STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. Building B. Wing	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Preferred Care at Absecon	1020 Pitney Road Absecon, NJ 08201

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 18750 Complaint#: NJ164242 Based on observation, interview, and policy review, the facility failed to provide a clean and sanitary environment for one of six residents (Resident (R)14) reviewed room disrepair out of a total sample of 33 residents. On 09/25/23 at 3:33 PM, an interview was attempted with R14. She did not respond to questions asked about her room. During an interview on 09/26/23 at 10:15 AM, family Member (FM)25 was asked about R14's room. FM25 stated, The room is not sanitary. The window screen is bent up in the window. There are white patches on the wall near the bathroom and above the toilet paper holder in the bathroom. The floor is dirty. Plaster is missing around the air conditioner, and it looks like mold. The rooms are disgusting. During an observation on 09/27/23 at 11:57 AM, R14's room revealed a patch of white was seen on the wall next to the bathroom door at eye level. From the doorway brown colored stains on the privacy curtains could be seen. Walking into the room revealed plaster was missing around the air conditioning unit exposing holes and cracks along with a dark substance was seen on the wall. Near the baseboard on the wall was a hole. In the corner behind the bed was a brown colored stain and the floor behind the bed also was stained. The wall where the television was located also had a brown colored stain. Two holes in the bed linen were also noted on the right top corner of the resident's bed. During an interview on 09/28/23 at 8:25 AM, the Maintenance Director (MD) was shown the room and the concerns that were found. The MD confirmed the concerns and was asked if he had noticed them. The MD stated, I do checks when I walk around the building. Staff can also let me know if there are concerns and report them in the system. Everything is planned to be remodeled, but I do not know when that is, but the room should not look like this. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/28/23 at 8:39 AM, the Director of Housekeeping (DOH) was asked about the curtains and the stains on the floor and walls. The DOH stated, I don't know what happened that the curtains, floor and walls look like this. They should not look like this. The curtains should have been taken down and replaced with clean ones. The staff should be cleaning the walls and floors better than this. The DOH was asked about the sheets with the holes. He stated, staff should be looking at the sheets in laundry when they are washing them, but the CNAs [Certified Nursing Aides] should also report them. During an interview on 09/28/23 at 3:43 PM, the Administrator was asked what his expectations were in regard to the upkeep of the building and the cleanliness. The Administrator stated, Something like that should be one's right [for comfortable, clean room]. We want everyone to be comfortable. Review of the facility policy titled Quality of Life- Home Like Environment, with a revised date of 10/2022, revealed Policy statement: Residents are provided with a safe, clean and comfortable environment. Policy Interpretation. 2. The facility staff management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized home-like setting. These characteristics include a) Cleanliness and order. Review of the facility policy titled Routine Cleaning and Disinfection, with a revised dated of 11/2022, revealed, Policy: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. 13. Cleaning of walls, blinds and window curtains will be conducted when visibly soiled. 14. Privacy curtains in resident rooms will be changed when visibly dirty by laundering or cleaning with an EPA [Environmental Protection Agency] . NJAC 8:39-4.1(a)11 NJAC 8:39-31.2(e) NJAC 8:39-31.4(a)(f)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750 COMPLAINT# NJ167015 Based on observation, interview, record review, and policy review, the facility failed to protect a resident's right to be free of physical abuse for one of (Resident (R)72) of seven residents reviewed for abuse out of a total sample of 33 residents. Findings include: 1. Review of R72's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 06/28/23, located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE], a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating moderate cognitive impairment, diagnoses of Alzheimer's disease, cerebral infarction (stroke), and hemiplegia and hemiparesis (paralysis and weakness) following nontraumatic intracerebral hemorrhage affecting left non-dominant side, and had verbal behavioral symptoms directed towards others. These behaviors were documented as not interfering with other residents' care. Review of R72's 06/23/23 care plan, located in the EMR under the Care Plan tab, revealed R72 Has behavior(s)verbally aggressive, hard to redirect at times. Review of R72's nurse notes 07/28/23 to 08/26/23, located under the Progress Notes tab, revealed R72 did not have prior altercations with other residents at the facility. Review of R72's 08/27/23 incident notes, located in the EMR under the Progress Notes tab, revealed R72 went into the dining room and sat at the same table as another resident. Another resident who was sitting at the table hit [R72] in the face. Residents immediately separated and kept separated. Complete head-to-toe assessment- completed, acquired skin tear/scratch under left eye 1cm [centimeter] in length and bruise under the cut and around the eye, the bump on the eyebrow. Scant bleeding from right nostril -pressure applied and stopped. Family, MD [physician], DON [Director of Nursing], admin [Administrator], UM [unit manager], AND Psychiatrist [name] were made aware. Skin tear was cleansed with NSS [normal saline solution] and left open to the air, and no active bleeding was noted. VSS [vital signs]. The family doesn't want to involve the Police. On 09/25/23 at 2:15 PM, R72 was observed at the end of her hall dressed and groomed and ambulating with a walker. 