STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Glen Center	25 E Lindsley Road Cedar Grove, NJ 07009

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 38327 Based on the interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold policy for one of (1) of two (2) residents, (Resident #82), reviewed for hospitalization s. This deficient practice is evidenced by the following: On 8/01/24 at 10:39 AM, the surveyor observed Resident #82 lying on their bed while watching the television with an indwelling catheter (a catheter which is inserted into the bladder, via the urethra and remains in situ to drain urine). There was an Enhanced Barrier Precaution (EBP) sign outside the door. The surveyor reviewed the hybrid (a combination of paper, scanned, and computer-generated records) medical records of Resident #82. The Admission Record (or face sheet, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to essential hypertension (elevated blood pressure), other retention of urine, anemia (low blood count) unspecified, type 2 diabetes mellitus without complications. According to the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 7/16/24, revealed in Section C Cognitive Patterns a brief interview for mental status (BIMS) score of 14 out of 15 which indicated that the resident was cognitively intact. Further review of the MDS showed that there were four most recent Discharge Return Anticipated (DRA) MDSs, indicating that the resident was transferred to the hospital. A review of the Progress Notes showed the following: -On 5/05/24, Registered Nurse #1 (RN#1) documented that the resident was transferred to the hospital. -On 5/14/24, RN#2 documented that the resident was transferred to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/23/24, RN#3 documented that the resident was transferred to the hospital. -On 7/05/24, a Licensed Practical Nurse (LPN) documented that the resident was transferred to the hospital. On 8/05/24 at 8:36 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) regarding the resident's transfers to the hospital. The RN/UM stated that it was the responsibility of the Business Office Manager (BOM) to notify the responsible party (RP) of the resident about the bed hold. On 8/05/24 at 9:06 AM, the BOM in the presence of the survey team informed the surveyor that she was responsible for the bed hold notification. The BOM provided a copy of the Bed hold Notice-Deliver Upon Transfer Policy with a revision date of 8/2022. She also provided a copy of the Bed Hold Notice of Policy & Authorization for the date 5/15/24 and confirmed that was all she had for the bed hold transfer notification of Resident #82. On 8/09/24 at 8:12 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) of the above concern that there were no copies of the Bed Hold Notice of Policy & Authorization for dates 5/05/24, 5/23/24 and 7/05/24. A review of the facility's Bed hold Notice-Deliver Upon Transfer Policy with a revision date of 8/05/22 that the BOM provided revealed: Process: Prior to a resident's transfer out of the center to a hospital or for therapeutic leave, the staff member conducting the transfer out will provide both the resident and representative, if applicable, with the Bed Hold Policy Notice & Authorization form. -Notice must be given regardless of payer. -Resident copy is given directly to the resident prior to transfer and noted in the medical record. -Representative copy can be delivered electronically via email/secure fax or hard copy via mail if the representative is not present at the time of transfer. (Must be done within 24 hours.) . What does the Business Office do? . -Keep a copy of the Bed Hold Policy Notice & Authorization form to monitor that the original is signed and returned within a reasonable time; and -Place the signed letter in the resident's financial file when it is returned. On 8/09/24 at 12:41 PM, the survey team met with the LNHA and Director of Nursing for the Exit conference. The facility management did not provide additional information and did not refute findings. N.J.A.C. 8:39-5.1 (a); 5.2 (a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 46049 Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for three (3) of 24 residents, Residents #23, 109, and 167, reviewed for accuracy of MDS coding. This deficient practice was evidenced by the following: 1. The surveyor reviewed the electronic health record (EHR) of Resident #109 which revealed the following: The Admission Record (AR; a summary of important information about the resident) revealed that Resident #109 had diagnoses that included, but were not limited to, spinal stenosis (narrowing of the space around the spinal cord), osteoporosis (a condition which bones become weak and brittle), and hypertension (high blood pressure). The most recent Discharge-Return Not Anticipated (DRNA) MDS assessment, under section A, A2105, Discharge Status it was coded that the resident was discharged to 4. Short-Term General Hospital. A review of progress notes (PN) revealed the resident was discharged (d/c) on 7/18/24 to the community. On 8/05/24 at 01:10 PM, the MDS Coordinator (MDSC) was not available for interview. The surveyor interviewed the Regional Clinical Reimbursement Manager (RCRM) who was responsible for overseeing the MDSCs. The surveyor discussed with the RCRM about the concern for the coding of the resident's d/c status. The RCRM stated she would review Resident #109's MDS assessment. On 8/06/24 at 9:50 AM, the LNHA stated the RCRM reviewed the MDS assessment for Resident #109 and it was modified to reflect that the resident was d/c to the community and not to the hospital. 2. On 8/01/24 at 10:29 AM, the surveyor observed Resident #23 lying in their bed, alert and verbally responsive. Resident #23 stated they had wounds and received wound treatment from nursing staff. The resident further explained they had chronic non-pressure ulcers to both lower legs and a wound physician visited weekly to examine the wounds. The surveyor reviewed the EHR of Resident #23 which revealed the following: The AR revealed that Resident #23 had diagnoses that included, but were not limited to, peripheral vascular disease (a condition of narrowed blood vessels which reduce blood flow to the limbs), and non-pressure chronic ulcer of the left and right lower limb. A Quarterly MDS assessment, dated 6/21/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #23 scored a 15 out of 15, which indicated the resident was cognitively intact. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under section M, M1030, Number of Venous and Arterial Ulcers [ulcers caused by problems with blood flow] it was coded 0 to indicate that the resident had no venous and arterial ulcers. A review of June 2024 wound consultant PN and wound assessment notes revealed the resident was being treated for venous ulcers to the lower extremities. On 8/07/24 at 12:00 PM, the survey informed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) of the above concerns of Residents #23 and #109. The surveyor requested the facility's MDS policy. On 8/08/24 at 12:47 PM, the LNHA and DON met with the survey team. The DON acknowledged that the DRNA MDS assessment for Resident #109 was not coded accurately. The DON also acknowledged that the MDS assessment for Resident #23 was not coded accurately to reflect that the resident had venous ulcers and stated the MDS assessment was modified. On that same date and time, the DON further stated that there was no facility MDS policy and the MDSC followed the Resident Assessment Manual (RAI) manual guidelines. A review of the latest version of the Center for Medicare/Medicaid Services - RAI 3.0 Manual (updated October 2023), Chapter 3-page A-42, under A2105, Coding Instructions read: .Code 1, Home/Community: if the resident was d/c to a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care . Code 4, Short-Term General Hospital (acute hospital/IPPS): if the resident was d/c to a hospital . A review of the latest version of the Center for Medicare/Medicaid Services - RAI 3.0 Manual (updated October 2023), Chapter 3-page M-31, under M1030, Coding Instructions read: .Enter the number of venous and arterial ulcers present .Enter 0: if there were no venous or arterial ulcers present. 39885 3. On 8/05/24 at 12:06 PM, the surveyor reviewed the closed medical record for Resident #167 who no longer resided at the facility. A review of Resident #167's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down), neuropathy (a nerve condition that can lead to pain, numbness, weakness or tingling in one or more parts of the body) and chronic viral hepatitis C. A review of Resident #167's Discharge Return Anticipated Minimum Data Set (DRAMDS) reflected that the resident did not have any pressure ulcers. A review of the EHR indicated hospital records which included documentation that the resident was transferred from the hospital to the facility with an unstageable, necrotic sacral wound. On 8/06/24 at 9:12 AM, the surveyor interviewed the DON regarding Resident #167's pressure ulcer. The DON stated that the resident had a wound when the resident was admitted to the facility. The surveyor then asked the DON to view the Resident #167's DRAMDS and that it was coded as no for unhealed pressure ulcer/injury. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/06/24 at 11:45 AM, the DON stated that she spoke with the MDSC and that the MDS was not coded correctly. She added that the MDS would be corrected. On 8/07/24 at 12:16 PM, in the presence of the survey team, the surveyor notified the LNHA and the DON the concern that Resident #167's DRAMDS was not accurate and did not contain the residents pressure ulcers. The DON stated that Resident #167's DRAMDS was modified (corrected). On 8/08/24 at 12:52 PM, in the presence of the survey team, the DON stated that the facility did not have a policy for MDS. She added that the facility followed the RAI manual. The facility did not provide any additional information. N.J.A.C. 8:39-11.1, 11.2

