STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. Building B. Wing	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Haven Rehab and Nursing Center	350 Oxford Road Oxford, NJ 07863

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 31654 Based on interview, record review and review of pertinent facility provided documents, it was determined that the facility failed to rule out abuse for an injury of unknown origin and an allegation of sexual abuse, for 1 of 2 residents reviewed for reportable events (Resident #29). Resident #29 had diagnoses which included but were not limited to; Dementia, major depressive disorder, anxiety, and paroxysmal atrial fibrillation (irregular heartbeat). A review of an Accident/Incident report, signed by a Licensed Practical Nurse (LPN), dated 01/26/23, revealed a right-hand bruise with no indication of the origin or if the bruise had been witnessed or unwitnessed. Further review of the Accident/Incident report revealed an attached Investigation/Witness Statement dated 01/24/23 at 6:45 PM, which included that the resident .was in bed [Resident #29] was screaming rape . A nurse progress note documented on 01/24/23 at 18:42 (6:42 PM), revealed .resident was screaming Rape at the top of [his/her] lungs for over an hour . On 09/19/23, the nurse was interviewed and acknowledged that the resident had been yelling Rape and that she did not report the allegation to a supervisor. A nurse progress note documented on 01/26/23 at 14:42 (2:42 PM), revealed at 1:30 PM, a bruise was noticed on right top hand . 2 [centimeter cm] x 1.5 [cm]. The facility's failure to protect the resident, to rule out abuse, and ensure the allegation of sexual abuse was investigated resulted in an Immediate Jeopardy (IJ) situation. The IJ situation began on 01/24/23 and was identified on 09/19/23 at 4:09 PM. The Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) were notified of the IJ situation. An acceptable removal plan was received at 09/19/23 at 8:22 PM and was verified as implemented on 09/20/23 at 9:59 AM. 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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/19/23 at 12:02 PM, the surveyor reviewed facility provided incident reports for injuries of unknown origin for Resident #29. The reports included a Resident Accident/Incident Report signed and dated 01/26/23, by a Licensed Practical Nurse (LPN). The Date of Accident/Incident was 01/26/23 at 1:30 PM. The Description and Facts of Event: revealed [right upper hand bruise purple in color]; What does the Resident state happened: revealed why, now nothing happed to my hand?; Injury: revealed bruise; Injury was left blank which included check off boxes for known, unknown, and occurred during care; Resident/Staff Allegations section was left blank which included check off boxes for Physical Abuse, Verbal Abuse, Sexual Abuse, Mental Abuse and Neglect; The Current BIMS (Brief Interview for Mental Status) score was 12/15 which indicated the resident was moderately impaired, alert, and oriented X 1 [self]. The Interventions Implemented to Prevent Future Occurrences: revealed 24 [hours], [statement] 01/24/23 staff, [rule out] infection, if negative, then [redacted physician service name], (recent increase of Zyprexa on 01/12/23 for stated depression). The Resident Accident/Incident Report failed to document a conclusive summary of findings of a bruise of unknown origin. One Investigation Witness Statement Form was attached and revealed the Date/Time of the Incident was 01/24/23, and was signed by Certified Nurse Aide (CNA #1) at 6:45 PM. The Witness Statement: revealed . While attempting to transfer Resident #29 to bed, resident grabbed my arm and dug [his/her] nails into my side after releasing grip, Resident #29 grabbed my side and started digging his/her nails into my side, after releasing his/her grip, Resident #29 grabbed another CNA's arm and dug his/her nails into the CNA's arm. While attempting to put the [Standing Mechanical Lift Machine] sling on Resident #29, the Resident began screaming at the top of lungs and was trying to rip the sling off. After Resident #29 had care completed and was in bed, Resident #29 was screaming Rape . An attached Investigation of Unknown Injury- 24 Hour Look Back revealed the Type of Occurrence: Bruise, 01/26/23 at 1:30 PM, and failed to address if the bruise of unknown origin was ruled out for abuse. The look back statements were documented by 3 CNAs and depicted the residents condition on 01/25/23. There was no Accident/Incident Report to address when Resident #29 screamed Rape on 01/24/23, and the Resident Accident/Incident Report also failed to document any additional staff statements, or 24 hour look back statements. A review of the Care Plan included a focus area initiated 01/24/21, diagnosis and history of dementia with behavioral disturbances. Interventions included but were not limited to; two staff for all care. Caregivers to provide opportunity for positive interaction. Continue to monitor for worsening mood and aggressive behavior. Consult for psychiatric and behavioral health services. Redirect using calm approaches and distraction. If resistant to care, assure he/she is safe and reapproach at a later time. Monitor behavior episodes and attempt to determine underlying cause. Document behavior and potential causes. The Care Plan did not include allegations of sexual abuse, or any history of abuse or trauma. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The surveyor reviewed the Abuse Identification & Prevention Program policy effective September 2018. The policy revealed, C. 4. Nursing and social workers identify those residents whose personal histories render them at risk for becoming a victim of abuse from others. D. Clues to Help Identify Abuse included but was not limited to; 1. Physical Abuse: color of bruises - red, purple, or black indicated a one-day old bruise. E. Investigation: Upon receipt of information (verbally or in writing) related to observed abuse, overheard abuse, suspected abuse, injury of unknown origin, or misappropriation of resident's property, the director of nursing/designee will ensure an investigation (if one has not been initiated previously) is initiated. 1. The Director of Nursing notifies the administrator of the situation and that an investigation has started. 3. The Director of Nursing/designee will: Have an unusual occurrence/incident report completed, Collect and preserving physical and documentary evidence, Interview alleged victim/s and witness/es, Obtain statements from caregivers, others directly involved with the resident 48 hours prior to the alleged abuse and 24 hours after, Interview other residents to determine if they have been abused or mistreated, Interview staff who worked the same shift to determine if they have been abused or mistreated, Interview staff who worked previous shifts to determine if they were aware of an injury or incident, Obtain statements from caregivers and others directly involved with the resident for the forty-eight hours prior to the alleged abuse and up to twenty-four hours after, Involve other regulatory authorities who may assist, e.g. local law enforcement, elder abuse agency . The DON will maintain an investigative package which includes . a conclusive summary of findings which indicated why or if and how abuse has been ruled out. On 09/19/23 at 11:36 AM, the DON stated the above incident was not reported to the state [New Jersey Department of Health]. The DON stated that the facility would have to do an investigation and gather the facts. She stated Resident #29's bruise was unwitnessed and that if there was a significant injury and we suspect abuse, we call right away. The DON stated Resident #29 moves around a lot and we figured it was shear or friction and was not significant and did not suspect abuse. On 09/19/23 at 12:27 PM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. The surveyor inquired if the abuse policy reviewed was the facility abuse policy and the LNHA confirmed that it was the abuse policy. The DON stated that the types of abuse included physical, emotional, financial, verbal, sexual, and neglect. The DON stated the abuse policy did not speak to the injury of unknown origin. The surveyor asked what would constitute an allegation of sexual abuse? The LNHA stated a resident saying someone touched them inappropriately, or an unusual injury and fear of certain people. The surveyor asked the LNHA if a resident verbalizing rape would also constitute an allegation of sexual abuse. The LNHA stated, of course. The surveyor asked the LNHA what the process would be if a resident alleged rape. The LNHA stated the facility would ensure the resident was safe, remove the abuser, interview the resident, and all the caregivers, anyone who had been around the resident, and not only the CNAs. The DON stated that if this happened in the evening, the nurse should contact her, and a head-to-toe physical assessment would be completed, witnessed by two people and the police would also be contacted. The surveyor asked the DON and LNHA about the statement completed on 01/24/23, regarding Resident #29 exclaiming Rape. The DON stated that the resident had a history of saying these things and that the family had informed her that the resident had been raped in the past. The surveyor asked what was the process that was completed after Resident #29 stated rape. The DON stated she would have to check as she could not recall. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/19/23 at 1:17 PM, the surveyor interviewed a Registered Nurse Unit Manager (RN UM) regarding the process if an allegation of abuse was made or suspected. The RN UM stated she would inform a supervisor, obtain witness statements, and investigate the allegation. On 09/19/23 at 1:30 PM, the surveyors interviewed the DON and asked when she was first made aware of the allegation that Resident #29 made on 01/24/23. The DON stated the incident report was brought to morning meeting on 01/27/23. The DON stated the nursing unit contacted her via telephone, and she could not recall who she had spoken with on 01/26/23 and that was about a bruise that occurred at 1:30 PM. The DON stated that a UM, she could not recall which one, informed her of the bruise that was identified on that the same day, 01/26/23, for Resident #29. The DON stated that the nurses knew how to complete an investigation and would also complete a 24- hour look back to obtain statements from all caregivers 24 hours prior to the discovery/when the allegation was made. The DON stated the nurses have been educated on how to complete the incident reports and obtain statements only from the staff who provided hands on care. The DON reviewed the investigation in the presence of the survey team and stated that there was a missing statement from one of the CNA's who was in the room with Resident #29 at the time of the allegation. The DON stated she only received a statement from CNA#1 and not from CNA #2. The DON stated she would have CNA #2 write a statement today, 09/19/23. The DON stated she brought the Incident Report to the morning report meeting held on 01/27/23, and at that time the incident report, and the 24 hours look back had not yet been completed and that nothing else had been provided for the investigation. The DON stated she was not provided CNA #1's statement on 01/27/23 regarding rape and could not recall when she was given that statement. The DON confirmed there were two CNAs in the room with Resident #29 and she just realized that she did not have CNA #2's statement. The DON stated, I know I read it quickly knowing what had happened and stated what happened was that resident was throwing food, digging nails, a horrible scene. The DON stated Resident #29 had a history of an abusive spouse. The DON stated the expectation was to have received all the statements and that it was ultimately my [DON] responsibility. The DON stated that on 01/27/23, the Accident/Incident report had been signed as reviewed but was not complete and stated the LNHA who also signed the report was no longer at the facility. The DON acknowledged she may have known about the allegation of rape, but it was the resident's normal behavior. The DON stated that the expectation would have been for the nurse to do a head-to-toe assessment, document any behaviors, and report the allegation. The DON stated that the investigation should have been completed within 24 hours and that it had not been reported to the Department of Health (DOH) or the police. The DON further stated that the facility did not have a written policy and procedure on sexual abuse, but the staff should have known what to do because they had been educated. The Licensed Nursing Home Administrator (LNHA) stated she was not working at the facility at that time, but that she would expect the staff to act on an allegation of rape, perform an assessment, and report it [to DOH]. The LNHA acknowledged there were no other files or documents regarding the allegation of rape by Resident #29. On 09/19/23 at 2:14 PM, during another interview with the surveyor, the RN UM stated she was responsible to initiate the questions on the back page of the Accident/Investigation report, but that the floor nurse would complete the front-page information. The RN UM stated that she would ask the staff to write statements. The RN UM further stated that Resident #29 has expressed behaviors however, had never made allegations of rape. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/19/23 at 2:22 PM, CNA #2 was interviewed by the survey team. CNA #2 stated she had never been educated on what to do if a resident yelled rape. On 09/19/23 at 3:02 PM, the LPN who cared for Resident #29 on 01/24/23, was interviewed by the survey team. The LPN stated she had cared for Resident #29 and knew the resident had been combative and would also yell at people. The LPN stated the resident required two- staff assistance to provide care. The LPN's progress note was read to the LPN, and the LPN acknowledged she documented the note, and also recalled the documentation regarding the resident yelling rape. The LPN further stated the resident screamed anything, but she had not documented before that the resident had screamed rape. The LPN stated she had not reported that the resident had yelled rape because it had not happened on my watch, and that it was a normal behavior for the resident to yell things for hours. The LPN further stated, I guess looking back that was something I should have reported. I just did not because the resident would say crazy things. The LPN stated, well I guess I wouldn't know if something had happened earlier in the day to Resident #29. A review of the facility provided, Abuse Identification & Prevention Program dated September 2018, included but was not limited to; C. Prevention 4. nursing and social workers identify those residents whose personal histories render them at risk for . becoming a victim of abuse. D. Identification of Signs and Symptoms of Abuse - clues to help identify abuse 1. physical abuse clues: color of bruises red, purple, or black indicate a bruise one day old. Note: Intentional or unintentional abuses necessitate an immediate investigation. During the investigation, the resident must be protected. E. Investigation 3. obtain statements from the caregivers and others directly involved with the resident 48 hours prior and 24 hours after. Interview other residents to determine if they had been abused or mistreated. Ensure the investigation is completed with three working days of the alleged abuse. The DON will maintain an investigative package with the copy of the incident report, all statements obtained and a conclusive summary of finding which indicated why or if and how abuse has been ruled out. A review of the facility provided, Abuse and Neglect Policy and Procedure undated, included but was not limited to; prohibiting mistreatment, neglect, and abuse of residents . Such steps include .monitoring and investigation of incident and accidents. Procedure included but was not limited to; 1. when the abuse is detected remove the resident from the harmful situation; 2. Physically assess the resident for injuries; 3. Get the facts; 4. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation are reported immediately to the DON, LNHA, attending physician, and resident's family/responsible party. The facility will thoroughly investigate and document each alleged violation and will prevent further potential abuse while the incident is under investigation. NJAC 8:39-4.1(a)5; 27.1 38079

