| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315044 | A. Building<br>B. Wing | 06/26/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mohawk Meadows | 1 O'Brien Lane<br>Lafayette, NJ 07848 |

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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40823<br><br>REF: F600IJ<br><br>Complaint #: NJ00164724<br><br>Based on interviews and record review, as well as the review of pertinent facility documents on [DATE], [DATE], and [DATE], it was determined that the facility failed to communicate the care needs and services to the Physician and related Practitioners of a change in the Resident's condition in accordance with the current standards of practice for a Resident who had a change in condition (CIC) for 1 of 3 residents (Resident #2) reviewed for significant CIC. On [DATE] at approximately 3:45 p.m., the Licensed Practical Nurse (LPN #1), who was at the nurse's station, did not respond immediately when Resident #2's roommate (Resident #1) reported that something might be wrong to Resident #2 in the Solarium. Instead, LPN #1 instructed the Quality Assurance Certified Nursing Assistant (QACNA) to check on Resident #2. QACNA went to check and found Resident #2 sitting in a wheelchair, verbally unresponsive. The QACNA performed a sternal rub, to which the resident did not fully respond. The QACNA immediately called the receptionist to call LPN #1 STAT [Immediately] for immediate assistance. When LPN #1 responded, Resident #2 was verbally unresponsive, and his/her head was leaning down towards the right side. Resident #2 was transferred to his/her bed and assessed by LPN #1 as having a petite mal seizure lasting approx. [approximately] 2 minutes, as documented by LPN #1 in the progress notes (PN) dated [DATE] at 6:29 p.m. Resident #2 remained in bed and closely monitored by a Certified Nursing Assistance (CNA #2) for safety. At approximately 3:59 p.m., LPN #1 instructed the QACNA to stay on the unit and wait until Registered Nurse (RN #1) assigned to the resident for the 4:00 p.m. to 12:00 p.m. shift arrived. LPN #1 left the building without notifying the resident's Primary Care Physician (PCP) of the first resident's seizure activity/CIC. At approximately 4:10 p.m., the QACNA checked on Resident #2 after LPN #1 left the building because RN #1 did not arrive. The QACNA found Resident #2 in bed, quiet, blank, staring, and verbally unresponsive. The QACNA immediately reported to the 3:00 p.m. to 11:00 p.m. shift Supervisor (LPN #2). Resident #2 had a second CIC. He/she was transferred to an Acute Care Hospital (ACH) and died on [DATE].<br><br>The facility's failure to immediately address Resident #2's seizure activity/CIC and notify the resident's PCP of the changes posed a likelihood of serious harm to the health and wellbeing of Resident #2 and potentially all other residents assigned to LPN #1 in an Immediate Jeopardy (IJ) situation.<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The IJ was identified and reported to the facility on [DATE] at 7:14 p.m. The IJ began on [DATE] and continued until [DATE]. The facility provided an acceptable removal plan on [DATE]. On [DATE], the Surveyor returned to the facility to ensure the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating staff. The non-compliance remained on [DATE] for no actual harm with the potential for more than minimal harm that is not an IJ.<br><br>A review of cellphone text messages (CTM) provided to the Surveyor by the PCP on [DATE] at 2:55 p.m. reflected that on [DATE], the following text was received from LPN #1, at 4:22 p.m. [Resident #2] had a seizure lasting about two minutes FYI [for your information], at 5:01 p.m., the PCP responded and asked the LPN Anymore? At 5:15 p.m., the LPN responded, Yes, sent [him/her] to ER [emergency room ].<br><br>The Surveyor conducted a telephone interview with the PCP on [DATE] at 2:44 p.m.; the PCP stated that he was first notified of the seizure activity/CIC through text message on [DATE] at 4:22 p.m. The PCP stated that the facility is expected to call him immediately if a resident has a CIC. The PCP explained that timing is very important and that something went wrong.<br><br>The facility's policy titled CHANGE OF CONDITION, dated ,d+[DATE], indicated under POLICY: All staff members shall communicate any information about resident status change to appropriate licensed personnel immediately upon observation. DEFINITIONS .Acute: a.) Sudden Onset b.) A marked change . Uncharacteristic: Any unusual a typical symptom that is not of the ordinary for a resident. PROCEDURE .6. Notification of physician, time, and date (month, day, and year) are to be documented in the nurse's notes. The licensed nurse must speak directly to the physician: you may not leave a message with the answering service or receptionist. The physician must call back .