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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 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. 38327 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) act upon the recommendations of the Urologist for one (1) of two (2) residents (Resident #82) reviewed for the care of urinary catheter and b.) ensure a resident's medication administration time was adjusted to accommodate their dialysis (a clinical purification of blood as a substitute for the normal function of the kidneys) for one (1) of one (1) resident (Resident #12), reviewed for dialysis, according to facility's policies and standards of clinical practice. 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 or 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 regimes 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. On 8/01/24 at 10:39 AM, the surveyor observed Resident #82 lying on their bed while watching the television with an indwelling catheter (a catheter which is inserted into the bladder, via the urethra and remains in situ to drain urine). There was an Enhanced Barrier Precaution (EBP; gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multidrug-resistant organisms] as well as those at increased risk of MDRO acquisition [example, residents with wounds or indwelling medical devices]) sign outside the door. The surveyor reviewed the hybrid (a combination of paper, scanned, and computer-generated records) medical records of Resident #82. The Admission Record (AR; or face sheet, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to essential hypertension (elevated blood pressure), other retention of urine, anemia (low blood count) unspecified, type 2 diabetes mellitus without complications. According to the quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 7/16/24, revealed in Section C Cognitive Patterns a brief interview for mental status (BIMS) score of 14 out of 15 which indicated that the resident was cognitively intact. Section H Bladder and Bowel revealed that Resident #82 had an indwelling catheter. (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 Inpatient Consult to Urology note that was uploaded on 5/17/24 to the resident's electronic medical records [in the documents], the date of the Consult Note was 5/15/24 revealed the reason for consult was BPH (benign prostatic hyperplasia; age-associated prostate gland enlargement that can cause urination difficulty) and urinary retention with assessment and recommendations to start Tamsulosin (or Flomax; a medication (med) that can treat an enlarged prostate (BPH). There was no documented evidence that the resident's medical doctor (MD) was notified of the above recommendations on 5/15/24 Urology Consult and why the Tamsulosin med was not ordered. On 8/07/24 at 9:11 AM, the surveyor interviewed the Director of Nursing (DON) regarding the resident's indwelling catheter. The DON informed the surveyor in the presence of the survey team that the MD ordered to remove the foley catheter and do voiding trial. The DON stated that the voiding trial failed and the resident was sent out to the hospital on 5/23/24 with diagnosis of Urinary retention. On that same date and time, the DON stated that there was a Urology consultation done in the hospital dated 5/15/24 with recommendations to start on Tamsulosin. The DON further stated that she (DON) discussed the recommendations and Consult notes with the MD yesterday (8/06/24) and the MD ordered the med to be started. At that time, the surveyor asked the DON why the recommendations on 5/15/24 were not acted upon until the surveyor's inquiry. The DON responded, I do not know why, it was not followed and relayed to the MD at that time. She further stated that it was an expectation that recommendations should have been relayed to the doctor and followed through promptly. The DON acknowledged that the 5/15/24 recommendations were not acted upon until almost three months after the surveyor's inquiry. On 8/07/24 at 12:00 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON. The Surveyor notified of the above findings and concerns regarding Resident#82. On 8/09/24 at 12:41 PM, the survey team met with the LNHA and DON for the Exit conference. The facility did not provide an additional information and did not refute findings. 46049 2. On 8/01/24 at 9:42 AM, the surveyor observed Resident #12 sitting up on their bed. The resident was alert, and verbally responsive. The resident stated they went to dialysis every Tuesday, Thursday, and Saturday. Resident #12 further explained they left the facility to dialysis around 01:00 PM and returned from dialysis around 7:00 PM. On 8/05/24 at 9:14 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #12. The AR documented that the resident had diagnoses that included but were not limited to, end stage renal [kidney] disease, and anemia. A qMDS with an ARD of 4/28/24, indicated the facility assessed the resident's cognition using a BIMS test, Resident #12 scored a 15 out of 15, which indicated the resident was cognitively intact. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order (PO) dated 01/30/24 read, Hemodialysis at [Dialysis Center Name] on TUESDAY-THURSDAY-SATURDAY Chair time at [time], Pick up by [Transport Company] at [time]. [Dialysis Center's address and phone number] A PO dated 01/23/24 read, Vitamin D3 Oral Tablet 125 MCG (5000 UT) (Cholecalciferol) Give 1 tablet by mouth one time a day for Supplement . A review of the electronic Med Administration Record (eMAR) for July and August 2024 revealed: The Vitamin D3 medication entry was scheduled be given daily at 1700 [5PM] and signed as administered by the assigned nurses. A review of progress notes in July and August 2024 revealed on dialysis days it was documented that the resident returned from dialysis to the facility after 6 PM. On 8/05/24 at 10:41 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to care for Resident #12. The LPN stated med administration times should accommodate a resident's dialysis time. The LPN further explained meds could be given an hour before or an hour after it was scheduled to be administered. The surveyor reviewed the eMAR with the LPN and informed her the times the resident was documented as returning from dialysis. The LPN stated if the resident was returning after 6 PM, the med time for the Vitamin D3 med should be adjusted. On 8/05/24 at 10:48 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) who stated med times should be adjusted to accommodate dialysis times. The surveyor reviewed with the RN/UM the eMAR and nurse documentation of the resident's return time from dialysis. The RN/UM stated the Vitamin D med administration time had to be updated. The RN/UM further explained it would be expected that the nurse would hold the med and follow up with the physician to clarify the med scheduled time. On 8/07/24 at 12:00 PM, the surveyor informed the LNHA and the DON of the above concerns. The DON stated it was expected for the med administration times to be adjusted to accommodate a resident's dialysis schedule. The surveyor requested any policies related to med scheduling for dialysis residents. On 8/08/24 at 12:47 PM, the LNHA and DON met with the survey team. The DON stated the scheduled time for Resident #12's Vitamin D was clarified to be administered at a time the resident was not in dialysis. The DON further explained she was following with the assigned nurses on the evening shift about what happened. The DON stated the resident was coming back usually between 6-7 PM. The DON and LNHA stated there were no other policy besides the dialysis policy. The surveyor requested the facility's med administration policy. The surveyor reviewed the facility provided policy Dialysis: Hemodialysis (HD- Communication and Documentation with a last revision date of 6/15/22. The provided policy did not address adjustment of med schedule to accommodate a resident's dialysis schedule. The surveyor reviewed the facility provided policy Medication Administration General Guidelines dated 01/24. Under Procedure, Med Administration it read, 1. Meds are administered in accordance with written orders of the prescriber . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-11.2 (b); 27.1 (a); 29.2(d)

