intake .Notify Medical Doctor (MD) of significant abnormalities and/or significant changes from baseline. The resident's Care Plan failed to contain an entry for the resident's refusal of medications or noncompliance with related interventions. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Brook Rehabilitation and Healthcare Center	3718 Church Road Mount Laurel, NJ 08054

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #173's Electronic Health Record (EHR) revealed a Nurse Practitioner (NP) Note dated 10/05/24 at 9:32 AM, which indicated, The reason for the visit was: f/u (follow up) hypokalemia (low potassium level)/chf (congestive heart failure)/Pleural effusions.The NP documented that the resident was seen per nursing request. Pur [sic.] nursing the patient is refusing potassium supplementation. The patient is currently on bumex (diuretic), metolazone (diuretic), and acetazolamide (diuretic). The NP documented that the resident refused to talk to this author. reports he/she does not wish to take potassium or medications, attempted to discuss with patient risk for hypokalemia if untreated, risk of low potassium with large amount of diuretics, patient placed head phones back on head and refused to speak. no signs of acute distress noted Psychiatric: Oriented to self, Pleasant, cooperative Oriented to person, Oriented to place, Oriented to year and refused exam or speaking to NP regarding care.Spoke with nursing and will discontinue medications for now due to patient refusing potassium supplementation and high use of diuretics puts patient at risk for low potassium, patient will be at risk for Congestive Heart Failure/pleural effusion will monitor fluid volume status closely if patient will allow .Rx (prescription) to discontinue metolazone placed, rx to discontinue diamox, rx for potassium chloride 40 meq (milliequivalent) in the am only, continue bumex to 1 mg once daily . depression: placed order for psych eval . On 10/9/24 at 11:52 AM, the surveyor interviewed the Nurse Practitioner (NP) who stated that she recalled speaking with Resident #173 and the resident would not listen to me and put headphones on. The NP stated that the doctor was called and he told me to decrease the diuretics if we could not get him/her to take the potassium. The NP stated she asked the resident if there was a reason that they refused to take the potassium? She stated that was when he/she put the headphones on and refused to talk to me. The NP further stated that the resident did not ask to stay on diuretics. During an interview with the surveyor on 10/9/24 at 1:18 PM, Licensed Practical Nurse/Unit Manager (LPN/UM) #4 stated that he had spoken with Resident #173 and the resident did not tell him that he/she was upset, just depressed. LPN/UM #4 stated that the nurses said the resident was refusing medications and we put the resident in to see psychiatry. LPN/UM #4 stated that the resident did not bring it to his attention that he experienced maltreatment from the NP. During a follow-up interview with the surveyor on 10/10/24 at 12:39 PM, the surveyor asked LPN/UM #4 if he reported Resident #173's allegation of abuse by the NP? The LPN/UM #4 stated that sometimes the resident did not take their medications and wanted to do things the natural way. LPN #4 further stated, I am going to report it. On 10/15/24 at 9:44 AM, the surveyor requested all incidents and investigations related to Resident #173 and the Licensed Nursing Home Administrator (LNHA) confirmed that there were none. During an interview with the surveyor on 10/15/24 at 9:47 AM, the surveyor interviewed LPN/UM #4 who stated, I reported the allegation of abuse to the administrator when I was done talking to you and he ordered the Social Worker to talk with the resident directly. He stated that no further investigation was completed on his end. A review of a Social Services note dated 10/08/24 at 4:37 PM revealed that the SW documented, SW rounded on resident and provided active listening and psychosocial support.A psychology referral made for an added layer of mental health support. SW will continue to monitor and remain available. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/15/24 at 10:08 AM, the LNHA stated that LPN/UM #4 had not conveyed any concerns to her regarding Resident #173. The LNHA reconfirmed that no reportable events or investigations were completed for the resident. The Director of Nursing (DON), who was present, stated that while no abuse allegation was made, the SW mentioned to the DON that the resident did not want to follow the NP's recommendations. The DON stated that the Director of Social Services (DSS) came to me last week and stated that, The resident did not want to follow the recommendations of the Nurse Practitioner because he/she has been told what to do all of his/her life and did not want to be told what to do. The DON stated that if abuse were suspected, then it would be reported immediately. At that time, the SW who was present, stated that she did not recall who informed her of a need to speak with Resident #173, and she did not think that it was LPN/UM #4. The SW stated that she was not informed that the resident felt abused prior to seeing the resident. The SW stated that the resident chose not to follow the plan of care or recommendations or abide by their Care Plan. The SW stated the resident was calm and just wanted to do things on their terms and understood the potential risks or dangers of not following medications as prescribed and wanted to do things on their terms as his/her responsible party. At that time, the DON stated that LPN/UM #4 should have reported to him or the LNHA and we should have followed the protocol to report to the Department of Health after an investigation within five days. The DON stated, None of that has been done. The LNHA stated, We will report it now, since we were just made aware. A review of an undated facility policy, Recognizing Signs and Symptoms of Abuse/Neglect revealed the following: All types of resident abuse, neglect, exploitation or misappropriation of resident property are strictly prohibited. All personnel are expected to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services immediately. A review of a facility policy, Accidents and Incidents-Investigating and Reporting dated revised July 2017 revealed the following: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. .The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the director of nursing services within 24 hours of the incident or accident. The director of nursing services shall ensure that the administrator receives a copy of the Report of Incident/Accidents for each occurrence . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-9.4(f)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 48781 Based on interview and record review, it was determined that the facility failed to complete a Tracking Record (Discharge) Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, for 2 of 38 residents (Resident #108 and Resident #406) reviewed for resident assessments. The deficient practice was evidenced by the following: 1. On 10/11/24 at 1:00 PM, the surveyor completed record review of Resident #108 specific to MDS assessment. Resident #108 was discharged to home on 9/10/24. The Discharge Return Not Anticipated/End of PPS Part A Stay MDS was completed on 10/11/24. The discharge MDS was 17 days overdue. 2. On 10/11/24 at 3:00 PM, the surveyor completed record review of Resident #406 specific to MDS assessment. Resident #406 was discharged to the hospital on 7/9/24. The Discharge Return Anticipated MDS was completed on 8/2/24. The discharge MDS was 10 days overdue. Resident #406 was discharged to the hospital on 7/15/24. The Discharge Return Anticipated MDS was completed on 8/2/24. The discharge MDS was four days overdue. Resident #406 was discharged to the hospital on 8/9/24. The Discharge Return Anticipated/End of PPS Part A Stay MDS was completed on 8/28/24. The discharge MDS was five days overdue. Resident #406 was discharged to the hospital on 8/20/24. The Discharge Return Anticipated/End of PPS Part A Stay MDS was completed on 9/12/24. The discharge MDS was nine days overdue. On 10/15/24 at 10:36 AM, the surveyor interviewed the MDS Coordinator, License Practical Nurse (LPN), who has been working in the facility for almost four years. The MDS Coordinator stated, The MDSs get completed on the 14th day, which we try to do. We were behind on completing the MDSs because we had many admissions and discharges. The discharge MDSs for those two residents, yes, they're discharges were all completed late. On 10/15/24 at 12:25 PM, the MDS Coordinator provided the surveyor with the MDS Validation Reports from the Centers for Medicare and Medicaid Services (CMS) data base, which revealed the 9/10/24, 7/9/24, 7/15/24, 8/9/24, and 8/20/24 discharge MDS assessments were all completed late. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 1:50 PM, the surveyor in the presence of the Federal surveyor discussed with the facility administrative staff: Regional Director of Clinical Services (RDCS), License Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Director of Operations (RDO), regarding the concerns with the late MDSs completion. The RDO, who was the previous LNHA acknowledged, I do not recall how long the problem has been, but I know that this was an issue. The surveyor informed the administrative staff that the CMS validation reports verified the late MDSs. A review of the most current facility Policy and Procedure titled MDS Completion and Submission Timeframes, revised in October 2023 revealed, 'Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. NJAC 8:39 - 11.1

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities 43308 Based on interviews, record review, and review of pertinent facility documentation it was determined that the facility failed to accurately complete a Preadmission Screening and Resident Review (PASARR) to ensure the resident was referred to the appropriate state-designated authority for level II PASARR evaluation and determination. This deficient practice was identified for one (1) of 1 resident (Resident #97) reviewed for level II PASARR and was evidenced by the following: On 10/15/24 at 10:08 AM, the surveyor reviewed the electronic medical record for Resident #97. A review of the Admission Record face sheet (an admission summary) reflected that the resident had diagnosis that included, intellectual disability, schizophrenia and generalized anxiety. A review of the PASARR level I Screening Tool dated 2/7/24 and signed by the facility's social worker (SW), indicated the following: Section II - Mental Illness Screen showed the resident had diagnosis or evidence of a major mental illness and the screen was negative. Section II- Intellectual Disability/Developmental Disability/Related Conditions Screen (ID/DD/RC) indicated a positive screening, which required a level II PASARR to be completed. Step 2: Determine Final Level I Screening Outcome revealed a positive screening and to refer to Division of Development Disabilities (DDD). Section VIII - PASRR level Screening Outcome and Certification of Screening Professional Completing Level I form revealed a negative screen: admit to nursing facility (NF). A review of the Notice of Referral for Level II Preadmission Screening and Resident Review (PASARR) Evaluation dated and signed on 2/7/24 by the SW reflected a referral was made for a level II PASARR evaluation and determination for placement in a Medicaid certified nursing facility. Further review of the EMR revealed there was no evidence of a level II PASARR was completed. On 10/15/24 at 10:29 AM, the surveyor interviewed the SW and the Director of Social Work (DSW). The DSW stated that their role regarding the PASARR included that upon admission the PASARR was uploaded into the electronic medical record (EMR) and that she kept a spreadsheet to ensure she had one for every resident. She further stated that she reviewed the PASSARs, updated the PASSAR's every year, and then uploaded them into the EMR. The DSW explained if the resident came from the hospital and was in subacute rehab and had a positive level I and level II it would be a part of the admission records. She further explained if the resident was in long term care she would review the level I and level II and they would update the PASARR every year. When asked about Resident #97's negative level I and the notification for referral for level II PASARR evaluation completed by the SW on 2/7/24. Both the SW and the DSW stated they would need to review it and then they could provide the clarification for the negative level I and notice of referral for level II. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 11:00 AM, the DSW provided the level I PASARR and stated that it was corrected to reflect a positive level I. When asked about the referral of the notification for the level II and was a level II completed, the DSW stated she would have to look into it. During an interview with the surveyor on 10/15/24 at 11:17 AM, the DSW stated the full level II application will not be completed until Thursday 10/17/24 by the psychiatrist and then it would be filled out and submitted that day. When asked when it should be completed? The DSW stated she would have to get the answer from the regional SW to see when the level II should be completed. The DSW confirmed the resident had a positive level I screening and a level II should have been completed prior to surveyor inquiry. On 10/15/24 at 11:20 AM, the DSW provided another level I PASARR. At that time, the DSW stated that the level I that was originally in the EMR was uploaded by error and that it was modified and the second copy she provided was accurate of the positive PASARR. When asked for the clarification on Section II a positive screening but the outcome of level I was negative. The DSW stated that she would get clarifications on the PASARR. On 10/15/24 at 11:30 AM, the SW provided a third copy of the level I PASARR. At that time, the SW stated that she just modified the level I PASARR in the EMR. She stated that she would have to speak to the supervisor to see when the positive screening should have been reflected on the level I and after the notification of the referral for level II when the level II should be completed. During a follow up interview with the DSW on 10/15/24 at 12:01 PM, the DSW stated once the notification of referral was submitted then the state would review it and complete the level II. She was unable to speak on when they should follow up if there was no response for the completion of the level II. The DSW emphasized the resident would have the level II completed and acknowledged it should have been completed prior to surveyor inquiry. On 10/15/24 at 4:51 PM, the Licensed Nursing Home Administrator (LNHA) stated in the presence of the [NAME] President of Clinical (VPCS), Regional Director of Clinical Services (RDCS), the Regional Director of Operations (RDO), Director of Nursing (DON) and the survey team the expectation was that the level II would be completed prior to admitting the resident. The LNHA acknowledged that the level II PASARR should have been completed. A review of the facility's policy Admission Criteria revised March 2019, included 8b. If the level I screen indicates that the individual may meet the criteria for a MD [mental disorder], ID [intellectual disabilities], or RD [related disorders, he or she is referred to the state PASARR representative for the level II (evaluation and determination) screening process. 8d. The state PASARR representative provides a copy of the report to the facility. NJAC 8:39-11.2(i), 27.1(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40041 Based on observation, interview, record review, and review of pertinent facility documents, it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives, timelines, and interventions to meet resident's psychological needs specifically by failing to implement a care plan for a resident diagnosed with anxiety on admission. The deficient practice was identified for 1 of 6 residents (Resident #167) reviewed for unnecessary medication. This deficient practice was evidenced by the following: On 10/8/2024 at 9:31 AM, during the initial tour, the surveyor observed Resident #167 in their room. A review of Resident 167's Admission Record face sheet (an admission summary) revealed that they had a diagnosis that included but not limited to; major depressive disorder, bipolar disorder, and generalized anxiety disorder. A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 9/5/2024, under Section I- revealed an active diagnosis of anxiety. A review of the physician orders (PO) revealed the following: lorazepam (a medication used to treat anxiety) oral tablet 0.5 milligrams (mg), Give one (1) tablet by mouth every six (6) hours as needed for anxiety. A review of the Individualized Comprehensive Care Plan (ICCP) did not include a focus area and interventions that addressed that Resident #167 had anxiety. During an interview with the surveyor on 10/15/24 at 12:28 PM, the Director of Nursing (DON) stated that if a resident had a diagnosis of anxiety and was being treated for it, he would expect it to be on the resident's care plan. A review of the facility's policy titled Care Plans, Comprehensive Person Centered, date revised March 2022, revealed, 7. The Comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, metal, and psychosocial well-being . NJAC 8:39-11.2

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41072 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to revise a resident's individualized comprehensive care plan (ICCP) related to smoking for 3 of 6 residents (Resident #73, #102 and #198) reviewed for accidents. This deficient practice was evidenced by the following: 1.) On 10/9/24 at 1:52 PM, the surveyor observed Resident #102, awake and alert, sitting in a chair at a table in the outside smoking patio. The surveyor observed a red pack of cigarettes with a black lighter on top of the pack of cigarettes on the patio table. The resident confirmed the cigarettes and lighter were his/hers and that he/she did not use a smoking apron anymore. Resident #102 further stated that he/she can come out to smoke anytime between 8:00 AM and 8:00 PM, and there was no supervision by the staff. Resident #102 stated that they kept their cigarettes in the drawer in their room. A review of the Admission Record face sheet (an admission summary) reflected that Resident #102 was admitted to the facility with diagnoses which included, but were not limited to, Parkinsons Disease (a disorder of the central nervous system that affects movement, often tremors), chronic pain syndrome, chronic obstructive pulmonary disease, and muscle weakness. A review of the annual comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate resident care, dated 03/01/24, revealed a Brief Interview for Mental Status score of 14 out of 15, which indicated the resident's cognition was intact and currently used tobacco. A review of the Smoking Safety Evaluation, dated 9/2/24, revealed that Resident #102 was able to smoke independently, follow facility policy, and safely secure all smoking materials in their room. The interventions included: I will adhere to the facility smoking policy through the review date, that for my safety the facility will store my nicotine products and my lighter, and the facility will store my lighter and cigarettes for safety reasons. The interventions did not include a smoking apron was needed. A review of Resident #102's ICCP, with revision date of 9/2/24, included a focus area of I smoke cigarettes, with interventions that included: I understand that for my safety, the facility will store my nicotine products and my lighter, I understand that the facility will store my lighter and cigarettes for safety reasons, I am able to smoke safely independently (initiated 06/08/24), and I use a smoking apron (initiated 05/22/24). 41260 2.) On 10/9/24 at 1:35 PM, the surveyor observed Resident #198 outside smoking in the smoking area. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/9/24 at 1:46 PM, the surveyor observed Resident #198 return to his/her room. At that time, the resident stated he/she had been smoking since admission to the facility and kept smoking materials in his/her bedside drawer. The surveyor observed three boxes of cigarettes in a brown bag on the resident's chair and the resident patted his/her pocket when the surveyor asked where he/she kept the lighter. A review of the most recent admission Minimum Data Set (MDS), an assessment tool, dated 9/12/24, included the resident had a Brief Interview for Mental Status score of 13 out of 15, which indicated the resident's cognition was intact. A review of the resident's Smoking Safety Evaluation, dated 9/19/24, included the resident smoked and two conflicting interventions that the resident was to store all smoking materials in my room, and that, the facility will safely secure all smoking materials. A review of the resident's ICCP included a focus, created 9/19/24, of I smoke, with two conflicting interventions: store all smoking materials in my room, and that, the facility will safely secure all smoking materials. During an interview with the surveyor on 10/15/24 at 11:53 AM, Certified Nursing Assistant (CNA) #2 stated she was made aware of the smokers on her assignment through verbal report. The CNA further stated that residents should not have smoking materials in their rooms and that smoking materials were locked up by the nurse. During an interview with the surveyor on 10/15/24 at 12:01 PM, Licensed Practical Nurse (LPN) #4 stated that the Smoking Safety Evaluation determined if a resident was allowed to keep smoking materials in their room. The LPN further stated that all nurses were responsible for reviewing and revising the resident care plans so that all staff would know the resident's current status. During an interview with the surveyor on 10/15/24 at 12:26 PM, the Registered Nurse/Unit Manager (RN/UM) stated that residents who smoke were assessed upon admission to determine whether the resident could hold onto their own smoking materials or if smoking materials would be kept by the facility. The RN/UM further stated that the nurses were responsible for reviewing and revising the resident care plans to reflect the most current information about the resident. When asked about Resident #198, the RN/UM stated that the resident kept his/her own smoking materials in his/her room. At that time, the surveyor reviewed the resident's ICCP with the RN/UM and asked how someone reading the ICCP would know where the resident's smoking materials should be kept. The RN/UM stated, You wouldn't. The Care Plan would have to be clarified. The RN/UM further stated it was important to accurately document where the resident's smoking materials should be kept to make sure the residents are safe. 43308 3.) On 10/9/24 at 11:31 AM, the surveyor observed Resident #73 lying in bed, resting with their eyes closed. A review of the Admission Record reflected that the resident had diagnoses that included, diabetes, high cholesterol, and tobacco use. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, dated 10/6/24, included the resident had a Brief Interview for Mental Status score of 7 out of 15, which indicated a severely impaired cognition. A review of the resident's Smoking Safety Evaluation, dated 10/8/24, included, the resident smoked, and two conflicting interventions that the resident was to store all smoking materials in my room, and that, the facility will safely secure all smoking materials. A review of the resident's ICCP included a focus, revised 7/8/24, of I smoke with two conflicting interventions: I am able to smoke independently and store all smoking materials in my room, and that, for my safety, the facility will safely secure all smoking materials. During an interview with the surveyor on 10/9/24 at 12:00 PM, LPN #8 stated that she worked per diem but was given report that the resident was a smoker and generally went out to smoke after lunch. LPN #8 stated that the cigarette pack was kept in the medication cart. At that time, she looked in the medication cart and showed the surveyor the pack of cigarettes. When asked where the lighter was kept, LPN #8 stated she was not sure who kept the lighter. During an interview with the surveyor on 10/9/24 at 12:03 PM, CNA #9 stated the resident was a smoker and generally smoked in the afternoon. CNA #9 stated the nurse kept the cigarettes and the lighter and that the aide went out with the resident to the courtyard when he/she wanted to smoke. She further stated the resident did not need an apron they were just supervised. During an interview with the surveyor on 10/9/24 at 12:09 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM #2) stated the resident was a smoker. LPN/UM #2 further stated that the cigarettes and the lighter were kept in the medication cart. During a follow up interview with the surveyor on 10/15/24 at 2:17 PM, LPN/UM #2 stated she was responsible for completing the ICCP to ensure that it was done. She further stated that anyone could do it, but it was her responsibility. LPN/UM #2 stated the care plan was updated quarterly and as needed. She explained the care plan was generally discussed during the care conference which was done quarterly and anything new would be updated on the ICCP. LPN/UM #2 stated that if things were contradicting on the ICCP, she would try to review it and resolve it. On 10/15/24 at 2:20 PM, LPN/UM #2 reviewed the ICCP in the electronic medical record (EMR) and stated that the resident was not on the west unit at that time the ICCP was created. She stated because the resident was on the memory care unit which had wandering residents, she wanted the cigerrettes and the lighter to be stored on the medication cart. She further stated that she updated the ICCP to include that all items were stored at the nurse's station. Further review of the ICCP, reflected it was revised on 10/14/24 by the Director of Nursing (DON) and LPN/UM #2 to include intervention I am able to smoke with supervision, and store all smoking materials at the nurse's station after surveyor's inquiry on 10/9/24. During an interview with the surveyor on 10/15/24 at 4:20 PM, in the presence of the survey team, the Director of Nursing (DON) stated that the smoking care plan was auto populated by the responses on the Smoking Safety Evaluation and that any conflicting interventions should have been corrected the next day by nursing management. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Care Plans, Comprehensive Person-Centered policy, revised 03/2022, included, Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. NJAC 8:39-27.1(a)