<br><br>NJAC 8:,d+[DATE].1 (d)<br><br>NJAC 8:,d+[DATE].1 (a)<br><br>NJAC 8:39- 5.1 (a) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40823<br><br>Complaint #: NJ00164724<br><br>Based on interviews, review of medical records (MRs), and other pertinent facility documents on [DATE], [DATE], and [DATE], it was determined that the facility failed to provide services necessary to prevent neglect of a resident (Resident #2) after a seizure activity/change in condition (CIC), follow the facility's policies titled CHANGE OF CONDITION and Abuse Prevention and Prohibition Program, and the LICENSED PRACTICAL NURSE job description. On [DATE] at approximately 3:45 p.m., Resident #2's roommate (Resident #1) went to the Nurse's station and reported to the Nurse that something might be wrong with [Resident #2]. The Nurse in charge (Licensed Practical Nurse - LPN #1) instructed the Quality Assurance Certified Nursing Assistant (QACNA) to check Resident #2 in the Solarium. The QACNA found Resident #2 sitting in a wheelchair, verbally unresponsive and responded to a sternal rub performed by QACNA. The QACNA immediately called the Receptionist to call LPN #1 STAT [Immediately] for immediate assistance because the resident was not responding fully. When LPN #1 responded, she observed Resident #2 was verbally unresponsive, leaning the head down to the right side and staring blankly. Resident #2 was then transferred to bed by the QACNA, CNA #2, and CNA #3 and assessed by LPN #1, who identified the Resident as having a petite mal seizure for approx. [approximately] 2 [two] minutes. Resident #2 remained in bed, and LPN #1 instructed the QACNA to notify a nurse and/or the Nursing Supervisor (NS) in case something happens to [Resident #2]. LPN #1 also assigned CNA #2 to remain outside the Resident's room to ensure that Resident #2 did not get out of bed. LPN #1 then left the building without reporting to a Registered Nurse (RN), the Director of Nursing (DON), and/or the NS of the Resident's seizure activity/CIC. In addition, LPN #1 instructed the QACNA to stay at the Nurse's station until the 4:00 p.m. - 12:00 a.m. nurse arrived. At Approximately 4:10 p.m., Resident #2 had another episode of a seizure/CIC; he/she was transferred to an Acute Care Hospital (ACH) and died on [DATE].<br><br>The facility's failure to immediately address Resident #2's seizure activity/CIC and notify the appropriate staff of the changes posed a likelihood of serious harm to the health and well-being of Resident #2 and potentially all other residents assigned to LPN #1 in an Immediate Jeopardy (IJ) situation.<br><br>The IJ was identified and reported to the facility on [DATE] at 7:14 p.m. The IJ began on [DATE] and continued until [DATE]. The facility provided an acceptable removal plan on [DATE]. On [DATE], the Surveyor returned to the facility to ensure the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating staff. The non-compliance remained on [DATE] for no actual harm with the potential for more than minimal harm that is not an IJ.<br><br>This deficient practice was identified for 1 of 3 residents (Resident #2) and was evidenced by the following:<br><br>According to the facility ADMISSION RECORD (AR), Resident #2 was admitted on [DATE] and discharged on [DATE] with a diagnosis that included but was not limited to Seizures.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Minimum Data Set (MDS), an assessment tool, dated [DATE], revealed a Brief Interview of Mental Status (BIMS) of 12, which indicated the Resident's cognition was moderately impaired and the Resident needed extensive assistance with Activity of Daily Living. The MDS indicated that Resident #2 had Seizure Disorder.<br><br>A review of the Care Plan (CP), initiated on [DATE], included Resident #2 was at risk for a fall due to a Seizure diagnosis. The intervention included but was not limited to Observing for response and providing a safe environment during a seizure episode.<br><br>A review of the Progress Note (PN) documented by LPN #1, dated [DATE] at 6:29 p.m., revealed Resident #2 had a seizure activity at approximately 3:45 p.m. According to the PN, Resident #2 was at the Solarium in her/his wheelchair and had a petite mal seizure lasting approx [approximately] 2 minutes. The PN indicated that the Resident was transferred to his/her bed, yelling at the Nurse to stop taking his/her vital signs (VS) and to get her/him out of bed. The PN indicated Resident's VS were blood pressure (BP) ,d+[DATE], pulse rate (PR) 94 beats per minute (bpm), respiration (R) 20 bpm, temperature (T) 97.1 Fahrenheit (F), and oxygen saturation (OS) was 97%. The PN further indicated that Resident #2 had a seizure and needed to be kept in bed for safety and to monitor closely. The PN indicated that the resident's Primary Care Physician (PCP) was made aware of the episode. At approximately 4:15 p.m., the Resident had another seizure, and that appeared to be grand mal [seizure]. The PN revealed VS were BP ,d+[DATE], PR 44 bpm, R 30 bpm, oxygen saturation 87% (percent). Oxygen was placed on the Resident, and transport was arranged to the hospital while the Resident was being closely monitored by staff. Resident #2 was transported to the hospital at 5:00 p.m. The PN indicated that the PCP and residents' family members were notified.