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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. 49078 Complaint#: NJ#174298 Based on interviews, record review, and review of other pertinent facility-provided documentation, the facility failed to ensure a.) that the resident with injury of unknown origin received treatment and implemented an intervention according to comprehensive assessment and person-centered care plan in accordance with professional standards of practice, and facility's policy and procedure for one (1) of three (3) residents, Resident #165, reviewed for abuse. 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 or 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 regimes 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 Resident #165's hybrid (combination of paper and electronic) closed medical records revealed the following: The Admission Record (an admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; repeated falls, unspecified dementia, and hypertension (high blood pressure). The Physician's progress note dated 8/24/23 included, new onset area of ecchymosis near rt (right) eye pt (patient also known as resident) has no pain or recent injury improving. A review of the Reportable Event dated 8/21/23 for Resident #165 showed documentation that included an investigation for an injury of unknown origin and reflected a description of the incident, a conclusion, and interventions. The documentation reflected that the injury was a bluish-purplish discoloration around the left eye. Additional documentation included but was not limited to witness statements, incident reports, and resident-specific care plans. Further review of the 8/21/23 Reportable Event revealed Summary and Conclusion a description of the incident and a conclusion that reflected the facility findings for how the resident obtained the injury. The facility findings reflected that the resident received the injury while leaning or pushing their face on a bedside rail. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attached to the 8/21/23 Reportable Event were five witness statements. There were none of the statements reflected any mention of side rails or the resident leaning on the side rails. Furthermore, the hybrid medical records and Reportable Event on 8/21/23 showed that there was no documented evidence that the staff observed or noted that the resident used or leaned on side rails that had caused the bluish-purplish discoloration around the left eye. The individualized Care Plan (CP) revealed: 1. Focus: at risk for falls (initiated 8/11/23): cognitive loss and lack of safety awareness. Interventions included: Ambulation assistance of one with a rolling walker and low bed position. 2. Focus: at risk for injury or complications related to (r/t) anticoagulation therapy medication: Aspirin and clopidogrel. Interventions included continue to provide supervision for safety, (initiated on 8/21/23). 3. Focus: resident exhibits or is at risk for alterations in comfort r/t acute pain, and chronic pain (initiated 8/11/23). Interventions included assist the resident to a position of comfort and utilizing pillows and appropriate positioning devices (initiated 8/11/23). Further review of the CP showed that there was no focus CP and interventions were initiated for 8/21/23 injury of unknown origin to the left eye. On 8/07/24 at 12:16 PM, the surveyor in the presence of the survey team met with the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) to discuss the above concerns with the incident of 8/21/23. The surveyor requested if there was any further information that could be provided that was pertinent to the resident care plans, witness statements, and investigations specific to side rails for the 8/21/23 incident and if the CP interventions should match and specifically address the incident. On 8/08/24 at 12:47 PM, the surveyor in the presence of the survey team met with the DON and LNHA. The DON stated that the investigation concluded that ruled out a fall and the resident was observed leaning on the side rail. The surveyor asked the DON if there was a statement in the medical record. The DON stated she would provide one. On that same date and time, the DON provided a copy of the resident's CP that reflected an intervention of pillows and positioning. The DON also provided a copy of the resident's CP with a focus that the resident was at risk for elopement r/t expressed a desire to leave the facility and diagnosis of dementia that included interventions to monitor the resident's location with visual checks at all times every shift that was initiated on 8/22/23. At that time, the surveyor reviewed the provided CP interventions for pillow and positioning which showed that this intervention was initiated on 8/11/23, and the incident occurred on 8/21/23. (continued on next page)

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Arbor Glen Center	25 E Lindsley Road Cedar Grove, NJ 07009

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that same time, the surveyor asked the DON if these visual checks were documented, if there was always an order for visual checks of location every shift, and how the staff knew what to do. The DON stated that there was no specific documentation, and there was no specific order. The DON stated that the staff, such as nurses, nurse aides, and therapy personnel should check periodically the resident while providing care or services, but no specific times or how many times per shift. The DON was not able to further specify how this intervention would be put in place and why it did not address the concern for the 8/21/23 injury of unknown origin. On 8/9/24 at 12:00 PM, the surveyor met with the DON and LNHA in the presence of the survey team. No further documentation or pertinent information was provided. A review of the facility-provided policy Person-Centered Care Plan with a reviewed/revised date of 10/24/2022, revealed the following: Purpose: To eliminate or mitigate triggers that may cause re-traumatization of the patient. N.J.A.C. 8:39-27.1 (a)

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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. 46049 Complaint #NJ160835 Based on interview, and record review it was determined that the facility failed to provide care and services consistent with professional standards of clinical practice for a resident with pressure ulcers. This deficient practice was identified in one (1) of four (4) residents, Resident #168, reviewed for pressure ulcer care and prevention. The deficient practice was evidenced by the following: On 8/05/24 at 12:19 PM, the surveyor reviewed the hybrid (paper and electronic) medical records for Resident #168. The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, dementia, and muscle weakness. A quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/18/22, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #168 scored a 3 out of 15, which indicated the resident had severe cognitive impairment. A review of the November 2022 Treatment Administration Record (TAR) for Resident #168 revealed: A Physician's Order (PO) dated 7/15/22 read, Bilateral 1/4 rails as enabler for turning and repositioning while in bed. every shift. There were seven (7) of 90 entries not signed by the nurse and left blank. A PO dated 9/06/22 read Moisture Barrier - apply every shift and as needed to peri-area and buttocks every shift for MASD (moisture-associated skin damage). There were seven (7) out of 90 entries that were not signed by the nurse and left blank. A review of the December 2022 TAR for Resident #168 revealed: A PO dated 7/15/22 read, Bilateral 1/4 rails as enabler for turning and repositioning while in bed. every shift There were six (6) of 93 entries not signed by the nurse and left blank. A PO dated 9/06/22 read Moisture Barrier - apply every shift and as needed to peri-area and buttocks every shift for MASD. There were six (6) out of 93 entries that were not signed by the nurse and left blank. A PO dated 12/01/22 read, Float heels while in bed on pillow every shift for intact blood blister to right heel ensure pillow is located underneath the ankles for proper usage. There were six (6) out of 93 entries that were not signed by the nurse and left blank. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A PO dated 12/01/22 read Skin Prep Wipes Miscellaneous (Ostomy Supplies) Apply to right heel topically every shift for intact blood blister for 21 Days cleanse prior to application with H2O[water] + soap, air dry, leave open to air and elevated on pillow located underneath the ankles. There were five (5) of 63 entries not signed by the nurse and left blank. A PO dated 12/19/22 read Low airloss mattress to bed every shift Settings ___Check settings and functions every shift. There was one (1) of 37 entries not signed by the nurse and left blank. A PO dated 12/25/22 read, Apply skin prep to the right heel every shift every shift for Wound care On while on bed, off when out of bed. There was one (1) of 20 entries not signed by the nurse and left blank. A PO dated 12/26/22 read Heel boot on left heel while in bed, monitor for placement. every shift on while on bed, off when out of bed. There was one (1) of 18 entries not signed by the nurse and left blank. A PO dated 12/26/22 read Heel boot on right heel, monitor for placement every shift for Wound care. There was one (1) of 18 entries not signed by the nurse and left blank. A PO dated 12/27/22 and was discontinued 12/27/22 read Apply non sting barrier on sacrum DTI (deep tissue injury) wound daily and PRN (as needed) every day shift. The entry of the order was not signed by the nurse and left blank. A PO dated 12/27/22 read Apply skin prep on the left lateral calf DTI and cover with optifoam, change it daily and PRN every day shift. There was one of five entries not signed by the nurse and left blank. A PO dated 12/27/22 and was discontinued 12/27/22 read Cleanse wound with normal saline, pat dry and apply zinc oxide and open to air daily and PRN every day shift. The entry of the order was not signed by the nurse and left blank. A PO dated 12/28/22 and was discontinued 12/28/22 read Cleanse wound on sacral (DTI) area with normal saline, pat it dry and apply zinc oxide, open to air daily and PRN every day shift. The entry of the order was not signed by the nurse and left blank. A PO dated 12/28/22 read, Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to Sacral wound topically every day shift for Sacral wound Cleanse wound with normal saline, pat dry and apply santyl to the slough area and cover with dry protective dressing. There was one (1) of 4 entries not signed by the nurse and left blank. The surveyor reviewed progress notes (PN) for Resident #168. A nurse PN dated 12/01/22 indicated the resident had a right heel wound. A wound consultant PN dated 12/01/22, documented the resident was referred to the wound care team due to a new right heel DTI wound. The resident was examined, and wound care recommendations provided. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse PN dated 12/19/22, documented the resident had a new left lateral (side of) calf DTI and sacral DTI. Additionally, the note documented the physician and family member was made aware and wound treatment orders carried out. A wound consultant PN, dated 12/22/22, documented that the resident was seen and examined for a right heel DTI wound, new left lateral (side of) calf partial thickness DTI and new sacral partial thickness DTI wound. The wound consultant recommended wound care treatment orders. A nurse PN dated 01/05/23 documented that the resident had a new left heel DTI wound. A wound consultant PN, dated 01/05/23, documented that the resident was seen and examined for a right heel DTI wound, left lateral calf DTI, sacral DTI and new a new left heel partial thickness DTI. Additionally, the note documented poor wound prognosis related to the resident's medical complexity and contributing factors. The wound consultant recommended wound care treatment orders. The surveyor reviewed incident reports provided by the facility. An incident report, dated 12/01/22, for a new in-house wound of the right heel was reviewed. The report included wound description, assessment of wound, evaluation of resident status and environment, assessment of wound, staff statements, resident representative and physician notified, interventions to be implemented and conclusion. There were no additional incident reports found for Resident #168. On 8/08/24 at 12:10 PM, the surveyor interviewed a Licensed Practical Nurse (LPN) in the presence of the Registered Nurse Unit Manager (RN/UM) regarding wound care protocols. The LPN stated if a resident was found with a new wound, a change of condition, incident report would be initiated. The nurse would notify the physician, resident representative, the resident's treatment plan would be reviewed, the resident's care plan updated, and orders carried out as per the physician. The RN/UM stated skin assessments were conducted weekly and the unit managers made rounds with the wound consultant who visited weekly. There was a skin/wound evaluation assessment that was to be completed weekly by the unit manager and the wound consultant notes were in the residents' medical records. On 8/08/24 at 01:10 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The surveyor informed the DON and LNHA of the concern that there were no investigations found for the wounds the resident acquired in the facility after 12/01/22. The DON stated it was expected for an investigation to be completed when a resident was found with a facility acquired wound. The DON stated she was not the current DON at that time and would have to follow up to provide further information. On 8/09/24 at 11:30 AM, the DON provided the surveyor with an incident report for the resident's left heel wound found on 01/05/23. The report dated 01/05/23 included the wound description, assessment of wound, action taken, evaluation of resident status and environment, resident representative and physician notified, interventions to be implemented and conclusion. The report listed staff who provided statements. There were no statements attached with the report. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor asked the DON if there were any reports for the sacral and left lateral calf DTI wound the resident acquired in December 2022. The DON stated she could not find any additional investigation reports for the resident. On 8/09/24 at 11:54 AM, the survey team met with the LNHA and DON. The surveyor informed the LNHA and DON of the above concerns with no investigations for the resident's sacral and left lateral calf wound. The surveyor also discussed the concern for entries in the TAR that were not signed by the nurses and left blank, which included pressure relieving interventions and wound treatments. The DON stated it would be expected for the nurses to complete the TAR and sign whether a treatment was administered or not. The DON acknowledged if the entries are blank and not signed, then it was considered not done. There was no additional information provided by the facility. The surveyor reviewed the facility's policy Skin Integrity and Wound Management, with a review dated of 5/01/24. Under Policy it read: The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed. Under Practice Standards it read: . 3. Complete risk evaluation on admission/readmission, weekly for the first month, quarterly, and with significant change in condition. 4. Identify patient's skin integrity status and need for preventions or treatment interventions through review of all appropriate assessment information . 6. The licensed nurse will .6.4 Perform and document skin inspection on all newly admitted /readmitted patients weekly thereafter and with any significant change of condition .6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds .6.7 Notify interdisciplinary team members for a comprehensive approach to care including prevention and wound treatments, as indicated . 7. Collaborate with the wound provider to review co-morbid conditions that may affect healing. 8. Notify physician/APP (advance practice provider) to obtain orders. 