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 27193 Based on interviews, review of medical records (MR) and other facility documentation, it was determined that the facility failed to report an injury of unknown origin to the New Jersey Department of Health (NJDOH) for 2 of 2 sampled residents (Resident # 29 and #50) reviewed for injuries of unknown origin. This deficient practice was evidenced by the following: 1. According to the Admission Record (AR), Resident #50 was admitted to the facility with diagnoses which included but were not limited to; Neurocognitive disorder with Lewy Bodies (chemical deposits in the brain that can affect thinking), Parkinson's disease, and malignant neoplasm of tonsillar pillar. The Significant Minimum Data Set (MDS) Assessment (an assessment tool used by the facility to prioritize care) dated 05/22/23 reflected that Resident #50 had some difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said. Section 1310 B. Inattention was coded 2. Resident #50 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS). Review of Resident #50's Care Plan (CP) initiated 12/08/22, revealed the following: [Resident #50] had impaired cognitive function related to Neurocognitive Disorder with Lewy Bodies (chemical deposits in the brain that can affect thinking) and is at risk for falls related to Parkinson Disease. According to the Progress Notes dated 10/24/22 timed 10:30 AM, the Certified Nursing Assistant (CNA) reported a bruise to the resident right hip identified during care, measuring 1.5 centimeter (cm) 1.5 cm. The physician and the family were notified. A statement dated 10/23/22 from the CNA who worked the 3:00 PM-11:00 PM shift, revealed that she observed the bruise and reported it to the nurse. The root cause analysis revealed that Resident #50 had a fall on 10/13/22 and was too far back to correlate the fall with the bruise on the resident right hip. The investigation reflected that a sensor pad alarm was then added to alert the staff of Resident #50's attempt to get out of the bed without assistance. On 09/19/23 at 10:30 AM, the surveyor reviewed again the facility Accident/ Incident report dated 10/24/22. The Accident/Incident report indicated that the bruise was found to the right hip. Resident #50 could not explain how he/she got the bruise. Review of the Investigation/Nursing Administration Review, Summary and Follow up /Conclusion to the incident, submitted by the DON on 09/19/23, dated 10/24/22 was left blank. On 09/20/23 at 12:36 PM, the DON stated that the incident was not reported to the NJDOH. Upon inquiry, the DON acknowledged that the injury was unwitnessed and should have been reported to the NJDOH. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/20/23 at 1:40 PM, the Administrator confirmed that any injury of unknown origin should be reported to the NJDOH. The Administrator explained that the facility does not have a specific policy for reporting injuries of unknown origin to the NJDOH. On 09/21/23 at 9:18 AM the facility did not provide any further information regarding the above incident. 2. A review of the AR revealed that Resident #29 had diagnoses which included but were not limited to; Dementia with other behavioral disturbance, major depressive disorder, cognitive communication deficit, and anxiety. A review of the person-centered Care Plan included a focus area dated 01/21/21, dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits, physical limitations. Another focus area dated 01/24/21, has activities of daily living (ADL) self-care performance and mobility deficit related to dementia, anxiety, weakness. Interventions included but were not limited to; two staff for all care. Resident requires extensive assist. On 09/19/23, two surveyors reviewed facility provided Resident Accident/Incident Reports for Resident #29. The Reports included but was not limited to the following: Date 09/08/23 at 9:15 AM, the Hospice Aide reported to the Registered Nurse (RN) supervisor on the East unit that Resident #29 had an unwitnessed 5.5 cm x 5.0 cm reddish purple discoloration on the right elbow. Resident #29 was unable to inform the staff what happened. A statement from the Hospice Aide was attached and 3 CNA statements related to their observations on 09/7/23. Dated 01/26/23 at 1:30 PM, a description of events revealed right upper hand bruise purple in color. The resident was unable to inform staff what happened. The bruise measured 2 cm x 1.5 cm. A statement was attached from one of the two CNAs who were providing care to Resident #29 and was signed with a date of 01/24/23 and a time of 6:45 PM. The statement did not document anything about a bruise, but did document that the resident was resistive and screaming rape. There were statements dated 01/25/23 and were related to their observations on 01/25/23. No behaviors were noted from the additional three CNA statements. On 09/19/23 at 11:36 AM, the DON was interviewed in the presence of members of the survey team. The surveyor asked if the unwitnessed incidents of injury of unknown origin, or the allegation of rape were reported to NJDOH? The DON stated she had to do an investigation but did not suspect abuse. We gather the facts first and then call. The DON acknowledged the injuries of unknown origin were unwitnessed and further stated, if it is a significant injury and we suspect abuse, we call right away. [Resident #29] moves around a lot and we figured it was friction and was not significant and did not suspect abuse so we did not call it in. On 09/19/23 at 12:27 PM, the DON and LNHA were interviewed in the presence of members of the survey team. The DON stated the Abuse policy did not include injury of unknown origin. The DON further stated that abuse could be physical, emotional, financial, verbal, sexual, or neglect. The DON stated that the Accident/Incident reports were usually reviewed the day after. When asked about Resident #29's allegation of rape, the DON stated the resident has a history of this in the past and just says these things. The DON stated the resident had a history of an abusive spouse. The DON further stated that she may have known about the allegation of rape but it was the residents normal behavior. The LNHA stated that if a resident made an allegation of rape, she would expect the staff to act on that allegation, complete an assessment and report the allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided, Abuse Identification & Prevention Program dated September 2018, included but was not limited to; G. Reporting. All alleged or suspected incidents of abuse, neglect or mistreatment shall be reported promptly to the NJDOH and Senior Services. 2. The Administrator/DON will notify the Department of Health of the alleged abuse, by telephone immediately. Notification will include the details known up to this point in time, and that the investigation has been started. 4. The DON / designee will notify the Department of Health (no later than the third working day from the date of the alleged abuse) that the investigation has been completed. 5. The Administrator / designee will communicate with the Department of Health the results of the investigation including the conclusion that A. they feel no evidence of abuse, neglect or mistreatment, or B. not able to determine, or rule out that abuse, neglect, or mistreatment occurred and their findings are inconclusive, or C. there is strong evidence to support the complaint of abuse, neglect or mistreatment. 