STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. Building B. Wing	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millville Center	54 Sharp Street Millville, NJ 08332

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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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 43308 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to maintain professional standards of nursing practice: a.) for not following a Physician's Order (PO) for the documentation of urine output on the Treatment Administration Record (TAR), b.) for not consistently documenting weekly skin assessments as ordered by the physician, and c.) for not signing the Controlled Medication Utilization Record (a narcotic declining inventory sheet that keeps a record of the amount of medication available) after the removal of the narcotic from inventory. This deficient practice was identified for two (2) of 26 residents, (Resident #7 & Resident #57) reviewed for following physician orders related to professional stands of nursing practice and for one (1) of four (4) medication carts, (300-unit back hall medication cart) during narcotic reconciliation related to medication storage. 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 casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The deficient practice was evidenced by the following: (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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(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 - Some	1.) On 01/20/23 at 10:26 AM, the surveyor observed Resident #57 lying in bed watching the television. The resident stated that he/she was waiting to go to therapy. At that time, the surveyor observed an indwelling urinary catheter drainage bag (a bag that collects urine from your bladder) hanging on the side of the bed as well as a nephrostomy (a catheter that is inserted through your skin and into your kidney; the tube helps to drain urine from your body) bag next to the resident. Resident #57 stated that the staff emptied the urinary catheter bag as well as the nephrostomy catheter bag every shift. Resident #57 further stated that he/she had a Urinary Tract Infection (UTI) about a month ago, but that he/she was doing better. The surveyor reviewed the electronic medical record (EMR) for Resident #23. A review of the resident's Admission Record reflected that the resident was admitted to the facility January of 2022, with diagnoses which included, but were not limited to UTI, complications of nephrostomy catheter, hydronephrosis with renal and ureteral calculous obstruction (kidney swelling and blockage), benign prostatic hyperplasia (the flow of urine is blocked due to the enlargement of prostate gland). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the managemnt of care dated 11/09/22, reflected a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated an intact cognition. A further review of the resident's MDS, Section H - Bladder and Bowel reflected that the resident had an indwelling catheter. A review of the resident's individualized Care Plan revised 01/11/23, reflected that Resident #57 was at risk for infections related to history of UTI and required an indwelling catheter due to obstructive uropathy (blockage of urine flow). The interventions included to monitor urine for sediment, cloudiness, odor, blood, and amount. A review of the January Order Summary Report revealed that Resident #57 had active orders for the following: - Start date: 05/11/22 and discontinued 11/22/22: Record amount right nephrostomy tube every shift for percentage. - Start date 11/22/22: Record amount of drainage from right nephrostomy tube three times a day for percentage. - Start date 03/10/22: Empty catheter drainage bag at least once every eight hours to when it becomes half to two-thirds full every eight hours. - Start date 03/10/22: Empty catheter drainage bag at least every eight hours to when it becomes half to two-thirds full as needed. A review of the October 2022 TAR revealed there was no documentation for the following: - The percentage and the documentation of a chart code (completed or hospitalized) for the PO, Record amount right nephrostomy tube were left blank on the following dates and times: * The day shift (7:00 AM to 3:00 PM) on 10/01/22, 10/02/22, 10/03/22, 10/13/22, and 10/28/22. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* The evening shift (3:00 PM to 11:00 PM) on 10/11/22, 10/12/22, 10/13/22, 10/14/22, and 10/26/22. * The night shift (11:00 PM to 7:00 AM) on 10/02/22 and 10/14/22. - A chart code for the PO: Empty catheter drainage bag at least once every eight hours to when it becomes half to two-thirds full was left blank on the following dates and times: * 0600 (6:00 AM) on 10/03/22, 10/15/22, and 10/21/22. *1400 (2:00 PM) on 10/01/22, 10/02/22, 10/03/22, 10/13/22, and 10/28/22. *2200 (10:00 PM) on 10/11/22, 10/12/22, 10/13/22, 10/14/22, and 10/26/22. A review of the November 2022 TAR revealed there was no documentation for the following: - The percentage and the documentation of a chart code for the PO, Record amount right nephrostomy tube were left blank on the following dates and shifts: * The day shift on 11/01/22, 11/02/22, 11/04/22, 11/09/22, and 11/17/22. * The evening shift on 11/15/22 and 11/18/22. *The night shift on 11/02/22, 11/10/22, 11/11/22, and 11/21/22. - The milliliters (mls) and the documentation of a chart code for the PO, Record drainage amount from right nephrostomy tube were left blank on the following dates and times: *0600 on 11/24/22 and 11/25/22. *2200 on 11/22/22 - A chart code for the PO: Empty catheter drainage bag at least once every eight hours to when it becomes half to two-thirds full was left blank of the following dates and times: * 0600 on 11/03/22, 11/11/22, 11/12/22, 11/13/22, 11/24/22, and 11/25/22. *1400 on 11/01/22, 11/02/22, 11/04/22, 11/09/22, and 11/17/22. *2200 on 11/15/22, 11/17/22, 11/18/22 and 11/22/22. A review of the December 2022 TAR revealed there was no documentation for the following: - The milliliters (mls) and the documentation of a chart code (completed or hospitalized) for the PO Record drainage amount from right nephrostomy tube were left blank on the following dates and times: *0600 on 12/16/22 and 12/19/22. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*1400 on 12/08/22, 12/09/22, 12/10/22 12/20,22, 12/24/22, and 12/29/22. *2200 on 12/15/22, 12/16/22, 12/23/22 and 12/30/22. - A chart code for the PO: Empty catheter drainage bag at least once every eight hours to when it becomes half to two-thirds full was left blank of the following dates and times: * 0600 on 12/16/22 and12/19/22. *1400 on 12/09/22, 12/10/22, 12/24/22, and 12/29/22. *2200 on 12/15/22, 12/16/22, 12/23/22 and 12/30/22. A review of the January 2023 TAR revealed there was no documentation for the following: - The milliliters (mls) and the documentation of a chart code (completed or hospitalized) for the PO, Record drainage amount from right nephrostomy tube were left blank on the following dates and times: *0600 on 01/02/23, 01/12/23, 01/14/23 and 01/21/23. *1400 on 01/02/23, 01/06/23, 01/08/23, 01/11/23, 01/12/23, 01/17/23, 01/18/23 and 01/22/23. *2200 on 01/03/23 and 01/19/23. - A chart code for the PO: Empty catheter drainage bag at least once every eight hours to when it becomes half to two-thirds full was left blank of the following dates and times: *0600 on 01/02/23, 01/12/23, 01/14/23, and 01/21/23. *1400 on 01/08/23, 01/11/23, 01/12/23, 01/13/23, 01/17/23, 01/18/23, and 01/22/23. *2200 on 01/03/23 and 01/19/23. A review of the Progress Notes from October 1, 2022 through January 22, 2023 revealed that there was no documentation to indicate the reason the urine output was left blank. On 01/26/23 at 10:54 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who stated that the Certified Nursing Assistant (CNA) emptied the urine catheter bags. He further stated that the nurses documented the amount and if it was emptied in the EMR. LPN #1 concluded he was not sure if Resident #57 had a history of UTIs. On 01/27/23 at 09:51 AM, the surveyor interviewed CNA #1 who stated that both the CNAs and the nurses were responsible for emptying the urinary drainage bags. She stated that if the CNA emptied the urinary bag, then they would inform the nurse of the amount to be documented in the EMR. On 01/27/23 at 10:52 AM, the surveyor interviewed LPN #2 who stated that the nurses were responsible for documenting the urine output in the EMR if there was a PO for it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/27/23 at 10:58 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that Resident #57 had an indwelling urinary catheter and a nephrostomy tube. The RN/UM stated she was not aware if the resident had a UTI recently because she was still learning all the residents. The RN/UM stated that the CNAs emptied both urinary bags and reported the amount back to the nurses to document in the EMR. At that time, the surveyor and the RN/UM reviewed the electronic TAR which revealed the blanks for the POs. The RN/UM stated that she believed it was a missed communication as the CNAs may have forgotten to inform the nurse or the nurses forgot to input the amount. The RN/UM acknowledged it was important to follow the POs and that there should be documentation corresponding to the blanks. On 01/27/23 at 11:01 AM the surveyor interview LPN #1 again who stated he cared for Resident #57 and that the CNAs informed him of the urine output from both the indwelling urinary catheter bag and the nephrostomy bag. LPN #1 stated that it was important to document the urine output and to know the amount because it assured the kidneys were functioning properly, there was no blockage and no infections. On 01/27/23 at 11:03 AM, the surveyor interviewed CNA #2 who stated she was responsible for emptying both the indwelling urinary catheter and the nephrostomy bag. She further stated that she reported the urine amount to the nurses and the nurses documented in the EMR. CNA #2 stated that it was important to keep track of the urine output because it ensured everything is flowing, and the kidneys are working properly. She further stated that the amount was reported per shift. CNA #2 stated that Resident #57 had a history of a UTI and that was the reason for the urinary catheters. On 02/01/23 at 11:18 AM, the DON in the presence of the Administrator, Consultant Pharmacist and the survey team stated that there was no facility policy to record the urine output for the nephrostomy. The DON stated the nurses are putting in the order as extra when they document the urine output. She then stated it was important to ensure the resident had urine output but that it was not a true I&O [intake and output] if staff was only documenting the output and not the intake. The DON stated that Resident #57 was hospitalized from 10/11/22 to 10/15/22 with a diagnosis of UTI. The DON acknowledged that there should not be blanks on the TAR. On 02/02/23 at 09:22 AM, the DON stated that staff were required to follow the physician's order. She further stated that the importance of documentation was for the continuity and quality of care for the resident. A review of the facility's policy, Catheter: Indwelling Urinary - Care of, revised 02/01/23, included 15. Empty the catheter drainage bag when it becomes 1/2 to 2/3 full 15.2 record output, if ordered 22. Document: 22.2 Amount of urine output if ordered. 2.) The Admission Record indicated that Resident #7 was admitted to the facility with the diagnoses which included but were not limited to pressure ulcer of the sacral region, unspecified stage, and multiple fractures of the pelvis. The admission MDS dated [DATE], indicated that the resident was cognitively intact and required extensive assistance with activities of daily living. The MDS also reflected that the resident had a stage 1 or greater pressure area over a bony prominence and was at risk for developing pressure ulcers. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/20/23 at 11:35 AM, the surveyor observed Resident #7 in the room sitting up in the wheelchair. The resident was well dressed and reading a newspaper. The surveyor interviewed the resident at that time who stated that he/she had swelling in the lower legs. The surveyor observed that the resident had plus three pitting edema (Pitting edema occurs when excess fluid builds up in the body, causing swelling; when pressure is applied to the swollen area, a pit, or indentation, will remain) in both lower extremities. He/she pulled up his/her pant legs to show the surveyor. The resident stated that he/she didn't know if the doctor knew about the edema. Resident #7 also explained that he/she was receiving good care and that the facility was treating his/her wounds. The resident further stated that his/her wounds were not getting worse, they were healing, and that the facility were performing treatments. The surveyor reviewed Resident #7's clinical records which revealed that last skin check assessment that was documented in the assessment section of the EMR was recorded as being done on 12/07/23. The surveyor reviewed the January 2023 TAR which reflected the following physician's order dated 11/23/2022: -Skin checks on the 3:00 PM - 11:00 PM shift weekly every Wednesday for skin inspections document findings in PCC (the electronic medical record). The surveyor observed that there was a nurse's signature on the TAR every Wednesday on the 3:00 PM - 11:00 PM shift that indicated that skin checks were completed however, the skin check assessment form that the findings were documented on, were not completed since 12/07/22. On 01/23/23 at 12:51 PM, the surveyor interviewed the Registered Nurse (RN) who had been employed in the facility for [AGE] years and was caring for Resident #7, who explained to the surveyor that skin assessments were completed once a week and that there was a PO on the TAR. She stated that after the nurse completed the skin assessment the finding was documented on a form in the EMR called skin assessments. She added that if a nurse or Certified Nursing Assistant (CNA) discovered a new finding regarding the resident's skin, it should be documented as soon as it was found no matter what day it was. She continued to explain that the nurse would document any new findings such as pressure, skin tears, or bruising on the skin check form. She stated that edema (swelling) should be part of the resident's everyday assessment. She stated that the nurse or CNA should report edema and the physician should be notified so that they could be started on medication. The RN reviewed the TAR with the surveyor and confirmed that the nurse on the 3:00 PM -11:00 PM shift signed the TAR indicating that the skin assessment was done. The RN also confirmed that the weekly skin assessment was documented as being completed on the TAR however, the findings of the skin assessment had not been documented on the Skin Check assessment since 12/07/22. The RN also confirmed that the physician was made aware of the resident's lower extremity edema and that the resident was started on medication to manage the edema. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/23/23 at 01:09 PM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) who stated that she was unsure why the nurses documented that they were performing the skin checks on the TAR but were not filling out the skin check assessments in the EMR. She explained that it would be important to document the finding on the skin check sheet to indicate if there were any changes in the resident's skin or if the skin remained the same or improved. She stated that the nurse signing off the skin assessments on the TAR should also be documenting the information about the resident's skin assessment on the skin check assessment in the EMR. The RN/UM confirmed that there were no skin checks assessments findings documented since 12/07/22. On 01/24/23 at 11:29 AM, the surveyor interviewed the facilities Registered Dietician who stated that he reviewed the skin check assessment sheets as part of the nutritional assessment to assess the proteins needs and nutritional needs for a resident that has skin breakdown. He further stated that the skin check sheets were an important factor during his nutritional assessments so that he would know if there were any changes in a resident's skin condition and if there was a change, he could adjust the nutritional needs of the resident to better aid in wound healing. On 01/24/23 at 11:43 AM, the surveyor interviewed the LPN #3 who stated that she was the facilities wound care nurse. LPN #3 explained that as a wound care nurse she always utilized the skin check assessment sheet in the assessment section of the computer to see if it matched her findings. She stated that when the wound check sheet was completed on admission, she checked the sheet the next day to make sure the documentation was accurate and reflected her assessment of the resident's skin. LPN #3 added that the weekly skin check assessments were completed by the nurses on the units and that it would be important that they were completed so the wound nurse could assure that adequate treatments were appropriate for the type of wound, and interventions were put in place to aid in healing. She stated that the nurse performing the skin check was responsible to sign the TAR that they completed the skin check but were also responsible to fill out their findings on the skin check form. On 01/24/23 at 12:44 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the skin check sheet in the assessment section of the EMR would show changes in the resident's skin condition and confirmed that the nurse should have completed the weekly skin assessment. The DON reviewed Resident #7's EMR and confirmed that there were no skin checks assessments findings documented for Resident #7 since 12/07/22. The surveyor reviewed the facilities policy dated 09/01/22 and titled, Skin Integrity and Wound Management indicated that the facility was to perform and document skin inspections on all admitted and readmitted residents and weekly thereafter and with any significant change on condition. The policy also indicated that the facility completed the wound evaluation upon admitted /readmission, new in-house acquired, weekly and with unanticipated decline in wounds. 43307 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.) On 01/23/23 at 12:03 PM, on the 300 unit, the surveyor inspected the back hall medication cart locked narcotic box with LPN #4 and observed that three Controlled Medication Utilization Records (CMURs) were not accurate. Resident #134's CMUR for Oxycodone (a pain reliever) revealed that there was documented a quantity of five pills and that the blister pack (a cardboard casing that stores the medication for dispensing) revealed a quantity of four pills. Resident #124's CMUR for Tramadol (a pain reliever) revealed that there was documented a quantity of 22 pills and that the blister pack revealed a quantity of 21 pills. Resident #58's CMUR for Percocet (a pain reliever) revealed that there was documented a quantity of 27 pills and that the blister pack revealed a quantity of 26 pills. LPN #4 stated that she had previously administered all of the medications and then proceeded to sign out the medications on each resident's CMUR in front of the surveyor. LPN #4 acknowledged that the medications should have been signed out at the time they were administered and stated that it was important that the resident's medications were monitored and that an accurate narcotic count was maintained. On 01/23/23 at 12:16 PM, the surveyor interviewed the Unit Manager (UM) for the 300 unit who stated that narcotics were signed out when they were removed from the narcotic drawer in the med cart prior to patient administration. The UM was informed LPN #4 acknowledged that she administered narcotics to three residents and did not sign the CMUR at the time of administration and that LPN #4 signed the CMURs in front of the surveyor. The UM confirmed from the electronic medical record documentation that each resident received the pain medication and stated that LPN #4 should have signed out the narcotics when she popped them out of the blister pack for resident administration and that she should have signed the narcotic book before she went to each resident's room. The UM further stated that it was important to document correctly for an accurate narcotic count and to confirm when a resident received the narcotic medication. On 01/23/23 at 1:15 PM, the surveyor interviewed the DON who stated that when a narcotic was administered that the nurse should have signed it out when the medication was popped out of the blister pack. The DON stated, You pop it in the container and sign in the narcotic book, do a triple check of the resident, then sign it out in the medication administration record. The DON further stated that it was important to document correctly for consistency and control and to make sure that the medication was given to the correct patient and at the correct time. On 01/24/23 at 12:39 PM, during an interview with the surveyors the Consulting Pharmacist stated it was best practice that narcotics were signed out immediately and that reconciliation was used as a backup. Review of the facility's policy, Omnicare, LTC Facility Pharmacy Services and Procedures Manual, Policy #/Title: 6.0 General Dose Preparation and Medication Administration, revised 01/01/22, revealed Procedure, 5.5 Document the administration of controlled substances in accordance with the Applicable Law. 6.1 Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given .on appropriate forms. NJAC 8:39-27.1(a);29.2(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 43308 Based on observation, interview, record review and review of other pertinent facility documents, it was determined that the facility failed to consistently document blood sugars and administer diabetic medications in accordance with the physician order. This deficient practice was identified for one (1) of two (2) residents, (Resident #10) reviewed for diabetic medication administration and was evidenced by the following: On 01/20/23 at 10:10 AM, the surveyor observed Resident #10 standing up looking out their room's window. Resident #10 stated he/she was feeling fine. The surveyor reviewed the electronic medical record (EMR) for Resident #10. A review of the resident's Admission Record reflected that the resident was admitted to the facility August of 2022, with diagnoses which included: type two diabetes mellitus (DM) (high blood sugar), Alzheimer's disease, and chronic kidney disease. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 11/10/22, reflected a Brief Interview for Mental Status (BIMS) score of 08 out of 15, which indicated the resident had moderately impaired cognition. A further review of the resident's MDS, Section N - Medications revealed that the resident received insulin injections (a medication that helps sugar enter the body's cells). A review of the individualized Care Plan (CP) revised 09/01/22, reflected that Resident #10 had a diagnosis of DM with insulin dependence. A further review of the CP revealed the intervention included administer hypoglycemic medications as ordered. A review of the January Order Summary Report revealed that Resident #10 had active physician orders for the following: - Start date 08/24/23: Lantus (long-acting insulin)100 unit per milliliter (ml). Inject 12 units subcutaneously (under the skin) two (2) times a day for DM. - Start date 08/23/22: Humalog (fast-acting insulins)100 unit/ml. Inject four (4) units subcutaneously with meals for DM. Call the physician for less than (<) 70 or greater than (>) 400. - Start date 08/04/22: Humalog 200 unit/ml. Inject four (4) units subcutaneously at bedtime for DM. - Start date 08/05/22: Nateglinide (control high blood sugar) 120 milligrams (mg) tablet. Give one (1) tablet by mouth before meals for DM. A review of the Medication Administration Record (MAR) from November 2022 to January 2023 revealed the following: - On 11/09/22 at 11:30 AM, the Blood Sugar (BS) and the documentation of a chart code (administered or held) for Humalog four (4) units with meals were left blank. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 11/13/22 and 11/14/22 at 6:30 AM, the documentation of a chart code for Nateglinide 120 mg before meals were left blank. - On 01/11/23, 01/12/23, at 01/13/23 for 11:30 AM the BS and the documentation of a chart code for Humalog four (4) units with meals were left blank. - On 01/13/23 at 7:30 AM, the BS and the documentation of a chart code for Humalog four (4) units with meals were left blank. - On 01/11/23, 01/12/23, and 01/13/23 at 11:30 AM, the documentation of a chart code for Natelinide 120mg before meals were left blank. - On 01/14/23 at 6:30 AM, the documentation of a chart code for Natelinide 120mg before meals was left blank. - On 01/19/23 at 2000 (8:00 PM), the documentation for a chart code for Lantus 12 units two (2) times a day was left blank. - On 01/19/23 at 2100 (9:00 PM), the documentation of a chart code for Humalog four (4) units at bedtime was left blank. A review of the resident's Progress Notes from November 1, 2022 through January 22, 2023 revealed that there was no supporting documentation to indicate the reason why the medications and blood sugars were blank on the MARs. On 01/25/23 at 10:47 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) for the 200 Unit who stated the nurses were responsible for checking the resident's BS. She further stated that depending on the results they would administer the insulin. The RN/UM stated the importance of checking the BS was to ensure that the resident was not hypoglycemic (low BS) or hyperglycemic (high BS). She further stated that the nurses should document in the EMR the BS as well as document if they administered or held the diabetic medications. The RN/UM stated that if there were blanks on the MAR, the staff would not know if the resident received the medication. On 01/25/23 at 10:57 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that the expectation was to check the BS and if it was in the appropriate range, then they would administer the insulin. LPN #1 stated that the nurses were responsible for checking the BS and documenting the number in the EMR. He then stated that the MAR should never be left blank because that was how the staff knew if it was done. On 01/25/23 at 11:09 AM, the surveyor interviewed LPN #2 who stated that the nurses were responsible for checking the resident's BS prior to the administration of insulin. She stated it was important to know the BS, because depending on the number they would either administer the medication or hold it. LPN #2 further stated if there was a space on the MAR to document the BS then it should be documented. She explained that the nurses should also document the location of the insulin injection or if the medication was not administered. LPN #2 stated that if there were blanks on the MAR that was an indication that the medication was not administered, or the BS was not taken by the nurse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/25/23 at 11:37 AM, the surveyor interviewed the Director of Nursing (DON) who stated that checking the BS and administering medications were resident specific. The DON stated that the nurses should check the BS and administer the medication according to the physician's order. The DON stated that if there were blanks on the MAR then that indicated the resident wasn't in the building, the nurse forgot to sign it, or it was not done. The DON acknowledged that it was important to document so that everyone knew what was done. On 02/01/23 at 11:13 AM, the DON acknowledged in the presence of the Administrator, the consultant pharmacist and survey team that there should not be blanks on the MAR. The DON stated she spoke with the nurses involved, who stated they checked the BS and administered the medication to Resident #10 but, may have forgotten to sign the MAR. On 02/02/23 at 09:22 AM, the DON stated that staff were required to follow the physician's order. She further stated that the importance of documentation was for the continuity and quality of care for the resident. A review of the facility's policy, General Dose Preparation and Medication Administration, revised 01/01/22, revealed 6. After medication administration, facility should take all measures required by facility policy 6.1 document necessary medication administration/treatment information (e.g., . when medications are given, injection site of a medication, if medications are refused, PRN medications, applications sight) on appropriate forms. NJAC 8:39-27.1(a)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 33106 Based on observation, interview, review of clinical records and other pertinent facility documentation it was determined that the facility failed to: a.) provide adequate supervision for a resident identified as a high risk for falls, b.) implement appropriate fall prevention interventions for a resident after sustaining multiple falls with a major injury, c.) update the resident's Care Plan in a timely manner, d.) perform neuro-checks (assess an individual's neurological functions, motor and sensory response, and level of consciousness) as per facility policy for a resident who had three falls resulting in head injuries. This deficient practice was identified for one of five residents, (Resident #193) reviewed for accidents. The resident had five (5) falls since 01/04/23, and three (3) out of 5 falls resulted in the resident sustaining head injuries. The deficient practice was evidenced by the following: On 01/20/23 at 10:56 AM, the surveyor was touring the 300 unit and observed the staff mechanically lifting Resident #193 into a geri-chair (specialized recliner) off the floor, in front of the nurse's station. The surveyor asked the Registered Nurse Unit Manager (RN/UM) what happened, and the RN/UM stated that Resident #193 fell out of the wheelchair in front of the nursing station. The Admission Record indicated that Resident #193 was admitted to the facility with the diagnoses which included but were not limited to metabolic encephalopathy (abnormalities of the water, electrolytes, vitamins, and other chemicals that adversely affect brain function), unspecified falls, diabetes mellites (DM), and Dementia. The admission Minimum Data Set (MDS), an assessment tool used t0 facilitate the management of care dated 01/09/2023, indicated that the resident had short term and long-term memory loss and had impairments in cognitive decision making. The MDS also indicated that the resident required extensive assistance with activities of daily living and had a history of falls. On 01/23/23 at 11:07 AM, the surveyor observed the resident sitting in a specialized recliner at the nurse's station. The resident was unable to be interviewed due to cognitive impairments. The resident was quiet and resting. On 01/23/23 at 11:27 AM, the surveyor conducted a telephone interviewed the resident's responsible party (RP) who stated that Resident #193 had about 10 falls both at home and in the facility. The RP explained that the resident was experiencing falls at home and required more supervision than the family could provide and decided to admit Resident #193 to the facility for more supervision. The RP stated that Resident #193 had to be sent to the hospital a couple times due to falling in the facility. The RP further added that they did not know all the details regarding how Resident #193 had fallen. The RP requested the surveyor to inquire and review the Resident's medical record to find out how many times the resident fell . A review the resident's Care Plan (CP) dated 01/05/23, reflected Resident #193 was at risk for falls due to lack of safety awareness, decreased mobility, fatigue, anemia and diabetes mellitus. A review of the Progress Note (PN) dated 01/04/23 at 17:47 (5:47 PM) indicated that Resident #193 was admitted for the following reason(s): Status post fall and ambulatory dysfunction. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 01/25/23 at 11:25 AM, the facility provided the surveyor with incidents and accident reports for Resident #193 which indicated that Resident #193 had falls on the following dates: The surveyor reviewed the facility Fall Investigation Statement (FIS) dated 01/12/23 at 4:30 PM, written by Licensed Practical nurse (LPN#3) for fall #1. The FIS indicated that Resident #193 was observed lying on the floor on the right side next to the specialized recliner in front of the nurse's station. The fall was witnessed by the ward clerk. The Risk Management System form (RMS) #358 indicated that the resident did not bang or hit his/her head during the 01/12/23 fall. It also indicated that there were no injuries, and the RP and medical doctor (MD) were notified. The intervention on the RMS form indicated adding a non-skid mat to the cushion of the wheelchair to prevent the cushion from sliding. The CP further reflected that the intervention was not created until 01/24/23 but was initiated on 01/13/23. The surveyor reviewed the Risk Management System (RMS) form #359, dated 1/14/23 at 14:35 (2:35 PM) for fall #2 which reflected that Resident #193 was found on the floor in his/her room on his/her back, beside the wheelchair and verbalized pain to the back of their head. The nurse assessed the resident and observed a lump where the resident had complained of pain. According to the report, the resident was unable to explain what happened. The FMS indicated that a neuro-check was conducted, 911 was called and the resident was sent to the emergency room (ER). The FMS indicated that the resident had dementia, a lack of safety awareness and was impulsive. The FMS also indicated that the resident's son was visiting prior to the fall and left the resident alone in the room and did not inform nursing that he was leaving. A review of the PN dated 1/14/23 at 18:18 (6:18 PM,) indicated that the resident returned from the hospital to the facility around 5:00 PM. The PN further reflected while at the hospital the CT scan (several x-ray images) of the head and cervical x-rays were negative. The facility could not provide the surveyor with neurological checks for Resident #193 after falling and suffering a head injury on 01/14/23 at 2:35 PM. The surveyor reviewed the resident's CP which indicated interventions were not implemented on the resident's CP to prevent falls until 01/17/23, which was 3 (three) days after the resident fell and suffered a head injury. The intervention on the CP dated 01/17/23 indicated that staff were to remind family and visitors to inform staff when they were done visiting the resident. The FMS form #361 dated 1/14/2023 at 21:17 (9:17 PM), for fall #3 indicated that the resident was at the nurse's station after returning from the hospital after an un-witnessed fall. The resident continued to attempt to get up from the chair and walk and the nurse continued to reorient the resident that his/her lower extremities were weak and reminded the resident that he/she was unable to walk. The Licensed Practical Nurse (LPN #1) documented that she provided the resident with a coloring book with crayons. The nurse then had to leave the resident alone because another resident needed her care. During this time, another nurse called for