2. Review of R79's quarterly MDS with an ARD date of 07/12/23, located in the EMR under the MDS tab revealed an admitted [DATE], a BIMS score of 15 out of 15 indicating R79's cognition was intact, had a diagnosis of schizophrenia, and had behaviors of delusions. Review of R79's 07/05/23 care plan, located under the Care Plan tab in the EMR, revealed R79 Has behavior(s) . poor impulse control, can be argumentative at times . r/t [related to] schizophrenia. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R79's behavior notes, dated 03/01/22 to 09/28/23 and located under the Progress Notes tab, revealed R79 did not have prior incidents of resident-to-resident altercations at the facility. On 09/25/23 at 2:25 PM, R79 was observed sitting in the lobby dressed and groomed watching television with other residents sitting in and around her. R72 was not observed in the immediate area. During an interview on 09/26/23 at 9:44 AM, R79 denied any problems with other residents and any resident-to-resident altercations. During an interview on 09/26/23 at 12:46 PM, Certified Nurse Aide (CNA)4 was asked about R79's behaviors. CNA4 stated she's worked at the facility for four months. CNA4 was asked if R79 had any problems with other residents such as hitting, and she said no. During an interview on 09/26/23 at 4:55 PM, Registered Nurse (RN)18 was asked if R79 had any special instructions staff should follow. RN18 stated no. RN18 was asked if R79's had abusive behavior toward other residents. RN18 stated she'd worked at the facility for four years and never known R79 to be abusive towards other residents as R79 keeps to herself. RN18 went on to say if R79 gets upset she may throw a temper tantrum but does not hit. During an interview on 09/27/23 at 9:29 AM, RN17 was asked about R79's behaviors. RN17 stated she was on duty 08/27/23, the day of the incident. RN17 stated they keep the residents [R79 and R72] separated. RN17 stated R79 isn't the type typically to hit someone as she keeps to herself and is very mild mannered. During an interview on 09/28/23 at 9:24 AM, Unit Manager (UM)20 was asked about R72 and R79's altercation 08/27/23. UM20 stated it was an isolated incident. UM20 went on to say both residents just happened to sit next to each other, and now staff know to ensure R72 and R79 don't interact with each other. UM20 stated, no incident has occurred before or since then. Review of the facility investigation, dated 08/27/23, revealed On 8/27/23, [R79] was sitting in the dining room; [R72] came and sat down at the same table. Suddenly, [R79] hit [R72] in the face. Residents were immediately separated and kept separated- a head-to-toe assessment was completed on both residents. [R79] was placed on 1:1 and sent to [hospital]. Conclusion: Abuse and neglect have been ruled out. Based on the investigation, the incident was isolated and unavoidable and related to behavior and emotional instability related to increased anxiety and the inability of the resident to deal with the feeling. There was no motive and intention to hurt another patient but rather the impulse of inability to deal with one's emotions. Review of the policy titled, Abuse, neglect, exploration, mistreatment and misappropriation of resident property, dated 11/03/22, revealed The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves . D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. NJAC 8:39-4.1(a)5

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 36190 Based on observation, interview, record review, and policy review, the facility failed to implement timely pressure reducing measures before and after the identification of a pressure ulcer and failed to consistently implement an air mattress at the proper setting, offload heels, and reposition for pressure ulcer prevention for one (Resident (R30) of four residents reviewed for pressure ulcers out of a total sample of 33 residents. This failure resulted in harm when R30 developed a pressure ulcer on the sacrum that worsened to unstageable before pressure relieving measures were put in place. Findings include: Review of R30's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 04/30/23, located in the MDS tab of the electronic medical record (EMR), revealed no score for a Brief Interview for Mental Status (BIMS), cognition was severely impaired, had diagnoses of; dementia, pressure ulcer of other sites, unstageable, and required extensive assistance for bed mobility. Review of R30's quarterly MDS with an ARD of 07/31/23, revealed an assessment of one unstageable pressure ulcer, severe cognitive impairment, and extensive assistance of one for bed mobility. Review of R30's care plan, revised on 06/22/22 and located in the EMR under the Care Plan tab, revealed a focus area of [R30] is at risk for skin breakdown secondary to incontinence, medical diagnosis of Dementia and varied po intake. Interventions included Apply barrier cream to sacrum every shift, Air mattress was applied, Dietitian consult as needed, Keep resident skin clean and dry, patient will be frequently turned and repositioned, Turn and re position as per protocol. Review of R30's 