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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. 40041 Complaint #: NJ176224 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) a resident was assessed by a Registered Nurse (RN) after sustaining a fall and b.) a resident was evaluated by a physical therapist as per a physician's order. This deficient practice was evidenced for 1 of 6 residents (Resident #305) reviewed for accidents and 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 review of the Admission Record (an admission summary) reflected Resident #305 was admitted to the facility with diagnoses which included, but not limited to; seizures, muscle wasting and atrophy, hemiplegia and hemiparesis, and legal blindness. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 1/20/24, revealed that Resident #305 had a Brief Interview for Mental Status (BIMS) of 12 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the MDS included in Section GG-Functional Abilities and Goals that the resident required partial assistance with activities of daily living (ADLs). A review of the individualized comprehensive care plan (ICCP), initiated on 11/6/23, included a focus area of I am at risk for falls related to impaired mobility, unsteady gait, weakness. Interventions included: Create a safe environment. A review of the facilty's Full QA (quality assurance) Report revealed, on 12/20/23 at 10:00 AM, Resident #305 sustained a fall during a transfer from the bed to the wheelchair. CNA #13 reported, I was transferring the patient and as [he/she] got in the chair, the cushion [he/she] has on the chair slide making [him/her] slide and I assisted as [he/she] slide to the floor . There was no evidence that a Registered Nurse (RN) assessed Resident #305 after the fall on 12/20/23. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Nurse Practitioner's (NP) progress note, dated 12/21/23 at 6:32 PM, revealed, the NP assessed the resident and recommneded a follow-up with Physical Therapy (PT) for chair safety. There was no evidence that Resident #305 was evaluated by PT as recommended by the NP. During an interview with the surveyor on 10/15/24 at 11:09 AM, the Licensed Nursing Home Administrator (LNHA) confirmed that the PT evaluation was not done. When asked if it should have been done as per the NP's recommendation, she replied, yes. During an interview with the surveyor on 10/15/24 at 12:26 PM, the Director of Nursing (DON) stated that their process was after a PO was written then PT would be notified that the resident needed to be evaluated. During an interview with the surveyor on 10/16/24 at 10:27 AM, the DON stated, yes, an RN assessment was conducted after the fall on 12/20/23. A review of an undated facility policy Investigating Resident Injuries revealed, 1. The director of nursing services or a designee assesses all resident injuries and documents findings in the medical record.6. The medical director or attending physician shall review and verify conclusions about the possibility of a medical or other similar cause of the findings. NJAC 8:39-27.1(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37547 Complaint #: NJ177592 Based on interview, record review, and a review of other pertinent documentation, it was determined that the facility failed to ensure that the appropriate care was provided with no delay in treatment for a.) a resident who had a change in condition, with left lower extremity swelling and bruising, suspected DeepVein Thrombosis (DVT, blood clot) received a STAT (immediate) venous doppler (diagnostic test to rule out DVT) in a timely manner before being transferred to the hospital with emergency services, and b.) a resident who had a change in condition and experienced nausea, weight loss, and indigestion was rescheduled for an outpatient CT scan (x-ray image) in a timely manner in accordance with professional standards of nursing practice. This deficient practice was identified for 1 of 1 resident (Resident #255) reviewed for a change in condition and 1 of 5 residents (Resident #7) reviewed for nutrition. This deficient practice was 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. 1.) A review of Resident #255's Admission Record face sheet (an admission summary), revealed that the resident was admitted to the facility with diagnosis which included but were not limited to; Fusion of spine, lumbar region (lower spine), thoracic region (middle spine), hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness), and glaucoma (a group of eye conditions which can cause blindness), and a history of falling. A review of Resident #255's comprehensive Minimum Data Set (MDS), an assessment tool, dated 09/23/24 revealed that the resident's Brief Interview for Mental Status (BIMS) score was 15 out of 15, and indicated that the resident was fully cognitively intact. The remainder of the MDS was still in progress and was not able to be viewed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #255's individualized comprehensive Care Plan (ICCP) revealed an entry with a Focus of: I have impaired skin integrity related to unspecified, Goal: I will be at reduced risk for new or worsened impaired skin integrity daily through the review date. Interventions included: Monitor for new or worsening signs and symptoms of complications and infection: erythema (redness), warmth, edema (swelling), . pain/tenderness, fever/chills, etc. Report to physician if noted and follow-up as indicated; and Obtain and monitor lab/diagnostic (testing) work as ordered. Report results to physician and RN (Registered Nurse)/LPN (Licensed Practical Nurse) follow-up as indicated. A review of Resident #255's Order Summary Report revealed an order written on 9/23/24 for a STAT left leg venous doppler r/o DVT on 09/23. A review of a Nurse Practitioner (NP) Note within Resident #255's Progress Notes revealed an entry dated 9/23/24 at 11:38 AM, written by Nurse Practitioner #2 indicated: This patient is being seen per nursing request. Per nursing the patient left leg is having some increased swelling and bruising. Patient is seen today in bed .reports increased swelling to his/her left leg. He/She reports this was noticed yesterday by his/her responsible party. The patient denies change in gait (walking). The patient denies sob (shortness of breath) or palpitations. Further review of the Nurse Practitioner Note revealed interventions which included: Spinal Fusion: ordered stat left leg venous doppler to r/o dvt .Plan: Nursing: POC (plan of care) reviewed with nursing . A review of a Health Status Note entry written by Licensed Practical Nurse/Unit Manager (LPN/UM) #1, dated 09/23/24 at 6:01 PM revealed, Resident has chills and reports not feeling well (Imaging Company name redacted) has not done STAT doppler for likely DVT. LLE notably warm to touch with swelling. (Responsible Party) at bedside requesting 911 transfer. NP made aware. 911 dispatched at 5:55 pm. A review of an SBAR (Situation, Background, Assessment, Recommendation) note written by LPN/UM #1 at 19:01 (7:01 PM) revealed: Situation: DVt [sic.] likely to LLE, Background: recent spinal fusion, Assessment: LLE swelling warm to touch, Recommendation: send to ER for eval and tx (treatment), Response: 911 per (responsible party) request. Further review of the EHR revealed that there was no documented evidence that the facility contacted the hospital to provide or receive a clinical update on the resident's condition and disposition. A review of a New Jersey Universal Transfer Form (a form that communicates pertinent, accurate clinical patient care information at the time of transfer between the health care facilities) indicated that the time of transfer was on 09/23/24 at 7:00 PM. The resident's code status (desired preference for resuscitation if indicated), reason for transfer (must include brief medical history and recent changes in physical function or cognition), Primary Diagnosis, Secondary Diagnosis, and Skin Condition sections of the form were not filled in as required to alert the receiving facility of the resident's clinical status at the time of transfer to a higher level of care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/09/24 at 11:01 AM, LPN/UM #1 stated that she believed that Resident #255 had a DVT in his/her leg. LPN/UM #1 stated that the NP put the order in for the STAT doppler in the computer. LPN/UM #1 stated that she reached out to the third party imaging company via the portal, faxed a face sheet (an Admission Record) and called the company. LPN/UM #1 stated that when she called the company for an ETA (estimated time of arrival) they could not give me one, they stated within three hours, not a specific ETA. LPN/UM #1 stated that the order was time stamped and confirmed by me at 11:48 AM. LPN/UM #1 stated that she would have contacted the imaging company by phone around 12:00 PM or 12:15 PM, and an ETA was not available. LPN/UM #1 stated that around 5:00 PM or 6:00 PM, she called the imaging company back and they said the wait time was 90 minutes. LPN/UM #1 stated that the resident's responsible party arrived and did not want to wait. LPN/UM #1 stated that the imaging company arrived about 20 minutes after the resident was sent to the hospital. At that time, LPN/UM #1 further stated Resident #255 .complained of warmth and pain earlier in the day, and at around 5:00 PM, then it got more swollen and tender and was a little bit more warm. LPN/UM #1 stated, The resident did have a DVT, a large blood clot in the right leg, confirmed by the hospital to myself. The surveyor asked why the residents's change in status and confirmed hospital diagnosis were not documented in the resident's medical record? LPN/UM #1 stated that if we do not document in the EHR, then we were required to do a status update note. The surveyor requested that LPN/UM #1 review the resident's EHR and demonstrate where the documentation was charted. LPN/UM #1 stated, It does not appear that there was one in here. LPN/Um #1 stated that she did a follow up with the hospital just to see where the resident was at and put the orders on hold and admissions discharged the resident out of the system once confirmed. LPN/UM #1 stated that night shift called the hospital to confirm resident status and then I called the next morning. LPN/UM #1 stated, Both the night shift and myself should have documented the call to the hospital and the resident' status. At that time, LPN/UM #1 further stated that if we have a STAT order, it was expected to be completed within an hour or two, and give grace up until about three hours. LPN/UM #1 stated that the NP was notified of the delay, and she stated that it would be okay if it were not done by the end of the night then the resident would need to go out for evaluation. LPN/UM #1 stated, I did not document that conversation anywhere. During an interview with the surveyor on 10/09/24 at 11:43 AM, the Nurse Practitioner (NP) #1 stated that she was contracted to work at the facility since March or April of 2024. When the surveyor asked NP #2 about the process for ordering a STAT doppler she stated, They do not do STAT dopplers here. We found that out after we ordered it. NP #2 stated that she followed up when it was not ordered by the evening time, and sent the resident out to the hospital. NP #2 stated that she was informed by the Director of Nursing (DON) that the imaging company does to do STAT ultrasounds. NP #2 confirmed that Resident ##255 was admitted to the hospital with a DVT. NP #3 who was present at that time, stated that we attended a Return to Hospital Meeting to see if there was anything we could have done better, with root cause analysis, then we learned the resident was admitted with a DVT. NP #1 stated that we did not realize that they do not do the order STAT. NP #1 stated that nursing notified me that the imaging company was not coming and the resident's family wanted the resident sent out. NP #2 stated that it was up to the facility and their protocol for nursing to document the conversation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/11/24 at 10:44 AM, the Director of Nursing (DON) stated that when an order was placed for STAT diagnostic test nursing acknowledged the order and notified the provider. The DON stated that for a STAT doppler the company usually lets us know how expeditiously they can or can not come. He stated that was contingent upon the clinical picture of the patient. The DON further stated, generally within four hours was an acceptable wait time. The DON stated that if the provider can not get here within four hours, we let the health care provider know and they make further recommendations. At that time, the DON further stated that the New Jersey Universal Transfer form should be completed and sent with the resident, and we also called report to the ER (emergency room) to advise of the reason for transfer. The DON stated that he would have expect for the nurses to do it and document it. The DON stated that he would expect the nurse to do a pain assessment and document in a narrative note or on the pain assessment sheet. The DON stated that we usually called the hospital and documented the outcome in the clinical record. 2. During the initial tour of the facility on 10/08/24 at 11:53 AM, the surveyor observed Resident #7 lying in bed awake. The resident expressed concern regarding transportation and stated that he/she was unable to eat and had missed four appointments for diagnostic testing related to transport. The resident still had their breakfast tray in front of them that was untouched. The resident stated I have no appetite and they are giving me nutritional supplements (a liquid nutritional drink). A review of Resident #7's Admission Record, an admission summary, revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: Unspecified protein calorie malnutrition, abnormal weight loss, and age-related cognitive decline. A review of Resident #7's most recent Quarterly Minimum Data Set (MDS), an assessment tool, dated 10/01/24 revealed that the resident had a Brief Interview for Mental Status score of 15 out of 15, which indicated that the resident was fully cognitively intact. Review of Section K0300 Swallowing /Nutritional Status revealed that the resident had an identified weight loss of 5% or more in the last month or loss of 10% or more in the last six months. A review of Resident #7's Order Summary Report revealed an order dated 07/15/24: Please have patient set up for outpatient CT scan of abdomen without contrast due to nausea/weight loss/indigestion. A review of a Nurse Practitioner Note dated 07/12/24 at 13:26 (1:36 PM) that was written by Nurse Practitioner (NP) # 2 documented .pending CT abdomen without contrast due to nausea/weightloss/indigestion, reviewed GI (Gastroenterologist) recommendations, recommending GI scope in 3 months-patient is currently refusing scope . Further review of Resident #7's Electronic Health Record (EHR) revealed a Nurse Practitioner Note dated 07/25/24 at 11:12 AM, which detailed: .Interventions: .GERD (gastroesophogeal reflux disease)/nausea: ordered npo (nothing permitted orally) after 12 am on 08/07 for ct of abdomen, pending CT abdomen without contrast due to nausea/weight loss/indigestion . Further review of Resident #7's EHR revealed a Health Status Note dated 08/08/24 at 13:53 (1:53 PM) which indicated: Patient as unable to go for CT scan due to transport having wrong address. Pt and Scheduler made aware. Pt will be rescheduled. No orders at this time. Care ongoing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #7's EHR revealed an Acknowledgement note dated 08/23/24 at 8:40 AM, that was written by Unit Clerk (UC) #1 and indicated, unit clerk received a call from .radiology stating they needed a new scrip faxed over. Notified NP .Update was made Trip confirmation #50807. Further review of Resident #7's EHR revealed a Health Status Note dated 08/28/24 at 3:37 PM which indicated, Transport arrived to escort resident to CT scan appointment, appointment scheduled for 10 am, transportation stated they could not sit with resident until scheduled appointment.radiology stated that pt needed to drink contrast prior to arriving. Transport stated they could not take resident at present time and a new ride needed to be scheduled. Further review of Resident #7's EHR revealed a Nurse Practitioner Note dated 08/30/24 22:14 (10:14 PM) which indicated .Interventions: GERD: , on 9/9 pending ct scan of abdomen, pending upper gi scope. Further review of Resident #7's EHR revealed a Nurse Practitioner Note dated 09/09/24 at 8:30 AM, which indicated: .The patient would like to know when he/she will have outpatient ct scan. The patient had outpatient GI evaluation and EGD (esophagogastroduodenoscopy, procedure to examine the upper part of the gastrointestinal tract) was recommended. The patient does not want to do EGD. The patient reports ongoing poor po (oral) intake, indigestion, denies nausea/vomiting. Further review of Resident #7's EHR revealed a Nurse Practitioner Note dated 10/09/24 at 2:20 PM which indicated: .GERD: pending outpatient ct can of abdomen, pending upper gi scope. No current symptoms or distress on today's exam . During an interview with the surveyor on 10/09/24 at 11:30 AM, UC #1 stated that Resident #7 had a few issues with missed appointments which were not transportation related. UC #1 stated that Resident #7 was scheduled for a CT Scan and nursing was confused as to why the appointment was scheduled two hours early to allow for the resident to complete the test prep (oral contrast given prior to CT Scan) and the nurse sent the driver away. UC #1 stated that she was no longer assigned to that unit and was unsure if the CT scan was not rescheduled. During an interview with the surveyor on 10/09/24 at 11:39 AM, UC #2 stated that she has not set up transportation for Resident #7, and would need to follow up. During an interview with the surveyor on 10/09/24 at 11:59 AM, NP #2 stated that she ordered a CT Scan for Resident #7 and they came, but the resident did not make it out to the appointment. When the surveyor asked if she had a responsibility to follow up and ensure that the CT scan was completed? NP #2 stated, The facility would handle it. NP #3 was present at that time and stated, We write the prescription and the staff handled it from there. During an interview with the surveyor on 10/09/24 at 12:05 PM, Licensed Practical Nurse (LPN) #4 stated that she reviewed Resident #7's Progress Notes for nurse communication and there were no notes about missed transport for a scheduled CT Scan. LPN #4 further stated that there was an order for a CT on 07/15/24, re: nausea and weight loss, but there were no results in the system to show it was done. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Brook Rehabilitation and Healthcare Center	3718 Church Road Mount Laurel, NJ 08054