<br><br>Further review of the PN showed no documented evidence that an RN and/or the NS was notified of the Resident's first seizure activity/CIC at 3:45 p.m.<br><br>A review of the cellphone text messages (CTM) provided to the Surveyor by the PCP on [DATE] at 2:55 p.m. reflected that on [DATE], the following text was received from LPN #1, at 4:22 p.m. [Resident #2] had a seizure lasting about two minutes FYI [for your information], at 5:01 p.m., the PCP responded and asked the LPN Anymore? At 5:15 p.m., the LPN responded, Yes, sent [him/her] to ER [emergency room ].<br><br>The Surveyor conducted a telephone interview with the PCP on [DATE] at 2:44 p.m.; the PCP stated that he was first notified of the seizure/CIC through text message on [DATE] at 4:22 p.m. The PCP stated that the facility is expected to call him immediately if a resident has a CIC. The PCP explained that timing is very important and that something went wrong.<br><br>Review of the Transportation Company run sheet (TCRS) report, dated [DATE] at 4:28 p.m., the TCRS received a call from the facility and was dispatched for Unconscious/Fainting. The TCRS revealed the chief complaint was: Patient unresponsive, actively seizing.<br><br>A second TCRS report, dated [DATE] at 4:29 p.m., revealed the TRCRS received a call at 4:29 p.m. and was dispatched for Convulsions/Seizure. The report further showed, PT [patient] is reported to have been seizing for 28 minutes as per staff at the facility. PT is noted to have stiff limbs and flickering eyes. PT is assessed and treated in [the] ambulance .<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of Resident #2's Hospital MR (HMR) dated [DATE] at 5:40 p.m. indicated that Resident #2 presented to the hospital in status epilepticus (A seizure that lasts longer than 5 minutes, or having more than 1 seizure within a 5 minutes period, without returning to a normal level of consciousness between episodes) and was seen immediately on presentation, intubated (insertion of a tube either through the mouth or nose and into the airway to aid with breathing, deliver anesthesia or medications, and bypass a blockage) for airway protection.<br><br>A review of the EMPLOYEE WARNING REPORT (EWR), dated [DATE], written by the former Director of Nursing (DON), indicated that LPN #1 had a violation of misconduct and failed to perform her duty. The EWR further revealed the following: On [DATE] at 4:00 p.m., the Director of Nursing was notified by [Resident #1] that [Resident #2] needed help, the nurse [LPN #1] knew about it, and someone needed to check on her/him stat. The DON wrote on the EWR that she did not see anyone at the Nurse's station, and a CNA was sitting in a chair outside Resident #2's room. The CNA stated, She was watching the patient, who was actively having a tonic-clonic status epilepticus seizure. [LPN #1] was paged, and another CNA [QACNA] notified management that [LPN #1] had 'stepped out of the building to do something for her kids and would be right back' but asked her [CNA] to 'sit at the nurse station to wait for [RN #1]' which was the incoming Nurse. [LPN #1] did not notify nursing management that she was leaving the building at any time. There was no nursing coverage on the unit. The EWR further indicated that Resident #2 needed an immediate medical intervention, required oxygenation, and was sent to [ACH] for further evaluation and admitted to the ICU [intensive care unit]. The EWR indicated, [LPN #1] reported that [Resident #2] had a seizure at about 3:55 pm, and she left the building at exactly 4:00 pm .[LPN #1] further stated that she meant to call the nursing director [DON] to notify that she needed to leave the building but doesn't 'know what happened'. As a Licensed Practical Nurse at [facility], it is your duty to ensure that you make an effort to provide safe patient care to all patients and especially upon change in clinical condition. During this incident you showed failure to perform the duties of your job classification by knowingly leaving the facility after one of your assigned patients had a change in clinical condition and failure to notify your supervisor or management. Failure to provide safe patient care/conditions will result in disciplinary action up to and including termination. 2 DAY SUSPENSION to take place at this time. The EWR was signed by the former DON #1 on [DATE], and LPN #1 refused to sign the EWR.