02/01/23 pressure sore risk assessment, located in the EMR under the Assessment tab, revealed a score of 13.0 indicating R30 was at a moderate risk. Review of R30's 03/23/23 nursing note, located in the EMR under the Progress Note tab, revealed CNA [certified nurse aide] alerted this nurse of sore on sacrum. This nurse observed two open areas on sacrum. One measuring 2cm [centimeter] x 1cm and another measuring 1cm x 0.5cm. No tunneling or undermining, no s/s [sign/symptom] of infection. DR [physician], Adon [assistance director of nursing] & [and] UM [unit manager] notified. New TX [treatment] order in place. Patient shows no s/s of pain or discomfort. Review of the EMR Medication Administration Record (MAR), located under the Orders tab and dated 03/25/23, after the pressure ulcer was identified on 03/23/23, revealed R30 was receiving supplements of multivitamin, Vitamin C, zinc, and protein for wound healing. There were no orders dated 03/23/23 for pressure relieving interventions. Review of the nursing notes, dated 03/02/23 through 03/23/23 and located in the EMR under the Progress Notes tab revealed the first note for turning and repositioning was documented on 03/24/23, after the pressure ulcer was identified on 03/23/23. Review of the March and April 2023 EMR MAR, located under the Orders tab revealed no documentation of turning and repositioning every two hours until May 2023. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R30's 05/01/23 wound note, located in the EMR under the Progress Note tab revealed Team met to discuss [R30's] facility acquired unstageable pressure injury to her sacrum. Sacral wound measures 2cm x 6cm x 0.3cm . Review of R30's 05/09/23 order, located in the EMR under the Orders tab revealed Turn and reposition every 2 hours for Preventive skin care. Review of R30's 05/09/23 order, located in the EMR under the Orders tab revealed Place heel float boots to bilateral feet while patient is in bed every shift for pressure relief. Further review of the Orders tab revealed these orders dated 05/09/23 were the first-time orders were issued for off-loading of pressure from the sacrum and/or the heels. Further review of R30's care plan, dated 06/22/22 and located in the EMR under the Care Plan tab, revealed new interventions to Off load bilateral heels while in bed as tolerated every shift for skin prevention [05/23/23] . Place heel float boots to bilateral feet while patient is in bed every shift for pressure relief [05/09/23]. Review of R30's 05/23/23 order, located in the EMR under the Orders tab revealed Off load bilateral heels while in bed as tolerated every shift for skin prevention. Review of R30's 06/19/23 wound observation, located in the EMR under the Assessment tab, revealed an unstageable Sacrum, pressure type wound, that measured 2.0 cm length x 2.5 cm width x depth 4.0 cm with a moderate serous exudate. Date of onset if acquired in-house- 3/23/2023. Review of R30's 07/15/23 orders, located in the EMR under the Orders tab revealed Alternating pressure mattress to bed check at the beginning of shift and end of the shift for inflation and [sic] alternating pressure. every shift for Wound prevention. Review of R30's 08/22/23 wound observation, located in the EMR under the Assessment tab revealed a stage III Sacrum, pressure type wound, that measured 1.0 cm length x 1.0 cm width x depth 0.5 cm with a moderate serous exudate. Date of onset if acquired in-house- 3/23/2023. Review of R30's 09/12/23 wound observation, located in the EMR under the Assessment tab revealed an unstageable Sacrum, pressure type wound, that measured 3.0 cm length x 3.0 cm width x depth 2.0 cm with a moderate serous exudate. Date of onset if acquired in-house- 3/23/2023. Review of R30's 09/26/23 wound observation, located in the EMR under the Assessment tab revealed a stage IV Sacrum, pressure type wound, that measured 3.0 cm length x 3.0 cm width x depth 2.0 cm with a moderate serous exudate. Date of onset if acquired in-house- 3/23/2023. Review of F30's care plan, revised 09/23/23, located in the EMR under the Care Plan tab, revealed R30 has an open area on her sacrum related to decreased mobility, incontinence and varied po [oral] intake. Interventions included air mattress . turning and positioning q [every] 2hrs [hours] . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the MAR/TAR, dated 05/2023 through 09/27/23 and located in the EMR under the Orders tab, revealed that the nursing staff signed that R30 was being turned and repositioned every two hours and bilateral heels were offloaded/boots applied as ordered. However, review of the MAR/TAR, dated 09/25/23, 9/26/23, and 09/27/23 and located in the EMR under the Orders tab, revealed the nursing staff documented the pressure relief interventions were implemented despite observations made that the interventions were not implemented. Review of the operation manual for R30's air mattress, undated, provided by the facility revealed Users can adjust air mattress to a desired firmness according to patient's weight or the suggestion from a health care professional. Review of R30's 09/22/23 weight, located in the EMR under the weight tab, revealed 118.0 Lbs (pounds.) On 09/25/23 at 11:00 AM and at 3:34 PM, R30 was observed in bed positioned on her back on an air mattress that was set at 130 pounds. R30's feet were not elevated and did not have heel protectors in place. On 09/26/23 at 9:01 AM, at 9:36 AM, at 10:30 AM, and 11:41 AM, R30 was observed in bed positioned on her back on an air mattress that was set at 130 pounds. R30's feet were not elevated and did not have heel protectors in place. A positioning