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/09/24 at 1:12 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) # 4 stated that there must have been a miscommunication because the Unit Clerk sets the pick up time, and she did not alert the nurse of a need to get the prep done. He stated that we should have rescheduled the CT scan for another day and the NP should have been notified. LPN/UM #4 stated, That is a delay, we have to rectify it, and set it up for him/her. A review of Resident #7's EHR revealed an Acknowledgement note dated 10/09/24 at 14:30 (2:30 PM) that specified: .CT scan of adomen [sic.] w/o (without) contrast .Aide needs to be present. Will f/u (follow up) with transport. A second Acknowledgement note dated 10/09/24 at 14:32 (2:32 PM) indicated: .Appt. 10/31 @ 11 am. Needs to be there 2 1/2 hours early to drink solution . The surveyor noted that the appointment for CT Scan was rescheduled after surveyor inquiry. During an interview with the surveyor on 10/15/24 at 11:02 AM, the Director of Nursing (DON) stated that when a CT Scan was ordered the nurse verified the order and the information was given to our scheduler to schedule it. Then we implement the diagnostic and verify that transportation was ordered and they can accommodate the resident. If transport were unable to take the resident, we notify the provider and attempt to reschedule. The DON stated that if it were missed, we typically verify through a chart check or documentation. The DON stated there was a responsibility on the provider to follow up and see if it were done. The DON stated that it should have been documented in a progress note. The DON stated that we have not identified the etiology of the cause of why the CT Scan was not reordered. A review of an undated facility policy, Request for Diagnostic Services revealed the following: .Orders for diagnostic services will be promptly carried out as instructed by the physician's order. Emergency requests must be labeled stat to assure that prompt action is taken. A review of the facility policy, Lab and Diagnostic Test Results-Clinical Protocol (Revision November 2018) revealed the following: The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory, diagnostic radiology provider, or other testing source will report results to the facility. .A nurse will identify the urgency communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition. A nurse will try to determine whether the test was done: a. As a routine screen or follow-up; b. To assess a condition change or recent onset of signs and symptoms; . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) .The reason for getting a test often affects the urgency of acting upon the result. .Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: Whether the physician has requested to be notified as soon as a result is received. Whether the results should be conveyed to a physician regardless of other circumstances (that is, abnormal result is problematic regardless of any other factors). Whether the resident/patient's clinical status is unclear or he/she has signs and symptoms of acute illness or change and is not stable or improving, or there are not a previous result for comparison. .Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record and not on the lab results report, because test results could be correlated with other relevant information such as the resident's overall situation, current symptoms, advance directives, prognosis, etc. Physician's or nurses who have concerns about how tests have been handled and reported should communicate such concerns to the DON and/or Medical Director. Such concerns or disagreements should not prevent timely, clinically appropriate management of a current result or clinical situation. A review of a facility policy, Alert Charting and Documentation (Adopted November 2023) revealed the following: Services provided to the resident that outline a change in the resident's medical or mental condition, shall be documented in the resident's medical record. .All changes in a resident's status are to be promptly communicated to the physician for further review, evaluation and interventions as appropriate. A review of the facility policy, Transfer or Discharge, Facility-Initiated (Revision October 2022) revealed the following: .Each resident will be permitted to remain in the facility, and not be transferred or discharged unless: the transfer or discharge is necessary for the resident's welfare and the resident's needs can not be met in this facility; .the safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident; .Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge. .All special instructions or precautions for ongoing care, as appropriate such as: .special risks such as risk for falls . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37547 Based on observation, interviews, record review, and review of other pertinent documentation, it was determined that the facility failed to perform and document a skin assessment, obtain a treatment order, and implement timely interventions to prevent the development of a pressure ulcer upon the identification of an alteration in skin integrity for a resident previously identified to be at risk for the development of pressure ulcers. This deficient practice was identified for 1 of 2 residents (Resident #101) reviewed for pressure ulcers. This deficient practice was evidenced by the following: On 10/8/24 at 10:18 AM, during the initial tour of the facility the surveyor observed Resident #101 lying awake in bed with an air mattress motor noted at the foot of the bed. The resident stated that they had a wound on their bottom and did not receive care or pain medicine for the wound in a timely manner when requested during the 11 PM to 7 AM shift. The resident stated that the last incidence occurred three (3) weeks ago when they waited 3 hours. A review of Resident #101's Admission Record face sheet (an admission summary), revealed that the resident had diagnosis which included but were not limited to; pressure ulcer of the sacral (a bone in the lower back) region, morbid obesity, and chronic pain syndrome. A review of Resident #101's annual comprehensive Minimum Data Set (MDS), an assessment tool, dated 9/12/24 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was fully cognitively intact. Further review of the MDS, in Section M Skin Conditions, indicated that the resident was identified to have been at risk for pressure ulcer development but did not have one or more unhealed pressure ulcers. A review of Resident #101's Care Plan revealed an entry dated 9/25/24, with a Focus: I have a Potential for skin breakdown related to diabetes, history of skin breakdown, impaired mobility, incontinence and kidney disease. A Goal of: I will be at reduced risk for skin breakdown daily through the review date. Intervention/Tasks included: .I need reminding/assistance to turn/reposition at least every 2 (two) hours, more often as needed and requested, Notify nurse immediately of skin changes: redness, blisters, bruises, discoloration, etc. noted during care, Monitor for new worsening signs/symptoms of complications or alterations: necrosis (tissue death), erythema (redness), warmth, edema (swelling) exudate (drainage), foul odor, maceration (soften), pain/tenderness, fever, chills, etc. Report to physician if noted and follow-up as indicated. A review of Resident #101's Treatment Administration Record (TAR) revealed a treatment order dated 7/31/24 at 5:00 PM, for calmoseptine external ointment 0.44-20.6% (menthol zinc oxide, a white, solid medicinal ointment) Apply to bilateral-, (both sides) buttocks topically two times a day for skin irritation for three (3)months. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had a wound on their left buttock and received normal saline solution (nss) and medi honey daily. LPN #9 stated that the resident's last skin check was on 10/4/24, which identified that no new skin impairments were identified, and she further stated that the skin check did not entail existing wounds. LPN #9 stated that the wound treatment order for medi honey was documented on the resident's Treatment Administration Record (TAR). When the surveyor asked if she had received complaints of delayed care on the 11PM to 7AM shift she stated, I have received complaints about delayed care on the 11-7 shift in the past two months, but it was getting better. A review of Resident #101's TAR and Physician Order's failed to contain a wound treatment order for NSS and Medihoney daily for treatment of a left buttock wound as previously described by LPN #9. During an interview with the surveyor on 10/10/24 at 12:25 PM, Certified Nursing Assistant (CNA) #10 stated that Resident #101 still had a pressure ulcer on their bottom that came and went. Resident #101 stated that when CNA #10 was there he/she received better care. Resident #101 further stated that CNA #10 placed something beneath him/her to assist the resident with turning off of their bottom. During an interview with the surveyor on 10/10/24 at 12:41 PM, Licensed Practical Nurse/Unit Manager (LPN/UM) # 4 stated that Resident #101 had chronic wounds. He stated that the resident's skin was intact, but periodically opened up. LPN/UM #4 stated that the wound was not opened now. LPN/UM #4 stated that the resident was only ordered zinc oxide and no other wound treatment was in place. The surveyor relayed that CNA #10 reported that Resident #101 still had a pressure ulcer on their bottom. LPN/UM #4 stated, I have to look at it. LPN/UM #4 further stated that the resident had the potential, but his/her skin was intact. A review of Resident #101's Skin Assessments dated 10/04/24 and 10/11/24 revealed that the resident had no documented skin impairments. During an interview with the surveyor on 10/15/24 at 9:49 AM, LPN/UM #4 agreed to assess Resident #101's buttocks/sacral area with resident permission in the presence of the surveyor. Certified Nursing Assistant (CNA) #11 assisted LPN/UM #4 to turn the resident onto his/her side. At that time, the surveyor observed that the resident's buttocks had a thick white substance on it, and there was an opened area on the gluteal cleft (the deep midline groove in the gluteal region). CNA #11 stated that the resident's wound opened on Sunday and she alerted the nurse. CNA #11 stated, The nurse looked at it, and stated that it was not as bad as she thought. LPN/UM #4 stated, It was a superficial opening, a chronic wound. The resident stated that he/she was last changed at 5:00 AM. CNA #11 stated that the resident was a heavy wetter and should have been changed every two hours, but she had not gotten to change or turn the resident yet, since 7:00 AM. LPN/UM #4 stated, The resident should have been changed every two hours. LPN/UM #4 further stated, The nurse should have done a skin assessment and a risk assessment should have been completed. During an interview with the surveyor on 10/15/24 at 10:04 AM, LPN #10 confirmed that she was assigned to Resident #101 and had not received a report of skin breakdown on the resident this morning. LPN #10 stated that the supervisor should have been notified of skin breakdown, a skilled risk management report should have been completed, and a skin assessment should have been completed upon identification of skin breakdown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/15/24 at 10:35 AM, the Director of Nursing (DON) stated that upon identification of a wound or pressure ulcer he would have had the nurse evaluate the area and the information was then relayed to the provider, and a treatment would then be implemented, with a potential referral for a wound care consult. The DON stated that when the aide told the nurse of a wound opening, the nurse should have looked at the affected area and documented it. The DON stated that the LPN/UM should have evaluated the wound as well upon the initial surveyor inquiry. The DON stated that the suggested incontinence care was every two hours and when indicated by the resident. The DON stated that if the resident were last changed at 5 AM, then the resident should have been checked by change of shift, around 7:00 AM, and then checked by 9:00 AM ideally. The DON further stated, The nurse who was notified should have evaluated the area and called the provider for a treatment order. A review of a Health Status Note in Resident #101's Electronic Health Record (EHR) dated 10/15/24 at 18:29 (6:29 PM) revealed, Rounded on resident to assess skin. Pressure Ulcer noted on Coccyx (tail bone) 2.5 (no unit of measurement) x 0.4 (no unit of measurement). Pain and skin assessment completed. Incontinence care provided. Site cleaned with NSS, Medi honey applied, covered with Bordered dressing. MD/Family notification made. Wound Care initiated. A review of an Interim Skin Check dated 10/15/24 revealed that a new skin impairment was identified ., Pressure Injury, Site: Coccyx, Description: Stage 2 (two) (Partial thickness loss of dermis presenting as a shallow, open ulcer with a red or pink wound bed) meas. 2 cm (centimeters) x 0.4, with no additional skin impairments noted. A review of the facility policy, Assessment of Skin Condition and Integrity (March 2021) revealed the following: The purpose of this policy is to provide information regarding the routine assessment of skin integrity. Conduct a comprehensive head-to-toe skin assessment upon admission, weekly, prior to discharge, and as needed. .Inspect the skin daily when performing or assisting with personal care or ADLs (activities of daily living). .Reporting: .Notify physician of new skin alteration (s) noted. Notify family, guardian or resident of new skin alteration (s) noted. Report other information in accordance with facility policy and professional standards of nursing practice. A review of the facility policy, Pressure Ulcers/Skin Breakdown-Clinical Protocol (Revision Date March 2014) revealed the following: Assessment and Recognition: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer (s). In addition, the nurse shall describe and document/report the following: Full assessment of pressure sore including location, stage, length, width, depth, presence of exudates or necrotic tissue; Pain assessment' Resident's mobility status; Current treatments, including support surfaces; and all active diagnosis. .the physician will authorize pertinent orders related to wound treatments, including wound cleansing . dressings, .and application of topical agents if indicated for type of skin alteration. NJAC 8:39-27.1 (a) (b)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40041 Part A: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure their smoking policy interventions were implemented to reduce hazard(s) and risk(s) for residents who smoked tobacco and to ensure resident safety. This deficient practice was identified for 1 of 7 residents reviewed for smoking (Resident #144). On 10/9/24 at 12:27 PM, the surveyor entered Resident #144's room and smelled a cigarette-like smoke scent. The resident was observed lying in bed with the fan on and the window open. At that time, the surveyor interviewed the resident who stated they were not allowed to smoke in their room, but they had to wait for hours for the staff to come into the room to assist them. The resident stated that the staff did not take them out to smoke, so they smoked tobacco in their room. During a follow-up interview with the surveyor on 10/9/24 at 2:19 PM, the resident pulled a lighter out of a red bag to show the surveyor and the resident ignited the flame. Resident #144 stated the facility did not review the smoking policy with them, and acknowledged the last time they smoked in their room was today (10/9/24) at 5:00 AM. During an interview on 10/9/23 at 2:16 PM, the Certified Nursing Assistant (CNA #1), stated that a few months ago she reported to the nurse that she observed the resident holding a lighter and smoking in their room. A review of Resident #144's incident reports revealed that the resident was observed smoking cigarettes in their room on 11/16/23, 1/26/24, and 2/9/24. Interventions included that the individualized comprehensive care plan (ICCP) was updated. The facility's failure to implement the smoking policy for safety to reduce hazard(s) and risk(s) for residents who smoked tobacco posed a likelihood of serious injury, harm, impairment, or death could occur to all residents. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 11/16/23, when Resident #144 was reported to have smoked tobacco in their room. The facility Administration was notified of the IJ on 10/9/24 at 5:13 PM. The facility submitted an acceptable Removal Plan (RP) on 10/10/24 at 9:51 AM. The survey team verified the implementation of the RP during the continuation of the on-site on 10/10/24. The evidence was as follows: A review of the facility's Smoking policy dated revised March 2024, included, 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Smoking is not allowed inside the facility under any circumstances .11. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely and with available levels of support and supervision .13. Residents who have independent smoking privileges are permitted to keep cigarette, electronic cigarettes, pipes, tobacco, and other smoking items in their possession. Only disposable safety lighters are permitted. All other forms of lighters, including matches, are prohibited. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/9/24 at 12:27 PM, the surveyor entered Resident #144's room and smelled a cigarette-like smoke scent. The resident was observed lying in bed with the fan on and the window open. At that time, the surveyor interviewed the resident who stated that they were not allowed to smoke in their room, but they had to wait for hours for the staff to come into the room to assist them. The resident stated that the staff did not take them out to smoke, so they smoked tobacco in their room. On 10/9/24 at 1:15 PM, the surveyor reviewed the medical record of Resident #144. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to; paraplegia, muscle wasting, lack of coordination, major depressive disorder, and tobacco use. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 9/18/24, included the resident had a Brief Interview for Mental Status score of 15 out of 15, which indicated a fully intact cognition. A review of the ICCP included a focus area, dated 5/3/23, for smoking interventions that included: I understand that for my safety, the facility will store my nicotine products and my lighter. The ICCP was updated on 6/12/24, to include the intervention. I am able to smoke independently, follow facility policy, and store all smoking materials in my room. These interventions were added to the ICCP after the resident was discovered smoking in the facility three times. A review of the Full Quality Assurance (QA) Reports (incident report) for Resident #144 revealed the following: On 11/16/23 at 3:00 PM, the Licensed Practical Nurse (LPN) observed the resident smoking in their room. Actions taken included that the resident was re-educated on the smoking policy. On 1/26/24 at 11:00 AM, the resident was noted smoking and the resident admitted to smoking in their room. Actions taken included that the ICCP was updated, and a psychiatric consultation ordered. On 2/9/24 at 9:30 AM, the resident was noted smoking tobacco in their room. Actions taken included local police department was notified, and the resident was educated on safety concerns related to smoking in the room. On 3/12/24 at 12:00 PM, another resident suspected Resident #144 of smoking and called the local police. Actions taken included local police department came to the facility and the resident was re-educated on safety concerns and the smoking policy. On 4/18/24 at 11:00 AM, during rounds, a staff member smelled cigarette smoke coming from resident's room, and towels were observed covering the bottom of the floor. Actions taken included clinical staff were assigned to the unit; monitor for further behaviors; ICCP updated; routine safety checks; and the resident was educated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with the surveyor on 10/9/24 at 1:30 PM, the Director of Nursing (DON) stated that the resident was assessed as an independent smoker and was allowed to hold their cigarettes and lighter. When asked did the resident smoke in their room, the DON stated that the resident informed them that they had smoked in their room. The DON stated the facility had completed several incident reports, called the resident's representative, and they have called the local police because staff reported smelling smoke in the resident's room. During an interview with the surveyor on 10/9/24 at 2:08 PM, CNA #5 stated that she never observed the resident smoking in the facility, but the CNA had smelled tobacco smoke in the resident's room. CNA #5 stated that she often smelled smoke and reported it to the Nursing Supervisor. CNA #5 stated that certain residents were able to keep their smoking materials, but if a resident was a supervised smoker or an independent smoker who was caught smoking in the facility, then the smoking material was kept at the front desk, or the nurse kept it in the narcotic box. CNA #5 stated that the resident probably had smoking material in their possession, but she never saw the resident smoking, she just smelled smoke. CNA #5 stated that the resident was able to transfer themselves out of the bed onto the motorized wheelchair with a one person assist and took themselves outside. She stated that the resident sometimes refused to get out of bed. During an interview with the surveyor on 10/9/24 at 2:16 PM, CNA #1 stated that she was familiar with the resident's smoking habits and stated that she guessed the resident smoked cigarettes because she smelled it in the hallway. CNA #1 stated that visitors had also raised concerns regarding the smell of cigarette smoke in the hallway. When asked if she had ever witnessed the resident smoking in their room, CNA #1 nodded her head, yes. CNA #1 stated that a couple of months ago when she went into the resident's room, she saw the resident holding a lit cigarette in their hand. CNA #1 stated that she reported it to the nurse but could not recall which nurse she reported it to. CNA #1 stated that the staff reported that the resident smoked in their room, but nothing happened after the smoking was reported. She explained that the smoking material was supposed to be kept at the front desk, and when the resident was ready to go outside, staff provided the resident with the smoking materials. CNA #1 stated that the resident used to go outside, but now the resident just laid in the bed and smoked, even though the resident could go outside at any time. During a follow-up interview with the surveyor on 10/9/24 at 2:19 PM, Resident #144 stated that it took one and a half hours to get help just to see what I want. When asked if they smoked, the resident stated, yes, because my nerves get really bad and most of the time I wait until late night to smoke. At that time, the resident pulled a lighter out of a red bag to show the surveyor and ignited the flame. The resident stated that the facility called the local police department on them because they smelled smoke. The resident further stated that the facility did not go over a smoking policy with me and that they do not do anything. The resident stated in the past, the front desk kept their smoking materials, but staff was not getting them out of bed regularly, so they purchased another lighter. Resident #144 stated that the last time they smoked tobacco in the room was on 10/9/24 at 5:00 AM (that morning). The surveyor conducted a telephone interview on 10/16/24 at 8:48 AM, with the Medical Doctor (MD), who stated that he had a problem with Resident #144 smoking since they had been caring for the resident. The MD stated that the resident had been resistant to care and that the staff bend over backward. The MD stated that the facility had done everything to keep the lighter and cigarettes from the resident, and the facility was going to do better with the smoking residents and the other residents. (continued on next page)

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	315524	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Brook Rehabilitation and Healthcare Center	3718 Church Road Mount Laurel, NJ 08054