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of LPN #1's statement, dated [DATE], revealed that on [DATE] at approximately 3:45 p.m., she was called by the QACNA in the Solarium because Resident #2 was having what appeared to be a petite mal seizure in his/her wheelchair. Resident #2 was transferred to bed by 3 CNAs (QACNA, CNA #2, and CNA #3). LPN #1 further indicated that immediately following the transfer, the patient [Resident #2] became more alert, talkative, and [her/his] usual argumentative self .I explained to [him/her that he/she] would need to stay in bed for the rest of the night and [he/she] should try to get some rest .At about 3:57 [p.m.]. I returned to the patient's room to check on [the Resident] again and observed [him/her] in bed with [his/her] eyes open .I returned to the desk, looked at my watch, and noted it was 3:59 [pm]. I picked up the desk phone to page a supervisor to inform them I'd be stepping out of the building when [QACNA] walked into my view. Distracted by [QACNA], I put the phone down and said to [QACNA], 'I need to step out. Would you sit here at the desk for a minute or two because [RN #1] should be here any second?' [QACNA] agreed and sat at the Nurse's station. On my way out of the building, I stopped in the lobby where I saw [LPN #2], a nursing supervisor, in the short A2 hallway .and I said to her, 'I am stepping out for a brief time. Do you need anything[?].' She said ok. I left the building and was back by 4:17 [pm] /4:18 [pm]. When I returned .they were sending [Resident #2] to the ER [emergency room ] .I then went to check on the patient, who appeared to be having a seizure and had a non-rebreather. The EMTs eventually were on the unit, followed by the paramedics. They transferred [Resident #2] out at approximately 5 p.m. [5:00 p.m.] .<br><br>The statement further revealed that on [DATE], at 2:15 p.m., DON #1 told LPN #1, .'you are here today because you left the building yesterday without telling anyone, left a patient in distress, and now [he/she] is in the hospital on a ventilator and will possibly die'. LPN #1 responded .that was not the truth, that the patient was NOT in distress, the patient was, in fact, stable, alert and her argumentative self. I also reminded her that I did NOT leave the building without telling 'anyone' and that I informed [QACNA] and was sure she was at the Nurse's station awaiting [RN #1's] arrival, which should have been within literally one or two minutes. I attempted to remind her about seeing [LPN #2] in the hallway, but she [DON #1] kept interrupting and would not give me much of an opportunity to speak. I also mentioned the patient has a long history of seizure disorder along with multiple other co-morbidities, and I had seen on Epic the patient was on a ventilator 'for sedation to properly medicate for seizure . LPN 1# explained in the statement, It is not uncommon practice to ask aid to sit at the desk while a nurse steps out. I also informed [LPN #2], the nursing supervisor, that I was stepping out .I can say with full certainty that there was absolutely NO DELAY in the care the patient received. In fact, when the patient [resident] was found to be having a second seizure, there was an aide sitting right outside the patient's [resident's] room watching [Resident #2]. I left the building at 3:59 p.m. with [QACNA] sitting at the desk and the patient alert and stable. There were [approximately] 6 other nurses in the building .<br><br>Review of the investigation report (IR), conducted by the Administrator, dated [DATE]. The IR's conclusion was the nurse [LPN #1] had informed another nurse/nurse supervisor before stepping out of the building, that [LPN #1] put measures in place to keep watch of [Resident #2] by assigning an aide by the resident and instructing the aid to notify a nurse/nursing supervisor in case something happens to [Resident #2].<br><br>The IR did not indicate that LPN #1 informed LPN #2 and/or an RN of the Resident's first CIC before leaving the building.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of the QACNA statement, dated [DATE], indicated, Around 3:35 p.m. I found [Resident #2] having a Seizure in the Solarium. I called [LPN #1] to come and check [Resident #2]. We put the Resident back to bed with the help of ,d+[DATE] [3:00 p.m. to 11:00 p.m.] aids .[LPN #1] checked [Resident #2] vitals, and [Resident #2] was talking at that time. [LPN #1] said vitals were good that's when we left the room. [CNA #2 and CNA #3] stay [stayed] with [Resident #2] .An aide stay [stayed] by the room. At that time, I went to the desk, and [LPN #1] asked me to stay and wait for [RN #1], which was around 4 p.m. [4:00 p.m.] .