6. The DON will ensure all documentation corresponding to the investigation has been completed and available for review by the DOH. 7. The DON / designee will notify the individual who reported the incident whether or not the DOH has been notified of the investigation or that abuse has been ruled out. N.J.A.C. 8:39-9.4 (f)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 38079 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to thoroughly investigate an injury of unknown origin and an allegation of rape. This deficient practice was identified for 2 of 2 residents (Resident #29 and #50) reviewed for accidents and incidents. The deficient practice was evidenced by the following: 1. According to the medical records, Resident #50 was admitted with diagnoses which included but were not limited to; Parkinson's disease and neurocognitive disorder. A review of the Care Plan (CP) revealed a focus area of impaired cognitive function related to neurocognitive disorder. Another focus area of at risk for falls related to Parkinson's Disease. A review of a facility provided, Resident Accident/Incident Report dated 10/24/22 at 10:30 AM, included but was not limited to; Description and facts of even: bruise found on R [right] hip during A.M. [morning] care. It was documented that the resident reported he/she had no idea it was there. Measurements of the bruise were documented as 1.5 centimeters (cm) x 1.5 cm. Under the section of Injury, there were three areas to be checked off known, unknown, occurred during care. The section was left blank. The resident was noted to have a Brief Interview of Mental Status (BIMS) of 15 at the time which indicated the resident was cognitively intact. Attached to the Accident/Incident Report, was one statement from the Certified Nursing Assistant (CNA) who discovered and reported the bruise. Another attachment provided was Investigation of Past 24 Hours. There were three CNA statements. The CNA who worked the 11 PM to 7 AM shift, dated 10/24/22, documented she had seen the bruise and reported it. The second CNA who worked the 3 PM to 11 PM shift, dated 10/23/22, documented she had not given care to that resident. The third CNA who worked the 7 AM to 3 PM shift, dated 10/24/23, was the CNA who found and reported the bruise. The facility failed to follow their policy and provide statements for a 48 hour look back, a 24 hour post incident statement, or to complete the Accident/Incident Report. The Director of Nursing (DON) documentation included but was not limited to; the resident had a fall 10/13/22, but it was too far out from this discovery to correlate. On 09/20/23 at 12:36 PM, the DON acknowledged that the injury was unwitnessed. On 09/20/23 at 1:40 PM, the Licensed Nursing Home Administrator (LNHA) confirmed that this was an injury of unknown origin. 2. A review of the medical record for Resident #29 revealed diagnoses which included but were not limited to; Dementia with behavioral disturbances, cognitive communication deficit, and anxiety. A review of the Care Plan included a focus area dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits and physical limitation. Another focus area revealed has activities of daily living self-care performance and mobility deficit related to dementia, anxiety, and weakness. Interventions included 2 staff for care. On 09/19/23, two surveyors reviewed the facility provided, Resident Accident/Incident Report for Resident #29. The report included but was not limited to the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dated 01/26/23 at 1:30 PM, Description: R upper hand bruise purple in color. Resident documented as stated, why now nothing happened to my hand? The resident was documented as being non-ambulatory. Under the section of INJURY, there were three areas to choose from known, unknown, occurred during care. The section was left blank. The resident was noted as having a BIMS of 12 out of 15 which indicated mildly impaired cognition. The bruise was measured as 2 cm x 1.5 cm and purple in color. Attached to the Report was a Investigation Witness Statement Form dated 01/24/23 at 6:45 PM. The statement was completed by a CNA and indicated another CNA was present during care of the resident. The statement revealed, After PM [evening] care and [Resident #29] was in bed he/she was screaming rape. Also attached was an Investigation of Unknown Injury 24 Hour Look Back form which indicated the date/time of occurrence as 01/26/23 at 1:30 PM. The form was filled out by three CNAs who reported on the resident from 01/25/23. The facility failed to follow their policy by not obtaining any statement from the second CNA providing care on 01/24/23; obtain statements for a 48 hour look back and 24 hour post incident statements from 01/23/23 and 01/26/23; a witness statement for 01/26/23 the injury of unknown origin; had not completed the Accident/Incident Report; and had not completed either investigation within 3 days. On 09/19/23 at 11:36 AM, the DON was asked about Resident #29 and the injury of unknown origin and the allegation of rape. The DON stated she, had to do an investigation but did not suspect abuse. On 09/19/23 at 12:27 PM, the DON and LNHA were interviewed in the presence of the survey team. The DON stated the facility Abuse policy did not include injury of unknown origin. The DON stated that the Accident/Incident Reports were usually reviewed the day after the incident. The DON further stated that she may have known about the allegation of rape but it was the residents normal behavior. On 09/19/23 at 1:30 PM, the surveyors interviewed the DON and asked when she was first made aware of the allegation that Resident #29 made on 01/24/23. The DON stated the incident report was brought to morning meeting on 01/27/23. The DON stated the nursing unit contacted her via telephone, and she could not recall who she had spoken with on 01/26/23 and that was about a bruise that occurred at 1:30 PM. The DON stated that the nurses knew how to complete an investigation and would also complete a 24- hour look back to obtain statements from all caregivers 24 hours prior to the discovery/when the allegation was made. The DON reviewed the investigation in the presence of the survey team and stated that there was a missing statement from one of the CNA's who was in the room with Resident #29 at the time of the allegation. The DON stated she only received a statement from CNA#1 and not from CNA #2. The DON stated she would have CNA #2 write a statement today, 09/19/23. The DON stated she brought the Incident Report to the morning report meeting held on 01/27/23, and at that time the incident report, and the 24 hours look back had not yet been completed and that nothing else had been provided for the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated she was not provided CNA #1's statement on 01/27/23 regarding rape and could not recall when she was given that statement. The DON confirmed there were two CNAs in the room with Resident #29 and she just realized that she did not have CNA #2's statement. The DON stated, I know I read it quickly knowing what had happened and stated what happened was that resident was throwing food, digging nails, a horrible scene. The DON stated Resident #29 had a history of an abusive spouse. The DON stated the expectation was to have received all the statements and that it was ultimately my [DON] responsibility. The DON stated that on 01/27/23, the Accident/Incident report had been signed as reviewed but was not complete and stated the LNHA who also signed the report was no longer at the facility. The DON stated that the investigation should have been completed within 24 hours. On 09/19/23 at 2:14 PM, during an interview with the surveyor, the Registered Nurse Unit Manager (RN UM) stated she was responsible to initiate the questions on the back page of the Accident/Investigation report, but that the floor nurse would complete the front-page information. The RN UM stated that she would ask the staff to write statements. The RN UM further stated that Resident #29 has expressed behaviors however, had never made allegations of rape. On 09/19/23 at 3:02 PM, the LPN who cared for Resident #29 on 01/24/23, was interviewed by the survey team. The LPN stated she had cared for Resident #29 and knew the resident had been combative and would also yell at people. The LPN stated the resident required two- staff assistance to provide care. The LPN's progress note was read to the LPN, and the LPN acknowledged she documented the note, and also recalled the documentation regarding the resident yelling rape. The LPN further stated the resident screamed anything, but she had not documented before that the resident had screamed rape. The LPN stated she had not reported that the resident had yelled rape because it had not happened on my watch, and that it was a normal behavior for the resident to yell things for hours. The LPN further stated, I guess looking back that was something I should have reported. I just did not because the resident would say crazy things. The LPN stated, well I guess I wouldn't know if something had happened earlier in the day to Resident #29. A review of the facility provided, Abuse Identification & Prevention Program dated September 