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An acceptable RP on 10/10/24, indicated the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including the resident was placed on one-to-one (1:1) supervision on 10/9/24 at 3:10 PM; the resident was re-educated on the facility's smoking policy and relinquished their smoking materials; a smoking evaluation was completed; the facility will conduct routine safety rounds in Resident #144's room; and the ICCP was updated. The survey team verified the implementation of the removal plan during the continuation of the on-site survey on 10/10/24. 37547 Part B. The facility further failed to: complete a safe smoking evaluation immediately upon the identification of a change in resident's smoking status. This deficient practice was identified for 1 of 7 residents (Resident #191) reviewed for smoking. This deficient practice was evidenced by the following: 2.) On 10/9/24 at 1:44 PM, the surveyor attempted to meet with Resident #191 who was not in their room. Licensed Practical Nurse (LPN) #10 was present outside of the resident's room and stated that the resident was outside smoking. The surveyor went to the courtyard and observed Resident #191 seated at a table with another resident in the designated smoking area. When interviewed, the resident stated that they only smoked now and then. Resident #191 stated that they had matches and a pack of cigarettes and proceeded to show the surveyor the matches that were stored in a pencil case and a pack of cigarettes that were on the table in front of the resident. The resident stated that there was no smoking allowed inside of the facility. The resident stated that he/she was allowed to keep their smoking materials in their room. There was no smoking attendant in the courtyard at the time of the observation. A review of Resident #191's Admission Record (an admission summary), revealed that the resident was admitted to the facility with diagnosis which included but were not limited to; Fracture of one rib, left side, Fracture of unspecified part of neck of right femur (the bone of the thigh, articulating at the hip and the knee), and emphysema (a lung condition that causes shortness of breath). A review of Resident # 191's Comprehensive Minimum Data Set (MDS), an assessment tool, dated 08/27/24 revealed that the resident's Brief Interview for Mental Status (BIMS) score was 13 out of 15, which indicated that the resident was fully cognitively intact. A review of Section J-Health Conditions indicated that the entry was coded as a 0 or No for Current Tobacco Use. A review of Resident #191's Care Plan failed to identify Resident #191 as a smoker. A review of Resident #191's Admission/Readmission Evaluation Packet dated 8/23/24 at 3:45 PM revealed that the resident Smoking Safety Evaluation and History of Smoking detailed that the resident did not currently smoke or vape. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with the surveyor on 10/9/24 at 1:55 PM, LPN #10 stated that smoking assessments were completed upon admission. LPN #10 reviewed Resident #191's electronic health record (EHR) in the presence of the surveyor and stated that she did not see that a smoking evaluation was completed for the resident. LPN #10 stated that Resident #191 needed a smoking evaluation to see if he/she were safe to smoke. During a review of Resident #191's EHR the surveyor observed a Smoking Safety Evaluation that was completed on 10/9/24 at 2:19 PM after surveyor inquiry, which detailed, Does the resident currently smoke or Vape? Yes. Further review of the assessment revealed that the resident was safe to light their own cigarette, hold their own cigarette, and self extinguish or ash cigarette in an ashtray without adaptive equipment such as a smoking apron, cigarette holder,or flameless lighter. Further review of the assessment revealed that the resident was able to smoke independently, follow the facility policy, and safely secure all smoking materials in their room. On 10/10/24 at 10:29 AM, the surveyor observed Resident #191 seated in a chair at the bedside. When interviewed, the resident stated, A man told me yesterday that I am not allowed to have matches, so I threw the matches down the toilet. The resident stated that his/her friend had given the resident a lighter. The resident stated, I was told to follow the rules, with no matches. The resident further stated, I did not know that I could not use matches. LPN #10 was present at that time, and stated that residents were not permitted to borrow lighters. LPN #10 stated that if a resident was admitted as a non-smoker then the resident needed to be reassessed. During an interview with the surveyor on 10/10/24 at 10:45 AM, the Registered Nurse/Unit Manager (RN/UM) stated that upon admission to the facility nursing did a smoking assessment as part of the screening process. The RN/UM stated that upon admission to the facility Resident #191 was deemed to be a non-smoker and within the past day or two, was identified as a smoker. The RN/UM stated that she did not know who identified when the resident started smoking or when he/she was identified as a smoker. The RN/UM stated that it was brought to our attention that the resident was going outside and smoking. The RN/UM stated that the resident may only use a safety lighter (equipped with a child resistant mechanism) and matches were not permitted. The RN/UM stated that a smoking assessment was necessary to determine if a resident were safe to smoke. During an interview with the surveyor on 10/15/24 at 11:13 AM, the Director of Nursing (DON) stated that the smoking evaluation was part of the admission assessment. The DON stated that the purpose of a smoking assessment was to identify if the resident was a smoker, and to make sure that the resident had the dexterity to safely manage smoking materials. The DON stated, As part of the admission agreement, resident's are not supposed to have matches in their rooms, and are supposed to have lighters. The DON stated that when he spoke to Resident #191 the resident only had one match left that was already struck. The DON stated that the resident obtained lights from other residents in the courtyard. The DON stated that a smoking evaluation should have been completed when the nurse realized that the resident was smoking. The DON further stated, If it were not done, there was a potential safety hazard. A review of the facility policy, Smoking Policy-Residents dated revised October 2023 revealed the following: This facility has established and maintains safe resident smoking practices. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Smoking is only permitted in designated smoking areas, which are located outside of the building. Smoking is not allowed inside the facility under any circumstances. .Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: Current level of tobacco consumption; method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); desire to quit smoking; and ability to smoke safety with or without supervision (per a completed Safe Smoking Evaluation). The staff consults with the attending physician and the director of nursing services (DNS) to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. .Resident's who have independent smoking privileges are permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession. Only disposable safety lighters are permitted. All other forms of lighters, including matches, are prohibited. Residents are not permitted to give smoking items to other residents . N.J.A.C 8:39-31.6(e)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41260 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure an indwelling urinary catheter drainage bag and tubing did not touch the floor and b.) ensure the urinary catheter drainage bag was changed as ordered by the physician for 2 of 2 residents (Resident #174 and #188) reviewed for urinary catheter. This deficient practice was evidenced by the following: 1.) On 10/8/24 at 11:27 AM, the surveyor observed Resident #188 sitting in a wheelchair with a urinary catheter drainage bag (a collection device attached to a tube placed in the body to empty urine) secured to the wheelchair. The drainage bag was touching the floor. On 10/9/24 at 09:03 AM, the surveyor observed Resident #188 sitting in a wheelchair with a urinary catheter drainage bag secured to the wheelchair. The tubing that connected the drainage bag to the catheter was touching the floor. On 10/10/24 at 10:24 AM, the surveyor observed Resident #188 sitting in a wheelchair with a urinary catheter drainage bag secured to the wheelchair. The tubing that connected the drainage bag to the catheter was touching the floor. The surveyor also observed that the drainage bag was dated 9/25 3-11, which indicated the drainage bag was last changed on 9/25/24 on the 3:00 PM to 11:00 PM shift. According to the Admission Record (admission summary), Resident #188 had diagnoses which included, but were not limited to, unspecified dementia and retention of urine. Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 8/18/24, included the resident had a Brief Interview for Mental Status score of 8, which indicated the resident's cognition was moderately impaired. Further review of the MDS included the resident had an indwelling catheter. Review of the Individualized Comprehensive Care Plan (ICCP) included a focus, created 8/12/24, of I have an indwelling catheter r/t [related to] urinary retention, with an intervention to provide catheter care every shift and as needed. The ICCP did not include an intervention to keep the drainage bag and tubing off the floor nor did it include an intervention to indicate how often the drainage bag should be changed. Review of the Order Summary Report, as of 10/10/24, revealed a physician's order to Change urinary drainage bag every week on shower day: Wednesday 3-11, ordered 8/13/24. Review of the October 2024 Treatment Administration Record (TAR) included the aforementioned order was signed out as completed on 10/2/24 and signed out as not completed due to the resident being out of the facility on 10/9/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes, dated 09/25/24 through 10/10/24, did not include a rationale for why the catheter drainage bag was not changed on 10/2/24 or that the resident was out of the facility on 10/9/24. During an interview with the surveyor on 10/10/24 at 10:43 AM, Certified Nursing Assistant (CNA) #3 stated urinary catheter drainage bags and tubing should not touch the floor for infection control reasons. At that time, the CNA accompanied the surveyor to Resident #188's room and acknowledged the urinary catheter tubing was touching the floor. The CNA then repositioned and secured the drainage bag to the wheelchair so that the drainage bag and tubing were not touching the floor. During an interview with the surveyor on 10/10/24 at 10:51 AM, Licensed Practical Nurse (LPN) # 5 stated urinary catheter drainage bags should be kept off the floor for sanitary reasons. The LPN further stated the drainage bags should be changed to prevent the risk of infection. During an interview with the surveyor on 10/10/24 at 11:02 AM, the Registered Nurse/Unit Manager (RN/UM) stated that urinary catheter drainage bags and the tubing should not touch the floor for infection prevention. The RN/UM further stated that drainage bags should also be changed as ordered by the physician for infection prevention. At that time, the surveyor reviewed Resident #188's October 2024 TAR with the RN/UM. The RN/UM verified that the resident's drainage bag was ordered to be changed weekly and accompanied the surveyor to the resident's room. The RN/UM acknowledged that the drainage bag was last changed on 09/25/24 and that the nurse should not have signed the order as completed on 10/02/24. The RN/UM further stated that on 10/09/24, the nurse should have rescheduled the treatment order to be completed on the following shift. The RN/UM stated that it was important to accurately document in the resident's medical record to maintain continuity of care. During an interview with the surveyor on 10/10/24 at 1:10 PM, the Director of Nursing (DON) stated urinary catheter drainage bags and tubing should not touch the floor for infection control reasons. The DON further stated that nurses should follow the physician's orders on when to change the drainage bags and then label the catheter bag with the date it was changed. The DON also stated that it was important to accurately document on the TAR to ensure the order was completed. 40041 2.) On 10/8/24 at 10:35 AM, during the initial tour, the surveyor observed Resident #174 resting in bed with his/her eyes closed. The urinary catheter drainage bag and tubing was touching the floor. On 10/10/24 at 10:28 AM, during another visit to the resident's room, the urinary drainage bag and tubing were touching on the floor. On the same day at 10:42 AM, the surveyor accompanied the Licensed Practical Nurse Unit Manager (LPN/UM) #1 to Resident #174's room to confirm the findings. LPN/UM #1 picked the urinary catheter bag off the floor and emptied the bag. A review of the Admission Record (admission summary) reflected that the resident was admitted with diagnoses, which included but were not limited to; chronic kidney disease, acute kidney failure, retention of urine, and Autistic Disorder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the admission comprehensive Minimum Data Set (MDS), an assessment tool dated 8/28/24, included the resident had a Brief Interview for Mental Status score of 00, which indicated the resident's cognition was severely impaired. Further review of the MDS included the resident had an indwelling catheter. A review of the Individualized Comprehensive Care Plan (ICCP) included a focus area, created 5/27/24, for indwelling catheter related to urinary retention. Intervention included: to provide catheter care every shift and as needed. The ICCP did not include an intervention to keep the drainage bag and tubing off the floor. A review of the physician's orders included, Catheter Care every shift. During an interview with the surveyor on 10/10/24 at 10:50 AM, LPN/UM #1 stated the catheter bags should not touch the floor and that they usually used the underframe of the bed to keep it off the floor. LPN/UM #1 stated, when the residents are mobile on the unit, we always attempt to utilize a leg bag. LPN/UM #1 further stated if they refuse the leg bag, then we ensure they have privacy bag and it is stored underneath the wheelchair so it does not get in their way. LPN/UM #1 stated it was important to keep the urinary catheter drainage bag and tubing off the floor for infection control purposes, dignity, and prevent the tubing from getting yanked. Review of the facility's Catheter Care, Urinary policy, revised 08/2022, included, Be sure the catheter tubing and drainage bag are kept off the floor. Further review of the policy did not include to change the drainage bag as ordered by the physician. NJAC 8:39 - 27.1(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 41260 Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) provide fortified foods as prescribed by the physician, b.) obtain weekly weights as recommended by the Registered Dietician, and c.) obtain re-weights according to the facility's policy for 2 of 5 residents (Resident #91 and #7) reviewed for nutrition. This deficient practice was evidenced by the following: 1.) On 10/11/24 at 12:12 PM, the surveyor observed Resident #91 receive his/her lunch tray which included a sealed pudding pack without a label. According to the resident's meal ticket, the resident was supposed to receive fortified pudding (pudding that contains extra nutrients). The surveyor took a picture of the lunch tray. At 12:35 PM, the Korean Program Assistant Director translated for the resident who stated he/she would sometimes eat the pudding and did not have a preference for flavor. On 10/15/24 at 12:37 PM, the surveyor observed Resident #91's lunch tray which included a serving of pudding packaged by the facility. According to the resident's meal ticket, the resident was supposed to receive fortified pudding. The surveyor took a picture of the lunch tray. At that time, the Activity Assistant (AA) translated for the resident who stated he/she enjoyed the food and would eat the pudding later. According to the Admission Record, an admission summary, Resident #91 had diagnoses which included, but were not limited to, mild protein-calorie malnutrition and Vitamin D deficiency. Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 9/8/24, included the resident had a Brief Interview for Mental Status score of 15 which indicated the resident's cognition was intact. Further review of the MDS included the resident had a weight loss of 5% or more in the last month or 10% or more in the last six months and was not on a physician-prescribed weight loss regimen. Review of the Individualized Comprehensive Care Plan (ICCP) included a focus, revised 5/29/24, that the resident had a nutritional problem related to weight loss and inconsistent intake with meals and supplements. Further review of the ICCP included an intervention for Fortified Foods: . Pudding: Lunch and Dinner, revised 9/19/24. Review of the Order Summary Report, as of 10/15/24, included a physician's order for Fortified pudding with Lunch and Dinner, ordered 4/10/23. Review of the Quarterly Nutrition Assessment, dated 9/9/24, included the resident was on fortified pudding twice a day which provided 300 kcal (kilocalorie) and 12g (grams) of protein. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/15/24 at 1:49 PM, the Food Service Director (FSD) stated that fortified pudding was made in-house daily, but that there wasn't any fortified pudding currently in the building. At that time, the surveyor showed the FSD the pictures of Resident #91's lunch trays on 10/11/24 and 10/15/24 and the FSD confirmed that fortified pudding was not given to the resident. The FSD further stated he was unsure why fortified pudding was not provided for the resident. The FSD explained that a Dietary Aide was responsible for checking the residents' meal trays to ensure fortified foods were included on the designated trays. The FSD further stated that if fortified pudding was not available, he would either increase the amount of pudding on the tray or contact the dietician for recommendations. During an interview with the surveyor on 10/15/24 at 1:56 PM, the Dietary Aide responsible for checking the meal trays stated there wasn't any fortified pudding to provide to the residents on 10/11/24 or 10/15/24 but was not sure why. During an interview with the surveyor on 10/15/24 at 2:08 PM, the Registered Dietician (RD) stated he makes rounds to ensure designated residents receive fortified pudding on their meal trays. When asked how the RD knows whether the pudding on the resident's tray is fortified or not, the RD stated he just assumes that the pudding provided was fortified if the meal ticket indicated fortified pudding. The RD further stated he had not been notified that the kitchen was unable to provide fortified pudding on 10/11/24 and 10/15/24, and if he had been notified, he would have developed new interventions for residents on fortified pudding until it was available again. The RD added that the kitchen staff should not determine their own intervention, but should instead notify the RD when fortified foods are not available. During an interview with the surveyor on 10/15/24 at 4:16 PM, in the presence of the survey team, the Director of Nursing (DON) stated the fortified pudding or a reasonable substitute should have been provided to Resident #91. Review of the SNP (Special Nutrition Program) Roster, dated 10/16/24, revealed there were 30 residents at the facility who were supposed to receive fortified pudding at lunch. Review of the facility's Special Nutrition Program policy, revised 08/08/22, included, The Special Nutrition Program (SNP) is a fortified food program that should provide for the increased nutritional requirements of residents who are underweight, have pressure injuries, experiencing significant weight loss, have poor intake and/or have a low albumin. Further review of the policy did not indicate what the facility should do if fortified foods were unavailable. 2.) On 10/15/24 at 12:37 PM, the surveyor observed Resident #91 lying in bed. The resident's lunch tray was on the bedside table with approximately 50% of the meal eaten. At that time, the AA translated for the resident who stated he/she enjoyed the food and had enough to eat. According to the Admission Record, an admission summary, Resident #91 had diagnoses which included, but were not limited to, mild protein-calorie malnutrition and Vitamin D deficiency. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 9/8/24, included the resident had a Brief Interview for Mental Status score of 15 which indicated the resident's cognition was intact. Further review of the MDS included the resident had a weight loss of 5% or more in the last month or 10% or more in the last six months and was not on a physician-prescribed weight loss regimen. Review of the Care Plan included a focus, revised 5/29/24, that the resident had a nutritional problem related to weight loss and inconsistent intake with meals and supplements. Review of the Significant Weight Change Assessment, written by the Registered Dietician (RD) and dated 5/10/24, revealed the resident had a 6.3% weight loss in 30 days and experienced a small decline in oral intake. The RD further recommended to start Ensure (an oral nutritional supplement) twice a day. Review of the Nutrition Note, written by RD #2 and dated 05/16/24, included a recommendation for weekly weights for four weeks to monitor resident's weight. Review of the Weights and Vitals Summary, generated 10/15/24, revealed the following weights for May and June 2024: -5/2/24: 104 lbs (pounds) -6/6/24: 100 lbs There were no additional weights for May or June 2024 in the resident's electronic medical record (EMR). During an interview with the surveyor on 10/15/24 at 12:40 PM, Certified Nursing Assistant (CNA) #4 stated that residents are weighed monthly unless the nurse notified the CNA of more frequent weights. The CNA further stated that weights are documented in a weight book and then the nurse enters the weight into the EMR. During an interview with the surveyor on 10/15/24 at 12:46 PM, Licensed Practical Nurse (LPN) #7 stated residents were weighed monthly unless the RD recommended more frequent weights. The LPN further stated that weights were documented in the weight book and then entered into the resident's EMR. When asked the importance of adequately monitoring weights for a resident who experienced a significant weight loss, the LPN stated, to determine the cause of the weight loss. During an interview with the surveyor on 10/15/24 at 12:54 PM, Licensed Practical Nurse/Unit Manager (LPN/UM) #3 stated residents were weighed monthly unless otherwise instructed by the RD or physician. The LPN/UM further stated that weights are written in the weight book, transferred into the residents' EMR, and then the paper copies of the weights were shredded. When asked about Resident #91's weekly weights that were recommended in May 2024, the LPN/UM reviewed the resident's EMR and verified the weekly weights were not completed and that she could not find a discontinued physician's order for the weekly weights. The LPN/UM added that the weekly weights should have been done if the RD recommended it to prevent malnutrition issues. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Brook Rehabilitation and Healthcare Center	3718 Church Road Mount Laurel, NJ 08054

