| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315083 | A. Building<br>B. Wing | 08/24/2023 |

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| Acclaim Rehabilitation and Nursing Center | 198 Stevens Ave<br>Jersey City, NJ 07305 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>07342<br><br>Based on observations, record review, interviews, and facility procedure review, the facility failed to ensure that two (Resident (R)3 and R114) of the 34 sampled residents were treated with dignity and respect that promotes enhancement of quality of life.<br><br>Findings include:<br><br>1. Review of the electronic medical record (EMR) for R3 revealed diagnoses of unspecified cerebral infarction, hemiplegia and hemiparesis affecting right side following cerebral infarction, unspecified dementia, dysphagia following cerebral infarction, aphasia following cerebral infarction.<br><br>According to the most recent quarterly Minimum Data Set (MDS) assessment with reference date (ARD) of 08/18/23, R3 has a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated the resident was moderately cognitively impaired. He was also noted to be incontinent of bowel and bladder.<br><br>Interview with Family Member (FM)1of R3 on 08/22/23 at 11:29 AM revealed the privacy curtain in the bedroom of R3 was broken and could not be pulled shut. FM1 stated I've told all the nurses and nurse aides on the unit for months and nothing is done about it. I'm frustrated. She stated the privacy curtains had been in this condition since the day he moved in October 2022.<br><br>Attempts to interview R3 regarding the privacy curtain revealed a nod of the head to indicate the privacy curtain was broken as observed on 08/22/23 at 3:55 PM.<br><br>Review of the red binder at the nursing station on the third floor labeled maintenance revealed the log since October of 2022 or since R3's admission. The log revealed no reference to maintenance requests to repair the privacy curtains in R3's bedroom.<br><br>Observation on 08/23/23 at 3:55 PM revealed the privacy curtain in R3's bedroom, a double room was broken. The curtain could not pull beyond the foot of the bed. In addition, the privacy curtain for the roommate or R114 was also broken and could not pull beyond the window side of the bed. Therefore, both curtains provided no privacy for either resident.<br><br>2. Review of the EMR for R114 revealed diagnoses of major depressive disorder, acute respiratory failure, cardiac arrest, and bipolar disorder.<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 |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R114's most recent quarterly MDS with an ARD date of 08/04/23 indicated a BIMS score of 11 out of 15 which indicated the resident was moderately cognitively impaired. was also noted to be incontinent of bowel and bladder.<br><br>Interview with R114 on 08/22/23 at 3:56 PM revealed neither curtain could be used to shield each resident from the other or provide privacy. When asked if R114 could see R3 getting his brief changed in R3's bed, he said yes I can, and he can see me. There is no privacy.<br><br>Interview with the Registered Nurse (RN)2 on 08/22/23 at 4:00 PM verified the curtains for both beds did not slide on the track properly and supply R3 and R114 with full visual privacy. She stated she would report to maintenance to have the problem corrected.<br><br>Interview with Certified Nurse Aide (CNA)1 on 08/23/23 at 9:55 AM revealed I try to change each resident when the other is out of the room to provide privacy. She verified the curtains for both residents did not work to provide full visual privacy.<br><br>Interview with the Maintenance Man (MM) on 08/23/23 at 10:20 AM indicated the curtains were fixed. He stated he did not know if this issue had been reported in the past. He stated this was the first time he looked at the problem.<br><br>Observation of the curtains on 08/23/23 at 11:00 AM revealed the curtains still did not close or move any further to provide full visual privacy than when first reported.<br><br>Interview with the Administrator on 08/24/23 at 10:14 AM indicated the curtains in the bedroom for R3 and R114 were fixed.<br><br>Further observation on 08/24/23 at 10:30 AM revealed the curtains had not been fixed and were in the same condition.<br><br>Further interview with the Administrator on 08/24/23 at 11:00 AM indicated that both residents would be moved to another room while maintenance removed the tracks and replaced R3 and R114's privacy curtain tracks and privacy curtains.<br><br>NJAC 8:39-4.1(a)12 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 37245<br><br>Based on interview, record review, and facility policy review, the facility failed to protect the residents' right to be free from physical abuse by another resident for four of four residents (Resident (R)19, R83, R26, and R74) reviewed for abuse in a total sample of 34 residents.