2018, included but was not limited to; C. Prevention 4. nursing and social workers identify those residents whose personal histories render them at risk for . becoming a victim of abuse. D. Identification of Signs and Symptoms of Abuse - clues to help identify abuse 1. physical abuse clues: color of bruises red, purple, or black indicate a bruise one day old. Note: Intentional or unintentional abuses necessitate an immediate investigation. During the investigation, the resident must be protected. E. Investigation 3. obtain statements from the caregivers and others directly involved with the resident 48 hours prior and 24 hours after. Interview other residents to determine if they had been abused or mistreated. Ensure the investigation is completed with three working days of the alleged abuse. The DON will maintain an investigative package with the copy of the incident report, all statements obtained and a conclusive summary of finding which indicated why or if and how abuse has been ruled out. NJAC 8:39-4.1(a)5; 9.4(f)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 27193 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to: a.) follow acceptable standards of clinical practice and inform the physician that Resident #28 had been refusing Insulin (a medication to control blood sugar), and b.) ensure the accuracy of physician orders for Resident #44. This deficient practice was identified for 2 of 6 residents reviewed during the medication pass observation and was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter. Nursing Board The Nurse Practice Act for the State of New Jersey states; The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing a 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 with in the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. a.) On 09/11/23 at 7:25 AM, Surveyor #1 observed the Licensed Practical Nurse (LPN) administer medications to Resident #28. Resident #28 had refused an oral diabetic medication at that time. Resident #28 stated I am not taking that. I don't have diabetes. At that time, the LPN stated that she would document that the medication was refused and that would trigger a note to be completed in the electronic medical record (EMR) progress notes (PN). A review of the Admission Record revealed that Resident #28 had diagnoses which included Type 2 Diabetes. A review of the annual Minimum Data Set (MDS) an assessment tool dated 06/22/23, included Section E, Rejection of Care was exhibited 1 to 3 days of the 7 day look back. A review of the person-centered comprehensive Care Plan revealed a focus area of Diabetes Mellitus insulin dependent date initiated 06/15/23. Interventions included but were not limited to; diabetes medication as ordered by doctor. The care plan did not include behaviors of refusing Diabetic medications. A review of the Order Summary Report included a physician's order dated 07/20/23, Insulin Glargin Subcutaneous solution pen-injector 100 units/ml (milliliters) inject 10 units subcutaneously at bedtime. A review of the Medication Administration Record (MAR) dated September 2023 and included through 09/12/23, revealed that on 9/2/23, 9/4/23, 9/6/23, 9/9/23, 9/10/23, and 9/11/23, Resident #28 had refused his/her night time insulin. A review of the PN date range 08/30/23 through 09/12/23, revealed there was no documentation that the nursing staff alerted the physician about the resident refusing the night time insulin for 6 out of 11 days. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/12/23 at 10:18 AM, during an interview with Surveyor #1, an LPN stated the process was that if a resident refused a medication, the staff would attempt three times to administer the medication. If the resident still refused, the staff would educate the resident, call the physician, and document the refusal. The LPN further stated it was important to inform the physician if a resident refused medication. On 09/12/23 at 10:24 AM, during an interview with Surveyor #1, a Registered Professional Nurse (RN) supervisor stated that the process was if a resident refused medication, the staff would try three times and then notify the physician. The RN supervisor further stated the refusal would be documented and the care plan would be updated. On 09/12/23 at 10:32 AM, a RN stated that if a resident refused their medication, she would attempt to give it again and try to find out why the resident refused it. The RN stated if the resident refused insulin it could be more dangerous so the staff would call the physician and monitor the resident blood sugars. On 09/12/23 at 11:42 AM, the Director of Nursing (DON) stated that if a resident refused medication, the staff would be expected to educate the resident and attempt to administer the medication again. The DON stated that the staff should notify the Nurse Practioner (NP) or the physician and document in the progress notes. The DON and Surveyor #2 reviewed Resident #28's MAR. On 09/13/23 at 11:27 AM, the DON stated that a Diabetic could become hyperglycemic if they refused their diabetic medications. She stated the staff were educated to document when they call the physician or the NP but they [the staff] did not do that [regarding Resident #28 refusing insulin]. The DON further stated there were no PN documenting that Resident #28 had refused insulin or that the NP or physician had been made aware of the insulin being refused. The DON stated, I will have to talk to my staff about it. A review of the facility provided, Medication Refusal policy and procedure revised 06/2021, included but was not limited to; Policy: the facility staff will document any incident of medication refusal by a resident. Procedure: 5. The nurse will notify the resident's attending physician of the medication refusal when the refusal presents unfavorable outcomes. A review of the facility provided, Documentation Policy & Procedure reviewed 06/23, included but was not limited to; Policy: documentation is a professional tracking to enhance the continuity of care. Good clinical practice dictates what goes into a medical record. Key goals of sound clinical documentation are to describe what is happening to the resident. Enhance continuity of care on all shifts and disciplines. Monitor outcomes of care. Procedure: 1. required documentation - included in response to facility policies i.e. behavior monitoring. 2. b. what will be documented - included problem identification to resolution. c. document in the progress notes. d. document at the time of the incident. b.) On 09/11/23 at 8:15 AM, Surveyor #2 observed an RN administer medications to Resident #44. Resident #44 received the following medications as per the order on the Medication Administration Record (MAR) Tylenol 500 mg 1 tab (analgesic for pain management) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Desmopressin 0.2 mg 1 tab (Antidiuretic and clotting promoter) Depakote 500 mg 1 tab (Mood Stabilizer) Depakote 250 mg 1 tab (Mood Stabilizer) Fluvoxamine 50 mg 1 tab (anti-depressive) Fluvoxamine 50 mg 1/2 tab (anti-depressive) Colace 100 mg 1 caps.(Stool Softener) On 09/11/23 at 9:50 AM, during review of the medical record, Surveyor #2 observed 09/01/23 Physician's Orders (PO) that included a Physician's order for the resident to receive Tylenol extra strength 500 mg 2 tablets for fracture. The surveyor then observed that the RN administered one tablet only of 500 milligrams. The dose prescribed was 1000 milligrams. The surveyor reviewed the Physician Order Sheet (POS) and did not observe any change in the order. There was no verbal physician's order documented to reflect the change in dosage. Prior to administering the medications to Resident #44, Surveyor #2 asked the RN to verify the number of medications in the cup, the RN confirmed there were 7 tablets in the medication cup. During an interview on 09/15/23 at 9:47 AM, the RN stated Resident #44 should have received 2 tablets according to the POS. She further stated that she thought that she administered 2 tablets. The RN informed the surveyor that she was aware of the protocol to follow. A nursing Progress notes dated 09/11/23 timed 11:24 AM, confirmed that the Physician was called and gave an order to administer the 500 milligrams of Tylenol at 11:22 AM. During the exit conference held on 09/22/23 at 10:30 AM, the facility did not have any additional information regarding the medication omission. NJAC 8:39-11.2(b) 29.2(d). 38079