<br><br>During an interview on [DATE] at 10:00 a.m., Resident #1 stated that on [DATE] at approximately 3:38 p.m. (unsure exact time), he/she found Resident #2 in the Solarium, breathing heavy, unresponsive, and right hand was dangling. Resident #1 further stated that he/she ran (with the rollator) to the Nurse's station and asked for help. According to Resident #1, QACNA and LPN #1 were at the Nurse's station, and Resident #1 notified them that Resident #2 was down. Call 911! Then, Resident #2 was transferred to bed. Resident #1 further stated that a few minutes later (unable to recall the time), he/she saw Resident #2's whole body shaking and immediately looked for help. Resident #1 further stated that he/she did not find staff at the Nurse's station; he/she went to the front to look for staff and found the former DON #1 in the dining room lobby and told her, [Resident #2] is down! According to Resident #1, the DON immediately went to see Resident #2.<br><br>During an interview with QACNA on [DATE] at 12:22 p.m. The QACNA stated that she was at the Nurse's station with LPN #1 (who was on the phone) on [DATE] at approximately 3:30 p.m. to 3:40 p.m., Resident #1 came to the Nurse's station and reported that Resident #2 was down and needed help. The QACNA further stated that LPN #1 gestured to check Resident #2 in the Solarium. QACNA found Resident #2 sitting in a wheelchair, verbally unresponsive, leaning to the right side of the wheelchair. Resident #2 responded to sternal rub performed by QACNA. The QACNA immediately called the Receptionist to call LPN #1 STAT [immediately] for immediate assistance because the Resident was not responding fully. When LPN #1 responded, Resident #2 was verbally unresponsive. A few seconds later, Resident #2 started talking. According to the QACNA resident was transferred to his/her bed, and the LPN took the Resident's V/S. The QACNA stated that according to the LPN, VS was good, and there was no indication to call for a CODE. The QACNA left, and 2 CNAs stayed; the QACNA returned to the Nurse's station to continue her duty. The QACNA stated that LPN #1 checked on Resident #2 twice and said the VS were ok. A few minutes later, LPN #1 instructed QACNA to stay on the unit and wait until RN #1 arrived. LPN #1 then left the building. The QACNA checked on Resident #2 after LPN #1 left, while RN #1 did not arrive yet. The QACNA found Resident #2 in bed, quiet, looking straight but not verbally responsive. The QACNA immediately went to another wing (A2) to ask LPN #2 (3:00 p.m. -11:00 p.m. Nursing Supervisor) to check Resident #2. LPN #2 responded to the emergency along with a few licensed nurses.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 10:34 a.m. LPN #1 stated that on [DATE], she was at the Nurse's station with the QACNA when Resident #1 came to the Nurse's station. LPN #1 heard Resident #1 say, Something might be wrong with [Resident #2] in the Solarium. While on the phone with the pharmacy, LPN #1 instructed the QACNA to check on Resident #2. According to LPN #1, after a few seconds, she followed the QACNA to the Solarium. LPN #1 found Resident #2 in the Solarium sitting in the wheelchair, verbally unresponsive, head leaning down towards the right side, and Resident #2 looked different. The LPN further stated that the Resident was transferred to his/her bed with 3 CNAs (QACNA, CNA #2, and CNA #3). LPN #1 took Resident's VS. While performing VS, Resident #2 was fighting to get out of bed. The LPN further stated that she explained to the Resident that she/he had a seizure and needed to remain in bed for close monitoring. According to the LPN, I thought she/had a focal seizure that had a blank stare; I am not a doctor; I can't diagnose. The LPN further stated that when Resident #2 was being transferred to bed, Resident #2 was lethargic and did not verbally respond when called. LPN #1 stated a few minutes later. She instructed the QACNA to stay at the Nurse's station until RN #1 (Nurse from 4:00 p.m. to 12:00 p.m.) arrived. LPN #1 then left the unit, and on the way out, she saw the Nursing Supervisor (LPN #2), who told her, I have to step out for a minute. Do you need anything? LPN #2 responded, Fine, and left the building. LPN #1 confirmed that she did not endorse or report the Resident's CIC to the Nursing Supervisor or any facility staff because, according to LPN #1, the patient was ok to me, verbally and not in immediate danger to me, [Resident #2] went back immediately to normal. When I left, I told [QACNA] and [LPN #2] that I'm leaving. LPN #1 stated that she notified the PCP via text message. However, LPN #1 could not verify that the PCP was notified of the first CIC at approximately 3:45 p.m. LPN #1 confirmed that an LPN should report to an RN or the Resident's PCP to verify the assessment for any CIC.<br><br>During an interview with the current Director of Nursing (DON #2) and the Administrator on [DATE] at 11:47 a.m., the DON stated that the standard of practice for CIC was for the LPN to evaluate the Resident's CIC, and LPN then reported to the RN to determine the CIC. The DON further stated that LPNs were not allowed to assess; the RN needed to verify and cosign the LPN's assessment. They both agreed that the facility's protocol for CIC was for the LPN to report to an RN. They further agreed that it was not their practice to leave a patient when there is CIC without reporting to the Nursing Supervisor. In addition, they also stated that the LPN should have asked another licensed nurse to monitor the CIC instead of a CNA.<br><br>Review of the Licensed Practical Nurse job description, dated ,d+[DATE], included under PRIMARY FUNCTIONS .7. Notes changes in condition of residents .Notifies Supervisor of findings .<br><br>(continued on next page) |