<br><br>Findings include:<br><br>Review of a Reportable Event Record/Report, provided to the survey team by the facility, dated 06/19/23, revealed the facility reported to the State Agency (SA) the following: Around 2:30 PM [R83] came to speak to [R19] As per [R19], [R83] came too close to his face; they started arguing, and the staff immediately separated them; while the nurse went inside the nurse station to sign the out on pass for [R83], [R19] came close to [R83] and hit him with a cane that he was carrying back to his room. [R83] fought back [R19] and hit him on the left side of his face. Both residents were separated immediately. A complete body assessment was done on both residents without any apparent injuries noted.<br><br>1. Review of R19's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with diagnoses of metabolic encephalopathy (brain dysfunction) and anxiety disorder.<br><br>Review of R19's annual Minimum Data Set (MDS), located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 04/21/23, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R19 was moderately cognitively impaired.<br><br>Review of R19's Care Plan dated 04/19/23, located in the EMR under the Care Plan tab, indicated R19 had attention seeking behaviors.<br><br>Review of R19's Progress Notes located in the EMR under the Progress Notes tab dated 06/19/23, revealed, At 2:30 pm [R19] and [R83] was arguing and yelling at each other, then we separated them. After 5 minutes [R19] came with his cane and started hitting [R83] on his legs. [R83] starting [sic] hitting back, he hit [R19] on his left check [sic]. And then we separated them. NP [Nurse Practitioner] made aware, MD [Medical Director] aware order to monitor and neuro check for [R19].<br><br>2. Review of R83's Admission Record located in the EMR under the Profile tab, revealed an admitted [DATE] with diagnoses of adjustment disorder, and major depressive disorder. R83 was discharged on [DATE].<br><br>Review of R83's quarterly MDS, located in the EMR under the MDS tab with an ARD of 05/12/23, revealed the resident had a BIMS score of 14 out of 15, indicating R83 was cognitively intact.<br><br>Review of R83's Care Plan dated 07/22/22, located in the EMR under the Care Plan tab, indicated R19 had non-compliant behaviors related to diet order.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of R83's Progress Notes located in the EMR under the Progress Notes tab dated 06/19/23, revealed, It was reported to me by H floor low side nurse that resident was arguing with another resident [R19] both resident were arguing and yelling at each other staffs intervened separated them, 5 minutes later resident [R19] came back with his cane starting hitting him on his lt leg then resident [R83] punch resident [R19] in his face left side, staffs separated from each other. Body assessment done no apparent injury noted, denied pain. Resident stated, I was signing my oop [out on pass] form at the station when the resident [R19] came to me hit me in my left leg with his cane, he hit me twice so I punched him in the face. Both resident were arguing and yelling at each other staffs separated them, 5 minutes later resident [R19] came back with his cane starting hitting him on his lt [left] leg then resident [R83] punch resident [R19] in his face left side, staffs separated from each other.<br><br>During an interview on 08/21/23 at 1:23 PM, R19 stated, I hit him twice on his leg with my cane. R19 further stated, I'm nice. I don't like to cause trouble for anyone. I'm sorry.<br><br>During an interview on 08/24/23 at 9:35 AM, the Director of Nursing (DON), who was also the Abuse Coordinator, gave a recapitulation of the incident. The DON stated the incident was definitely abuse when they hit each other, and I substantiated it as such. The DON stated the facility substantiated the incident as abuse because one resident hit another resident.<br><br>During an interview on 08/24/23 at 10:40 AM, Licensed Practical Nurse (LPN)1 stated, I was at the nurses' station and heard [R19] and [R83] talking. They always joke and play with each other. [R83] had just returned from a pass so I'm not sure what made [R19] irritated but he did get that way and hit [R83] with the cane. [R83] then hit [R19] in the face. [Certified Nursing Assistant (CNA)2] helped me stop them and then I called the DON. They [R19 and R83] had never argued before. They were friends. Neither one of them is aggressive. I don't know why they got upset that day.<br><br>During an interview on 08/24/23 at 10:47 AM, CNA2 stated R83 and R19 were at the nursing station. CNA2 stated R83 had just returned from being out of the facility and was checking in with the nurse. CNA2 stated that R19 said R83 was too close to him and yelled at him and hit him with the cane. CNA2 further stated that R83 then hit R19 in the face. CNA2 stated he and LPN1 separated the two residents. CNA2 confirmed there were no prior incidents involving R19 and R83.