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 27193 Based on observation, interview, record review, and review of facility provided documentation, it was determined that the facility failed to ensure that incontinence care was provided to dependent residents in a timely manner for 2 of 2 residents, (Resident #49, Resident #50) reviewed for Activities of Daily Living (ADLs). This deficient practice was evidenced by the following: 1. On 09/06/23 at 10:22 AM, the surveyor toured the East Unit of the facility and observed Resident #49 in bed. A strong foul urine odor permeated as the surveyor approached the resident's bed. On 09/06/23 at 10:35 AM, the surveyor exited the room and while in the hallway heard an alarm sounding. The surveyor returned to the room and observed the resident was now out of the bed and was wearing a blue incontinent brief that was observed bulging in the rear. At 10:36 AM, a Certified Nurse Aide (CNA) emerged from the bathroom door inside of the resident room and observed Resident #49 was out of the bed. The CNA then escorted the resident back to bed and told the resident to wait until she had completed care for the resident next door. The CNA informed the surveyor that Resident #49 would try to get out of the bed whenever if he/she was soiled. On 09/08/23 at 08:43 AM, the surveyor interviewed the 7:00 AM -3:00 PM Certified Nursing Aide (CNA) #1 on the East Unit. The CNA stated that she currently had 12 residents on her assignment and was the only CNA on the floor. Upon inquiry regarding the workload, the CNA stated, I tried to find time and I usually finished my assignment by 12:00 PM or 1:00 PM. The CNA added, Not all of the residents would be out of bed due to staffing. The residents at risk for falls would be out of the bed almost daily. When inquired regarding if administrative staff were aware, she stated, They make the schedule they knew about it. On 09/08/23 at 11:30 AM, the surveyor interviewed the 7:00 AM - 3:00 PM CNA #2 on the East Unit who stated that she had been working at the facility for several years and currently had 13 residents on her assignment. CNA #2 stated that she only worked the 7:00 AM - 3:00 PM shift and would usually have 12 to 14 residents on her assignment on the weekends. CNA #2 further stated that the number of residents on her assignment depended upon how many staff were working. On 09/15/23 at 8:37 AM, the surveyor observed incontinence rounds in the presence of CNA #2 along with the Infection Control Preventionist (IP) on the East Unit. The surveyor observed that Resident #49 was wearing two incontinent briefs which were saturated with urine. CNA #2 stated that in the morning she made rounds to ensure that the residents were safe and in bed, however, did not check for incontinence. She further added that she had not yet provided care to Resident #49. When inquired about Resident #49 wearing two adult incontinent briefs, she stated that was not the protocol but occasionally she would observe residents wearing two incontinent briefs and would report it to the Registered Nurse/Unit Manager (RN/UM). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/15/23 at 11:11 AM, the surveyor interviewed the IP who assisted with incontinent care that morning. The IP confirmed that occasionally she would observe other residents wearing two incontinent briefs during incontinence care. She stated that she discussed the issue with the RN/UM and could not comment on/or if any in-service education had been completed to address the above issue. She added that the staff had to be careful because wearing two incontinent briefs could damage the skin and could be very uncomfortable. On 09/21/23 at 08:30 AM, during an interview with CNA #3 who cared for Resident #49 on 09/15/23 during the 11:00 PM-07:00 AM shift, she revealed that she began her last rounds at 4:00 AM, she provided incontinence care to Resident #49 and applied one brief. CNA #3 stated that she had some residents that were, heavy wetters on her assignment and she would change them as needed. CNA #3 added that she would place several blue bed pads on the bed, otherwise she would have to strip the whole bed in the morning. According to CNA #3's interview, approximately four hours had passed since Resident #49's incontinence brief had been changed. The surveyor reviewed the medical record for Resident #49. The Admission Face Sheet (an admission summary) reflected that Resident #49 was admitted to the facility with diagnoses which included but were not limited to: Syncope and collapse, repeated falls, unspecified Dementia. The Admission Minimum Data Set (MDS) an assessment tool used by the facility to prioritize care dated 08/02/23, reflected that Resident #49 had a BIMS (Brief Interview for Mental Status) of 09/15, indicative of moderate cognitive impairment. A further review of the resident's MDS, Section G - Functional Status indicated the resident required extensive assistance of one-person physical assist for personal hygiene. A review of the resident's Care Plan (CP) with revised date of 07/26/23, reflected a focus area that the resident had an ADL self-care performance deficit related to hospitalization , diagnosis of Syncope, bradycardia and recurrent falls. The goal was for Resident #49 would improve current level of function in ADL,s and mobility. The interventions for the resident CP included that Resident #49 requires assistance by 1 staff with oral care, personal hygiene, and toileting. 2. On 09/08/23 at 8:37 AM, the surveyor observed incontinence rounds in the presence of the Hospice Aide (HA) on the East Unit. The surveyor observed that Resident #50's incontinent brief was wet and yellow stained. The yellow liquid was observed to be covering the front and the back part of the resident's incontinence brief. Two blue pads were also noted on the bed and were also yellow stained. The HA stated that she worked for Hospice Monday through Friday and provided care to Resident #50. The HA added that Resident #50 would be wet every day whenever she received the resident. She reported to work and just started her shift at 8:30 AM and had not yet changed the resident. On 09/15/23 at 8:15 AM, the surveyor observed incontinence rounds in the presence of CNA #1 and the HA on the 2 East Unit for Resident #50. When the HA removed the resident's incontinence brief, the surveyor observed that two long sanitary-type pads were also inside the incontinence brief and were saturated and yellow. The contents of the sanitary-type pads had leaked through the incontinence brief and stained the blue bed pad that was placed on the bed to protect the bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor asked CNA #1 to have a supervisor report to the room. The Licensed Nursing Home Administrator (LNHA) was located on the floor and reported to the room. She informed the surveyor that she would call the DON. The HA remained in the room at the bedside with the surveyor. During a second interview with the HA, she stated that she informed both the nurses and the CNAs that Resident #50 needed to be checked for incontinence every 2 hours. On 09/15/23 at 8:30 AM, the DON entered the room where she observed Resident #50 was in bed, two sanitary-type pads soaked with urine, the incontinent brief also saturated with urine and yellow stained. The DON stated that the sanitary-type pads were in place to prevent MASD (Moisture- Associated Skin Damage -a general term for inflammation and erosion of the skin due to prolonged exposure to moisture) and the resident should have had only one pad inside the incontinent brief. On 09/15/23 at 10:30 AM, the facility provided two packages of the sanitary-type pads for review. The surveyors reviewed the package information on the sanitary-type pad. The packages revealed the products were Bladder Pads, Fits Inside Your Own Underwear. The instructions did not correlate with what the facility indicated the intended use was regarding placing the pad inside the incontinent brief. The surveyors requested the facility provide evidenced based guidance regarding using one incontinent product (Bladder Pad) inside of an incontinent brief. On 09/18/23 at 12:00 PM, the surveyor interviewed the UM/RN of the East Unit. She stated