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/15/24 at 1:01 PM, the RD stated that if weekly weights are recommended, the RD will obtain a physician's order and then review the completed weights in the resident's EMR. When asked about Resident #91's weekly weights for May 2024, the RD stated that the weekly weights should have been obtained based on the recommendation and then entered into the resident's EMR. During an interview with the surveyor on 10/15/24 at 4:16 PM, in the presence of the survey team, the Director of Nursing (DON) stated Resident #91's weekly weights should have been completed as recommended by the RD. 37547 3.) During the initial tour of the facility on 10/8/24 at 11:53 AM, the surveyor observed Resident #7 lying in bed with a meal tray in front of him/her that was untouched. The resident stated that he/she had no appetite, but received dietary supplements. A review of Resident #7's Admission Record, an admission summary, revealed that the resident was admitted to the facility with diagnosis which included, but were not limited to, abnormal weight loss, type 2 (two) diabetes (a condition in which the body had trouble controlling blood sugar), and unspecified protein calorie malnutrition. A review of Resident #7's quarterly Minimum Data Set (MDS), an assessment tool, dated 10/01/24 revealed that the resident had a Brief Interview for Mental Status score of 15 out 15, which indicated that the resident was fully cognitively intact. Further review of the MDS under Section K-Swallowing/Nutritional Status reflected that the resident had a weight loss of 5 % or more in the last month or 10 % or more in the last six months and was not on a physician-prescribed weight-loss regimen. A review of Resident #7's Individualized Comprehensive Care Plan (ICCP) revealed an entry with a revision date of 7/29/24, and a focus of: I have a nutritional problem r/t (related to) .significant weight changes .The Goal included: I will consume at least 75% of meals and fluids through next review date .Interventions/Tasks included but were not limited to: .Monitor weights as ordered: Monthly unless otherwise indicated. Resident may refuse to be weighed. Educate and encourage on importance of weight obtainment. A review of Resident #7's Electronic Health Record (EHR) revealed a Nutrition Note dated 9/20/24 at 7:40 AM, that was written by Registered Dietician (RD) #1 and indicated that the resident was evaluated for a Significant Weight Change: .Assessment: The resident has experienced a 40 #/14.9% weight loss x 180 days. Weight loss not planned, but is appropriate in the presence of good intake. CBW (current body weight) is only obtained weight since increasing supplement regimen on 7/1/24 due to resident refusal The resident has good intake of meals and excellent intake of ONS (Oral Nutritional Supplements) .Plan: 1. Continue POC (Plan of Care) 2. Monitor weights, labs, skin and intake. Further review of Resident #7's EHR revealed a Nutrition Note, dated 10/1/24 at 8:16 AM, that was written by RD #2 and indicated that on 3/13/24 the resident weighed 267.8 pounds and the resident had documented weight refusals on 06/05/24 and 08/25/24. On 9/6/24 the resident weighed 228 pounds and a significant weight change was addressed. RD #2 documented that an October 2024 weight was pending. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed Resident #7's weights under the weights and vitals tab in the EHR which revealed: -On 11/5/23 the resident weighed 284 pounds (mechanical lift) -On 11/10/23, the resident weighed 282.9 pounds (mechanical lift) -There was no weight recorded in December of 2023. -On 1/10/24, the resident weighed 255 lbs. -There was no weight recorded in February of 2024. -On 3/13/24, the resident weighed 267.8 pounds (mechanical lift). -On 4/5/24, the resident weighed 248 pounds (mechanical lift). -On 04/23/24, the resident had a documented weight refusal. -On 05/01/24 the resident weighed 246.1 pounds (standing). -On 09/06/24 the resident weighed 228 pounds (wheelchair). During an interview with the surveyor on 10/09/24 at 11:15 AM, Licensed Practical Nurse/Unit Manager (LPN/UM) #1 stated that both the aides and nurses weighed the residents together and the weight was recorded in the EHR. LPN/UM #1 stated that residents were weighed upon admission, then weekly for four weeks, then monthly thereafter unless there was a 5% weight fluctuation. LPN/UM #1 stated that RD #1 informed the nursing staff when a re-weight was required. LPN/UM #1 stated, Sometimes weights get missed .and the charting process was not always the best. On 10/10/24 at 12:23 PM, the surveyor observed Resident #7 lying in bed with their meal tray in front of him/her that was not touched. The resident stated that he/she was not hungry today. During an interview with surveyor on 10/10/24 at 1:00 PM, RD #1 stated that weights were done on the first of the month and were due by the fifth of the month. He stated that if a 5 (five) pound weight gain or loss was noted, a repeat weight was requested. RD #1 stated that he put the requests in a book on the unit and communicated with the unit manager. RD #1 stated that he questioned Resident #7's rapid weight change. He stated that the resident expressed a desire to lose weight and was recently placed on an oral supplement at the resident's request. RD #1 stated that it was not due to him/her not eating, the resident ate well most of the time. RD #1 stated that he did not recall the last time that he did a meal observation of the resident's intake. RD #1 stated that a review of the Certified Nursing Aid (CNA) documentation indicated that more often than not, the resident was eating. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, RD #1 stated that a reweight should be documented in the EHR if there was a change greater or less than five pounds in consecutive months. The surveyor questioned a weight change between 11/10/23 of 282.9 lbs (mechanical lift) and on 1/10/24 of 255 lbs (mechanical lift). RD #1 stated that the weight loss was desired. RD #1 stated that a reweight was required to be done in two days, but it did not appear that it was done. Further review of the resident's weights revealed that there was no documented evidence that the resident was reweighed in January 2024 and a monthly weight was not documented within the EHR in February 2024. Further review of the resident's documented weights revealed that on 3/13/24 the resident had a documented weight of 267.8 pounds, and a reweigh was not recorded. On 04/05/24 the resident had a documented weight of 248 pounds and a reweigh refusal was documented on 4/23/24, eighteen days after the initial monthly weight. The resident's last recorded weight of 228 pounds was documented on 9/6/24, with no documented reweight. During an interview with the surveyor on 10/15/24 at 11:02 AM, the Director of Nursing (DON) stated that the dietician followed resident weights and reweights, but typically, a weight fluctuation of 5% would trigger a reweight. The DON stated that the nurse aide reported the weight and the unit manager then noted if there was a disparity and notified the dietician. The DON further stated that the dietician would request a reweight if indicated. On 10/10/24 at 9:35 AM, The surveyor reviewed the Weight Book in the presence of the Assistant Director of Nursing (ADON) and noted that Resident #7's weight had not yet been documented for the month of October. The ADON stated that he was filling in for Licensed Practical Nurse/Unit Manager (LPN/UM) #4 who was off, and he was unable to explain why there were blanks on the October 2024 weight sheet. There was no documented evidence that staff had attempted to weigh Resident #7 in accordance with the facility protocol and policy. A review of the facility's Weight Assessment and Intervention policy, revised 03/2022, included, Residents are weighed upon admission and at intervals established by the interdisciplinary team, and, Weights are recorded in each unit's weight record chart and in the individual's medical record. Further review of the policy included, Resident weights are monitored for undesirable or unintended weight loss or gain, and, Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation . If the weight is verified, nursing will immediately notify the dietician in writing. NJAC 8:39-17.4(a)1,3; 27.2 (a)(e)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 37547 Based on observations, interviews, record review, and review of other pertinent documentation, it was determined that the facility failed to store respiratory equipment in a safe and sanitary manner when not in use to reduce the incidence of infection for 1 of 3 residents (Resident #123) reviewed for respiratory care. This deficient practice was evidenced by the following: On 10/8/24 at 1:11 PM, during the initial tour of the facility, the surveyor entered Resident #123's room with permission and observed a nebulizer machine (an electrically powered machine that turns liquid medication into a mist so that it can be inhaled directly into the lungs through a mask or mouthpiece) that was stored on top of a crowded table with the resident's personal belongings. The mask was not stored in a bag and condensation (moisture) was noted in the clear, plastic chamber. A vast area of an unknown brown substance was noted on two of the four sides of the nebulizer machine. The nebulizer unit was stored directly above a wall unit air conditioning unit which had a thick coating of dust on the vent covers. The resident stated that the mask was normally stored in a bag. The resident was unable to identify the brown matter on the nebulizer machine. A review of Resident #123's Admission Record, an admission summary, revealed that the resident had diagnoses which included but were not limited to: Chronic Obstructive Pulmonary Disease (COPD, condition of restriction of the airways and difficulty breathing). A review of Resident #123's Significant Change in Status Minimum Data Set, an assessment tool, 10/05/24 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated that the resident was fully cognitively intact. A review of Resident #123's Order Summary Report revealed an order dated 9/2/24 to: Change nebulizer tubing and delivery device with patient bedside bag for storage weekly on [Specify Day and Shift]. Change as needed for soiling and damage. Every night shift every Wed *Please date tubing*. A review of Resident #123's Medication Administration Record (MAR) revealed an entry with a start date of 9/3/24, for Ipratropium Albuterol Inhalation Solution 0.5-2.5 (3) MG (milligrams)/3 ML (milliliters) (Ipratropium-Albuterol) 3 ml Inhale orally every 6 hours for PNA (pneumonia). The entry was signed out as administered on 10/8/24 at 12:00 PM, prior to the surveyor's initial observation. On 10/9/24 at 12:35 PM, the surveyor observed Resident #123 lying in bed. The Resident stated that she had a breathing treatment today and the nurse took the machine off of the table above the air conditioning unit, during the treatment. The mask was dated 10/9/24 and it was stored in a plastic bag. A vast area of an unknown brown substance was noted on two of the four sides of the nebulizer machine. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/09/24 at 12:40 PM, Licensed Practical Nurse (LPN) #1 stated that she noticed that the nebulizer machine was a little dirty from Resident #123 touching it and that it needed to be wiped off when she administered the resident's nebulizer. The surveyor accompanied LPN #1 into the resident's room and pointed out that the nebulizer machine had not yet been wiped off as she had previously described. LPN #1 stated that the mask was supposed to be stored in a bag and should not have condensation in it. LPN #1 stated that the mask was in a bag and had no condensation in it when she arrived that morning. LPN #1 stated that both the mask and tubing was changed last shift. The surveyor showed LPN #1 the brown matter on the outside of the nebulizer machine and the thick coating of dust that covered the air conditioner vents. The surveyor asked LPN #1 what could result if the nebulizer mask were stored outside of the bag with condensation in the chamber above the air conditioning unit and LPN #1 stated, That is disgusting. If the resident breathed that in there was a chance of contamination. During an interview with the surveyor on 10/10/24 at 10:17 AM, the Registered Respiratory Therapist (RRT) stated that she expected for nebulizer respiratory masks to be stored in a bag and labeled with the resident's name, room number, and dated on both the bag and the tubing and it was good for one week. The RRT stated that she hoped that there was no condensation in the chamber to ensure that that medication was delivered. The RRT stated that if the nebulizer machine were dirty then wipe it, and if it were still dirty, change the machine out. The RRT stated that if the mask were left out of the bag and were exposed to dust and dirt on the air conditioner unit and you put the mask on someone's face it would expose the person to bacteria. The RRT stated that nursing was responsible for nebulizer care, but she would bring it to their attention if she noticed it. On 10/10/24 at 12:09 PM, the surveyor observed Resident #123 lying in bed awake. The surveyor noticed that the nebulizer machine no longer had a brown substance on it. The resident stated that it was cleaned yesterday. During an interview with the surveyor on 10/10/24 at 12:48 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) #4 stated that Resident #123's nebulizer machine should have been cleaned right away. The LPN/UM #4 stated that housekeeping worked on cleaning the air conditioner unit yesterday, but he would get them to come back again today if it was still not clean. During an interview with the surveyor on 10/11/24 at 11:22 AM, the Licensed Practical Nurse/Infection Preventionist (LPN/IP) stated that the nebulizer should be wiped down and stored in a plastic bag and labeled and dated. The LPN/IP stated that the tubing was dated and changed weekly and as needed. When asked what could result if the mask were left out of the bag with condensation in the mask above a dusty air conditioner unit, the LPN/IP stated that pneumonia could result. The LPN/IP stated that there was a risk for infection if the nebulizer machine were not wiped down and kept clean. During an interview with the surveyor on 10/15/24 at 10:58 AM, the Director of Nursing (DON) stated that there was a plastic bag where the mouth and nose piece of the nebulizer machine were stored. The DON stated that it was a potential infection control issue if it were not properly stored and the outside of the nebulizer machine would need to be cleaned. The DON stated there was a chance of cross contamination and the air conditioner machine vents should have been cleaned. A review of the facility policy, Administering Medications through a Small Volume (handheld) Nebulizer (Revision Date October 2010) revealed the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purpose of this procedure is to safely and aseptically (free from contamination caused by harmful bacteria, viruses or other organisms) administer aerosolized particles of medications into the resident's airway. .When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. .Rinse and disinfect the nebulizer equipment according to facility protocol, or: a. wash pieces with warm soapy water; b. rinse with hot water; c. place all pieces a bowl and cover with isopropyl (rubbing) alcohol. Soak for five minutes; d. rinse all pieces with sterile water (Not tap, bottled, or distilled); and e. allow to air dry on a paper towel . .When equipment is completely dry, store in a plastic bag with the resident's name and date on it. .Change equipment and tubing every seven days, or according to facility protocol. .Disinfect outside of the compressor between residents, according to manufacturer's instructions. NJAC 8:39-19.4(a)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Based on interview and review of pertinent facility documents, it was determined that the facility failed to complete a performance review of all Certified Nurse Aides (CNA) at least every twelve months and provide regular in-service education based on the outcome of employee job performance reviews. The deficient practice was identified for 2 of 6 CNAs (CNA # 12 and #8) reviewed for the completion of annual performance evaluations and was evidenced by the following: 1.) On 10/11/24 at 11:09 AM, the surveyor reviewed the personnel files of five Certified Nursing Assistants and noted that the Annual Staff Performance Appraisal of CNA #12 dated 12/20/23, was not signed by the employee, Supervisor or Department Head in the spaced provided. The caption above the signature block indicated, This performance appraisal has been reviewed and acknowledged by the Employee, Supervisor and Department Head, and a copy shall be placed in the employee's Human Resource File. During an interview with the surveyor on 10/11/24 at 12:00 PM, the Regional Human Resources Director (RHRD) stated, We do not necessarily make the employee sign the Annual Staff Performance Appraisal, but the [NAME] should have signed to confirm that the evaluation was given to the employee and that it was completed. The RHRD further stated that some employees refused to sign. During an interview with the surveyor on 10/15/24 at 10:57 AM, the Licensed Nursing Home Administrator (LNHA) stated that both the employee and their supervisor were required to sign the CNA's performance appraisal. 43308 2.) On 10/11/24 at 12:35 PM, the Regional Director of Clinical Services (RDCS) provided a copy of CNA #8's Employee Performance Improvement Notification (EPIN). A review of the EPIN revealed the following: On 9/21/23, CNA #8 received a verbal notice for an unsatisfactory performance, failure to follow instructions, failure to cooperate, and failure to respond timely to a resident. Residents on the CNA's assignment had complained of being rounded on only once, their call bells were on for a long time, and the sheets on the bed were soaked on 9/20/23, during the 11 PM to 7 AM shift. Further review indicated that the CNA was in-serviced on rounds with a verbal notice by the unit manager on 9/7/23 and not to touch the resident who filed the grievance. There was no evidence of an in-service for 9/20/23 after an unsatisfactory performance and not answering call bells. On 10/16/24 at 11:17 AM, the Licensed Nursing Home Administrator (LNHA) provided a summary for CNA #8, which indicated for September 2023 she was not in-serviced on unsatisfactory performance, failure to follow instructions, and not answering call bells, but was written up for not completing tasks. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Staffing, Sufficient and Competent Nursing policy, revised August 2022, included, 2. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements .5. Competency requirements and training for nursing staff are established and monitored by nursing leadership. .Competency requirements and training for nursing staff are established and monitored by nursing leadership with input from the medical director to ensure that: programming for staff training results in nursing competency; gaps in education are identified and addressed; education topics and skills are determined based on the resident population; tracking or other mechanisms are in place to evaluate the effectiveness of training; and training includes critical thinking skills and managing care in a complex environment with multiple interruptions . A review of the facility's undated Performance Evaluations (Version: 1.3 (H5MAPL0615)) policy, revealed the following: The job performance of each employee shall be reviewed and evaluated at least annually. .The written performance evaluations will contain the director's and/or supervisor's remarks and suggestions, any action that should be taken (e.g., further training, etc.), and goals. .The director and/or supervisor and the evaluated employee should sign and date the evaluation form. If the employee refuses to sign the form, the director and/or supervisor should note such refusal on the form. .The facility may alter, amend, modify, delete, add to, or eliminate, this policy, in whole or in part, at any time. NJAC 8:39-43.17(b)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 37547 Based on observations, interviews, record review and review of other pertinent documentation, it was determined that the facility failed to ensure that the current resident census was accurately reflected and recorded on the Nursing Home Resident Care Staffing Report prior to posting the notice in prominent areas for residents and the general public to view. This deficient practice was identified on three of six survey dates was evidenced by the following: On 10/8/24 at 9:11 AM, the Licensed Nursing Home Administrator (LNHA) stated that the facility census was 207. A review of the facility daily staffing sheet indicated that the resident census was 208. A review of the Nursing Home Resident Care Staffing Report dated 10/8/24-Day Shift, reflected that the Current Resident Census was 203. On 10/09/24 at 10:57 AM, the surveyor reviewed the Nursing Home Resident Care Staffing Report dated 10/9/24 which reflected that the current census was 203. A review of the facility daily staffing sheet indicated that the resident census was 208. On 10/11/24 at 1:08 PM, the surveyor reviewed the Nursing Home Resident Care Staffing Report and noted that the census was 206. A review of the daily staffing sheet indicated that the resident census was 203. During an interview with the surveyor on 10/11/24 at 1:09 PM, the Staffing Coordinator (SC) stated that the current census was 203. The SC stated that she posted the Nursing Home Resident Care Staffing Report with the current census based on the calculations formulated from the computer software that was used. When the surveyor asked why the current resident census of 203 that she reported differed from the recorded resident census number of 206 on the Nursing Home Resident Care Staffing Report that was posted in the main lobby, the SC stated, I was not aware of a census of 206. The SC stated that she obtained the daily resident census number during a group meeting and any pending admissions and discharges were reflected on the form prior to posting the following day. During an interview with the surveyor on 10/11/24 at 1:38 PM, the Director of Nursing (DON) stated that the current resident census was 203. When asked why the Nursing Home Resident Care Staffing Report that was posted in the main lobby reflected a census of 206, the DON stated that the he would follow up with the SC and clarify why she did not list the correct information. During an interview with the surveyor on 10/15/24 at 10:32 AM, the DON stated that the Business Office generated a midnight census report and sent it to the SC who did not have an updated version of the computer software, so the calculation that she made was not based on the midnight census. The DON stated that if the reported resident census were not accurate, it could affect staffing accuracy. The DON explained that if the resident census were higher than reported than the facility could have additional staff on duty, and if it were under, the inverse pattern of too few staff may be on duty. A review of the facility policy, Staffing, Sufficient and Competent Nursing (Revision Date August 2022) revealed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Brook Rehabilitation and Healthcare Center	3718 Church Road Mount Laurel, NJ 08054