her and she then found Resident #193 lying on the floor on right side. The resident's hands were covering his/her head and the resident had blood on his/her hands. The nurse applied gauze and pressure to the resident's head, another nurse called 911 and a third nurse came to clean and bandage the wound. The FMS form further indicated that the resident had a laceration to the back of his/her head and was sent to the ER. The FMS form indicated that the resident never lost consciousness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The surveyor could not find documentation that a neuro-check was performed on the resident after the resident had an unwitnessed fall and suffered a head injury. The FIS dated 01/14/23 at 6:00 PM and written by LPN#1 indicated that the resident was at the nurse's station accompanied by two nurses (LPN #1 and LPN #2) and a Certified Nursing Assistant (CNA #1). The statement indicated that the resident was attempting to walk, and the staff sat him/her in front of the nurse's station with a coloring book and crayons to redirect him/her. LPN#1 documented that she had to leave the nurses station to assist another resident when the resident got up and fell and was noted to be bleeding from the head. There was no documentation that a neuro-check was performed after the resident suffered a head injury or any further fall prevention interventions. The witness statement dated 01/14/23, from CNA #1 indicated that the resident was sitting at the nurse's station, and she had to answer another resident's light. When she came out from the other resident's room the resident was on the floor and was being sent to the hospital. The facility could not provide the surveyor with the statement from LPN #2, who was also identified as being at the nurse's station at the time the resident fell . The surveyor reviewed the CP and there were no interventions initiated after the third fall dated 01/14/23 at 6:00 PM and the resident sustained a laceration on the back of the head which required staples. Attached to the FMS #361 was a late entry progress note dated 01/16/23 at 18:48 (6:48 PM) that indicated that the interdisciplinary team (IDT) met to discuss Resident #193's fall of 01/14/23 and that the resident was receiving Physical Therapy (PT) and Occupational Therapy (OT) to work on transfers and ambulation. There were no new fall prevention interventions documented on the FMS form or on the CP regarding the resident's third fall at the nurse's station. On 02/02/23 at 11:10 AM, the surveyor interviewed the Rehabilitation Director (RD) who stated that Resident #193 received PT/OT from 01/5/23 through 01/24/23. The RD stated that the intervention for PT and OT services for the fall wasn't necessarily appropriate for the resident because the resident was already receiving services. The RD further explained that because the resident's cognitive status was limited, he/she wasn't benefiting from the PT/OT services provided and was discharged from services on 01/24/23 for that reason. A review of the PT Discharge Summary (DS) note dated 01/24/23, indicated that the resident was discharged from PT services due to reaching maximum potential. The DS note further revealed that the resident's performance varied depending upon level of alertness, arousal, and cognitive deficit. The PT discharge recommendations included the resident should be up out of bed daily, utilize a geri-chair for safety secondary to frequent falls, supervision when up out of bed, and use of a Hoyer lift due to fluctuations in the resident's performance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The surveyor reviewed the FMS #366 dated 01/16/23 at 20:58 (8:58 PM) for fall #4 which indicated that the resident was at the nurse's station and was provided with a coloring book, crayons, and towels for redirection; however, the resident was attempting to ambulate without assistance. The FMS indicated that the nurse sat with the resident for almost two hours along with other staff members because the resident had a history of falls. The FMS then indicated that Resident #193 was coloring and eating snacks when the nurse left the resident to take blood sugars for other residents. According to the FMS, when the nurse went into another resident's room, Resident #193, who was not being supervised, had fallen again at the nurse's station. The resident was sent to the hospital ER visit and three staples were applied to a laceration on the back of the resident's head. The PN dated 1/17/23 at 4:02 AM, indicated that Resident #193 returned from the hospital ER with staples to left side back of head and had no other injuries noted. The PN also indicated that the resident appeared in no pain and was in recliner chair at nurse station sleeping. The surveyor reviewed the PN and there was no documentation that fall prevention interventions were put in place immediately when the resident returned from the hospital after suffering a laceration to the scalp on 01/16/23. There were no neuro-checks documented or performed after the resident fell and hit his/her head and had a head injury. The surveyor reviewed the Resident's CP which was not updated until 01/17/23, to include new interventions to prevent the resident from falling. The fall interventions included the following: -Place the resident at the nurse's station for observation and safety -Staff to remind family/visitors to inform staff when done visiting. -When sitting in wheelchair, apply bilateral leg rest to aid in positioning -When sitting in the wheelchair, lock brakes. These interventions did not reflect that the resident continued to fall from a recliner while at the nurse's station and was not utilizing a wheelchair which was documented on the CP dated 01/17/23. The surveyor reviewed FMS #369 dated 01/20/23 at 11:06 AM, for fall #5 which indicated that Resident #193 fell from a wheelchair when in front of the nurses' station. The resident was assessed by the RN/UM, and it was determined that the resident had no injuries and no complaints of pain. Neuro-checks were initiated and completed. The FMS also revealed that fall prevention interventions for this fall were not initiated until 01/24/23, which was 4 (four) days after the fall. The CP reflected that on 01/24/23, fall interventions were put in place for this fall to include: -Scoop mattress -Fall matt next to bed -Staff to lay the resident down after meals -Toilet after meals (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/26/23 at 8:35 AM, the surveyor observed Resident #193 in bed with two half side rails up at the top of the bed, bed in low position and a floor mat observed on the floor next to the door side of the resident bed. The resident was unable to be interviewed due to confusion and severe cognitive impairment. The surveyor interviewed CNA#2 who entered the resident's room. CNA#2 stated that the resident was very confused and was unsteady on his/her feet. She stated that the resident required extensive assistance with Activities of Daily Living (ADLs) but was able to feed himself/herself after setting up of tray. On 1/26/23 at 8:40 AM, the surveyor interviewed LPN #4 who stated Resident #193 was confused and had cognitive impairment. LPN #4 stated that sometimes the resident was verbal and sometimes not. He stated that Resident #193 required complete care with all aspects of ADL's and was frequently incontinent of bladder and bowel. He explained that at times, the resident requested to be toileted and could walk short distance with assistance. He stated that the resident wore incontinent briefs and was toileted every two hours. LPN#4 added that staff had to anticipate the resident's needs. He stated that the resident had fallen frequently since admission and was a risk for falls. He stated that when a resident had a witnessed fall, the staff performed a full assessment to include vital signs (VS), make sure the resident did not have any pain, injury, and perform neuro-checks for head injury or unwitnessed fall for 72 hours post fall. LPN#4 further stated that the staff were also were required to call the resident's primary care physician and the responsible party (RP). He stated that witness statements were obtained, and a Risk Management System Assessment (RMS) was completed along with a change in condition form and progress notes. He explained that when the staff fill out the RMS there was a section to put in a fall prevention intervention to prevent the resident from falling again. LPN#4 explained that an unwitnessed fall was the same process as a witnessed fall, but that it was the facility's protocol to initiate neuro-checks and complete them 72 hours post fall. He stated that if a resident hit their head or had head trauma, It's the physician's call to send the resident to hospital, but 90 percent of the time the resident is sent to the hospital for a head injury. LPN#4 stated that Resident #193 should have had neuro-checks for any unwitnessed fall or head injury however the neuro-check form was not in the resident chart and that the RN/UM must have the resident's neuro-check sheets in her office. He stated that the neuro-check sheets were usually completed and put into the resident hard copy of the chart, but that Resident #193's neuro-check sheets were missing and not in the resident's chart. He stated that the CP should be updated with interventions after a fall but that the LPNs did not have the access to update the CP. He further stated that interventions to prevent a fall should be done immediately post fall to prevent the resident form falling. On 01/26/23 at 10:20 AM, the Director of Nursing (DON) came into the conference room and handed the surveyor the neuro-check sheets for Resident #193's five falls since admission. The DON stated that the resident only had one neuro-check sheet completed for the fall which occurred on 01/20/22, and he/she did not have any other sheets to provide the surveyor. The DON stated that the nurses thought that if the resident went to the hospital, that neuro-check did have to be done. The DON stated the resident had fallen two times on 01/14/23, and once on 01/16/23, and suffered a head injury each time and there was no documentation that the resident had neuro-checks performed for 72 hours post fall as per the facility policy indicated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 01/26/23 at 10:46 AM, the surveyor conducted a telephone interview with CNA #1 who stated that she remembered Resident #193 falling on 01/14/23, because she was the resident's primary care CNA that evening. CNA#1 added that she had written a statement regarding the fall. CNA#1 further stated that the resident fell right after her break. She explained that the resident's family member was visiting, and she asked the son to bring the resident to the nurse's station after the visit so that the resident could be supervised. When CNA#1 returned from her break, she had found out the resident had fallen in their room and had to go to the hospital. CNA#1 stated that the resident's first fall was on 01/14/23. CNA#1 then explained that when the resident returned from the hospital after the first fall, she performed PM care and the resident was placed at the nurse's station so that the staff could supervise the resident. She explained that the staff set the resident up with pen and paper to keep him/her occupied, but the resident wasn't using it. She stated that the pen and paper were just sitting in front the resident. She further added that the resident's attention span was not that long, and the resident would start using it and then lose interest quickly. CNA#1 further explained that she left the resident at the nurse's station so that she could answer another resident's call bell. She explained that there was a nurse at the nurse's station doing paperwork. She