11. Review care plan and revise as indicated . NJAC 8:39-27.1 (e)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39885 Based on observation, interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to initiate an active care plan for smoking and complete the entire smoking assessment for one (1) of one (1) resident reviewed for smoking (Resident #24). This deficient practice was evidenced by the following: On 8/01/24 at 01:45 PM, the surveyor reviewed the facility provided list of smokers which reflected that Resident #24 was an independent smoker. On 8/05/24 at 10:25 AM, the surveyor reviewed Resident #24's electronic medical record and revealed: Resident #36's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to spina bifida (a birth defect in which a developing baby's spinal cord fails to develop properly), acquired absence of kidney (missing one kidney due to an injury or operation), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, revealed in Section C Cognitive Status Brief Interview for Mental Status (BIMS) score of 15 out of 15 which reflected that the resident's cognition was intact. A review of Resident #24's Smoking Evaluation (an assessment used to evaluate if a resident was able to smoke independently or required supervision) dated 5/16/24, indicated under section E. Evaluation that Independent smoking is allowed. Further review indicated that in section F. Care Plan, the boxes for Focus, Goal, and any interventions were not checked. The Evaluation was not completed. The individualized care plan did not indicate there was a care plan for smoking. On 8/05/24 at 10:48 AM, the surveyor observed Resident #24 seated in a wheelchair outside in with another resident in the designated smoking area. The surveyor interviewed Resident #24 regarding the smoking process. Resident #24 stated that they had rules to follow and that the staff would keep the cigarettes and lighter. On 8/05/24 at 10:55 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the smoking process. The LPN stated that there was a designated area outside with scheduled times. The LPN stated that staff kept the cigarettes and lighter and would give it to the resident when they went to smoke and then collect them when they were finished. The surveyor asked if a resident that smoked would have a care plan for smoking. The LPN stated that they should have a care plan for smoking. The surveyor asked the LPN if Resident #24 smoked. The LPN confirmed that Resident #24 smoked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/05/24 at 11:00 AM, the surveyor asked the Unit Manager to print Resident #24's care plan. A review of the printed care plan reflected a care plan for smoking with a revision done by the UM on 8/05/24. The surveyor asked the UM about the care plan. The UM stated that the resident had stopped smoking and the care plan for smoking was resolved (no longer active and did not pertain to the resident at that time). She added that she just saw Resident #24 go outside to smoke today so she redid (unresolved to make active) the smoking care plan today. The surveyor then reviewed Resident #24's care plan history which included the following: Care plan for may smoke independently per smoking evaluation had a created date of 11/16/2023 and was revised on 11/30/2023 and 12/05/2023. The care plan was resolved on 2/16/2024. There was a revision which made the care plan active on 8/05/2024. There was no active care plan for smoking while the resident was on the facility's smoking list until after surveyor inquiry. On 8/05/24 at 12:33 PM, the surveyor interviewed the Director of Nursing (DON) regarding the care plan for residents that smoked. The DON stated that residents that smoked should have a smoking care plan. On 8/07/24 at 12:14 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and the DON the concern that Resident #24 did not have a care plan for smoking prior to surveyor inquiry and that the smoking assessment was not completed to include the section on care plan. On 8/08/24 at 01:01 PM, in the presence of the survey team and DON, the LNHA stated that Resident #24's smoking care plan had been resolved and that they did not know how it happened. She added that the care plan should have been active and not resolved prior to 8/05/24. The LNHA stated that all the residents that smoked were audited and their evaluations were done and that they were checking the facility process. The facility did not provide any additional information. A review of the facility provided policy titled, Smoking with a revision date of 10/24/22, included the following: 2.3 The admitting nurse will perform a Smoking Evaluation on each patient who chooses to smoke. 2.3.1 Patients will be re-evaluated quarterly and with a change in condition. 2.5 A care plan for patients who smoke shall include such elements as the need for supervision or physical assistance while smoking and safety devices that are needed, such as a smoking apron to prevent burns. The care plan will be updated as necessary. A review of the facility provided policy titled, Person-Centered Care Plan with a revision date of 10/24/22, included the following: 6.1 The care plan must be customized to each individual patient's preferences and needs (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals . N.J.A.C. 8:39-27.1(a)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 46049 Based on observation, interview, record review, and review of other pertinent facility documentation it was determined that the facility failed to ensure a resident with history of post-traumatic stress disorder (PTSD) was comprehensively evaluated and care planned to receive appropriate treatment and services to attain the highest practicable mental and psychosocial well-being. This deficient practice was identified for one (1) of one (1) resident (Resident #91) reviewed for mood and behavior. This deficient practice was evidenced by the following: On 8/01/24 at 10:01 AM, the surveyor observed Resident #91 resting in bed. The resident was alert, and verbally responsive. Resident #91 stated they liked to stay in their room and watch television. The resident verbalized no concerns. A review of the facility provided matrix (a document used to identify important care categories for residents in the facility) revealed Resident #91 was indicated as having PTSD/Trauma. The surveyor reviewed the electronic medical record of Resident #91 which revealed the following: The Admission Record (a summary of important information about the resident) revealed that Resident #91 had diagnoses that included, but were not limited to, depression, hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (a stroke) affecting the left side, and hypertension (high blood pressure). PTSD was not listed as a diagnosis for the resident. A comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/11/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #91 scored a 9 out of 15, which indicated the resident had moderate cognitive impairment. Under Section I-Active Diagnoses, Psychiatric/Mood Disorder the resident was only coded for depression. A Physician's Order (PO) dated 5/07/24 read, Dental, ophthalmology, podiatry, physiatry, psych,wound Obtain Consult as needed/indicated and treatment for patient health and comfort. A PO dated 5/07/24 read, DULoxetine HCl Capsule Delayed Release Particles 60 MG (milligram) Give 1 capsule by mouth one time a day for depression. A PO dated 5/07/24 read, Mirtazapine Tablet (tab) 7.5 MG Give 1 tab by mouth at bedtime for depression target behavior: verbalizing sadness. A PO dated 5/30/24 read, Ativan Oral Tab 0.5 MG (Lorazepam) Give 1 tab by mouth at bedtime for anxiety target behavior: yelling to exhaustion. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A PO dated 6/26/24 read, SEROquel Oral Tab 50 MG (Quetiapine Fumarate) Give 1 tab by mouth at bedtime for psychosis target behavior: delusional paranoia. A review of the Medication Administration Record for June 2024 and July 2024 revealed it did not address the resident's history of PTSD or any identified triggers. A review of the resident's care plans (CP) revealed there was no CP that addressed PTSD. On 8/06/24 at 11:23 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to care for Resident #91. The LPN stated staff were aware the resident had a history of PTSD. The LPN further explained the resident was apprehensive with care and anxious. The LPN stated the resident had since improved and there were no acute concerns with the resident. The LPN could not specify the resident's PTSD triggers that could cause resident to re-experience their original trauma. The LPN added that the resident did not currently exhibit any symptoms and was seen by the psychiatry team and a psychologist. On 8/09/24 at 9:03 AM, the surveyor interviewed the Psychiatry Physician Assistant (PPA#1) who had examined the resident. PPA#1 stated that she completed the initial evaluation for Resident #91, screened for PTSD, and it was negative. She further explained review of the medical records did not include diagnosis of PTSD. PPA#1 stated PPA#2 who saw the resident at the end of May 2024, documented in their note that resident had a history of PTSD, and could not speak to PPA #2's documentation. PPA#1 stated that based on the resident's symptoms, the resident more than likely had a history of PTSD. PPA#1 further explained the resident exhibited symptoms that included being jumpy, anxious, and had a history of psychosis. PPA#1 acknowledged that PTSD was not a disorder that simply goes away, it could reoccur, and the resident should be monitored. On 8/09/24 at 9:31 AM, the surveyor interviewed the Director of Social Services (DSS) who stated residents who were admitted into the facility were screened for PTSD/trauma. The DSS stated Resident #91 did not have a known diagnosis of PTSD prior to their admission and stated it was a family member who mentioned that the resident had a history of PTSD. The DSS stated the psychiatry team was notified to evaluate the resident. The DSS acknowledged if a resident was found with a history of PTSD the resident should be assessed and it should be CP. On 8/09/24 at 9:48 AM, the surveyor interviewed the Director of Nursing (DON) about the above concerns. The DON acknowledged that a resident with a reported history of PTSD should be evaluated, and CP, as a unknown PTSD trigger may cause the resident to re-experience trauma. On 8/09/24 at 11:54 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON about the concern of there not being a comprehensive interdisciplinary evaluation and CP for a resident identified with a history of PTSD. There was no additional information provided by the facility. The surveyor reviewed the facility's policy Trauma Informed Care with an effective date of 5/01/24. Under Policy it read, Centers will provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preferences and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Glen Center	25 E Lindsley Road Cedar Grove, NJ 07009