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staff. .Direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift. .Inquiries or concerns relative to our facility's staffing should be directed to the director of nursing services (DNS) or his/her designee. NJAC 8:39-41.2(c) (d)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44833 Complaint #: NJ177069 Based on observation, interview, and pertinent record review, it was determined that the facility failed to a.) ensure the accountability of the Narcotic Shift Count logs were completed in accordance with facility policy, b.) ensure that narcotics were properly secured under two secured locks per facility policy, and c.) obtain and administer a medication per physicians order. This deficient practice was observed in 1 of 5 medication carts reviewed for medication storage and 1 of 5 residents (Resident # 355) reviewed for medication adminsitration, and was evidenced by the following: 1.) On 10/10/24 10:45 AM, the surveyor, in the presence of Registered Nurse #1 (RN #1), reviewed the North 1 Unit's medication B Cart shift to shift narcotic count logs which indicated the following missing documentation: Nurse's signature going off duty for 9/26/24 7 AM - 3 PM shift Nurse's signature coming on duty 10/9/24 11 PM - 7 AM shift Nurse's signature coming on duty 10/10/24 7 AM - 3 PM shift The Is count correct: Yes / No column was blank for all shifts from 9/26/24 through 10/10/24 At that time, the surveyor interviewed RN #1 who stated that the incoming and outgoing nurses were supposed to perform the narcotic count together at each shift change and complete the count log and sign it together to indicate the count was performed and accurate. The RN further stated that there was not to be any missing documentation or nursing signatures. On 10/10/24 at 1:50 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the incoming and outgoing nurses were expected to perform the narcotic count for each medication cart at each shift change for narcotic accountability reasons. The DON further stated that there should be no missing signatures, and probably not acceptable for the column labeled is count correct? to have been left blank. 2.) On 10/10/24 10:45 AM, the surveyor, in the presence of RN #1, observed the North 1 Unit's medication B Cart and upon checking to see if the narcotic lock box was secured to the medication cart drawer by gently pulling up on the lock box by the edges of the lid, the lid opened revealing narcotics which were stored in the box. The lock box was then closed shut with the locking mechanism engaged into the latch of the box, and this was repeated with the same result of the box being opened. The RN then closed the lid and engaged the locking latch and tugged on the lid with the same result of having the narcotic box open without using a key. The RN then stated that the lock box was always in a locked position and should open only with the use of a key. She then confirmed that this box was able to be opened without a key and minimal effort. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 11:42 AM, the surveyor observed the [NAME] President of Clinical Services (VPCS) at the North 1 medication B Cart speaking with RN #1 and handling the narcotic lock box. At this time, the surveyor interviewed the VPCS who stated they will have someone come out and take a look at it. On 10/10/24 at 1:50 PM, the surveyor interviewed the DON who stated that narcotic lock boxes should be adequately secured and locked and that no one should be able to access contents without a key. On 10/16/24 at 9:15 AM, the Licensed Nursing Home Administrator (LNHA) acknowledged the narcotic lock box not adequately securing the contents of the box and informed the surveyor by email that a pharmacist was on-site and serviced the medication cart and that the narcotic box was addressed on 10/10/24. A review of the facility's Control of Controlled Dangerous Substances policy with updated date of October 2023 included but was not limited to: the controlled dangerous substances will be double locked at all times in the medication cart. The key to the medication cart shall be in the possession of the nurse on the unit at all times. Narcotic counts must be conducted by the incoming and outgoing nurse at the change of shift . both nurses sign the count on the Pharmacy Controlled Drug Record. 41072 3.) The surveyor reviewed Resident #355's electronic medical records (EMR) records and the paper medical records which revealed the following: A review of the Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included, but were not limited to; after care following joint replacement, presence of left artificial knee, and unilateral primary osteoarthritis. A review of the Social Services Assessment, dated 9/13/14, revealed the resident was cognitively intact and did not exhibit any behavior of rejecting care. A review of the individual baseline care plan, dated 9/12/24, revealed that the resident was on anticoagulant (blood thinner) therapy related to deep vein thrombosis (DVT) with an intervention to administer medication as ordered. A review of the Active Order Summary Report, dated 9/12/24, included a physican's order (PO) for Xarelto 20 milligram (mg) tablet; give one tablet by mouth in the evening for DVT for 14 days; monitor for signs and symptoms (s/s) of bleeding. A review of the corresponding September 2024 Medication Administration Record (MAR) revealed that the the Xarelto administration on 9/12/24 at 8:00 PM had a number 5 documented by the nurse. A review of Chart Code located on the MAR, indicated a 5 was hold. A review of the corresponding Progress Notes did not include documentation on 9/12/24, for why the Xarelto was held. A Physician History and Physical note, dated 9/13/24 at 1:22 PM, revealed that the resident informed the doctor that the resident did not receive their medications last night. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 10:29 AM, the surveyor interviewed Licensed Practical Nurse (LPN #2), who stated that if a medication was not available in the medication cart, the nurse checked the backup house stock or the Automated Mediation Dispensing System (AMDS). If the medication was not available in house stock or the AMDS, then the nurse contacted the pharmacy to see when the medication would be available, or called the doctor to get an order for a substitute medication. The surveyor reviewed the September 2024 MAR with LPN #2, who confirmed it was her initials with the number 5 documented on 9/12/24. LPN #2 stated that if she documented hold, that meant the medication was unavailable. LPN #2 stated that when a new admission came in on evening shift, the only medication available for administration was the house stock medications or in the AMDS. LPN #2 acknowledged that since the medication was a blood thinner, it should have been administered. On 10/10/24 at 10:30 AM, the Specialty Program Coordinator (SPC) provided the surveyor with an inventory of medications located in the backup AMDS which revealed that Xarelto was not a medication available in the backup system. On 10/10/24 at 11:07 AM, the surveyor interviewed the LPN Unit Manager (LPN/UM#1), who stated that if a medication was not available with the in house stock or in the AMDS, then the nurse should call the doctor or the pharmacy to see when the medication would be available. LPN/UM #1 stated that they were unsure if Xarelto was a medication available in the AMDS, but if it was not in the AMDS, the nurse should have called the pharmacy and see when it would have been available or notified the doctor. On 10/10/24 at 11:32 AM, the surveyor interviewed the Consultant Pharmacist (CP), who stated that they reviewed the AMDS inventory list provided by the SPC, and they confirmed that Xarelto was not on the list. The CP stated that if a medication was not available, the nurse should have called the pharmacy to find out when it would be available, and notified the doctor. The CP further stated that Xarelto should be given as ordered because it was a blood thinner and if not given, it increased risk for heart attack or stroke. On 10/10/24 at 1:12 PM, the surveyor interviewed the Director of Nursing (DON) who stated they would have expected the nurses to notify the pharmacy if a medication was not in the AMDS or back-up pharmacy and notify the physician. The DON further stated that a number 5 code on the MAR meant not administered and the nurse should have notified the physician and wrote a note in the Progress Notes. The DON stated that Xarelto was an anticoagulant, so you want to make sure the resident was monitored for potential DVT issues. A review of the facility's policy titled Unavailable Medication, dated June 2021, revealed that in the event that medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall: a. Contact the pharmacy regarding unavailable medication b. Attempt to obtain the medication from the Automated medication dispensing system or emergency kit c. Notify the physician of the unavailable medication, explain the circumstances, report the date of expected availability, and provide the alternative medication(s) recommended by pharmacy. i. obtain anew order and discontinue prior order or; ii obtain a hold order for the unavailable medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-27.1(a) NJAC 8:39-29.7(c)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41260 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) address recommendations for a gradual dose reduction (GDR) of psychotropic medications (mood altering medications), b.) ensure as needed (PRN) psychotropic medications were prescribed with a 14-day duration and re-evaluated for continued use, and c.) adequately monitor target behaviors for the use of psychotropic medications for 5 of 6 residents (Resident #17, #40, #109, #167, and #358) reviewed for unnecessary medications. This deficient practice was evidenced by the following: 1.) On 10/9/24 at 12:36 PM, the surveyor observed Resident #17 lying in bed. The resident was in a pleasant mood and had no complaints. A review of the Admission Record (an admission summary), Resident #17 had diagnoses which included, but were not limited to, generalized anxiety disorder, major depressive disorder, post-traumatic stress disorder, and panic disorder. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 07/03/24, included the resident had a Brief Interview for Mental Status score of 13 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident had no behaviors and received antipsychotic and antidepressant medications (types of psychotropic medications). A review of the individualized comprehensive care plan (ICCP), initiated 6/27/24, included that the resident used anti-psychotic and anti-depressant medication with interventions to consult with physician to consider dosage reduction when clinically appropriate. A review of the Psychiatric Evaluation (psych eval), dated 9/19/24, revealed the resident reported he/she had been refusing bupropion (an anti-depressant medication) because it gave him/her hallucinations and that he/she requested to stop olanzapine (an anti-psychotic medication). Further review of the psych eval included recommendations of a GDR by stopping bupropion and olanzapine. A review of the Nurse Practitioner (NP) note, written by NP #2 and dated 9/20/24, included, anxiety: pending psych eval and treat. Further review of the note did not indicate whether NP #2 addressed the psych eval recommendations for a GDR that were made the day prior. A review of the September 2024 Medication Administration Record (MAR) included the following physician orders: -Bupropion XL (extended release) 300 mg (milligrams) by mouth once a day for depression with an order date of 09/08/24 - 10/08/24. -Olanzapine 5 mg by mouth at bedtime for mood disorder with an order date of 09/09/24 - 10/08/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the October 2024 MAR included the following physician orders: -Bupropion XL (extended release) 300 mg (milligrams) by mouth once a day for depression with an order date of 09/08/24 - 10/08/24. The medication was last administered on 10/08/24. -Olanzapine 5 mg by mouth at bedtime for mood disorder with a start date of 10/08/24. The medication was administered 10/08/24 through 10/14/24. During an interview with the surveyor on 10/15/24 at 11:50 AM, Certified Nursing Assistant (CNA) #2 stated Resident #17 did not have any behaviors. During an interview with the surveyor on 10/15/24 at 11:55 AM, Licensed Practical Nurse (LPN) #4 stated the psychiatrist came to the facility weekly and if recommendations were made, the nurse would follow-up with the physician. The LPN further stated that psych recommendations should be addressed immediately to see if the medications are working and keep the resident safe. During an interview with the surveyor on 10/15/24 at 12:09 PM, the Registered Nurse/Unit Manager (RN/UM) stated when a resident was on a psychotropic medication, a psych eval was ordered to see if the resident was appropriate for a GDR. The RN/UM explained that when the psychiatrist made a recommendation, the physician would review the psych eval in the resident's EMR and address the recommendations as soon as possible. When asked about Resident #17, the RN/UM confirmed the resident was still ordered the olanzapine and that if NP #2 saw the resident after the psych eval, the NP should have addressed the recommendations. The RN/UM further stated that it was important to address psych recommendations to decrease the amount of time the resident is on psych meds if they are not appropriate. During an interview with the surveyor on 10/15/24 at 4:18 PM, in the presence of the survey team, the Director of Nursing (DON) stated that psych recommendations should be verified and implemented according to the provider. The DON further stated that the provider should document in the resident's medical record when recommendations were reviewed. 40041 2.) On 10/08/24 at 9:31 AM, the surveyor observed Resident #167 in his/her room. A review of the Admission Record (admission summary) reflected the resident had diagnoses which included, but were not limited to, anxiety disorder, depression, and bipolar disorder (mental illness that causes unusual shifts in mood). A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 9/4/24, revealed the resident had a Brief Interview for Mental Status score of 15 which indicated that the resident's cognition was intact. A review of Resident #167's Physician's orders located in the Electronic Medical Record (EMR) revealed an order for Lorazepam (medication used for anxiety) 0.5 milligram tablet to by given by mouth every 6 hours as needed for anxiety disorder, with a start date of 08/29/24. The active order did not include a duration for use or stop date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Pharmacy Consultant Report, dated 8/30/24, revealed the following documentation: Resident has a PRN (as needed) order for Lorazepam as needed. PRN psychotropic medications should be ordered for a duration of 14 days, then reassessed, reordered for a specific duration, scheduled routinely, or discontinued. CMS (Center for Medicaid Service) 14 Day Rule MEGA RULE. During an interview with surveyor on 10/15/24 at 3:57 PM, in the presence of the survey team, the Director of Nursing (DON) stated that typically after 14 days, the provider would be contacted and would determine if the medication should be extended or discontinued. The DON further stated that if the PRN was ordered beyond 14 days, then there should be documentation in the medical record. During an interview with the surveyor on 10/16/24 at 8:56 AM, the Medical Director (MD) stated the PRN order of Ativan (Lorazepam) should have been time-limited for 14 days and then re-evaluated. He further stated that when the PRN psychotropic was continued, there should be a progress note in the medical record with a rationale. A further review review of Resident #167's PO revealed that the resident had an active order for Quetiapine Fumarate tablet 100 MG give 1 tablet by mouth at bedtime for mood disorder. There was no evidence in the EMR that the resident's behavior was being monitored. During an interview with the surveyor on 10/15/24 at 3:57 PM, in the presence of the survey team, the DON stated that typically the behavior monitoring was done every shift and it would be documented on the Medical Administration Record (MAR). 41072 3.) On 10/8/24 at 10:43 AM, during the initial tour of the North 2 Unit, the surveyor observed Resident #358, awake and alert, lying in bed. During the observation, the resident started to cry and stated I lost my apartment, and I don't know if my sister can keep my cat for me. I may need to have an amputation of my leg. I was receiving therapy, but I had refused therapy, so they discontinued it. A review of the Admission Record revealed that Resident #358 was admitted to the facility with diagnoses including, but not limited to, acute embolism and thrombosis (blood clots) of the right lower extremity, difficulty walking, and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). The surveyor reviewed the residents October 2024 Physician OSR which reflected that Resident #358 was on the following psychoactive medications: A PO, dated 9/25/24, for Xanax Oral Tablet 0.25 MG (Alprazolam) Give 1 tablet by mouth every 12 hours as needed for Anxiety/agitation/restlessness. NO STOP DATE. A PO, dated 7/9/24, for Aripiprazole Oral Tablet 5 MG (Abilify) Give 1 tablet by mouth in the morning for bipolar. A PO, dated 7/9/24, for Latuda Oral Tablet 40 MG (Lurasidone HCl) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give 1 tablet by mouth at bedtime for Bipolar. A PO, dated 7/9/24, for Latuda Oral Tablet 20 MG (Lurasidone HCl) Give 1 tablet by mouth in the morning for Bipolar disorder. A PO, dated 7/9/24, for Duloxetine HCl Capsule Delayed Release Particles 30 MG Give 1 capsule by mouth two times a day for depression. A PO, dated 7/9/24, for Amitriptyline HCl Oral Tablet 25 MG (Amitriptyline HCl) Give 5 tablet by mouth at bedtime for Anxiety Take 5 tablets (125mg). A review of Resident #358's admission MDS, dated [DATE], included the resident had a BIMS score of 15 out of 15 which indicated the resident's cognition was intact. The MDS further revealed that the resident was on an anti-psychotic, hypnotic, and antidepressant medications and had not had any behaviors. A review of the resident's ICCP, included a Focus, created 7/9/24, I use anti-depressant medication, with interventions that included: Monitor/document/report to physician PRN (as needed) signs and symptoms (s/sx) of depression unaltered by antidepressant medication or worsening s/sx of depression. A review of the ICCP included a focus, created 7/9/24, I use antipsychotic medication related to bipolar and interventions did not include behavior monitoring. Further review of the ICCP included a focus, created 10/2/24, I use anti-anxiety medication, and interventions did not include behavior monitoring. A review of the psychiatry notes, dated 9/26/24, revealed that resident appeared anxious and stated that his/her mood was down after being transferred to his/her new room. A low dose Xanax was ordered to help with the anxiety. A GDR was not recommended. A review of the progress notes, dated 9/15/24 through 10/15/24, revealed a progress note date by LPN #3 dated 10/8/24 which included the resident was tearful, his/her house was sold, that encouragement was given, and the resident refused to get out of bed or go to activities. The resident told the NP that he/she was feeling manic and psychiatry and psychosocial was ordered. No other documentation of behaviors was noted in the progress notes. A review of the July, August, September and October 2024 MARS and TARs did not reveal any PO for behavior monitoring related to anxiety, depression or bipolar medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 10:37 AM, the surveyor interviewed LPN #3 who stated that when a resident was placed on a new psychotropic medication, behavior monitoring would be documented for 14 days every shift, either in the progress notes or in the MAR. LPN # 3 further stated that the facility does not do monthly psychotropic monitoring or daily behavior monitoring for residents on long term use of psychotropic medications. If the staff saw any change in the resident's behavior, then they would notify the doctor or Nurse Practitioner and have them seen by the psychiatrist. LPN#3 further stated that psychotropic medications ordered as a PRN (as needed), such as Xanax, should be ordered for 14 days and would need a stop date on the PO. On 10/15/24 at 10:52 PM, the surveyor interviewed the LPN/UM #3 who stated that if a new psychotropic medication was ordered or a resident's psychotropic medications were changed, then a 14-day behavior monitoring would be completed. LPN UM #3 further confirmed that a new PO for PRN Xanax should have a 14 day duration and a stop date on the order. The behavior monitoring would be documented in the progress notes or the MAR. The LPN/UM #3 stated it was important to conduct behavior monitoring so that they know that the resident was on the appropriate behavior management and appropriate dosages of medications. When asked how the psychiatrist or psychologist would know what behaviors the resident was presenting, LPN/UM #3 stated the psychiatrist would look at the PO to see what medications were ordered, review the progress notes, and would discuss with the nurses. During an interview with the surveyor on 10/15/24 at 3:57 PM, in the presence of the survey team, the Director of Nursing (DON) stated the facility utilized a batch order set to create physician's orders for behavior monitoring. The DON further stated that behavior monitoring should be documented on the MAR every shift. On 10/15/24 at 3:45 PM, in the presence of the LNHA, the Director of Clinical Services, the [NAME] President of Clinical Services and the survey team, the Director of Nursing (DON) stated that a PO for PRN Xanax would need a 14-day stop date on the order. 4.) On 10/9/24 at 9:20 AM and 10/10/24 at 12:45 PM, the surveyor observed Resident #40 in his/her room. The resident did not display any behaviors at that time. A review of the Admission Record revealed that Resident #40 was admitted to the facility with diagnoses including, but not limited to, major depressive disorder and generalized anxiety disorder. The surveyor reviewed the residents October 2024 Physician Order Summary Report (OSR) which reflected that Resident #40 was on the following psychoactive medications: -A physician's order (PO), dated 7/23/24, for Xanax (anti-anxiety medication) 0.25 milligrams (MG); Give 1 tablet by mouth every 12 hours for anxiety. -A PO, dated 4/22/24, for Zoloft (anti-depressant) 100 mg: Give 2 tablets by mouth at bedtime for antidepressant. A review of the resident's Significant Change MDS, dated [DATE], included the resident had a Brief Interview for Mental Status score of 14 out of 15 which indicated the resident's cognition was intact. The MDS further revealed that the resident was on an antianxiety and an antidepressant and had not had any behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's ICCP included a focus, created 1/3/23, of I use anti-anxiety medication related to anxiety. The interventions did not include any monitoring of target behaviors. The ICCP included a focus, dated 2/3/23, of: I use anti-depressant medication related to depressive disorder. The interventions did not include any monitoring of target behaviors. A review of a psychiatrist note, dated 8/7/24, revealed that the resident has a history of anxiety and depression and had been on Xanax 0.25 mg twice a day (BID) for the last 3 years. On 10/15/24 at 10:37 AM, the surveyor interview LPN #3 who stated that Resident #40 was currently on Xanax and Zoloft, but had no change in his/her behavior lately. LPN #3 stated that Resident #40 did not have any behavior monitoring and if there were any changes in the resident's behavior, a behavioral note would be written in the progress note and the psychiatrist would be notified. LPN #3 stated that the importance of behavior monitoring was to see if the resident needed an increase or decrease in their medications. On 10/15/24 at 10:52 AM, the surveyor interviewed LPN/UM #3 who stated that Resident #40 was not on any behavior monitoring, his/her behaviors included attention and medication seeking, and his/her medication had not been adjusted in a while. LPN/UM #3 confirmed that the last behavior monitoring documentation in the EMR was August 2023. A review of Resident #40's progress notes dated 6/1/24 through 10/15/24 did not reveal documentation of behavior monitoring. A review of the June, July, August, September and October 2024 MARs and TARs did not reveal any PO for targeted behavior monitoring related to anxiety or depression. 5.) On 10/9/24 at 12:36 PM, the surveyor observed Resident #17 lying in bed. The resident was in a pleasant mood and had no complaints. A review of the Admission Record, Resident #17 had diagnoses which included, but were not limited to, generalized anxiety disorder, major depressive disorder, post-traumatic stress disorder, and panic disorder. A review of the admission comprehensive Minimum Data Set (MDS), an assessment tool, dated 7/3/24, included the resident had a Brief Interview for Mental Status score of 13 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident had no behaviors and received antipsychotic and antidepressant medications (types of psychotropic medications). A review of the ICCP, initiated 06/27/24, included the resident was on anti-anxiety, anti-psychotic, and anti-depressant medications (psychotropic medications) with interventions to observe for effectiveness and side effects. A review of the Order Summary Report (OSR), with active orders as of 10/15/24, included the following physician's orders: -Buspirone 5 mg (milligrams) by mouth twice a day for anxiety. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Brook Rehabilitation and Healthcare Center	3718 Church Road Mount Laurel, NJ 08054