<br><br>Review of the facility's policy titled Abuse Prevention and Reporting, revised 05/20/23, indicated, Residents of [Facility Name] will be protected from abuse, neglect, mistreatment, or misappropriation of property in accordance with state and Federal Regulations.<br><br>29728<br><br>3. Review of R26's Admission Record located in the EMR under the Admission tab revealed an initial admitted [DATE] with diagnoses that included dementia with behavioral disturbances and an adjustment disorder with anxiety and depression.<br><br>Review of the quarterly MDS located in the EMR under the MDS tab with an ARD of 06/30/2023, revealed a BIMS score of 15 out of 15 indicating the resident was cognitively intact. The resident did not exhibit any behaviors during the MDS assessment period of the incident.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the Care Plan, located in the EMR under the Care Plan tab and revised on 07/12/23, revealed R26 was identified as exhibiting behavioral problems related to verbal aggression and using profanity towards the nurses and staff and was non-compliant with facilities policies.<br><br>4. Review of R74's Admission Record, located in the EMR under the Admission tab revealed an initial admitted [DATE] with diagnosis of bipolar disorder and major depression.<br><br>Review of the annual MDS located in the EMR under the MDS tab with an ARD of 06/02/2023, revealed a BIMS score of 15 out of 15 indicating the resident was cognitively intact. The MDS indicated the resident exhibited verbal behavior symptoms directed toward others.<br><br>Review of R74's Care Plan revised on 07/26/23 located in the EMR under the Care Plan tab, identified the resident was argumentative and belligerent with staff and refused to take medication for psychiatric behaviors.<br><br>Review of the facility's investigation of the Reportable Event Record/Report, submitted by the facility on 04/26/23, revealed the front desk receptionist observed R74 and R26 arguing and swinging at each other. Both residents were separated immediately and assisted back to their room. R74 stated that R26 wheeled his wheelchair into his legs so, he fought back. R26 was noted with blood in his mouth but upon inspection, no apparent injuries were identified. R26 stated R74 was blocking the entrance and he could not pass. Both residents were placed on 1:1 supervision. Both refused to be moved to another unit and R26 refused to go to the hospital for evaluation.<br><br>The investigation also noted there were no further alterations between R74 and R26. It was also documented that R11 had resided in the facility for the past six years without any aggressive behaviors towards other residents.<br><br>Review of the summary and conclusion of the facility's investigation revealed the following:<br><br>Around 6:37 PM, the receptionist called the unit to report that two residents got involved in a physical altercation. Around 6:37 PM, R26 and R74 were back from out on pass separately, and they started exchanging words right before they entered the building. According to the receptionist, R74 stopped at the front desk to sign back in from his out-of-on-pass [out on pass]. R26 followed R74 into the building and continued to verbally insult R74. R74 ignored R26 and started to leave the receptionist area when R26 turned his wheelchair and wheeled his wheelchair into R74's legs. R74 stated that he had to fight back against R26. R74 hit R26 on his face and they were seen engaging in a physical altercation. Residents were seen throwing punches and pulling on each other. Both residents were separated immediately. R74 called the police to report the incident; the police came in and advised R74 to stay away from R26.<br><br>The facility's investigation concluded with the following actions taken to protect the residents:<br><br>Both residents were immediately separated.<br><br>Support: Emotional reassurance rendered and will continue as needed.<br><br>Psych consultation<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Family and MD notification<br><br>Neurological checks as per facility protocol<br><br>Trauma Assessment<br><br>Both residents refused to be moved off the unit.<br><br>Review of the EMR under the task tab, revealed that on 4/28/23, R74 was evaluated by Senior Care Therapy, psych services, after the incident to address coping skills and problem-solving skills to deescalate difficult situations. The resident will continue to receive follow up visits with psych.