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|---|---|---|---|
| | 315044 | A. Building<br>B. Wing | 06/26/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mohawk Meadows | 1 O'Brien Lane<br>Lafayette, NJ 07848 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility's policy titled CHANGE OF CONDITION, dated ,d+[DATE], indicated under POLICY: All staff members shall communicate any information about Resident status change to appropriate licensed personnel immediately upon observation. DEFINITIONS .Acute: a.) Sudden Onset b.) A marked change . Uncharacteristic: Any unusual a typical symptom that is not of the ordinary for a resident. PROCEDURE: 1. The Resident's change of condition shall be reported immediately to the nursing supervisor .6. Notification of Physician, time, and date (month, day, and year) are to be documented in the Nurse's notes. The licensed Nurse must speak directly to the Physician: you may not leave a message with the answering service or Receptionist. The Physician must call back .8. Serious conditions call for nursing assessment skills and expertise to move the Resident to acute care surroundings, then the Resident shall be transferred to an acute care hospital, emergency transport service. This decision shall be made by the nursing supervisor in the situation that the patient's condition is so acute that time does not permit waiting for the Physician's response. 9. Director of Nursing and Administrator are to be immediately notified of a serious change of condition .12. Any persistent or recurrent condition change shall be placed on the patient's care plan with appropriate approaches to care until the problem is resolved .<br><br>The facility's policy titled Abuse Prevention and Prohibition Program, dated [DATE] is indicated under Policy I. Each Resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property .<br><br>NJAC 8:,d+[DATE].1 (a)<br><br>NJAC 8:,d+[DATE].1 (a) |

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| F 0658<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40823<br><br>COMPLAINT#: NJ00164724<br><br>REF: F600IJ<br><br>Based on interviews, review of medical records (MRs), and other pertinent facility documents on [DATE], [DATE], and [DATE], it was determined that the facility failed to follow the professional standards of nursing practice to a.) notify the Primacy Care Physician (PCP), b.) the policy titled, CHANGE OF CONDITION, and c.) the LICENSED PRACTICAL NURSE (LPN) job description. On [DATE] at approximately 3:45 p.m., the LPN left a resident (Resident #2) unattended and in the care of Certified Nursing Assistants (CNA) during seizure activity/change in condition (CIC). Resident #2's roommate (Resident #1) went to the Nurse's station and reported to the Nurse that something might be wrong with [Resident #2]. The Nurse in charge (LPN #1) instructed the Quality Assurance Certified Nursing Assistant (QACNA) to check Resident #2 in the Solarium. The QACNA found Resident #2 sitting in a wheelchair, verbally unresponsive and responded to a sternal rub performed by QACNA. The QACNA immediately called the Receptionist to call LPN #1 STAT [Immediately] for immediate assistance because the Resident was not responding fully. When LPN #1 responded, she observed Resident #2 was verbally unresponsive, leaning the head down to the right side and staring blankly. Resident #2 was then transferred to the bed by the QACNA, CNA #2, and CNA #3 and assessed by LPN #1, who identified the Resident as having a petite mal seizure lasting approx [approximately] 2 minutes. Resident #2 remained in bed, and LPN #1 instructed the QACNA to notify a nurse and or the Nursing Supervisor (NS) in case something happens to [Resident #2]. LPN #1 also assigned CNA #2 to remain outside the Resident's room to ensure that Resident #2 did not get out of bed. LPN #1 then left the building without reporting to a Registered Nurse (RN), the Director of Nursing (DON), and/or the NS of the Resident's seizure activity/CIC. In addition, LPN #1 instructed the QACNA to stay at the Nurse's station until the 4:00 p. m. - 12:00 a.m. nurse arrived. At Approximately 4:10 p.m., Resident #2 had another episode of a seizure /CIC; he/she was transferred to an Acute Care Hospital (ACH) and died on [DATE].