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Olanzapine 5 mg by mouth at bedtime for mood disorder. -Trazodone 100 mg by mouth at bedtime for insomnia. A review of the June, July, August, September, and October 2024 Medication Administration Record (MAR) revealed the following physician's orders: -Bupropion XL (extended release) 300 mg (milligrams) by mouth once a day for depression with order dates of 06/28/24 - 08/12/24; 09/08/24 - 10/08/24 -Olanzapine 5 mg by mouth at bedtime for mood disorder with order dates of 06/27/24 - 08/12/24; 09/07/24 - ongoing. -Trazodone 100 mg by mouth at bedtime for insomnia with order dates of 06/27/24 - 08/12/24; 09/07/24 - ongoing. -Buspirone 5 mg (milligrams) by mouth twice a day for anxiety with order dates of 09/08/24 - ongoing. Further review of the June through October 2024 MARs revealed there were no physician's orders to monitor target behaviors related to psychotropic medication use prior to 10/14/24. During an interview with the surveyor on 10/15/24 at 11:50 AM, Certified Nursing Assistant (CNA) #2 stated that if a resident had behaviors, the CNA would notify the nurse and come back later to attempt to provide care. The CNA further stated Resident #17 did not have any behaviors. During an interview with the surveyor on 10/15/24 at 11:55 AM, Licensed Practical Nurse (LPN) #4 stated the Unit Manager (UM) was supposed to evaluate residents monthly related to behaviors and psychotropic medication use. When asked where those assessments were documented, the LPN was unsure. The LPN further stated it was important to monitor behaviors for residents who received psychotropic medications for the resident's safety and to see if there is any change in the resident's status. The LPN added that Resident #17 did not have any behaviors. During an interview with the surveyor on 10/15/24 at 12:09 PM, the Registered Nurse/Unit Manager (RN/UM) stated that residents being monitored for target behaviors would have a physician's order and behaviors, or lack of behaviors, would be documented on the MAR. The RN/UM further stated she was unsure who was supposed to evaluate residents monthly related to behaviors and psychotropic medication use. When asked about Resident #17, RN/UM was unsure if the resident had behaviors, but the behaviors, or lack of behaviors, should have been documented on the resident's MAR. The RN/UM added that it was important to monitor behaviors for residents who received psychotropic medications for effectiveness and side effects. During an interview with the surveyor on 10/15/24 at 3:57 PM, in the presence of the survey team, the Director of Nursing (DON) stated the facility utilized a batch order set to create physician's orders for behavior monitoring. The DON further stated that behavior monitoring should be documented on the MAR every shift. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview with the surveyor on 10/16/24 at 10:43 AM, the DON stated behavior monitoring should have been ordered for Resident #17 when the resident's psychotropic medications were started. 43308 6.) On 10/9/24 at 11:30 AM, the surveyor observed Resident #109 lying in bed sleeping. A review of the Admission Record (an admission summary) reflected that the resident had diagnosis that included major depressive disorder, anxiety, and psychosis (a condition that causes a person to lose touch with reality, making it difficult to distinguish what is real and what is not). A review of the annual comprehensive Minimum Data Set (MDS), an assessment tool, dated 5/6/24, included the resident had a Brief Interview for Mental Status score of 0 out of 15, which indicated a severely impaired cognition. Further review in Section N - Medication included: the resident was on an antipsychotic medication. A review of the Order Summary Report (OSR) dated as of 10/16/24, included the following physician's order (PO): -A PO dated 11/10/23, for Risperdal 1 milligram (mg), administer 1 tablet by mouth two times a day for psychosis. -A PO dated, 5/9/24, for Lexapro 5 mg, administer 1 tablet by mouth in the morning for depression. Further review of the OSR indicated the following PO after surveyor inquiry: -A PO dated 10/11/24, Behavior/interventions - monitor for disorganized thinking with incoherent speech. -A PO dated 10/11/24, Behavior/interventions - monitor for yelling to the point of exhaustion. -A PO dated 10/11/24, Side effects - monitor for side effects of psychotropic medications every shift. A review of the October 2024 MAR reflected no evidence of behavior monitoring and monitoring of side effects of psychotropic medications prior to 10/11/24. A review of the resident's Individual Comprehensive Care Plan (ICCP) included a focus, revised 10/8/24, of potential to demonstrate verbal behaviors. Interventions created 10/13/24, included: monitor and document observed behavior and attempted interventions in behavior log. A review of the Progress Notes (PN) included Psychiatry Progress Note (PPN) which revealed the following: On 7/4/24 at 9:58 PM, the Advanced Practice Nurse (APN) assessed the resident and checked off psychiatric medication requiring management/risk assessment (effectiveness/monitored). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 10/15/24 at 1:07 PM, Licensed Practical Nurse/Unit Manager (LPN/UM #2) stated the resident had outburst of yelling when placed in a geriatric chair (geri-chair - useful for those with mobility issues and have difficulty sitting upright). She stated they would try to redirect the resident, but it could be difficult to calm him/her down. LPN/UM #2 stated that they would monitor the resident's behavior by documenting in the progress notes. She stated that the resident had not had any behaviors recently. She further stated the nurse did not report any behaviors to her lately and the hospice aide did not mention any recent behaviors. LPN/UM #2 stated the psychiatrist came last week and the last time the resident was seen was 7/4/24. On 10/16/24 at 9:33 AM, the surveyor conducted a telephone interview with the Medical Doctor (MD) in the presence of the survey team. The MD stated that he was not familiar with the standard protocol for behavior monitoring, but that the facility did document behaviors. He further stated if the resident had behaviors they would be seen more frequently. A review of the facility's Psychotropic Medication Use policy, revised 07/2022, included, Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications. Further review of the policy included, Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and, PRN orders for psychotropic medications are limited to 14 days. The policy also included, Psychotropic medication management includes: . adequate monitoring for efficacy and adverse consequences, and, Consideration for the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. Review of the facility's Behavioral Assessment, Intervention and Monitoring policy, revised 03/2019, included, When medications are prescribed for behavioral symptoms, documentation will include: . specific target behaviors and expected outcomes; . monitoring for efficacy and adverse consequences. Further review of the policy included, If the resident is being treated for an altered behavior or mood, the IDT [interdisciplinary team] will seek and document any improvements or worsening in the individual's behavior, mood, and function. NJAC 8:39-27.1(a) NJAC 8:39-29.2(d)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40041 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to ensure that all medications were administered without an error rate of 5% or less. During the medication pass observation on 10/9/24 at 8:21 AM, the surveyor observed four nurses administer medications to four residents. There were 32 opportunities and 2 errors which calculated to a medication administration error rate of 6.25%. This deficient practice was identified for 1 of 4 residents (Resident #92) and was evidenced by the following: On 10/9/24 at 8:21 AM, the surveyor observed Licensed Practical Nurse (LPN) #2 obtain a bottle labeled probiotic from the supply of house stock medications (medication that can be obtained over the counter without a prescription). The LPN placed the probiotic capsule in a medication cup and immediately after, documented on the Medication Administration Record (MAR) that the medication was administered. The LPN gathered all the resident's medications, including the probiotic. The surveyor asked the LPN if she had all the resident's correct medications in the cup and LPN #2 confirmed with the surveyor that all the medications were correct and that she was going to administer the medications. When the LPN was asked if probiotic was the same as the ascorbic acid ordered, she replied yes LPN #2 further stated, that was what they had in their house stock medication, and central supply said it is ok. A review of the Physician Orders (PO) there was an active order for Ascorbic Acid Tablet 500 milligrams (mg) one time a day at 9:00 AM for supplement with a start date of 11/3/23. At that time, the resident did not have an order for a probiotic. The surveyor continued to interview LPN #2 who stated, when a house stock bottle of medication was empty she could go to the central supply or go to the backup supply in the medication room. When asked did she check the medication supply room today (10/9/24), she replied no. LPN #2 then stated she also did not check with central supply for the medication today (10/9/24), She explained this was her first resident with an order for ascorbic acid. During an interview with the surveyor on 10/10/24 at 10:55 AM, the LPN/UM #1 stated the process for when a medication was not available in the medication cart, was she would contact the pharmacy immediately to get an explanation for an estimated time of arrival (ETA) or any underlining issue as to why the medication did not arrive. She explained that way they could notify the physician if there needed to be a one time orders or an adjustment for that medication. LPN/UM#1 stated that the automated medication dispensing machine would be checked first to see if it was available. LPN/UM #1 confirmed that ascorbic acid was a house stock medication. She stated, I have never encountered one of our house stock meds (medications) not being available. During the same medication administration observation, LPN #2 removed an oxybutin chloride ER (extended release) (medication that is gradually released over time)10mg tablet from the resident's medication packet. LPN #2 then placed the oxybutin chloride tablet in a plastic pouch and proceeded to crush the medication using the pill crusher. LPN #2 stated, the resident took their medications crushed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the PO revealed oxybutin chloride ER Tablet 24 hour 10mg give one (1) tablet by mouth one time a day for overactive bladder at 9:00 AM. There was no evidence that the medication should be crushed. During an interview with the surveyor on 10/10/24 at 11:39 AM, the consultant pharmacist stated the Oxybutin ER tablets could not be crushed. A review of the facility's policy revised on 4/2019, Administering Medications revealed, .4. Medications are administered in accordance with prescriber orders, including any required time frame.10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. N.J.A.C 8:39-29.2(d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44833 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to properly dispose of expired medical equipment and maintain clean and sanitary medication storage areas. This deficient practice was observed in 2 of 3 medication storage rooms and 1 of 5 medication carts reviewed for medication storage and labeling and was evidenced by the following: On [DATE] at 9:31 AM, the surveyor, in the presence of the Registered Nurse Unit Manager (RN/UM) observed the East Medication Storage Room, which contained one (1) box of Shiley inner cannulas (a plastic medical tube which is inserted into a resident's tracheostomy (an opening in the neck into the windpipe to help a person breathe) containing 10 expired cannulas with an expiration date of [DATE]. On [DATE] at 10:07 AM, the surveyor, in the presence of Licensed Practical Nurse Unit Manager #1 (LPN/UM #1) observed the North One nursing unit's medication storage room in which the following expired items were identified: One (1) tracheostomy care tray expired [DATE] Two (2) gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food.) feeding tube one expired on [DATE] and one expired [DATE] One (1) VAD access kit (a set of tools used to place a guide wire into a patient's vascular system) expired [DATE] On [DATE] at 10:45 AM, the surveyor, in the presence of Registered Nurse #1 (RN #1), observed the North One nursing unit's B medication cart which contained 13 unidentifiable loose pills of various shapes, colors, and sizes in the bottom of cart drawers. At this time, RN #1 informed the surveyor that there should not have been any loose pills in the medication cart. On [DATE] at 1:50 PM, the surveyor interviewed the Director of Nursing (DON) who stated that there should not have been any expired items in the medication storage areas and that there should be no loose pills in the medication carts. A review of the facility's undated Medication Labeling and Storage policy included but was not limited to: the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returninf or destroying these items. N.J.A.C. 8:,d+[DATE].4

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. 37547 Based on observation, interviews, record review, and review of other pertinent documentation, it was determined that the facility failed to provide necessary dental care services in a timely manner for 1 of 1 resident (Resident #143) reviewed for dental care services. This deficient practice was evidenced by the following: On 10/8/24 at 11:06 AM, during the initial tour of the facility the surveyor observed Resident #143 lying in bed awake with a visitor present at the bedside. The resident stated that he/she was ordered a mechanical soft diet (designed for people who have trouble chewing/swallowing). The resident further stated, I lost my bottom denture a year ago and thought that the facility was going to replace them, but it never happened. A review of Resident 143's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: Dysphagia (difficulty swallowing) following cerebral infarction (stroke), muscle wasting and atrophy (waste away), and type 2 (two) diabetes (the body has trouble controlling blood sugar and using it for energy). A review of Resident #143's quarterly Minimum Data Set (MDS), an assessment tool, 9/17/24 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated that the resident was fully cognitively intact. A review of Resident #143's Care Plan revealed an entry dated 3/6/23, with a Focus: I have oral/dental health problems r/t (related to) with no specification provided. The Care Plan Goal included: I will not experience complications of oral/dental health problems through the review date. Interventions/Tasks included: Coordinate arrangement for dental care, transportation as needed/as ordered . Monitor/document/report to physician PRN (as needed) s/sx (signs/symptoms) of oral/dental problems needing attention: .Teeth missing . A review of a Speech Therapy Treatment Encounter Note (s) dated 2/2/24 revealed, Pt (patient) seen in bedroom for skilled dysphagia tx. (treatment) .Mastication (chewing) prolonged, given partial dentition (condition of teeth), yet seen to be functional .A second entry dated 2/6/24, revealed .SLP (Speech Language Pathology) assisting pt to insert upper dentures; pt still awaiting new set of lower dentures . On 10/9/24 at 9:45 AM, the surveyor requested to view a list of those residents who had filed grievances for reimbursement of missing items. The surveyor reviewed the list provided and noted that the resident was not on the list. During an interview with the surveyor on 10/9/24 at 11:24 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that if a resident reported a missing item she immediately searched for the item with resident permission. LPN/UM #1 stated that if the item was not found, she reached out to housekeeping and dietary and all parties were made aware. LPN/UM #1 stated that Social Work filed a grievance and we started an investigation process. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/9/24 at 12:51 PM, the surveyor observed Resident #143 lying in bed with their meal tray in front of them. The resident stated that he/she reported the loss of their dentures to the Social Worker, but did not recall when the report was made. During an interview with the surveyor on 10/9/24 at 12:54 PM, the Social Worker stated that when someone lost their dentures she put a grievance into the portal and assigned it to both housekeeping and the laundry and then rerouted the grievance to the business office if they were not found. The Social Worker stated that there was a grievance filed on behalf of Resident #143 on 09/08/23, after the residents dentures were not found. The Director of Social Services (DSS) was present and stated that once the grievance was filed it went to everyone's email and the matter was discussed in morning meeting. The DSS stated that she did not remember if there was any follow up. The Social Worker stated that she spoke with the resident yesterday and he/she mentioned that he/she wanted their dentures replaced due to weight loss. The SW stated that she communicated that to both the Unit Manager and the Unit Clerk. The surveyor asked the Social Worker if she ever followed up with the grievance filed on 09/08/23 prior to yesterday and she stated that when the resident brought it up to her previously, she informed the resident that the facility was still looking for them. The surveyor asked the Social Worker if she documented when the resident asked about the status of his/her missing dentures and she stated, No. At that time, the DSS stated that the Social Worker should have documented the resident's concerns about their missing dentures and followed up. The DSS further stated that the delay could have been prevented if there was follow up with both the business office and the administrator. The DSS stated that there have been a few different Administrators and Business Office Officials since that time. On 10/9/24 at 4:15 PM, the surveyor reviewed a physician's order dated 10/9/24, within Resident #143's Electronic Health Record (EHR) for a Dental Consult RE: Bottom dentures, that was placed after surveyor inquiry. During an interview with the surveyor on 10/10/24 at 11:05 AM, the Business Office Manager (BOM) stated that she had worked at the facility since the end of July 2024. She stated that when a grievance was filed in the portal a notification email was sent that informed the recipient, A grievance has been assigned to your department. The BOM stated that the grievance should live in the system historically, but there may have been a discrepancy, as she did not see a grievance related to Resident #143's missing denture and could not speak to that. The BOM stated that this happened fairly recently with another resident and it was identified that it was the facility's liability and we received an invoice from the resident's dentist and paid the dentist directly. The BOM stated that she was informed yesterday that Resident #143's dentures were missing and spoke with the resident's spouse to initiate the process. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 10/10/24 at 11:52 AM, the surveyor interviewed the Regional Director of Operations (RDO) who stated that he was not the Licensed Nursing Home Administrator (LNHA) on record when Resident #143's grievance for missing dentures was reportedly filed. The RDO stated that a grievance was assigned to a party, and an email was sent out to all parties, and the LNHA was responsible to drive the investigation at that moment. The RDO stated the communication was well connected, but there was no answer on the grievance related to the missing dentures from September 2023. The RDO sated that he would have liked to have thought that the Social Worker followed up. The RDO stated, The grievance investigation starts and stops with the administrator. The RDO stated, There was certainly a lapse and delay there. The RDO further stated that the Social Worker did not follow up with the new administrator or it would have been taken care of. During an interview with the surveyor on 10/10/24 at 12:52 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) #4 stated that Resident #143 was set up to go and see the dentist for denture replacement after surveyor inquiry. LPN/UM #4 further stated that he did not think that the resident reported the missing dentures to him prior. During an interview with the surveyor on 10/15/24 at 10:51 AM, the Director of Nursing (DON) stated that when a resident's denture was missing and could not be found we contacted the family to verify and if we can not find it, we consult with dental and get an impression and pay for the service if we found out that we were at fault or the denture was lost. The DON stated, My expectation was for the service to be provided sooner. During an interview with the surveyor in the presence of the survey team on 10/16/24 at 10:33 AM, the DON stated that Resident #143's dental appointment was scheduled and the Business Office would pay for dentures. The DON provided the surveyor with an updated physician's order dated 10/15/24 at 20:51 (8:51 PM) for a Dental consult for replacement dentures. A review of an undated facility policy, Grievances/Complaints, Recording and Investigating revealed the following: All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve grievances (s). The administrator has assigned the responsibility of investigating grievances and complaints to the grievance officer. Upon receiving a grievance and complaint report, the grievance officer will begin an investigation into the allegations. .The Resident Grievance/Complaint Investigation Report will be filed with the administrator within five (5) working days of the incident. The Resident, or person acting on behalf of the resident will be informed of the findings of the investigation, as well as any corrective actions recommended. .Copies of all reports must be signed and will be made available to the resident or person acting on behalf of the resident. (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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-15.1(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. Building B. Wing	10/16/2024