<br><br>Review of the EMR under the task tab, revealed that on 04/27/23, R 26 was evaluated by NYNJ Psychiatric Services, after the incident. The evaluation revealed, Pt presents as irritable & not interested in evaluation. States, Hey, you are a psych doctor, GOODBYE. With much encouragement, pt agreed to talk. Pt shared he was outside when his peer provoked him. Denies feeling depressed/anxious. Denies S/H/I. Denies sleep disturbance or change in appetite. No ongoing agitation. The plan included follow up as needed, continued non-pharmacological interventions, and monitor and document any behavior concerns.<br><br>During an interview with the Social Worker on 08/23/23 at 9:21 AM, she stated that R26 has his days, he is not as pleasant as he should be but his moods shift. Regarding the incident between R26 and R74, she stated there were some words exchanged, they were separated, they calmed down and they have kept their distance. Both residents declined room changes and psychological counseling. She stated there have not been any further exchanges between the two residents since this episode. She was not aware of R74 having any altercations with other residents prior to this incident.<br><br>NJAC 8:39-4.1(a)5 |

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| F 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide routine and 24-hour emergency dental care for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20706<br><br>Based on observation, record review, interview, and facility policy review, the facility failed to assist one resident (Resident (R)50) of the total 34 residents sampled in obtaining dentures.<br><br>Findings include:<br><br>Review of policy for titled Dental Services, with effective date as 11/28/16 revealed that it is the policy of the facility to order a prompt referral for dental services as resident would need. It also revealed that Long Term residents should be seen annually. It further revealed that upon assessment of a dental issue by the nurse, it should be reported to the physician and a referral made to the Dentist. The policy stated that the nursing staff would monitor the resident's diet and ability to eat and report changes as needed to include speech therapy referral.<br><br>Review of the resident's Face Sheet, located in the electronic medical record (EMR) under the Profile tab, revealed R50 was initially admitted to the facility on [DATE] with a re-admitted [DATE] with diagnoses to include malignant neoplasm (cancer) of head, face and neck, and dysphagia (difficulty swallowing) as his admitting diagnoses.<br><br>Record review of the resident's Care Plan located in the Care Plan tab of the EMR revealed no concerns for dentures were documented.<br><br>Review of the resident's Care Plan, updated on 05/24/23, revealed dysphagia due to R50's neck cancer. It also revealed that R50 was on a mechanical (chopped) thin liquids diet.<br><br>Review of the resident's annual Minimum Data Set Assessment (MDS), with an Assessment Reference (ARD) date of 07/21/23 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident had intact cognition. R50 had no natural teeth or tooth fragments.<br><br>During an observation and interview on 08/21/23 at 2:55 PM R50 was in his room watching TV. R50 said he had been without his dentures for almost five years and had been asking for them but had not received them. He further stated he could not chew his food well.<br><br>Record review of handwritten Dentist Progress Notes, located in the paper chart, revealed an initial exam on 11/23/16, where R50 was requesting dentures. On 05/03/17, R50 had a denture fitting exam and required an adhesive.<br><br>A dental visit on 01/04/21 revealed that R50 stated his dentures did not fit and did not have them. Twelve other visits occurred until 08/14/23, and dentures were not mentioned. On 08/14/23, the resident again requested dentures. There was no documentation of the status of the resident's dentures.<br><br>An interview on 08/24/23 at 10:53 AM with Social Service Director (SSD) revealed that she was not aware that R50 had denture needs. She stated nursing usually had dentist order dental needs. SSD stated there were denture resources that could be used for the residents.<br><br>(continued on next page) |

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| F 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview on 08/24/23 at 3:30 PM with Regional Social Worker (RSW) revealed that R50 required a dysphagia diet to prevent aspiration [not due to having no dentures]; however, that did not mean the resident should not have dentures.<br><br>An Interview on 08/23/23 at 2:10 PM with Registered Nurse (RN)4 revealed that R50 had had several dental appointments, and she was not aware that R50 needed dentures.<br><br>An interview on 08/24/23 at 3:30 PM with the Director of Nursing (DON) and Speech Therapist revealed that R50 was placed on a dysphagia diet for swallowing issues. Both agreed that R50's dysphagia diet for swallowing and not chewing should not affect R50 receiving dentures.<br><br>NJAC 8:39-15.1(b) |