that she was not aware that staff were using two adult incontinent brief, and two pads inside the incontinent brief. She further stated that she could not recall if the CNA or the IP alerted her prior to 09/15/23 of the above concerns. The RN/UM further stated that incontinence rounds were to be performed every two hours and as needed for the residents. The surveyor reviewed the medical record for Resident #50. Resident #50 was admitted to the facility with diagnoses which included but were not limited to: Neurocognitive disorder with Lewy Bodies, Parkinson's disease malignant neoplasm of tonsillar pillar. The Significant Minimum Data Set (MDS) Assessment (an assessment tool used by the facility to prioritize care) dated 05/22/23 reflected that Resident #50 had some difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said. Section G of the MDS which addressed Activities of Daily Living (ADL) reflected that Resident #50 required extensive assistance from staff with bed mobility, transfer, personal hygiene, and toileting. A review of the resident's CP with revised date of 09/11/23, reflected a focus area that the resident had an ADL self-care performance and mobility deficit related to hospitalization , shuffling gait due to Parkinson's Disease. The goal of the resident's CP reflected that the resident would be free of complications related to immobility, skin breakdown. The interventions for the residents CP included extensive assist of 1 for dressing, toileting, hygiene. (The Care Plan failed to indicate that Resident #50 required incontinence care every two hours per the HA) When inquired regarding the facility policy for ADLs, the DON stated that the facility did not have a policy for ADL's. (continued on next page)

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Warren Haven Rehab and Nursing Center	350 Oxford Road Oxford, NJ 07863

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/21/23 at 8:05, the surveyor conducted a telephone interview with CNA #3 who cared for Resident #50 on the 11:00 PM-7:00 AM shift on 09/15/23. CNA #3 revealed that Resident #50 required total care, all needs must be anticipated. You have to do everything for [Resident #50], [he/she] is a heavy wetter. She stated she started her last rounds at 4:00 AM and changed the resident around 5:00-5:30 AM. This indicated that approximately four hours had passed since the resident had been provided incontinence care by a staff member, not two hours as was indicated by the HA. CNA #3 further stated that she provided incontinence care as much as she could. CNA #3 stated had 24 residents on her assignment that night. CNA #3 added that she left the facility at 7:15 AM on 09/15/23, and only one CNA reported to the floor for the day shift. She admitted that she put 2 pads inside the brief and stated that she was never informed how many pads could be placed inside the incontinent brief. CNA #3 further added that it was the facility protocol to have the pads inside the adult brief. When asked if she received some in-service education regarding how many pads to use, she stated, No. CNA #3 then stated, The amount of pads being placed in the incontinent brief was never discussed. She acknowledged receipt of in-service education on incontinent care on 09/16/23, only after surveyor inquiry. On 09/20/23 at 12:30 PM, the above concerns were discussed with the facility administrative staff. During an interview with the DON she confirmed that the facility had been using the pads inside the adult brief. The Director of Nursing (DON) stated that the protocol dated back when the facility was managed by the County. The DON added that the residents were care planned for the use of the pads inside the adult brief. When asked about the facility policy for ADLs the DON stated that the facility does not have a policy for ADLs and did not provide any evidenced based guidance regarding utilizing one bladder product inside of another for incontinence care. The facility did not offer any information why residents were not offered more frequent incontinent care. On 09/21/23 the facility provided an in-service policy titled, Maintaining our Resident's Quality of Life which included the following: Quality of Life: to improve or at the very least, maintain the resident's level of function in all aspect of life, safeguarding against lost of ability. Health's Care: ADLs provided are appropriate for the resident's ability- do for them only what they cannot do for themselves. Incontinence Care Residents require timely care when incontinent. A review of the facility's Job Description for Certified Nursing Assistant indicated under Essential Job Functions. Assist residents with bathing, dressing, grooming, dental care, bowel and bladder functions, preparation for medical tests and exams, ear and eye care and positioning in and out of beds, chairs, etc. Performs resident related activities directed throughout the shift including assisting with lifts of residents to wheelchairs/ [recliner], assists residents In transfer activities, assist residents in donning and removing appliances or splints, and guards residents in ambulation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing Care Functions Provide nursing functions as directed by Nurse Manager including daily perineal care, catheter care, turn residents in bed, sponge baths and showers. Resident's Right Functions Maintain resident confidentiality and privacy; treat residents with kindness, dignity, and respect; know and comply with Resident's Rights; and promptly report all resident complaints and incidents to supervisor. The Registered Nurse Supervisor Job Description Provide direct nursing care to the residents and to supervise the day-to-day nursing activities performed by the nursing personnel in accordance with current State, Federal, and Local standards governing the facility and as may be directed by the Director of Nursing to ensure highest level of quality care in maintained at all times. Administrative Functions Oversees day to day functions of the licensed practical nurses and the nursing assistants. Ensures that all nursing service personnel are giving proper resident care and performing their respective duties in accordance with written policies, procedures, and manuals. Nursing Care Functions Supervise direct care of resident on assigned shift. NJAC 8:39-27.1(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 27193 Repeat Deficiency Based on observation, interviews, record and review of other pertinent facility documentation, it was determined that the facility failed to: a.) ensure that a cognitively impaired resident admitted with a known history of falls was appropriately supervised and/ or monitored to prevent falls including falls with injury on 08/27/23 when Resident #50 had an unwitnessed fall and sustained front forehead wound and lump measuring 1.5 centimeter x 1.3 and 0.1., and b.) follow fall prevention interventions per the Care Plan, and ensure that assistive devices to alert staff of falls were functional. This deficient practice was identified for 2 of 3 residents reviewed for incident/ accidents (Resident #49 and #50) and was evidenced by the following: On 09/06/23 at 10:22 AM, the surveyor observed Resident #49 in bed, and a strong odor of urine permeated the room. On 09/06/23 at 10:35 AM, while in the hallway of the East Unit, the alarm sounded in room [ROOM NUMBER]. Resident #49 attempted to get out of the bed, blue brief was soaked with urine and bulging from the back. The Certified Nursing Assistant (CNA) emerged from the adjacent bathroom and escorted the resident back to bed. The CNA told the the resident to wait until she could complete care for the other resident that was observed in the bathroom. The CNA informed the surveyor that whenever Resident #49 was wet he/she would try to get out of bed. On 09/06/23 at 12:30 PM, observed Resident #49 in the dayroom with 6 other residents. The residents were unsupervised and there was no staff observed in the dayroom, or at the nursing station at that time. On 09/08/23 at 8:43 AM the surveyor interviewed the CNA who cared for the resident. She stated she was the only CNA on the floor, the other CNA would report to work around 9:00 AM. The CNA further stated that most of the time 2 CNAs would be assigned to the Unit. The Census was 25 and she