<br><br>The facility's failure to immediately address Resident #2's seizure activity/CIC and notify the appropriate staff of the CIC posed a likelihood of serious harm to the health and wellbeing of Resident #2 and potentially all other residents assigned to LPN #1 in an Immediate Jeopardy (IJ) situation.<br><br>The IJ was identified and reported to the facility on [DATE] at 7:14 p.m. The IJ began on [DATE] and continued until [DATE]. The facility provided an acceptable removal plan on [DATE]. On [DATE], the Surveyor returned to the facility to ensure the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating staff. The non-compliance remained on [DATE] for no actual harm with the potential for more than minimal harm that is not an IJ.<br><br>This deficient practice was identified for 1 of 3 residents (Resident #2) and was evidenced by the following:<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Reference: New Jersey Board of Nursing Law 45:,d+[DATE], revised on [DATE]. 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 .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.<br><br>The Surveyor conducted a telephone interview with the PCP on [DATE] at 2:44 p.m.; the PCP stated that he was first notified of the seizure/ CIC through text message on [DATE] at 4:22 p.m. The PCP stated that the facility is expected to call him immediately if a resident has a CIC. The PCP explained that timing is very important and that something went wrong.<br><br>During an interview on [DATE] at 10:34 a.m. LPN #1 stated that on [DATE], she was at the Nurse's station with the QACNA when Resident #1 came to the Nurse's station. LPN #1 heard Resident #1 say, Something might be wrong with [Resident #2] in the Solarium. While on the phone with the pharmacy, LPN #1 instructed the QACNA to check on Resident #2. According to LPN #1, after a few seconds, she followed the QACNA to the Solarium. LPN #1 found Resident #2 in the Solarium sitting in the wheelchair, verbally unresponsive, head leaning down towards the right side, and Resident #2 looked different. The LPN further stated that the Resident was transferred to his/her bed with 3 CNAs (QACNA, CNA #2, and CNA #3). LPN #1 took Resident's VS. While performing VS, Resident #2 was fighting to get out of bed. The LPN further stated that she explained to the Resident that she/he had a seizure and needed to remain in bed for close monitoring. According to the LPN, I thought she/had a focal seizure that had a blank stare; I'm not a doctor; I can't diagnose. The LPN further stated that when Resident #2 was being transferred to bed, Resident #2 was lethargic and did not verbally respond when called. LPN #1 stated a few minutes later. She instructed the QACNA to stay at the Nurse's station until RN #1 (Nurse from 4:00 p.m. to 12:00 p.m.) arrived. LPN #1 then left the unit, and on the way out, she saw the NS (LPN #2) and told her, I have to step out for a minute. Do you need anything? LPN #2 responded, Fine, and left the building. LPN #1 confirmed that she did not endorse or report the Resident's seizure activity/CIC to the Nursing Supervisor or any facility staff because, according to LPN #1, the patient was ok to me, verbally and not in immediate danger to me, [Resident #2] went back immediately to normal. When I left, I told [QACNA] and [LPN #2] that I'm leaving. LPN #1 stated that she notified the PCP via text message. However, LPN #1 could not verify that the PCP was notified of the first seizure activity/CIC at approximately 3:45 p.m. LPN #1 confirmed that an LPN should report to an RN or the Resident's PCP to verify the assessment for any CIC.<br><br>During an interview with the current DON (DON #2) and the Administrator on [DATE] at 11:47 a.m., the DON stated that the standard of practice for CIC was for the LPN to evaluate the Resident's CIC, and the LPN then reported to the RN to determine the CIC. The DON further stated that LPNs were not allowed to assess; the RN needed to verify and cosign the LPN's assessment. They both agreed that the facility's protocol for CIC was for the LPN to report to an RN. They further agreed that it was not their practice to leave a patient when there is a CIC without reporting to the NS. In addition, they also stated that the LPN should have asked another licensed nurse to monitor the CIC instead of a CNA.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility's policy titled CHANGE OF CONDITION, dated ,d+[DATE], indicated under POLICY: All staff members shall communicate any information about Resident status change to appropriate licensed personnel immediately upon observation. DEFINITIONS .Acute: a.) Sudden Onset b.) A marked change . Uncharacteristic: Any unusual a typical symptom that is not of the ordinary for a resident. PROCEDURE: 1. The Resident's change of condition shall be reported immediately to the nursing supervisor .6. Notification of Physician, time, and date (month, day, and year) are to be documented in the Nurse's notes. The licensed Nurse must speak directly to the Physician: you may not leave a message with the answering service or Receptionist. The Physician must call back .8. Serious conditions call for nursing assessment skills and expertise to move the Resident to acute care surroundings, then the Resident shall be transferred to an acute care hospital, emergency transport service. This decision shall be made by the nursing supervisor in the situation that the patient's condition is so acute that time does not permit waiting for the Physician's response. 