wedge was noted at the end of her bed and not being utilized. At 11:53 AM, R30 was observed awake in bed still positioned on her back but with the head of the bed elevated at about 30 degrees. R30's feet were uncovered and bare with no heel protectors nor were her feet elevated. A positioning wedge was observed at the end of her bed but not being utilized. At 12:09 PM, R30 was awake in bed with the head of the bed elevated at about 30 degrees while spoon fed her lunch by staff. At 4:39 PM, R30 was observed in bed with no heel protectors nor were her feet elevated. R30 was noted to have a positioning wedge tucked in on her right side offloading her sacrum. On 09/27/23 at 9:06 AM, at 9:30 AM, and at 9:55 AM, R30 was observed in bed on her right side on an air mattress that was set at 130 pounds. No heel protectors were observed in place. At 9:55 AM, CNA6 was observed in R30's room. On 09/27/23 at 9:58 AM, CNA6 was asked if there was anything special, she was supposed to do for R30 while in bed. CNA6 stated just a wedge under her because she had a wound. CNA6 was asked if heel protectors or offloading heels were required for R30, and she stated no. On 09/27/23 at 12:30 PM, R30 was observed in bed on her back with the head of the bed at about 30 degrees while spoon fed her lunch by staff. No heel protectors were in place. On 09/27/23 at 1:43 PM, at 2:31 PM, and at 4:43 PM, R30 was observed in the same position on her right side. No heel protectors were in place. During an interview on 09/27/23 at 4:49 PM, CNA7 was asked about R30's repositioning. CNA7 stated she just got to work but R30 should be turned every two hours. CNA7 was asked how she would know if a resident had been in a position too long if she's just coming on duty. CNA7 stated she would notice imprint marks and redness on their skin. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 09/27/23 at 4:58 PM, Licensed Practical Nurse (LPN)13 was asked how the CNAs coming on duty would know if R30 needed to be turned. LPN13 stated R30 is turned on the even hours every two hours. LPN13 was informed R30 had been in the same position since 1:43 PM. LPN13 stated she would have a CNA turn her. During an interview on 09/28/23 at 9:30 AM, the Director of Nursing (DON) was asked if R30's pressure sore on her sacrum developed in-house and how did it developed. DON confirmed it was in-house and the wound started out initially as dermatitis. DON stated R30 was seen every Monday by an outside wound company. DON stated interventions were in place that include nutrition support, repositioning, treatment, air mattress, a wedge to offload, and mist therapy (therapy system for the promotion of wound healing) twice weekly since June 2023. DON was asked if she was aware R30's wound was worse. DON stated she looked at the wound on Monday and it was unchanged from the previous weeks on 09/18/23 and 08/25/23. DON was asked what her expectation was for repositioning. DON stated repositioning should be done every two to three hours during care. DON was informed R30 was observed on several occasions in the same position for more than two hours. DON was asked if R30's heels should be elevated, and protectors applied. DON stated yes. DON was informed R30's heels hadn't been offloaded or heel protectors applied during the survey and CNA6 wasn't aware R30's heels had an order for this. On 09/28/23 at 10:03 AM, LPN16 was asked if R30's heels were to be elevated and required heel protectors. LPN16 stated no, it's not necessary, she doesn't have wounds on her heels. LPN16 stated repositioning and lowering the bed was what was necessary. LPN16 then checked the EMR and confirmed R30 had an order to elevate the heels and use heel protectors. During an interview on 09/28/23 at 2:29 PM, LPN16 was asked about R30's air mattress setting. LPN16 observed the setting on the end of the bed and confirmed it was set at 130 pounds. LPN16 stated it should be set according to R30's weight but the people that set the bed up are the people that adjust the settings as nursing had nothing to do with it. LPN16 was shown R30's current weight of 118 pounds per the EMR. LPN16 then stated, the mattress is very important and if R30 weighed 118 pounds the mattress could be too hard. During a telephone interview on 09/28/23 at 3:37 PM, the Medical Director was asked if he was aware R30's wound had developed in-house and was worse since it's development. The Medical Director was asked what his expectation was for repositioning R30. The Medical Director stated R30 should be repositioned every two to four hours. The Medical Director stated it was difficult to reposition a resident on an air mattress and keep them in that position. The Medical Director was asked what his expectation was for R30's heel protectors and offloading her heels. The Medical Director stated the heel protectors should be in place but went on to say R30 didn't have any issue on her heels at this time. The Medical Director confirmed repositioning was important as it would aid in the healing of R30's sacrum. The Medical Director went on to say repositioning takes the pressure off. On 09/28/23 at 4:24 PM, R30's sacrum wound was observed. The size appeared to match the last measure of 3cm in width on 9/26/23. The length appeared to be around 5cm. The edges of the wound were pink with no granulation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a follow-up interview on 09/28/23 at 4:39 PM, DON was asked about R30's air mattress set at 130-pound verses the mattress manufacture instructions that specified to adjust the air mattress to a desired firmness according to patient's weight or the