stated that when she returned to the nurse's station, all the nurses were surrounding the desk. She stated that LPN #2 was doing paperwork at the desk and couldn't get to the resident in time to prevent the resident from falling. She stated that the resident fell at the nurse's station and had sustained an injury to their head and there was a lot of bleeding, so the resident was sent to the hospital. On 01/26/23 at 10:51 AM, the surveyor attempted to telephone interview LPN #1 (Primary nurse for resident falls of 01/14/23) and did not get an answer. The surveyor left a message for LPN#1 to call back. On 01/26/23 10:57 AM, the surveyor telephone interviewed LPN #2 who was present on unit 300-unit on 01/14/23 and was sitting at the nurse's station doing paperwork when Resident #193 fell and suffered a head injury. LPN #2 stated that she worked on 01/14/23, completing admission documentation on the 300-unit. LPN #2 stated that she recalled when Resident #193 fell . LPN #2 stated, Yes. She did fall. She explained to the surveyor that the first fall happened on the 7:00 AM -3:00 PM shift in which Resident #193 fell and was sent to the hospital. She stated that herself and the primary nurse (LPN #1) were sitting at the nurse's station and LPN #1 was called to assist another resident in another room. She stated that while she was sitting at the nurse's station, her back was turned, and she was not facing the resident. LPN#2 stated that she was typing and looking in another direction and she did not observe the resident fall. She stated that she heard the fall. She added that the resident had blood all over because the resident was on a blood thinner, so they sent him/her back to the hospital. She stated that she didn't remember anyone asking her to write a statement even though she was present and at the nurse's station at the time the resident fell . She added that the resident was trying to stand up, so the staff gave the resident coloring books; however, the resident fell and hit his/her head. LPN #2 added that she was the only nurse sitting at the nurse's station at the time the resident fell because the resident's primary nurse (LPN#1) had gotten up to check on another resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 01/26/23 at 11:21 AM, the surveyor interviewed the Registered/Unit Manager, RN/UM who worked on the 300/400 units. The surveyor asked the RN/UM what the facility's process was for a witnessed fall and unwitnessed resident fall. The RN/UM explained that if a staff member witnessed a resident fall, then they would get a nurse and the nurse would immediately assess the resident and perform a head to toe assessment and obtain vital signs. If it appeared that the resident had no injuries, the staff would get the resident off the floor with an electric lift. She stated that if the resident had injuries, then they would call 911, the doctor, and the family or responsible party (RP). The RN/UM then stated that they would obtain witness statements from anyone that was involved with the fall, witnessed the fall or was in the area when the resident fell . She stated that the primary care CNA was responsible to fill out a statement even if they didn't witness the fall. She explained that the management would also get statements from anyone that was there and present in the area when the fall occurred. She indicated that a Risk Management System (RMS) form was completed and was given to the DON. The RN/UM explained that the IDT team consisted of nursing, therapy, recreation, and the interdisciplinary team would look at reasons why the resident could have fallen and think of things to do to prevent other falls from occurring. If a fall was an unwitnessed fall or if a resident suffered a head injury, then the staff would immediately initiate a neuro-check form. She stated that the nurse would be responsible for initiating the neuro-check form and that it was the responsibility of the RN/UM to make sure the neuro-checks were being conducted for the next 72 hours. The surveyor asked the RN/UM why Resident #193 did not have neuro-checks completed when the resident had suffered major head injuries on three different occasions (2 falls on 01/14/23 and 1 fall on 01/16/23). The RN/UM stated that the resident should have had neuro-checks done on the dates, however, did not have a response as to why the neuro-checks were not completed. The surveyor then asked the RN/UM why fall prevention interventions were not initiated or put on the CP until days later after the resident fell . The RN/UM explained that she did not implement the intervention for the CP because she was working on a medication cart that day. The surveyor reviewed the events that occurred regarding the two falls the resident had on 01/14/23 with the RN/UM. The RN/UM indicated that the first fall on 01/14/23 occurred at 1:27 PM. The RN/UM stated, We put [the resident] in front of the nursing station after returning from the hospital. The RN/UM stated that there was not a 3:00 PM - 11:00 PM supervisor to implement an intervention and the interventions were usually assessed by a RN/UM the next day. She stated, I don't want to say that they didn't do an intervention because they brought [the resident] in front of the nurse's station so someone could keep a better eye on [the resident] because the resident tried to get up on [his/her] own and walk and doesn't understand that [he/she] can't do that. The RN/UM further stated the resident could be supervised if they had the extra staff but that the intention of putting the resident in front of the nurse's station was to be supervised, however staff could not be at the nurse's station all the time because the nurses had to answer other residents call bells and had other duties and other residents to care for. (continued on next page)

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	315243	A. Building B. Wing	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millville Center	54 Sharp Street Millville, NJ 08332

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The RN/UM stated that if a resident fell over the weekend, then interventions would not be updated on the CP until Monday. She stated that if a resident fell over the weekend, the nurses working over the weekend could put an intervention in place, however, it wasn't until Monday that the IDT would meet to discuss interventions for the resident and then the CP would be updated after the IDT discussed the event. The surveyor asked the RN/UM, When the resident fell two times on 1/14/23, were there interventions put in place immediately to prevent further falls? The RN/UM responded, No, the interventions were not updated until the 17th because the fall occurred on the 14th which was a weekend. The surveyor asked the RN/UM what interventions should have been put in place or would have been appropriate to prevent the resident from falling and getting injured again and the RN/UM replied that the staff gave the resident crayons and paper and sat next to him/her for over two hours. The RN/UM then added that the definition of supervision was when someone was sitting near the resident and being able to see them with their eyes. The RN/UM stated that the nurses and CNA could not always supervise the resident because they had other duties. The RN/UM revealed that from the moment the resident was admitted to the facility he/she was a fall risk and that was why his/her RP brought the resident to the facility. The RN/UM stated that she had suggested one to one supervision at the IDT meeting and was told by the team that they didn't have the staff to provide one on one supervision to the resident. She further stated that a 'one on one' meant that someone would be assigned to always supervise the resident. She also revealed that the social worker was trying to call a memory unit to see if a memory unit would be better suited for the resident. On 01/26/23 at 12:01 PM, the survey team interviewed the DON who stated that after any resident fell , the resident was assessed by the nurse to rule out any injury and the nurse would obtain vital signs. She stated that if it was determined that the resident had no injury, the staff would get the resident off the floor, collect statements from staff, complete the RMS, call MD and then call the family/RP. The DON further explained that interventions to prevent further falls and injury should be put in place at the time of the fall. She stated that she would expect that the staff would put an intervention to prevent further falls immediately after the fall to prevent the resident from falling again. The DON stated that the nurses all have access to the CPs and should have updated the care plan immediately to reflect new fall prevention interventions. The DON further stated that if a fall was unwitnessed or the resident had a head injury then neuro-checks should have been initiated. The DON told the surveyor that if the resident sustained a head injury as a result from a fall, and the resident could not be managed in the facility, then the resident would be sent to the hospital. The DON stated that after Resident #193 returned from the hospital on 01/14/23 and 01/16/23 and had suffered a head injury, neuro-checks should have been completed. The DON could not recall how long neuro-checks had to be done and had to refer to the facility policy. The DON confirmed that neuro-checks should have been completed for 72 hours after the resident fell and suffered a head injury on two falls that occurred on 01/14/23 and one fall that occurred 01/16/23, however the neuro-checks were not done. The DON added that the term supervision was attempting to watch a resident to the best of their ability. She added that supervision meant putting a resident in a common area. She further added that it was the facility's responsibility to put appropriate fall prevention interventions immediately in place to prevent further falls and injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 02/01/23 at 11:47 AM, the surveyor interviewed the DON in the presence of the survey team who stated that if the staff turned their back for 30 seconds, the resident would stand and still have a fall. The DON further stated that the resident would be appropriate for a facility with a specialized dementia unit and the facility was currently working on facilitating that for the resident. On 02/01/23 at 12:08 PM, the surveyor interviewed the facility's Administrator in the presence of the survey team who stated that the resident needed to be one-to-one supervision to prevent them from falling. The Administrator further stated that supervision meant that staff had to be present and observing the resident. The facility policy dated 10/24/22 and titled, Accidents and Incidents indicated that any resident fall resulting in a head injury, suspected head injury or an unwitnessed fall will be observed for neurological abnormalities by performing neuro-checks according to the Neurological Evaluation Policy and procedure after the accident occurs. Interventions to eliminate if possible and if not, reduce the risk of accident and incident have been identified and implemented. The facility policy dated 06/01/21 and titled, Neurological Evaluation indicated that neurological evaluations will be performed as indicated or ordered. When a patient sustains an injury to the head or face and/or has an unwitnessed fall, neurological evaluations will be performed: -Every 15 min times 2 hours then -Every 30 minutes times 2 hours then -Every 60 minutes times 4 hours then -Every 8 hours until 72 hours has lapsed. The purpose of neurological assessments was to monitor for neurological compromise. The facility policy dated 10/24/22 and titled, Person Centered Care Plan that the purpose was to attain the patient's highest practical physical, mental, and