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under Process it read: .4. The Center will collaborate with patient trauma survivors, and as appropriate, the patient's family, friends, the primary physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized CP interventions .6. The Center will identify triggers which may re-traumatize patients with a history if trauma .8. The Center will evaluate whether the interventions have mitigated (or reduced) the impact of identified triggers on the patient that may cause re-traumatization . NJAC 8:39-27.1 (a), 28.1 (c)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 39885 Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to adequately monitor the target behavior for the use of a psychotropic medication specifically a antipsychotic medication (used to manage psychosis, a mental disorder characterized by a disconnection from reality) by not having an order for behavior monitoring and indicating the target behavior on the resident's individualized care plan for one (1) of five (5) residents (Resident #36) reviewed for unnecessary medications. This deficient practice was evidenced by the following: On 8/06/24 at 9:44 AM, the surveyor observed Resident #36 seated upright in bed. On 8/06/24 at 01:06 PM, the surveyor reviewed Resident #36's hybrid (a combination of paper, scanned, and computer-generated records) medical record. A review of Resident #36's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood), parkinsonism (a clinical syndrome and presenting with various neurodegenerative diseases, which manifest with motor symptoms such as rigidity, tremors, bradykinesia, and unstable posture, leading to profound gait impairment) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Resident #36's care plan (CP) included the following focus area: At risk for complications related to the use of psychotropic drugs Medication (med): Ativan (used to treat anxiety), Lexapro (used to treat certain mental/mood disorders such as depression and anxiety) Aripiprazole (an antipsychotic med which is also a psychotropic med, that helps treat several kinds of mental health conditions that balances the levels of dopamine and serotonin in the brain to regulate mood, behaviors and thoughts) for depression with anxiety with an initiated date of 7/13/2024. The focus area included the following interventions: Complete behavior monitoring flow sheet; Gradual dose reduction as ordered; Monitor for changes in mental status and functional level and report to MD as indicated; Monitor for continued need of med as related to behavior and mood; Monitor for side effects and consult physician and/or pharmacist as needed; Obtain psych evaluation as ordered. A review of the psychiatric progress note dated 7/18/24 included the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	History of depression treated with Lexapro and Abilify .Hallucinations (A perception of having seen, heard, touched, tasted, or smelled something that was not actually there) began about 3 weeks ago . Clinical Signs & Target Symptoms: Anxiety; depression; hallucinations MONITORED PSYCH MEDICATIONS (with DIAGNOSES): .Abilify (Aripiprazole) 5 mg (milligram) PO (by mouth) QD (daily) (adjunct depression (a constant feeling of sadness and loss of interest), psychosis . Resident #36's CP did not indicate the target behavior of hallucinations to be monitored for the use of the anti-psychotic med Abilify (Aripiprazole). A review of Resident #36's July and August 2024 electronic Medication Administration Record (eMAR) included the following order: Aripiprazole (Abilify) Tablet 15 MG Give 7.5 mg by mouth one time a day for Psychosis. With a Start Date of 7/19/2024. The order did not include a target behavior to be monitored. Further review of the July and August 2024 eMAR did not include any additional order for behavior monitoring related to a target behavior for the anti-psychotic med. There was no documented evidence on the eMARs that a target behavior was being monitored. There was also no documented evidence that the resident was being monitored for the side effects of an anti-psychotic med. There was no documented evidence in Resident #36's hybrid medical record that a target behavior was being monitored for the anti-psychotic med that Resident #36 was taking. On 8/07/24 at 11:22 AM, the surveyor interviewed the Registered Nurse (RN) regarding the process for psychotropic and antipsychotic medications (meds) and behavior monitoring. The RN stated that the process was if a resident was manifesting a behavior or received a psychotropic med (mood altering meds) that they would monitor behavior with a target behavior (specific behavior that the resident exhibited). She added the behavior would be documented in the electronic medical record on the eMAR. The RN stated that a particular question what is the behavior and what is the intervention would populate on the screen and would need to be answered. The RN stated that the behavior monitoring was part of the med order. The RN stated that the behavior monitoring was used by the physician to order new meds or to reduce the dose of the med used. The surveyor then asked the RN to view Resident #36's eMAR. The RN confirmed that the eMAR did not have an order for behavior monitoring and that the med order did not have a target behavior to be monitored. The RN stated that there should have been an order for behavior monitoring which included a target behavior and that she did not know why it was not on the eMAR. The surveyor then asked if the target behavior should be included in the resident's CP. The RN stated that the unit manager would do the CP and that the target behavior should be on the CP. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/07/24 at 11:38 AM, the surveyor interviewed the Director of Nursing (DON) regarding the process for psychotropic and antipsychotic meds and behavior monitoring. The DON stated that for a resident that received psychotropic meds there would have to be an appropriate diagnosis that indicated the need for the med. The DON stated that a psych consult would be done to review the need for the med and then the physician would follow up. The DON stated that behavior monitoring would be in the electronic medical record on the eMAR. The DON stated that there should be a CP for psychotropic meds which would include monitor for side effects and a target behavior. The surveyor asked the DON what the importance of behavior monitoring was. The DON stated that the importance of behavior monitoring was to see if the target behavior had improved and to make sure the resident was not placed on an antipsychotic that was not really indicated and for a gradual dose reduction if not contraindicated. On that same date and time, the surveyor notified the DON that Resident #36's CP did not have the target behavior listed for the use of the anti-psychotic med. The DON stated that the CP should have the target behavior. On 8/07/24 at 12:17 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and the DON the concern that Resident #36 did not have any documented behavior monitoring of the target behavior for the antipsychotic med and that there was no target behavior listed on the CP. On 8/08/24 at 01:06 PM, in the presence of the survey team and LNHA, the DON stated that Resident #36 did not have behavior monitoring for psychotropic med and that it was corrected. The DON stated that the CP should have had the target behavior and that it was updated. The survey requested a policy regarding anti-psychotic and psychotropic meds and behavior monitoring. On 8/09/24 at 9:01 AM, the DON stated that the facility did not have a specific policy for psychotropic or anti-psychotic meds. The DON stated that the facility only had a policy on Behaviors. The facility did not provide any additional information. A review of the facility provided policy titled, Behaviors: Management of Symptoms with a revision date of 7/01/24, included the following: Policy Patients exhibiting behavioral symptoms will be individually evaluated to determine the behavior. The interdisciplinary team identifies underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to the patient's behavior . Based on the comprehensive assessment, staff must ensure that a patient: -Who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; . Staff will use non-pharmacological interventions as the first line of approach to managing challenging behaviors. Behaviors and interventions will be addressed in the CP . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose To identify, prevent, and manage behavioral symptoms by: . Monitoring outcomes of CP interventions. To minimize the use of psychotropic meds, including antipsychotics, for patients with behavioral symptoms and/or dementia. Practice Standards 1. The Center utilizes the comprehensive assessment process to identify and assess a patient's mental and psychosocial status. 2. Staff will monitor for and document in the medical records any exhibited behavioral symptoms . 4. Implement individualized, person-centered, non-pharmacological interventions as the initial behavior mitigation strategy and update CP accordingly . 5. The Center will ensure that necessary behavioral health services are person-centered and reflect the patient's goals of care, while maximizing the patient's dignity, autonomy, privacy, socialization, independence, choice, and safety. A review of the facility provided policy titled, Behavioral Health Care and Services with a revision date of 10/24/22, included the following: Policy Each patient/resident (hereinafter patient) must receive and the Center must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a patient's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders Practice Standards 1. Patients will be provided the necessary behavioral health care and services to include: 1.1 Ensuring that the necessary care and services are person-centered and reflect the patient's goals for care, while maximizing the patient's dignity, autonomy, privacy, socialization, independence, choice, patient rights, and safety; . 1.5 Ensuring that pharmacological interventions (medications) are only used when non-pharmacological interventions are ineffective or when clinically indicated. N.J.A.C. 8:39-27.1 (a)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 38327 Based on the interview and review of pertinent facility documentation, the facility failed to have the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) present for one (1) of three (3) quarterly Quality Assurance Performance Improvement (QAPI) meetings. This failure had the potential to affect all 111 residents who currently live in the facility. The deficient practice was evidenced by the following: On 8/01/24 at 9:44 AM, the surveyor met with the LNHA and the DON during an Entrance Conference meeting. Both the LNHA and the DON confirmed that day census (total number of residents) of 111 with no bed hold. On 8/01/24 at 12:09 PM, the LNHA provided the last three-quarters of QAPI sign-in sheets and revealed the following: QAPI Attendance: 01/17/24=the Medical Director (MD), DON, and other Interdisciplinary Team (IDT) signed the QAPI Attendance sheet. There was no documented evidence in the sign-in sheet that the LNHA and the Infection Preventionist (IP) attended the meeting. 4/15/24=the LNHA, MD, DON, IP, IDT, and vendor representative signed the QAPI Attendance sheet. 7/17/24=the LNHA, MD, IP, IDT, and vendor representatives signed the QAPI Attendance sheet except for the DON. There was no documented evidence that the DON attended the meeting. A review of the provided copy of the QAPI Meeting Calendar 2024 the LNHA revealed the following schedules: 01/17/24 Quarterly 4/17/24 Quarterly 7/17/24 Quarterly 10/16/24 Quarterly On 8/07/24 at 12:00 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above findings regarding the attendance in QAPI meetings where the LNHA and the IP were not present on 01/17/24 and the DON on 7/17/24. On that same date and time, the LNHA stated that she was on vacation on 01/17/24 and also the IP was probably on vacation at that time. The LNHA further stated that on 7/17/24 the DON was on vacation which was why they were not present during the QAPI meetings. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/09/24 at 8:09 AM, the LNHA provided a copy of the IP's timesheet for 01/17/24 and revealed that the IP worked from 8:00 AM to 4:30 PM. The LNHA stated that the IP worked on 01/17/24 and she did not know why the IP did not sign the Attendance sheet for QAPI. A review of the facility's Center Quality Assurance Performance Improvement Process Policies and Procedures with a revision date of 10/24/22 that was provided by the LNHA revealed: Process: 2. The QAA (Quality Assessment and Assurance) Committee: 2.1 Functions under the authority of the Administrator and the Governing Body is composed of: 2.1.1 Administrator, 2.1.2 DON, 2.1.3 MD, 2.1.4 IP, or designee, 2.1.5 Consultant Pharmacist (recommended, 2.1.6 Patient and/or family representatives (if appropriate), 2.1.7 Three (3) additional staff representatives including, but not limited to, department heads, certified nursing assistants (CNA), rehabilitation services, hospice, home health, etc. 2.2 Meets at least quarterly. On 8/09/24 at 12:41 PM, the survey team met with the LNHA and DON for the Exit conference. The facility did not provide additional information and did not refute findings. NJAC 8:39-33.1 (b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 REPEAT DEFICIENCY Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene practices for one (1) of two (3) staff (Housekeeper) and b.) follow transmission-based precautions (TBP) and enhanced barrier precautions (EBP) protocol to prevent the potential spread of infection for two (2) of two (2) residents (Residents #82 and #108) reviewed for infection control, in accordance with the Center for Disease Control and Prevention (CDC) guidelines and facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient . Before moving from work on a soiled body site to a clean body site on the same patient . After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. According to the CDC guidelines dated 4/02/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) included information for EBP when to use PPE (personal protective equipment) during high contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use for EBP include: Dressing . Providing hygiene Changing linens . Device care or use: central line, urinary catheter, . Implementation (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When implementing Contact Precautions or EBP, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves Make PPE, including gowns and gloves, available immediately outside of the resident room . Incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education Provide education to residents and visitors . 1. On 8/01/24 at 10:27 AM, the surveyor interviewed the unit 1 SA (subacute) Registered Nurse/Unit Manager (RN/UM). The RN/UM informed the surveyor that residents with indwelling catheters (or foley catheters), tube feedings, and wounds would be placed on EBP and staff were required to use PPE and perform hand hygiene before and after using PPE. She further stated that EBP protocol would be observed when performing direct care to the resident and the environment of the resident on EBP. On 8/01/24 at 10:32 AM, the surveyor observed the Housekeeper (HK) came out of the toilet room from room [ROOM NUMBER] with gloves and a surgical mask. The HK immediately went to the cleaning cart which was parked in front of room [ROOM NUMBER] without removing used gloves and did not perform hand hygiene. There was a posted sign for EBP outside the door of room [ROOM NUMBER]. During an interview with the HK, the HK claimed that she cleaned the toilet room. Afterward, the HK went back to the room with the same gloves and wiped the nightstand table of room [ROOM NUMBER]D (the room near the door). Then, the HK went back to her cleaning cart and removed both used gloves, and donned (put on) a new pair of gloves without performing hand hygiene. There was no ABHR inside and outside the resident's room of 101. At that time, the surveyor asked the HK what she should do after removing her gloves, and the HK did not respond. The surveyor then asked the HK why she did not perform hand hygiene after removing and putting on a new pair of gloves. The HK stated that she should use ABHR in between gloves. The surveyor also observed the HK was looking inside the resident's room for something, and the HK stated and confirmed that there was no ABHR within the area that was why she did not perform hand hygiene. On 8/01/24 at 10:42 AM, the surveyor interviewed and notified the RN/UM of the above concerns regarding HK. The RN/UM stated that the HK should perform hand hygiene after removing gloves and before donning a new pair of gloves. She further stated that the HK should have removed her gloves after cleaning the toilet room prior to cleaning room [ROOM NUMBER]D's nightstand or immediate environment to prevent cross-contamination. A review of the facility's Personal Protective Equipment Policy with a revision date of 4/15/23 provided by the LNHA revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Process: 6. Gloves: 6.3. Change gloves after contact with each individual resident or after contact with contaminated articles. 