suggestion from a health care professional. DON stated the mattress allows for a 10-pound variance. Review of the mattress manual did not include an allowance of 10-pounds variance. Review of the facility's policy titled, Wound Prevention, revised 11/10/22, revealed The facility strives to ensure that a resident/ patient entering the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. For residents with a moderate risk, interventions included Implement an individualized turning schedule if applicable, Position body with pillows and/or support devices, Protect elbows and heels as needed and Provide a pressure reduction or pressure relief surface for bed and/ or wheelchair per the facility's support surface selection Algorithm. NJAC 8:39-27.1(e)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750 Based on interview, medical record review, and policy review, the facility failed to ensure the staff assessed the resident, notified the nursing supervisor, and/or complete an incident report to determine the cause of a fall for one of three (Resident (R)46) residents reviewed for falls out of a total sample of 33 residents. This deficient practice increased the potential for additional falls to not be reported and/or investigated thoroughly. Findings include: Review of R46's electronic medical record (EMR) revealed an Admission Record under the Profile tab which indicated R46 was admitted to the facility on [DATE] with diagnoses of schizophrenia, dementia, and glaucoma. Review of R46's EMR revealed a quarterly Minimum Data Set (MDS) assessment located under the MDS tab. The Assessment Reference Date (ARD) was 08/07/23. The MDS revealed R46 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognitive abilities. R46 was also assessed with hallucinations and delusions and required supervision for her activities of daily living. Review of R46's EMR revealed a Progress Note, located under the Progress Notes tab and dated 08/31/23 at 3:51 PM, noting a late entry for 08/26/23 at 10:38 PM, .Resident lost her balance and reach out with her left hand. Nurse reach out to break her fall then the resident pulls back, sat herself on the floor.Resident was assessed after, denies any pain and discomfort. Review of R46's EMR Progress Notes, from 08/26/23 through 08/31/23 revealed no documentation of any pain after the fall on 08/26/23. Review of R46's EMR revealed a Progress Note, located under the Progress Notes tab and dated 08/31/23 at 1:31 PM, Resident was visiting with [family member] reported that her L [left] hand was hurting her and was swollen. X-ray was ordered. X-ray revealed a fracture of the wrist. On 09/27/23 at 1:06 PM, an interview was attempted with R46. She was asked what happened to her arm in the cast. R46 stated, I don't talk about that because what is in the past is in the past. During an interview on 09/27/23 at 2:01 PM, Licensed Practical Nurse (LPN)12 was asked what happened. LPN12 stated on 08/26/23 at almost shift change, the resident came out of her room and started telling everyone to leave because the children were coming. LPN12 further stated that R46 was blind, and she was feeling her way around and was touching other residents on the head. I was trying to redirect her and she became agitated. She lost her balance, and I reached out for her and she slid down the door. She just sat on the floor. She said she was fine, and she said she had no pain. LPN12 was asked why she delayed in writing the note in the EMR and why she did not do an incident report. LPN12 stated, There were no supervisors working that evening and I did not do an incident report. The resident kept saying she was fine. (continued on next page)

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	315244	A. Building B. Wing	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Preferred Care at Absecon	1020 Pitney Road Absecon, NJ 08201

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/27/23 at 2:31 PM, the Director of Nursing (DON) was asked about the incident. The DON stated, The resident's [family member] came out and stated that [R46] was complaining of her wrist hurting and said that she had fallen. We immediately assessed her and got x-rays. We asked her when she fell , and she stated it was over the weekend. I spoke with the nurse. She did not do an incident report and she did not tell us about it. The DON was asked what the protocol was when a resident falls. The DON stated the resident should be assessed and an incident report submitted for investigation. The nurse should have notified the supervisor because the Assistant Director of Nursing (ADON) and a Unit Manager were both here that evening. The LPN did not follow protocol. During an interview on 09/27/23 at 3:05 PM, the ADON was asked about R46's fall. On 08/03/23, the nurse upstairs stated that R46's [family member] came out and said that [R46] had reported a fall and her wrist hurts. The LPN should have said something and filled out an incident report. I did work on 08/26/23 and she could have called me up at the time of the incident. Review of the facility policy titled, Fall Policy, with a revised date of 11/2022, revealed, Policy: to provide a system whereby residents falls are reported, their causes identified when possible, and timely interventions are established to reduce the probability of repeated incidents . Procedure: 1. A resident sustained a fall (or other incident which can potentially result in an injury), an Incident Report is completed by the nurse who first witnessed the incident. 