9. Director of Nursing and Administrator are to be immediately notified of a serious change of condition .12. Any persistent or recurrent condition change shall be placed on the patient's care plan with appropriate approaches to care until the problem is resolved .<br><br>NJAC 8:,d+[DATE].1 (a)<br><br>NJAC 8:,d+[DATE].1 (a) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40823<br><br>Based on observation, interview, and review of medical records and other pertinent facility documentation on 6/15/23, 6/20/23, and 6/27/23, it was determined that the facility failed to follow professional standards of clinical practice for a). the administration of medications and b.) following a physician's orders, and c). adhering to the facility's policy for using the Medication Administration Record for 1 of 2 residents (Resident #1) reviewed for medication administration.<br><br>The deficient practice was evidenced by the following:<br><br>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.<br><br>On 6/15/23 at 9:36 a.m., during the Resident's interview, the Surveyor observed 2 medicine cups filled with medications were found on Resident #1's breakfast table.<br><br>According to the admission record, Resident #1 was admitted on [DATE] with diagnoses that included but was not limited to: Hypothyroidism, Hypertensive Heart Disease Without Heart Failure, and Low Back Pain.<br><br>The Minimum Data Set (MDS), an assessment tool, dated 6/9/23, revealed a BIMS of 15, which indicated the Resident's cognition was intact and needed supervision during care with Activity of Daily Living.<br><br>A Care Plan (CP), initiated on 6/1/21 included that the Resident was at risk for a fall due to a diagnosis of Hypertension. The intervention included but was not limited to Administering medication as ordered.<br><br>The PHYSICIAN'S ORDER (PO) for 6/2023 reflected the following Physician's orders:<br><br>On 8/21/19, Levothyroxine tablet 25 mcg, give 1 tablet by mouth daily for Hypothyroidism, scheduled to be given at 6:00 a.m., Gabapentin 100 mg, give 1 capsule by mouth twice a day for Chronic Pain, scheduled to be given at 9:00 a.m. and 5:00 p.m., Clopidogrel tablet 75 mg, give 1 tablet by mouth daily for CVA, to be given at 9:00 a.m., Metoprolol tablet 25 mg, give 1 tablet by mouth daily at 9:00 a.m.<br><br>On 11/14/21, Divalproex 125 mg, give 1 tablet every morning for Schizoaffective Disorder, to be given at 9:00 a.m.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/24/21, Montelukast tablet 10 mg, give 1 tablet by mouth daily and Fexofenadine tablet 180 mg, give 1 tablet daily for Allergy, to be given at 9:00 a.m.<br><br>On 6/14/22, Myrbetriq 50 mg tablet, give 1 tablet by mouth daily for Urinary frequency at 9:00 a.m.<br><br>On 9/12/22, Ocuvite with Lutein, give 1 tablet by mouth twice a day for the supplement at 10:00 a.m. and 5:00 p.m.<br><br>The Routine Medication (RM) for the month of 6/2023 confirmed the aforementioned physician orders. The RM further indicated that the aforementioned medications were signed by LPN #3, indicating that the medications were administered to Resident #1 on 6/15/2023 according to the schedule.<br><br>During an interview on 6/15/23 at 9:40 a.m., LPN #3 stated that when she attempted to administer the medications scheduled to be given at 9:00 a.m., Resident #1 was sleeping. The LPN further stated that she left the medications on the Resident's breakfast table because she was running late. According to LPN #3, she should have taken the medications with her and returned later; she added that she should not have signed the MAR because the Resident did not take the medications.<br><br>During an interview on 6/15/23 at 4:52 p.m., the Administrator stated that nurses were not to leave any medications in the Resident's room. The Administrator added that if a resident is sleeping, the Nurse should try to wake up the Resident or return to reapproach later.<br><br>A review of LPN #3's competency dated 5/18/23 indicated that LPN was able to administer medication according to facility procedure.<br><br>The facility's policy titled Medication - Administration, dated 1/20/22, indicated To provide practice standards for safe administration of medications for residents in the facility .VIII. Medications will not be left at the bedside .<br><br>NJAC 8:39-29.4 (h) |