psychological wellbeing. NJAC 8:39-27.1(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37218 Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to identify a significant weight loss and implement interventions related to the significant weight loss for one of one residents, (Resident #37) reviewed for nutrition. This deficient practice was evidenced by the following: On 01/20/23 at 11:48 AM, the surveyor observed Resident #37 in their room, laying in bed. The resident appeared thin. The resident told the surveyor that he/she, sometimes had an appetite. On 01/23/23 at 12:34 PM, the surveyor observed the resident in his/her room eating lunch. The surveyor observed that the resident could feed himself/herself independently. At the time of the observation the resident had consumed one third of their lunch and drank all of their whole milk that was on their lunch tray. The surveyor reviewed the medical record for Resident #37. A review of the resident's Admission Record reflected that the resident was admitted to the facility at the end of August 2022 and had diagnoses which included, but were not limited to pneumonia, unspecified severe protein calorie malnutrition, type two diabetes mellitus without complications, hypothyroidism (a condition where the thyroid gland doesn't produce enough thyroid hormone that causes a disruption in heart rate, body temperature, and slows down metabolism), anxiety, and depression. A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 12/19/22, reflected that the resident's Brief Interview for Mental Status (BIMS) score was 13 out of 15 which indicated the resident was cognitively intact. A further review of the resident's MDS, Section K - Swallowing/Nutritional Status revealed that the resident had a significant weight loss that was not prescribed by the physician. A review of the resident's Weights and Vital Summary revealed the following weights: -08/26/22 a weight of 92.5 pounds (lbs.) -08/29/22 a weight of 92.5 lbs. -09/02/22 a weight of 93.8 lbs. -09/14/22 a weight of 85 lbs. -09/23/22 a weight of 82 lbs. -10/05/22 a weight of 83.5 lbs. -10/23/22 a weight of 83 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/27/22 a weight of 83 lbs. -11/02/22 a weight of 83 lbs. -11/15/22 a weight of 83 lbs. -12/12/22 a weight of 86 lbs. -01/05/22 a weight of 80 lbs. -01/25/23 a weight of 83 lbs. A further review of the Weights and Vital Summary indicated that Resident #37 had a 9.8% significant weight loss from 09/02/22 to 09/14/22. A review of the resident's Nutritional Assessment completed by the Registered Dietitian (RD), dated 10/28/22, indicated that the resident was readmitted to the facility on [DATE] and had triggered for a significant weight loss. On 10/28/22, interventions were initiated for the resident's weight loss. This was the first time the facility identified that the resident had a significant weight loss which was 44 days after the weight loss was documented in the resident's medical record. A review of the resident's Care Plan (CP), revised 01/12/23, revealed a focus area that the resident was a nutritional risk for malnutrition related to underweight status and required increased nutritional needs. The goal of the resident's CP was for the resident to gain weight and weigh between 90 - 100 lbs. within the next 90 days. The interventions in the resident's CP included to weigh the resident per protocol and alert the dietician and physician of significant weight loss or gain. On 01/25/23 at 11:16 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that she took care of the resident regularly and the resident's appetite varied. The CNA explained to the surveyor that the resident would eat more during breakfast and would eat about 25% of his/her lunch. The CNA further stated that the resident had lost weight since admission to the facility, and she would give the resident snacks in the afternoon after lunch. The CNA told the surveyor that the CNA's were responsible for weighing the resident and would call the nurse in charge if there was a weight discrepancy from the last time the resident was weighed, and the nurse was responsible for making sure the weight was accurate. On 01/25/23 at 11:52 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident's appetite varied, the resident would eat about 50% of their meals, and received snacks and supplements throughout the day to maintain their current weight. The LPN told the surveyor that if it was identified that the resident had a weight loss, especially a significant weight loss, the RD would be notified, immediately by nursing staff. The LPN stated that it was the RD's job to evaluate the resident's weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/25/23 at 12:18 PM, the surveyor interviewed the facility's RD who stated that he had worked at the facility since April 2022. The RD stated that if the CNAs or nurses weighed the resident and identified a weight discrepancy of plus or minus five pounds, they would re-weigh the resident, and notify the RD. The RD could not speak to the time frame for how quickly nursing should notify the RD and told the surveyor that he would have to speak with the facility's Director of Nursing (DON) before he could answer that question. The RD then stated that he would at least want to be notified within a week if the resident had a five-pound weight loss or gain. The RD further stated that if the resident had a significant weight loss, an assessment would be performed by him as soon as possible and interventions for weight gain would be implemented for the resident. On 01/26/23 at 12:51 PM, the surveyor conducted a follow up interview with the RD who stated that he performed an initial nutritional assessment for the resident on 08/30/22, shortly after the resident was admitted to the facility and recommended cottage cheese and a fruit cup for the resident at 2:00 PM and a magic cup for the resident at 7:00 PM. The RD told the surveyor that the next date he nutritionally assessed the resident was on 10/28/22, after the resident was readmitted to the facility from the hospital. On 10/28/22, he had identified that the resident had a significant weight loss and added additional interventions to the resident's plan of care such as health shakes and fortified cereal. The surveyor reviewed the facility's, Weight's and Height's Policy and Procedure in the presence of the RD which indicated that if a 5% significant weight loss occurred in a one-month time frame, the nurse was responsible for notifying the resident's primary care physician and the facility's RD. The RD stated that on 09/14/22 the resident's weight record indicated that a 5% significant weight loss had occurred. The RD stated that he should have been notified by nursing that the resident had a significant weight loss. The RD explained to the surveyor that the resident had a pleural catheter (a thin flexible tube that is placed in a person's lung/chest area that drains fluid from that space), which nursing was monitoring that could have led to the resident's weight loss as the catheter was continually draining fluid. The RD stated that the pleural catheter was not addressed in the resident's nutrition care plan or the resident's initial nutritional assessment as a contributing factor for potential weight loss. On 01/27/23 at 09:53 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that if a resident had a significant weight loss, a re-weight should have been conducted and nursing should have notified the RD. The RN/UM stated that the resident moved to the unit around mid-September and a weight was done on 09/14/22 that indicated the resident had a significant weight loss that was not addressed by nursing staff or the RD. The RN/UM further stated that the resident had a pleural catheter and there was a lot of fluid draining from the resident's lungs which was assessed as a possible cause of the resident's weight loss. The RN/UM stated that she was not sure if the pleural catheter was assessed as a potential cause of the weight loss by the RD prior to surveyor inquiry. On 02/01/23 at 11:06 AM, the surveyor interviewed the DON who stated that she could not tell if the resident's weight loss was an error on nursing. The DON explained that upon investigation she could not identify where the error occurred between notification of nursing and the RD. The DON further stated nursing and the RD should have been in communication regarding the resident's significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy, Medical Nutrition Therapy: Assessment and Care Planning Policy and Procedure, indicated A Registered Dietician/Nutritionist (RDN) or other clinically qualified nutrition professional is responsible for the completion of a comprehensive nutrition assessment for all residents/patients for the purpose of identifying and planning the nutrition care based on the needs, goals, and preferences of each resident/patient. The resident/patient nutritional status will be assessed upon admission and monitored at least quarterly. The facility's Medical Nutritional Therapy: Assessment and Care Planning Policy and Procedure further revealed that the RD would revise the resident's plan of care as indicated by the clinical condition of the resident. A review of the facility's Registered Dietician Job Description indicated that the RD would complete assessments and care plan development in accordance with state and federal regulatory guidance and consult with the interdisciplinary team as needed regarding the resident's plan of care. NJAC 8:39-27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 43308 Based on observation, interview, record review and review of other pertinent facility documents, it was determined that the facility failed to consistently complete the dialysis communication form for one (1) of two (2) residents, (Resident #23) reviewed for dialysis. This deficient practice was evidenced by the following: On 01/20/23 at 09:28 AM, during the initial tour, Licensed Practical Nurse (LPN #2) informed the surveyor that Resident #23 was out of the facility at dialysis. She stated that the resident went to dialysis on Monday, Wednesday, and Friday. On 01/20/23 at 10:44 AM, the surveyor observed the resident lying in their bed awake. Resident #23 stated that he/she just returned from dialysis. He/she further stated that the nurses woke him/her up around 4:00 AM and was picked up for dialysis at 5:00 AM. The resident further told the surveyor that their dialysis access site was in his/her left arm. Resident #23 stated that the nurses administered their medications at breakfast prior to leaving for dialysis. The surveyor reviewed the electronic medical record (EMR) for Resident #23. A review of the resident's Admission Record reflected that the resident was admitted to the facility March of 2022, with diagnoses which included: end stage renal disease (kidney failure), dependence on renal (kidney) dialysis, and type two diabetes mellitus (elevated blood sugar). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 12/10/22, reflected a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated an intact cognition. A further review of the resident's MDS, Section O - Special Treatment and Procedures, reflected that the resident received hemodialysis services (a process of purifying the blood due to impaired kidney function). A review of the resident's individualized Care Plan revised 01/10/23, reflected that Resident #23 was at risk for complications related to hemodialysis (HD -filtration of the blood by artificial equipment). A further review of the care plan revealed the intervention to send communication book to dialysis and review upon return. A review of the January 2023 Order Summary Report revealed that Resident #23 had active physician orders for the following: - Start date 03/04/22: Monitor AV (arteriovenous) fistula/graft (a connection that's made between an artery and a vein for dialysis access) site for signs and symptoms of infection, edema (swelling), bleeding and upon return from dialysis. - Start date 03/08/22: Weight every day shift every Monday, Wednesday, Friday post dialysis weight. - Start date 06/03/22: Assure resident is properly positioned in bed upon returning from dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/23/23 at 11:16 AM, the Unit Secretary (US) for the 200 unit provided the surveyor with Resident #23's Hemodialysis Communication Record (HDCR) book that was located at the nurses' station. The US then stated that a red folder went with the resident to dialysis for the dialysis facility to fill out. The US explained the 200 unit only had one resident on dialysis. A review of the resident's HDCR book revealed individual forms which contained three separate sections to be filled out: the top section - To be completed by center licensed nurse for dialysis patient prior to HD treatment, the middle section - to be completed by certified dialysis facility following dialysis treatment and to accompany patient on return to center post - HD, and the bottom section to be completed by center licensed nurse post - HD treatment. A further review of the HDCR forms from October 31, 2022 to January 20, 2023 revealed the middle section was not consistently filled out and the bottom section was not filled out. A review of the Progress Notes from October 2022 to January 23, 2022, reflected there was no documentation regarding the dialysis center being notified when the middle section of the HDCR form was left blank or an assessment was completed post - HD at the facility by facility nursing staff. On 01/23/23 at 11:36 AM, the surveyor interviewed Resident #23 who stated upon arrival from dialysis the nurses assessed him/her. The resident stated the nurses checked his/her access site and checked their blood pressure. On 01/24/23 at 09:49 AM, the surveyor interviewed LPN #1 who stated the nurse at the facility was responsible for filling out the top section of the HDCR and the dialysis center was responsible for completing the middle section. LPN #1 stated he was not sure if the nurses were responsible for filling out the bottom section of the HDCR. He then stated that if the dialysis center did not complete the middle section, then the nurses should follow up with the dialysis center to get a report. On 01/24/23 at 01:02 PM, the Director of Nursing (DON) in the presence of the Administrator, Consultant Pharmacist and the survey team stated the top section of the HDCR should be filled out prior to the resident leaving for dialysis. She further stated that the dialysis center should be filling out their section prior to the resident leaving the dialysis center. The DON then stated it has been a, battle with them but acknowledged the dialysis center should have consistently completed the middle section of the HDCR. The surveyor continued to interview the DON, who stated that she would have to look at the HDCR to confirm if the nurses should fill out the HDCR bottom section. The DON stated that if the dialysis center did not complete their section, the expectation of the nurses would be to call the dialysis center for a report. On 01/25/23 at 10:40 AM, the Registered Nurse/Unit Manager (RN/UM) stated that all the sections in the HDCR should be filled out by the nurses caring for the resident each time the resident went to and returned from dialysis. She stated that if the dialysis center did not fill out their section, then the nurses should call and follow up with the dialysis center. The RN/UM stated that it was important that all sections were completed because it assured the resident was stable and that they did not have any reactions. The RN/UM acknowledged that each section on the HDCR should have been filled out. She concluded that nurses documented their assessment on the HDCR and not necessarily in the progress notes. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/25/23 at 11:04 AM, the surveyor interviewed LPN #2 who stated the HDCR was filled out prior to the resident going to dialysis, the dialysis center then completed their section, and upon return the nurse was responsible for filling out the bottom section. She further stated that she documented the post weight in the EMR but she did not complete the bottom portion of the HDCR. LPN #2 stated the importance of filling out the bottom portion of the HDCR was to ensure the resident was stable upon arrival. She explained if the middle section was not filled out, then the nurse should call the dialysis center to get a report. On 01/26/23 at 11:36 AM, the RN/UM stated the nurses documented the post dialysis weights in the EMR but acknowledged they failed to complete the bottom section of the HDCR. On 01/27/23 at 12:10 PM, the DON in the presence of the Administrator and survey team stated she was still unsure if the nurses had to complete the bottom portion of the HDCR and would have to review the facility's policy. On 02/01/23 at 11:11 AM, the DON in the presence of the Administrator, Consultant Pharmacist, and survey team stated that the nurses informed her they were only recording the post-HD weights in the EMR. She further stated that the nurses informed her that they only looked at the HDCR but never filled out the bottom section. The DON acknowledged it was in the facility's policy that the nurses ensured the entire HDCR was filled out and signed. A review of the facility's policy, Dialysis: Hemodialysis (HD) - Communication and Documentation, revised 06/15/22, included, 3. Upon return of the patient to the center, a licensed nurse will: 3.2 Review the certified dialysis facility communication; 3.3 Complete the post-hemodialysis treatment section of the Hemodialysis Communication Record .4.1 Document notification of certified dialysis facility regarding return of form or other communication. A review of the facility's policy, Dialysis: Hemodialysis (HD) - Provided by a Certified Dialysis Facility, revised 06/01/21, included Ongoing communication and collaboration with the certified dialysis facility regarding HD care and services .2.1 The care of the patient receiving HD must reflect ongoing communication, coordination, and collaboration between the center and dialysis staff. NJAC 8:39-27.1(a)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to: a.) obtain an appropriate diagnosis for the use of a psychotropic medication, b.) create, document, and monitor target behaviors for the use of a psychotropic medication, c.) obtain a psychiatric consult for the use of a psychotropic medication, and d.) develop a Care Plan for the use of the psychotropic medication. This deficient practice was identified for one of five resident's, (Resident #2) reviewed for unnecessary medications. The deficient practice was evidence by the following: According to the Admission Record dated [DATE], Resident #2 was admitted to the facility with diagnoses which included but not limited to dementia, anxiety, and unspecified dislocation of the right hip. The admission Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care dated [DATE], indicated that the resident usually understands and was cognitively intact. The MDS also reflected that Resident #2 required extensive assistance with activities of daily living (ADLs) and did not exhibit behavioral issues, hallucinations, or delusions. On [DATE] at 10:28 AM, the surveyor interviewed Resident #2 who stated that he/she was tired today, but otherwise OK. The resident stated that he/she had no concerns. The surveyor observed that the resident was clean, dressed and sitting up in a wheelchair watching TV. The surveyor did not observe that the resident exhibited any behaviors. The conversation that the surveyor had with the resident was appropriate and the resident answered questions appropriately. The surveyor reviewed Resident #2's medical record which revealed the following: According to the Physician Order Summary Report (POSR) there was a physician order dated [DATE], for the antipsychotic medication, (Any medication capable of affecting the mind, emotions, and behavior) Risperdal Oral Tablet 1 milligram (mg) (Risperidone). Give 1 tablet by mouth two times a day for the diagnoses of dementia with behaviors. The Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated [DATE]-[DATE] and [DATE]-[DATE] did not reflect that behavior monitoring was being done or what targeted behaviors the resident exhibited. The surveyor reviewed the progress notes (PN) from an admitted [DATE] until [DATE] and could not find documentation indicating that the resident exhibited behaviors for the prescribed use of Risperdal. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the resident's Care Plan (CP) which did not reflect that the resident was on the antipsychotic medication Risperdal. A further review of the resident's CP did not reveal that the resident exhibited behaviors while at the facility or what target behaviors the resident exhibited for the prescribed use of the antipsychotic medication. On [DATE] at 08:52 AM, the surveyor interviewed the geriatric nursing specialist Certified Nursing Assistant (CNA) who explained that Resident #2 had been admitted and discharged from the facility multiple times. The CNA stated that the resident lived in adult senior housing and usually took care of himself/herself, but was admitted in August because of a dislocated right hip. She stated that the resident required total care with ADLs due to limited range of motion (ROM) in the right arm. She explained that the resident was cognitively intact but developmentally disabled and added that the resident had limited ability to read and write but was able to voice his/her needs and wants. She further stated that the resident did not exhibit hallucinations or delusions and did not exhibit any behaviors. She added that the resident sometimes had tics but had not exhibited any of this during his/her current admission at the facility. The CNA stated that the resident was never known to have behaviors and was pleasant, impulsive, and childlike. On [DATE] at 09:02 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who had been employed in the facility for six years and was Resident #2's primary care nurse. The LPN stated that Resident #2 was alert and oriented and had the mindset of a teenager. The LPN explained that the resident was, questionable with decision making however, knew the day, time, and staff. He stated that the resident had no behaviors that he was aware of and had no signs or symptoms of depression. He stated that resident was interested in sports and criminal shows. The LPN stated that he was not sure if the resident saw a psychiatrist since the admitted [DATE]. He stated that if a resident was seen by a psychiatrist, it would be documented under the assessment section of the computer program. He stated that the facility did psychotropic medication monitoring and that behaviors would be documented on the MAR. The LPN stated that the facility did behavior notes when a resident has a history of behaviors. He further added that a form called Abnormal Involuntary Movement Scale (AIMS) was a psychotropic assessment that was done on admission or when a resident started a new a psychotropic medication. The LPN reviewed Resident #2's medical record in the presence of the surveyor and could not find documentation on why Resident #2 was on the psychotropic medication Risperdal. The LPN also could not find a physician's order for the resident to have a psychiatric consult or if the resident was seen by the psychiatrist since their current admission to the facility. The LPN also confirmed that there were no targeted behaviors documented in the medication record and that he was not sure why the resident was on a psychotropic medication. On [DATE] at 09:42 AM, the surveyor interviewed the Social Worker (SW) who had been employed in the facility for [AGE] years. The SW stated that Resident #2 did not have a developmental disability and was cognitively intact however, insight and decision making were impaired. The SW stated that Resident #2 did not have behaviors that she was aware of and she was not sure why the resident was on the medication Risperdal. The SW reviewed the residents medical record in the presence of the surveyor and the SW could not find any documentation that the resident was seen by a physiatrist. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:05 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) who stated that Resident #2 was alert and oriented and required extensive assistance with ADLs. She stated that when a resident was on a psychotropic medication, there was usually a supplementation documentation attached to the psychotropic medication order that addressed behaviors. The RN/UM stated, I remember the resident being on the medication in past admissions for calling out. She further stated that when the pharmacy consultant performed the medication review, the pharmacy consultant usually looked for cognitive or behavioral needs related to the use of the psychotropic drug. The RN/UM stated that the pharmacy consultant did not mention or document anything on the last medication review on [DATE]. The RN/ UM did not have a response to why a CP was not developed for use of the antipsychotic medication Risperdal and did not have a response as to why specific targeted behaviors were not documented in the resident's medical record. She could not explain why specific behaviors were not being monitored. The RN/UM stated that Resident #2 had a psychiatric consult on previous admission, however, did not have a psychiatric consult since admission on [DATE]. The RN/UM also stated that the resident should have had an AIMS performed since he/she was on a antipsychotic medication. The surveyor could not find the AIMS form in Resident #2's medical record. On [DATE] at 12:47 PM, the surveyor interviewed the Director of Nursing (DON) who stated that Resident #2 had multiple admissions to the facility in the past and the resident was admitted on the psychotropic medication for the diagnosis of schizophrenia. The DON could not explain why the resident did not have the diagnosis of schizophrenia during his/her current admission. She stated that when the resident was admitted to the facility, the admission nurse should have looked to see if it was a new diagnosis or if the resident had a long-standing use of the medication. The DON explained the nurse should have told the attending physician to either discontinue or continue the medication. She confirmed that Resident #2 should have had a CP developed to include specific diagnoses and targeted behaviors for the use Risperdal and the targeted behaviors should have been monitored. The DON confirmed the AIMS form was not completed when the resident was admitted on the antipsychotic medication, however the facility did complete one after surveyor inquiry. On [DATE] at 09:02 AM, the surveyor interviewed the Primary Care Physician (PCP) who stated that he inherited Resident #2 on the psychotropic medication Risperdal and it was his first experience with the resident other than him seeing the resident riding around in the community in his/her electric wheelchair. The PCP stated that he could not disagree that he had never seen the resident with any behaviors and stated that he was completely unsure why the resident was on a psychotropic medication. He stated that he would not necessarily order a psychiatric consult for a resident that was admitted on a psychotropic medication especially if they were stable and not exhibiting any behaviors. He further stated that he would now investigate to see why the resident was on the medication Risperdal. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 09:29 AM, the surveyor interviewed the Medical Director (MD) and the MD explained that if a resident was admitted on the sub-acute unit and was on a prn (as needed) psychotropic medication then the medication should be discontinued right away. The MD told the surveyor that if the resident was admitted on a routine psychotropic medication without a psychiatric diagnosis than a psychiatric consult and evaluation needed to be done to see if the resident required the medication. He further added that the diagnosis of dementia with behaviors was not an appropriate diagnosis and there had to be a legitimate psychiatric diagnosis for a resident to be on a psychotropic medication. The MD explained the physician would assess the risk vs. benefit for the use of a psychotropic medication and if the resident came in on a psychotropic medication and there were no diagnoses of a major mental illness, then a psychiatric consult would have been important to obtain. He stated that previous admissions were irrelevant to current admissions and if it was not documented in the medical record then it did not happen regardless of past admissions to the facility. On [DATE] at 11:30 PM, the surveyor reviewed the Consultant Pharmacist Recommendations (CPR) dated [DATE], which indicated that the resident was recently admitted to the facility on the medication Risperdal for behaviors associated with dementia. The pharmacy consultant made recommendations for the physician to please consider obtaining a psychosocial workup along with performing a medical workup as soon as possible (asap) to assess for underlying causes of behaviors and that if workups, along with nursing behavior monitoring, revealed no significant behaviors or identification of a chronic psychiatric condition then it would be recommended to implement a tapering schedule for the medication and/or discontinuation of the medication Risperdal. The resident's PCP had signed the CPR and documented that the facility was to continue with behavior monitoring and that the resident was seen out patient and is in sub-acute rehabilitation. The surveyor reviewed the facility policy with a revised date of [DATE] and titled, Psychotropic Medication Use which indicated that the facility should not use psychotropic medications to address behaviors without first determining if there was a medical, physical, functional, psychological, social, or environmental cause for the resident's behaviors. The policy also indicated that psychotropic medications to treat behaviors would be used appropriately to address specific underlying medical or psychiatric causes of behavior symptoms. -Antipsychotic medications used to treat behaviors symptoms of dementia must be clinically indicated, be supported by an adequate rational for use and may not be used for a behavior with an unidentified cause. -Where physician or prescribe orders a psychotropic medication for a resident, the facility policy indicated that the facility should ensure that the physician or prescriber has conducted a comprehensive assessment of the resident and has documented in the clinical record that the psychopharmacologic medication as necessary. -The facility staff should monitor the resident's behavior pursuant to the facility policy using a behavioral monitoring or behavioral record for resident receiving psychotropic medications for organic mental syndrome with agitated or psychotic behaviors. Facility staff should monitor behavior triggers, episodes, and symptoms. Facility staff must document the number and/or intensity of symptoms and the resident's response to staff interventions . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the facility policy dated [DATE] and titled, Behaviors: Management of Symptoms. The policy indicated that the staff would monitor and document in the medical records any exhibited behavior symptoms and implement individualized, person-centered, non-pharmacologic interventions as the initial behavior mitigation strategy and update the care plan accordingly. The policy also indicated that the AIMS form was to be completed per nursing for patients receiving antipsychotic medications. NJAC 8:,d+[DATE].1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37218 Based on observation, interview, and review of facility documentation, it was determined that the facility failed to: a.) store, label, and date potentially hazardous foods to prevent food-borne illness, b.) discard potentially hazardous foods past their date of expiration, and c.) maintain cleanliness in food storage areas. This deficient practice was evidenced by the following: 1.) On 01/20/23 at 9:38 AM, during the initial tour of the kitchen in the presence of the Assistant Food Service Director (AFSD) the surveyor observed in the dairy walk in refrigerator a 16-ounce container of beef base dated 12/17. The AFSD stated that the beef base was good for 30 days. There was no use by date on the container. 2.) At 9:41 AM, the surveyor observed in the walk in freezer that the floor was covered in debris and sticky upon walking on it. The AFSD stated that the floor was cleaned nightly, but the Food Service Director (FSD) was in the process of trying to hire staff because they were short staffed. The surveyor asked the AFSD if there was an accountability record for cleaning the floors in the walk in freezer. The AFSD stated that they had one. The surveyor was never provided with an accountability log that documented the floor in the walk in freezer was cleaned regularly. 3.) At 9:43 AM, the surveyor observed in the dry storage area, a shelf which contained three dinner roll packages that had not yet been opened with an expiration date of 12/26/22. The AFSD stated that the dinner rolls had just been delivered and the expiration date should have been checked upon delivery. 4.) At 9:46 AM, the surveyor observed in the cooks reach in refrigerator, a plastic container of yellow, thin liquid, undated. The AFSD identified that the liquid was melted butter. The ASFD stated that the cooks made it the night prior and they should have dated it. The ASFD could not speak as to why the butter was in liquid form if it was put in the refrigerator the night before. 5.) At 9:48 AM, the surveyor observed in the desert reach in refrigerator no internal thermometer. The surveyor observed that the inside of the desert reach in refrigerator was clean, the food was dated and labeled, and cool to touch. The AFSD stated that there was no internal thermometer in the refrigerator. On 01/27/23 at 10:45 AM, the FSD stated that the floor to the walk-in freezer was cleaned twice a week. Once on Wednesday mornings after the food order were put away, then another random day throughout the week. The FSD did not speak to accountability for cleaning the walk-in freezer twice a week. On 01/27/23 at 10:48 AM, the FSD stated that the desert reach in refrigerator was always supposed to have an ambient thermometer inside of it. On 01/27/23 at 10:50 AM, the FSD stated that she did not see the melted butter and everything in the kitchen should be dated and labeled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's, Labeling and Dating Inservice dated 01/20/23 indicated that all foods should be dated upon receipt before being stored and should include the date of preparation. The inservice further indicated that the importance of labeling and dating foods was to ensure that items passed their due date were discarded. The Labeling and Dating Inservice revealed that the manufacturer expiation date when available was considered the use by date for unopened food items. A review of the facility's Refrigerator Temperature Recording Inservice dated 01/20/23 indicated that an accurate temperature reading thermometer would be placed in each refrigerator and freezer. NJAC 8:39-17.2(g)