4. The incident will be included in the 24- hour report and monitoring and documentation. NJAC 8:39-27.1(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20706 Based on observation, interviews, record review, and review of facility policy, the facility failed to properly secure indwelling catheter drainage tubing to prevent harm to the bladder for two of two residents (Residents (R)1 and R18) reviewed for urinary catheters out of a total sample of 33 residents. This failure had the potential to cause reoccurring urinary tract infections (UTI) and/or harm to the bladder if the catheter becomes dislodged. Findings include: 1. Review of the Face Sheet located in R1's electronic medical records (EMR) revealed the resident was admitted to the facility on [DATE], with diagnoses that included Right Staghorn Calculus (kidney stone), Recurrent Complicated UTI, and Chronic Indwelling Foley Catheter. Review of R1's Care Plan, dated 07/26/23 and located in the EMR Care Planning tab, revealed the resident had a foley catheter to drainage and to provide catheter care according to facility policy. Review of the R1's Physician Orders, dated 07/26/23 and located in the EMR Orders tab, revealed the resident was to have catheter care per facility policy. Observation on 09/25/23 at 12:58 PM, revealed a nonverbal resident in bed in a private room with a Foley catheter in place, with the collection bag hanging to the side of the bed draining cloudy yellow urine with sediment observed in the tubing and bag. No leg strap to the catheter tubing was observed. Observation on 09/26/23 at 12:42 PM, revealed R1 up in a chair with the foley catheter drainage bag clipped to the side of the chair. The catheter tubing was not secured to the R1's leg. Observation on 09/27/23 at 12:25 PM, revealed R1 in bed, with the foley catheter drainage bag clipped to the side of the bed with a privacy cover to the bag. The catheter tubing was not secured to R1's leg with a leg strap. 2. Review of R18's Face Sheet located in R18's EMR revealed the resident was admitted to the facility on [DATE], with diagnoses that included Neuromuscular Dysfunction of Bladder, Urinary Retention, and Chronic Foley Catheter. Review of R18's Care Plan, dated 08/16/23 and located in the resident's EMR Care Planning tab, revealed the resident had a foley catheter to drainage with a goal to remain free from catheter related injury and infection. Review of the R18's Physician Orders, dated 07/26/23 and located in the EMR section titled Orders, revealed the resident was to have catheter care per facility policy. Review of R18's Orders section of the EMR revealed an order for monthly Foley catheter change on the second day of the month. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/26/23 at 9:58 AM, revealed R18 in his room up in a chair, with the Foley bag clipped to the side of the chair with a privacy bag covering the collection bag, draining slightly amber colored urine with sediment in the tubing. R18 had on pants and a leg strap was not visible at that time. Observation and interview on 09/27/23 at 10:57 AM, revealed R18 in bed. Licensed Practical Nurse, (LPN) 22 came to the bedside in R18's room. LPN22 observed with the surveyor that R18's foley catheter bag was on the right side of the top of the bed with no leg strap or privacy bag to cover the bag. The privacy bag was hanging clipped on the opposite side of the bed. The urine was very dark amber color with sediment in the tubing. The collection bag appeared to be almost full. Interview with the LPN22 revealed that the bag needed to be emptied and covered with the privacy bag, but the LPN22 did not apply any foley leg strap to the tubing after emptying the bag. Interview on 09/27/23 at 3:39 PM, with Unit Manager (UM) 21, revealed that Foley catheter leg straps should be used for residents with a Foley catheter. UM21 observed that R1 and R18 did not have a leg strap in place. Interview on 09/28/23 at 9:20 AM, with Certified Nursing Assistant, (CNA)23, verified that R1 and R18 did not have a leg strap for the Foley Catheter. CNA23 stated that leg straps were used only for ambulatory residents. Interview on 09/28/23 at 4:00 PM, with the DON, revealed that Foley catheter leg straps were provided in the Foley catheter kit and should be applied to the residents and changed as needed for protection. Review of the facility's undated policy titled, Urinary Catheters reads in part Change the leg bag and leg strap when necessary . Indwelling catheters should be properly secured to prevent movement and urethral traction . Keep the collection bag below the level of the bladder . NJAC 8:39-19.4(a)5

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observations, interview, record review, and policy review, the facility failed to provide prescribed nutrition interventions to address significant weight loss for one (Resident (R)72) of six residents reviewed for nutritional status out of a total sample of 33 residents. Findings include: Review of R72's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 06/28/23, located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE], a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating moderate cognition impairment, had diagnoses of Alzheimer's disease, cerebral infarction (stroke), unspecified, malnutrition, dysphagia-oropharyngeal phase (difficulty swallowing), and hemiplegia and hemiparesis (paralysis and weakness) following nontraumatic intracerebral hemorrhage affecting left non-dominant side. Review of R72's revised 08/10/23 care plan located in the EMR under the Care Plan tab revealed [R72] Has nutritional problem or potential nutritional problem related to mechanically altered diet, meal refusals, limited food acceptance, need for