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41260 Based on observation, interview, and review of other pertinent facility documents, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was identified in the facility's kitchen and 5 of 5 refrigerators designated for resident food, and was evidenced by the following: On [DATE] from 9:30 AM to 10:45 AM, the surveyor, accompanied by the Food Service Director (FSD) toured the kitchen and observed the following: In the refrigerator identified as the Korean Refrigerator: 1. Two sealed bags of cooked rice with a use-by date of [DATE]. The FSD removed the two bags from refrigerator and discarded them. On [DATE] at 10:36 AM, the surveyor, accompanied by the Registered Nurse/Unit Manager (RN/UM) observed the following in the refrigerator designated for resident food in the East unit pantry: 1. Single-serving size containers of cranberry cocktail juice that had a use-by date of: -,d+[DATE] (1 container) -,d+[DATE] (1 container) -,d+[DATE] (1 container) -,d+[DATE] (1 container) -,d+[DATE] (3 containers) -,d+[DATE] (12 containers) -[DATE] (1 container) 2. Single-serving size containers of apple juice with a use-by date of: -,d+[DATE] (8 containers) -,d+[DATE] (2 containers) -,d+[DATE] (8 containers) 3. Single-serving size containers of orange juice with a use-by date of: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-,d+[DATE] (1 container) 4. Single-serving size container of fat-free lactose-free milk with a use by date of: -[DATE] (2 containers) -Undated (1 container) The RN/UM removed and discarded the expired beverages. 5. Two blue reusable tote bags with containers of unlabeled, undated food. One tote bag was stuck to the shelf of the refrigerator and was leaking a sticky, syrup-like liquid. The RN/UM stated the tote bags contained food brought in by visitors. During an interview at that time, the RN/UM stated she was unsure who was supposed to maintain the unit pantry. On [DATE] at 10:48 AM, the surveyor, accompanied by Licensed Practical Nurse (LPN) #1, observed the following in the refrigerator designated for resident food on the Central unit: 1. There was no thermometer inside the refrigerator, nor a temperature log posted on the outside of the refrigerator to monitor refrigerator temperatures. 2. Two unlabeled, undated plastic beverage cups that were covered with a lid. One cup contained an opaque white liquid, and the other cup contained a clear, yellow liquid. 3. A single-serving size container of vanilla yogurt and strawberry parfait which had a use-by date of [DATE]. During an interview at that time, LPN #2 stated she would discard the expired/undated items, but was not sure who was responsible for maintaining the refrigerator. At that time, Licensed Practical Nurse/Unit Manager (LPN/UM) #4 entered the nurses' station and stated the refrigerator thermometer must have been misplaced, and that the 3:00 PM - 11:00 PM and 11:00 PM - 7:00 AM shift nurses were responsible for checking the refrigerator temperatures. On [DATE] at 10:57 AM, the surveyor, accompanied by LPN/UM #2, observed the following in the refrigerator designated for resident food in the [NAME] Unit pantry: 1. The temperature of the refrigerator was 22 degrees Fahrenheit. The LPN/UM adjusted the refrigerator thermostat. 2. A single-serving size container of creamy strawberry Glucerna (nutritional supplement) that was in the back of the refrigerator and frozen. LPN/UM #2 removed the supplement to discard. 3. Five single-serving size containers of apple juice that had no use-by date. LPN/UM #2 removed the juice containers to discard. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. A plastic wrapped peanut butter and jelly sandwich that had a use-by date of [DATE]. LPN/UM #2 removed the sandwich to discard. During an interview at that time, LPN/UM #2 stated the nurses were responsible for maintaining the unit pantry and refrigerator temps. On [DATE] at 11:08 AM, the surveyor, accompanied by LPN/UM #3, observed the following in the refrigerator designated for resident food in the North 2 unit pantry: 1. A single-serving size fat-free lactose-free milk with a use-by date of [DATE]. LPN/UM #3 removed the milk to discard. During an interview at that time, LPN/UM #3 stated housekeeping maintained the unit pantry and nursing staff monitors the refrigerator temperatures. On [DATE] at 11:19 AM, the surveyor, accompanied by LPN/UM #1, observed the following in the refrigerator designated for resident food in the North 1 unit pantry: 1. Two sealed cheese sticks without a use-by date. LPN/UM #1 stated the cheese sticks could have belonged to staff, but removed them from the refrigerator to discard. 2. Two unlabeled, undated plastic beverage cups that were covered with a lid that were in the freezer portion of the refrigerator and contained frozen liquids. LPN/UM #1 stated the cups belonged to staff and left them in the freezer. During an interview at that time, LPN/UM #1 stated the nursing staff maintained the unit pantry. During an interview with the surveyor on [DATE] at 1:59 PM, the FSD stated nursing staff should be checking the unit pantries for expired food and monitoring the refrigerator temperatures daily. The FSD further stated that food brought in by visitors should be labeled and dated with a use-by date since it would only be good for three days. The FSD added that staff members should not be storing their personal food in the refrigerators designated for resident food. During an interview with the surveyor on [DATE] at 4:12 PM, the Licensed Nursing Home Administrator (LNHA) stated her expectations were that dietary staff should inspect all food items in the kitchen to ensure food is within date and to discard any expired foods. The LNHA further stated that the nursing staff and the FSD should have checked the nursing unit pantries to ensure all food items were stored properly, expired foods were discarded, staff were not storing personal food items in resident refrigerators, and the refrigerator temperatures were monitored. Review of the facility's Refrigerators and Freezers policy, revised ,d+[DATE], included, Refrigerators and/or freezers are maintained in good working condition. Refrigerators keep foods at or below 41 degrees Fahrenheit and freezers keep frozen foods solid, and, Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures. Further review of the policy included, Supervisors are responsible for ensuring food items in the pantry, refrigerators, and freezers are not past 'use by' or expiration dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Foods Brought by Family/Visitors, undated, included, Food brought in by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility-prepared food, and, The nursing staff will discard perishable foods on or before the 'use by' date. NJAC 8:,d+[DATE].2(g)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43308 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure staff implemented facility policies and procedures to ensure a.) residents were provided with care and services to achieve their highest practical wellbeing, and b.) maintain the resident environment, equipment and living areas in a safe, sanitary, and homelike manner. This deficient practice was identified for and 5 out of 5 nursing units, and was evidenced by the following: Refer to F584, F645, F657, F689, F758, and F812 A review of the Administrator's job description provided by the facility revealed the following: The Administrator's primary purpose is to direct the day-to-day functions of the center in accordance with current federal, state, and local standards, guideline, and regulations that govern nursing centers to assure that the highest degree of quality care can be provided to the residents at all times. Duties and Responsibilities included but not limited to: plan, develop, organize, implement, evaluate, and direct the center's programs and activities. Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the center. Review the center's policies and procedures at least annually and make changes as necessary to assure continued compliance with current regulations. Ensure that all employees, residents, visitors, and the general public follow the center's established policies and procedures. Delegate administrative authority, responsibility, and accountability to other staff personnel as deemed necessary to perform their assigned duties. Ensure that all Center personnel, residents, visitors, etc., follow established safety regulations, to include fire protection/prevention, smoking regulations, infection control, etc. Ensure that the building and grounds are maintained in good repair. Ensure that the Center is maintained in a clean and safe manner for resident comfort and convenience by assuring that necessary equipment and supplies are maintained to perform such duties/services. During the entrance conference on [DATE] at 9:45 AM, the LNHA stated that she started at the facility five (5) days ago and the Director of Nursing (DON) started at the facility three (3) months ago. At that time, the LNHA stated the facility had residents who identified as smokers. 1.) On [DATE] at 12:27 PM, the surveyor entered Resident #144's room and smelled a cigarette-like smoke scent. The resident was observed lying in bed with the fan on and the window open. At that time, the surveyor interviewed the resident who stated they were not allowed to smoke in their room, but they had to wait for hours for the staff to come into the room to assist them. The resident stated that the staff did not take them out to smoke, so they smoked tobacco in their room. A review of Resident #144's incident reports revealed that the resident was observed smoking cigarettes in their room on [DATE], [DATE], and [DATE]. Interventions included that the individualized comprehensive care plan (ICCP) was updated. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the surveyor on [DATE] at 1:30 PM, the DON stated that the resident was assessed as an independent smoker and was allowed to hold their cigarettes and lighter. When asked did the resident smoke in their room, the DON stated that the resident informed them that they had smoked in their room. The surveyor conducted a telephone interview on [DATE] at 8:48 AM, with the Medical Doctor (MD), who stated that he had a problem with Resident #144 smoking since they had been caring for the resident. The MD stated that the resident had been resistant to care and that the staff bend over backward. The MD stated that the facility had done everything to keep the lighter and cigarettes from the resident, and the facility was going to do better with the smoking residents and the other residents. 2.) During the tour of the facility throughout the survey, it was determined that the facility failed to maintain the residents' environment, equipment and living areas in a safe, sanitary, and homelike manner on all five nursing units (East, West, Central, North 1, and North 2). During an interview with the surveyor on [DATE] at 3:06 PM, the Director of Housekeeping (DHK) stated in the presence of the the Regional DHK (RDHK) and survey team, that the floor mats and mattresses should be cleaned. On [DATE] at 3:07 PM, in the presence of the survey team, the DHK stated that the air conditioner (AC) vents were supposed to be wiped daily and deep cleaned weekly. The DHK stated that she did not expect to see a thick coating of dust on the outside of the air-conditioning units. The DHK further stated that it could cause health issues in residents with respiratory problems. On [DATE] at 3:15 PM, the RDHK stated that the [NAME] Unit was the most difficult to clean. He stated there was more movement and upkeep of the unit and that it was harder to get clean with the clientele in that vicinity. During an interview with the surveyor on [DATE] at 4:14 PM, in the presence of the survey team, the LNHA stated that housekeeping and maintenance should ensure the AC units were cleaned and remained dust free weekly. 3.) On [DATE] from 9:30 AM to 10:45 AM, the surveyor, accompanied by the Food Service Director (FSD) toured the kitchen and it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. During an interview with the surveyor on [DATE] at 1:59 PM, the FSD stated the nursing staff should be checking the unit pantries for expired food and monitoring the refrigerator temperatures daily. The FSD further stated that food brought in by visitors should be labeled and dated with a use-by date since it would only be good for three days. The FSD added that staff members should not be storing their personal food in the refrigerators designated for resident food. 4.) On [DATE] at 10:08 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #97. A review of the PASARR level I Screening Tool dated [DATE], and signed by the facility's social worker (SW), indicated the following: (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Section II- Intellectual Disability/Developmental Disability/Related Conditions Screen (ID/DD/RC) indicated a positive screening, which required a level II PASARR to be completed. Further review of the EMR revealed there was no evidence of a level II PASARR was completed. During an interview with the surveyor on [DATE] at 4:51 PM, the LNHA stated in the presence of the [NAME] President of Clinical (VPCS), Regional Director of Clinical Services (RDCS), the Regional Director of Operations (RDO), DON, and the survey team that the expectation was that the level II PASARR would be completed prior to admitting the resident. The LNHA acknowledged that the level II PASARR should have been completed. 5.) A review of Resident #73, #102 and #198 individualized comprehensive care plan (ICCP) revealed conflicting interventions related to smoking. A review of Resident #198's ICCP included a focus, created [DATE], of I smoke. Interventions included two conflicting interventions: store all smoking materials in my room, and that, the facility will safely secure all smoking materials. A review of Resident #102's ICCP, with revision dated of [DATE], included a focus area of I smoke cigarettes. Interventions included: I understand that for my safety, the facility will store my nicotine products and my lighter, I understand that the facility will store my lighter and cigarettes for safety reason, I am able to smoke safely independently (initiated [DATE]), and I use a smoking apron (initiated [DATE]). A review of Resident #73's ICCP included a focus, revised [DATE], of I smoke. Interventions included two conflicting interventions: I am able to smoke independently and store all smoking materials in my room, and that, for my safety, the facility will safely secure all smoking materials. During an interview with the surveyor on [DATE] at 4:20 PM, in the presence of the survey team, the DON stated that the smoking care plan was auto populated by the responses on the Smoking Safety Evaluation and that any conflicting interventions should have been corrected the next day by nursing management. 6.) A review of 5 of 5 residents (Resident #17, #40, #109, #167, and #358) for psychotropic medications revealed the following was not addressed: recommendations for a gradual dose reduction (GDR) of psychotropic medications (mood altering medications); ensure as needed (PRN) psychotropic medications were prescribed with a 14-day duration and re-evaluated for continued use; and adequately monitor target behaviors for the use of psychotropic medications. A review of Resident #17's Psychiatric Evaluation (psych eval), dated [DATE], revealed the resident reported they had been refusing bupropion (an anti-depressant medication) because it gave them hallucinations and that they requested to stop olanzapine (an anti-psychotic medication). Further review of the psych eval included recommendations of a GDR by stopping bupropion and olanzapine. A review of Resident #17's June through [DATE] Medication Administration Records (MARs) revealed there were no physician's orders to monitor target behaviors related to psychotropic medication use prior to [DATE]. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident #40's June, July, August, September, and [DATE] MARs and Treatment Administration Record (TARs) did not include any PO for targeted behavior monitoring related to anxiety or depression. A review of Resident #358's [DATE] Physician Order Summary Report (OSR) reflected that the resident was on the following psychoactive medications: A physician's order (PO), dated [DATE], for Xanax (alprazolam), oral tablet 0.25 milligram (mg); give one tablet by mouth every 12 hours as needed for anxiety/agitation/restlessness. There was no stop date indicated. A review of Resident #358's July, August, September, and [DATE] MARs and TARs did not include any PO for behavior monitoring related to anxiety, depression or bipolar medications. A review of Resident #109's OSR dated as of [DATE], included the following PO: A PO dated [DATE], for Risperdal 1 mg; administer one tablet by mouth two times a day for psychosis. A review of Resident 109's [DATE] MAR did not include any behavior monitoring or monitoring of side effects of psychotropic medications prior to surveyor inquiry. A review of Resident #167's PO revealed that the resident had an order for quetiapine fumarate tablet 100 mg; give one tablet by mouth at bedtime for mood disorder. There was no evidence that the resident's behavior was being monitored. During an interview with the surveyor on [DATE] at 3:45 PM, in the presence of the LNHA, the Director of Clinical Services, the [NAME] President of Clinical Services and the survey team, the DON stated that a PO for Xanax would need a 14-day stop date on the order. During an interview with the surveyor on [DATE] at 3:57 PM, in the presence of the survey team, the DON stated the facility utilized a batch order set to create physician's orders for behavior monitoring. The DON further stated that behavior monitoring should be documented on the MAR every shift. During an interview with the surveyor on [DATE] at 4:18 PM, in the presence of the survey team, the DON stated that psych recommendations should be verified and implemented according to the provider. The DON further stated that the provider should document in the resident's medical record when recommendations were reviewed. On [DATE] at 10:26 AM, the LNHA acknowledged the concerns that were brought to her attention in the presence of the DON and the survey team. NJAC 8:,d+[DATE].2(a); 9.3(a); 27.1(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40041 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to A.) perform hand hygiene before preparing and administering medications. B.) failed to maintain a non-touch technique when returning excess medication to the original bottle. and C. failed to disinfect the blood pressure equipment after each use. This breach in infection control practice occurred during 2 of 4 medication administration observation. This deficient practice was evidenced by the following: 1.) On 10/09/2024 at 08:21 AM during the Medication Administration task, the surveyor observed Licensed Practical Nurse (LPN) #1 prepare and administer Resident #92's medication. He/She did not perform hand hygiene prior to preparing the resident's medication and after administration. 2.) During the same medication observation, Resident #92 had an order for Tylenol extra strength tablet, give two tablet by mouth every 12 hours. LPN #1 erroneously poured 3 tablets into the bottle cap instead of 2 tablets. As LPN #1 returned the excess tablet to the original bottle, she touched the resident's 2 tablets with bare hands to prevent them from falling back into the bottle along with the excess tablet. 3.) On 10/09/24 at 09:02 AM, during a medication observation, LPN#7 took Resident #16's blood pressure (BP). He/She did not disinfect the blood pressure cuff after taking the resident's BP. On 10/10/24 at 10:55 AM, during an interview with the surveyor, when asked when should hand hygiene be performed, LPN/UM#1 stated before entering and exiting a resident's room. LPN/#1 was also asked when should a blood pressure cuff be cleaned? She/He stated, it should be cleaned immediately after use and after every resident. On 10/11/24 at 11:54 AM, during an interview with the surveyor, the Infection Preventionist (IP) stated, hand should be performed prior to medication pass and after and in between each resident, by using alcohol based hand sanitizer or washing with soap and water. During further interview with the IP, she/he stated that pills should never be touched with bare hands. When asked what is the process for cleaning the BP cuff, the IP stated, it should be cleaned after every use, take them and wipe it down and sanitize them before using it for the next person. A review of the facility policy revised in 10/2023, Hand Washing/Hand Hygiene Administrative Practices to Promote Hand Hygiene 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene and preventing the transmission of healthcare-associated infections. Indications for Hand Hygiene 1. C. after contact with blood, body fluids or contaminated surfaces; NJAC 8:39-19.4(a)