6.4. Wash hands after removing gloves. A review of the facility's Hand Hygiene with a revision date of 5/01/24 provided by the LNHA on 8/5/24 at 10:29 AM showed: Policy: The use of gloves does not replace hand hygiene. If a task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves Process: 1. Perform hand hygiene: 1.1. Before patient/resident care; . 1.3. After any contact with blood or other body fluids, even if gloves are worn; . 1.5. After contact with the patient's environment 2. On 8/01/24 at 10:39 AM, the surveyor observed Resident #82 lying on their bed, with an indwelling catheter (a catheter which is inserted into the bladder, via the urethra and remains in situ to drain urine), while watching the television . There was an EBP sign outside the door. The surveyor reviewed the hybrid (a combination of paper, scanned, and computer-generated records) medical records of Resident #82. The Admission Record (AR; or face sheet, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to essential hypertension (elevated blood pressure), other retention of urine, anemia (low blood count) unspecified, type 2 diabetes mellitus without complications. According to the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 7/16/24, revealed in Section C Cognitive Patterns a brief interview for mental status (BIMS) score of 14 out of 15 which indicated that the resident was cognitively intact. Section H Bladder and Bowel revealed that Resident #82 had an indwelling catheter. A review of the Lab (laboratory) Results Report showed that RN/UM reviewed the report on 5/24/24 at 15:47 (3:47 PM) and showed that the urine cult (culture) colony ct (count) final report: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Colony count: 100,000+ Gram-negative rods Extended Spectrum Beta Lactamase (ESBL)-Positive . Contact precautions indicated. According to the Order Summary Report (OSR) there was a physician order (PO) dated 5/24/24 for Bactrim DS Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) Give 1 tablet by mouth every 12 hours for UTI (urinary tract infection) until 06/01/2024. A review of the antibiotic stewardship (antimicrobial stewardship is a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by MDROs) binder provided by the LNHA showed that on May 2024 and June 2024 monitoring and tracking list, the resident was not listed for positive ESBL in urine. Further review of the hybrid medical records revealed that there was no documented evidence that the physician was notified of the 5/24/24 ESBL positive results, no care plan (CP) nor PO for contact precaution. On 8/07/24 at 9:11 AM, the Director of Nursing (DON) informed the surveyor in the presence of the survey team that the Infection Preventionist Nurse (IPN) was on vacation and would not be at the facility. On 8/07/24 at 10:45 AM, the surveyor interviewed the RN/UM. The RN/UM informed the surveyor that as facility's practice and expectation, the nurse should notify the physician of the abnormal lab results and if it requires isolation like contact precautions according to the lab results, the facility will initiate the isolation, obtain a PO from the doctor of what kind of isolation, update the CP for isolation and document it in the electronic medical records. On that same date and time, the surveyor notified the RN/UM of the above concerns and findings regarding Resident #82's positive ESBL in urine results, and the RN/UM had no response. On 8/07/24 at 10:50 AM, the DON stated that after reviewing the resident's medical records, there was no PO for contact precaution for positive ESBL in urine and no CP initiated when the results came out on 5/24/24. The DON acknowledged and further stated that she was aware that there was no documented evidence that the physician was made aware of the lab results and that she (DON) met with the nurses about the above findings and concerns after the surveyor's inquiry. On 8/07/24 at 12:00 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON. The Surveyor notified of the above findings and concerns regarding the HK. The surveyor also notified the facility management of the findings about Resident#82's ESBL in urine for TBP that the facility failed to identify, track, monitor, and/or report the infection on 5/24/24 and there was no documented evidence that the physician was made aware of the ESBL report on 5/24/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Glen Center	25 E Lindsley Road Cedar Grove, NJ 07009

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Contact Precautions with a review date of 5/01/23 that was provided by the LNHA revealed: Process: . 3. Instruct staff, patient and their representative, and visitors regarding Precautions and the use of PPE . 6.1. Notify the healthcare provided in the receiving area of the impending arrival of the patient and of the precautions necessary to prevent transmission; . 8. Once the patient is no longer a risk for transmitting the infection (i.e., duration of the illness and/or can contain secretions), discontinue precautions. A review of the facility's Infection Prevention and Control Program Description Policy with a revision date of 6/07/21 that was provided by the LNHA showed: The major activities of the program are: 1. Surveillance of Infections which includes ongoing monitoring to identify possible communicable diseases or infections before they can spread to others in the Center and to whom they should be reported. 2. Process Surveillance to review infection prevention and control practices directly related to patient care. 5. Report of Infection and Communicable Disease which includes routine monthly infection control reporting and specific Department of Health reporting according to state and local regulations . 7. Antibiotic Stewardship Program which includes antibiotic use protocols and a system for monitoring antibiotic use Goals: The IPCP (Infection Prevention and Control Program) has been developed to provide staff with a coordinated organizational structure, technical procedures, comprehensive work practices, and guidelines to reduce the risk of transmission of infection or communicable diseases.The goals of the program are to: 1. Provide a safe, sanitary and comfortable environment; 2. Decrease the risk of infection to the patients and staff; 3. Monitor for occurrence of infection and communicable disease and implement appropriate control measures; . 3. On 8/01/24 at 10:45 AM, the surveyor observed Resident #108's room with a posted sign for Standard and Contact Precaution, and the resident was not inside the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/01/24 at 10:51 AM, the surveyor interviewed the RN/UM who informed the surveyor that Resident #108 was out of the facility for the hyperbaric treatment (or hyperbaric oxygen therapy involves exposing the body to 100% oxygen at a pressure that is greater than normal, to heal properly) of the diabetic wound right foot and would be back around 2 PM. The RN/UM stated that the resident was on EBP due to a wound. The surveyor reviewed the hybrid medical records of Resident #108 and revealed: The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to essential hypertension, type 2 diabetes mellitus with diabetic nephropathy, other acute osteomyelitis (an infection in a bone) right ankle and foot, gas gangrene (a rare bacterial infection that destroys blood cells and soft tissues), and acquired absence of other right toe(s). According to the comprehensive MDS with an ARD of 7/24/24, revealed in Section C BIMS score of 15 out of 15 which indicated that the resident was cognitively intact. Further review of the hybrid medical records revealed that there was no CP and nor PO for EBP. On 8/09/24 at 8:12 AM, the surveyor notified the LNHA of the concern that there was no PO and CP for EBP. On 8/09/24 at 8:27 AM, the RN/UM acknowledged that there was no PO and CP for EBP, and she further stated that should have been done. On 8/09/24 at 12:41 PM, the survey team met with the LNHA and DON for the Exit conference. The facility did not provide additional information and did not refute findings. NJAC 8:39-19.4(a)(1,2,5)(d)(g), 27.1(a)