appetite stimulant, variable po [oral] intakes, significant weight changes, pmhx [past medical history] for Cerebral infarction, Alzheimer's disease, hemiplegia and hemiparesis, alcohol abuse, traumatic subarachnoid hemorrhage, hypothyroidism, HLD [hyperlipidemia], HTN [hypertensive], adjustment disorder, dysphagia. An intervention revealed Provide diet as ordered. Regular diet, ground texture, thins (no straw) double portions fortified foods TID [three times a day]. On 09/27/23 the intervention was revised to double portions per request. Review of R72's 08/10/23 diet order located in the EMR under the Orders tab revealed Regular diet, Ground texture, Thin consistency, double portions, fortified foods TID. Review of R72's 09/21/23 Nutrition Assessment Quarterly and Weight Change, located in the EMR under the Progress Note tab, revealed Diet: Regular diet, ground texture thins. Double portions. No straw; fortified foods . female triggers for significant, undesirable weight loss related to variable po intakes, with need for constant cueing during mealtime and being distracted, meal refusals and increased energy needs due to ambulatory energy expenditure on unit, evidenced by 15.7% weight loss x 3 months. CBW [current body weight] is now 83.4 lbs - BMI [body mass index] is 17.4 (underweight) . Review of R72's weight history, located in the EMR under the Weight/Vitals tab, revealed R72 had lost 15% of her body weight in three months. This included: 09/18/23 at 83.4 Lbs [pounds] 08/08/23 at 87.2 Lbs 07/26/23 at 90.0 Lbs 07/17/23 at 92.0 Lbs 07/14/23 at 94.8 Lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/05/23 at 97.2 Lbs 06/22/23 at 99.0 Lbs On 09/26/23 at 12:38 PM, R72 was served her lunch that included ice cream, juice, a regular portion of brussels sprouts, a regular portion of ground beef with gravy, a regular portion of mashed potatoes with gravy. Review of R72's meal ticket revealed a regular diet, thin liquids, double portions. Review of R72's 09/26/23 meal intake located in the EMR under the Task tab revealed R72 consumed 51-75% of her lunch. On 09/27/23 at 11:21 AM, the tray line in the kitchen was observed with gravy, pureed gravy, sweet potatoes, mixed vegetables, pureed mixed vegetables, beef pot pie, mashed potatoes, grilled cheese sandwiches, hot dogs, cheeseburgers, pureed turkey, ground turkey, and pre-sliced turkey. No fortified items or double portion provisions were on the tray line. Dietary Aide (DA)1 was observed serving resident plates with four-ounce scoops and four-ounce ladles. DA1 confirmed these serving utensils and food items on the line at this time. On 09/27/23 at 1:05 PM, R72 was served milk, juice, a regular portion of mashed potatoes, a regular portion of ground turkey, a regular portion of pureed vegetables, and pureed cake. R72's meal ticket revealed a regular diet, thin liquids, double portions. Registered Nurse (RN)17 confirmed R72 received regular serving sizes and confirmed the meal ticket reflected double portions. On 09/27/23 at 3:51 PM, the Registered Dietitian (RD) was asked if she was aware of R72's 15% weight loss since admission and RD stated yes. RD was asked if she was aware that double portions were not provided at lunch on 09/26/23 and double portions and fortified foods were not provided at lunch on 09/27/23. RD stated, sometimes it goes missed by the kitchen. RD stated R72 was also receiving health shakes, magic cups, and an appetite stimulant to help with her intake. RD stated R72's intake could vary and agreed R72 was very active on the unit. RD stated once the nurse pointed it out to the kitchen double portions were not on R72's 09/27/23 lunch tray, double portions were provided. RD was asked if the nurse should be checking the trays to ensure accuracy of diets and she stated it would be good it they did. On 09/28/23 at 8:08 AM, the Dietary Director (DD) was asked about the fortified diet for R72 at lunch on 09/27/23. DD stated that it was an oversight yesterday at lunch, not having a fortified item. On 09/28/23 at 8:13 AM, DA2 was asked about fortified foods. DA2 stated they only have a few residents with a fortified diet. DA2 was asked what a fortified diet was. DA2 stated it was a separate pan of a food item on the tray line that had sugar, powdered milk, and/or butter added to it. DD was present and asked why there wasn't a separate pan yesterday at lunch on the tray line that was fortified. DD stated, it is a work in progress. DD pointed to a pan identifying it as hot cereal on the tray line as the fortified item for breakfast the morning of 09/28/23. On 09/28/23 at 8:33 AM, DD confirmed there should have been another pan for the fortified diets on the tray line at lunch on 09/27/23. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/28/23 at 9:45 AM, DON was asked about R72's significant weight loss. DON stated R72 was constantly moving and expending a lot of calories on the unit. DON went on to say R72 didn't like the consistency of her food. DON was asked if she was aware R72's diet wasn't fortified as ordered. At 11:22 AM, DON stated she checked with the kitchen, and they told her every resident was fortified yesterday, 09/27/23. Review of the facility's policy titled Nutrition Weight Loss- Clinical Protocol, revised 09/17, revealed The physician and staff will monitor nutritional status, an individual's response to interventions, . Review of the facility's policy titled Food and Nutrition Services, revised 10/17, revealed 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, . a. If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the Food Service Manager so that a new food tray can be issued. NJAC 8:39-17.4(a)1,2 NJAC 8:39-27.2(e)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, and policy review, the facility failed to serve food that was palatable, at the appropriate temperature, and nonrepetitive for five (Resident (R)93, R116, R51, R111, and R187) of seven residents reviewed for food palatability out of a total sample of 33 residents. Findings include: Review of the facility policy titled Food and Nutrition Services, revised 10/2017, revealed Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Review of the menus for the week of 09/24/23 revealed eggs were planned five out of seven breakfasts and green beans, carrots or a mixture of carrots and green beans were planned six out of 14 lunches and/or dinners. 1. Review of R93's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 07/17/23, located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE], a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R93's cognition was intact and had a diagnosis of type 2 diabetes mellitus. On 09/25/23 at 12:25 PM, R93 was served his lunch in his room on an overbed table that was pushed to the side against the wall. R93's lunch included a chicken breast, rice, mixed vegetables that included green beans, carrots, and a dessert. R93 stated the food wasn't good and he wouldn't be eating his lunch. R93's chicken breast had a dried-out appearance and the mixed vegetables appeared overcooked and soggy. R93 complained of always being served the same thing. On 09/27/23 at 12:20 PM, R93 was served his lunch tray in his room on an overbed table and the food was still covered. R93 opened the lid and his lunch included turkey with gravy, sweet potatoes, mix vegetables that included green beans, carrots, brussels sprouts, and cauliflower, ice cream, and cake. R93 stated the food wasn't good and he wasn't going to eat his lunch saying, it's always the same thing. 2. During an interview on 09/25/23 at 11:03 AM, R116 was asked about the food. R116 stated, I was able to manage my blood sugar at home better than they do here. It's all processed and high in sodium, and too many carbs. Review of R116's electronic medical record (EMR) quarterly Minimum Data Set (MDS) assessment located under the MDS tab, with an Assessment Reference Date (ARD) of 07/31/23, revealed a Brief Interview for Mental Assessment (BIMS) with a score of 15 out of 15 indicating cognitive intactness. Review of R116's EMR physician orders, located under the Orders tab, revealed on 02/06/23 a renal/ carbohydrate-controlled diet (CCD) with regular texture diet. 3. During an interview on 09/25/23 at 3:00 PM, R51 was asked about the food. R51 made a face and stated, I don't usually eat it. I don't eat a lot. My daughter will bring me something. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R51's EMR the quarterly MDS assessment located under the MDS tab, with an ARD of 07/31/23, revealed a BIMS with a score of 12 out of 15 indicating cognitive intactness. Review of R51's EMR physician orders, located under the Orders tab, revealed on 09/14/23 a carbohydrate-controlled diet (CCD) with regular texture diet. 3. During an interview on 09/26/23 at 9:11 AM, R111 was asked about the food. R111 stated, It is very bland most of the time. They don't give double portions. Review of R111's EMR admission MDS assessment located under the MDS tab, with an ARD of 07/19/23, revealed a BIMS with a score of 15 out of 15 indicating cognitive intactness. Review of R111's EMR physician orders, located under the Orders tab, revealed on 09/14/23 a renal/ carbohydrate-controlled diet (CCD) with regular texture diet. 4. During an interview on 09/26/23 at 9:36 AM, R187 was asked about the food. R187 stated, Once in a while it is decent, but it is just too bland. Review of R187's EMR revealed an admission MDS assessment located under the MDS tab with an ARD of 09/15/23, revealed a BIMS of 11 out of 15 indicating moderate cognitive impairment. Review of R187's EMR physician orders, located under the Orders tab, revealed on 09/12/23 a CCD and no added salt (NAS) with regular texture diet. On 09/27/23 at 11:05 AM, the tray line was observed with mixed vegetables that included green beans, carrots, brussels sprouts, and cauliflower. Review of the lunch menus revealed green beans had been served on 09/24/23, carrots on 09/25/23, and brussels sprouts 09/26/23. During the confidential resident council interview on 09/27/23 at 1:38 PM, six residents attended. Complaints were voiced about cold food, particularly scrambled eggs, rice, and noodles, and the menus lacked variety. Complaints were also voiced about the food was often too dry and needed more moisture. During an interview on 09/27/23 at 3:43 PM, the Registered Dietitian (RD) was asked how often she talks to the residents about the food. The RD stated, Everyday. I go to the residents for input. We recently went through a new food service provider. Our goal is to improve the quality and taste of the food. Once we get a food service director, we start working with them and then they leave, and we have to begin again. On 09/28/23 at 9:01 AM, a test tray was sampled with the Dietary Director (DD). The tray included scrambled eggs, cubed potatoes, cream of wheat, milk, and juice. The scrambled eggs were noted to be dry and in hard clumps and the cream of wheat was very soupy. During an interview on 09/28/23 at 9:08 AM, DD agreed the cream of wheat was too liquid and stated, the residents think the eggs are powdered. DD was asked about the repeat of food items on the menu such as poultry, eggs and vegetables. DM stated he was aware of the repetitive menu items. NJAC 8:39-17.4(a)2