had 12 residents on her assignment. When inquired regarding the residents observed in the dayroom she stated that the residents who were at risk for falls would be out of the bed first and then placed in the dayroom. She further added that not all residents would be out of bed daily due to staffing issue. When inquired regarding if administrative staff was aware of the concerns with residents care and staffing, she stated, They made the schedule they were aware. On 09/11/23 at 9:39 AM, the surveyor observed Resident #49 sitting in the dayroom with 3 other residents. The residents were unsupervised as there was no staff in present in the day room or at the nursing station. On 09/11/23 at 11:30 AM, the surveyor reviewed Resident #49's medical record. The Admission Face Sheet (an admission summary) reflected that Resident #49 was admitted to the facility with diagnoses which included but were not limited to: syncope (fainting) and collapse, repeated falls, unspecified Dementia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Admission Minimum Data Set (MDS) dated [DATE], an assessment tool used by the facility to prioritize care, reflected that Resident #49 had a BIMS (Brief Interview for Mental Status) of 09/15, indicative of moderate cognitive impairment. The MDS also reflected that Resident #49 required limited assistance of one person physical assist for bed mobility and transfer, and extensive assist for personal hygiene and toileting. A fall risk assessment completed by the facility on 08/11/23 indicated that Resident #49 was a high risk for fall. Resident #49 received a score of 90 on the Morse Fall Scale Morse Fall Scale; Scoring: High Risk 45 and higher. The surveyor reviewed a nurse Progress Note dated 08/11/23 timed 12:45 PM, which reflected that Resident # 49 was found lying on the floor on the right side and was asleep on the floor with feet inside the bathroom and head near the bed. Upon assessment, it was noted to have a circular skin tear to the left forearm measuring 3 centimeters (cm) was identified. A review of the facility's Accident/Incident Report dated 08/11/23 at 12:45 AM, indicated that Resident #49 was found asleep and was lying on the floor. At that time per the Accident report, the resident got out of the bed unassisted, climbed in and out of the bed. Interventions added: Moved to room [ROOM NUMBER]-A. Possible alarm to call bell system. Another entry in the nurse Progress Note dated 08/29/23 timed 6:30 PM, revealed that Resident #49 had another unwitnessed fall that occurred in the dayroom. According to the description of Facts and Event, the CNA heard a thud and found Resident #49 sitting on the ground with no apparent injury. Interventions added: 15 minutes monitoring, rehab screen, rule out infection. The CNA's statement revealed that she was at the nursing station and heard the thud and then observed Resident #49 on the floor. The root cause analysis of the event provided by the facility revealed that Resident #49 had poor safety awareness, required assistance with transfer and ambulation. The root cause analysis did not identify /address the lack of supervision as a factor. On 09/11/23 at 09:49 AM, the surveyor observed the Registered Nurse Unit Manager (RN/UM) sitting at the nursing station and was entering information into the computer. During an interview with the RN/UM, she stated that Resident #49 was a high fall risk and that the reason to be in the dayroom. When asked who was monitoring the dayroom, the RN/UM stated she could observed the resident while at the nursing station through the [redacted glass-type] window, but the activity staff should be in shortly. The surveyor observed that the glass window was at knee height and did not provide a full view of the dayroom. The RN/UM further stated that Resident #49 would attempt to ambulate unassisted at times,was not aware of his/her limitation, and needed to be monitored. The surveyor reviewed the following entries in Resident #49's clinical record: On 09/02/23 at 19:52 PM, the Licensed Practical Nurse documented: Resident #49 frequently leaving his/her wheelchair and attempted to ambulate, resident frequently switching seats, undressed in the dayroom. On 09/02/23 at 07:13 AM,the Registered Nurse wrote: Toileting x 8 this shift. Would not call for assistance, would jump out of the bed, unsteady walking to bathroom. Sometimes resident was already incontinent and would remove brief and throw on floor but majority of times would sit on toilet . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 09/19/23 at 12:30 PM, in the presence of the team regarding Resident #49's falls, the Director of Nursing (DON) stated that the facility does not have staff dedicated to monitor the dayroom. The DON stated that the residents in the dayroom were being monitored by all staff including the nurse on the medication cart and whomever was in the hallway or at the nursing station. The DON further added that the facility would provide distant supervision for residents in the dayroom. The DON was unable to provide any documentation to support resident monitoring. A review of Resident #49's Care Plan revealed that the line of supervision required for Resident #49, who was identified as a high fall risk since admission, was not addressed. 2. Resident #50 was admitted to the facility with diagnoses which included but were not limited to: Neurocognitive disorder with Lewy Bodies, Parkinson's disease malignant neoplasm of tonsillar pillar. The Significant Minimum Data Set (MDS) Assessment (an assessment tool used by the facility to prioritize care), dated 05/22/23, reflected that Resident #50 scored 13/15 on the Brief Interview for Mental Status (BIMS). The MDS also reflected that Resident #50 had some difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said. Section 1310 B. Inattention was coded 2. Section G of the MDS which addressed Activities of Daily Living (ADL) reflected that Resident #50 required extensive assistance from staff with bed mobility and transfer. Resident #50 was assessed to be at high risk for fall, Resident #50 received a score of 90 on the Morse Fall Risk dated 06/19/23 and 75 on the fall risk dated 08/27/23. On 09/06/23 at 10:33 AM, the surveyor observed Resident #50 sitting in a high back chair in the dayroom, unsupervised, and not respond to the surveyor's greeting. There was no staff in the dayroom or at the Nursing station. On 09/11/23 at 9:58 AM, the surveyor observed Resident #50 unsupervised, and sitting in the dayroom with 3 other residents. There was no staff observed in the dayroom or at the nursing station. On 09/14/23 at 12:05 PM, the surveyor observed Resident #50 sitting, unsupervised, in the alcove area with 2 other residents. There was no staff present in the hallway. A review of Resident #50's Comprehensive Care Plan for falls initiated on 09/30/21, revealed the following interventions: 1. Urinal within reach initiated 11/22/21. 2. Educate to use call bell for assist initiated 11/22/21. 3. Electronic Pad Alarm on bed initiated 10/13/22. 4. Hip protectors at all times initiated 10/25/22. 5. Sensor Pad to wheelchair initiated 02/04/23. 6. Rehab screen post fall, initiated 02/04/23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Common area when out of bed initiated 06/20/23. 8. Bolster mattress with egress as well as landing matt initiated 08/28/23. On 09/15/23 at 11:15 AM, the surveyor further reviewed the clinical record and noted the following entries: 10/13/22 07:10 AM, the Licensed Practical Nurse documented, (Unwitnessed fall) Resident #50 was found on the floor with an abrasion to the forearm. A review of the Accident/Incident Report revealed that upon assessment, Resident #50 was observed to have redness on left and right knees, a right forearm abrasion measuring 6 centimeters (cm) x 0.4 cm. 02/04/23 5:30 PM, (Unwitnessed fall) Resident #50 was found on the floor in front of the wheelchair in the room. The Director of Nursing documented: Interview of the nurse at the time of the fall, Resident #50 had been at the nurses station. This was just before dinner trays come to the floor. He had appropriate footwear on. No injury was noted by the nurse. The fall was unwitnessed and neuro-checks were implemented . Resident #50 is impulsive and he/she stands without assist. Root Cause analysis: Increase confusion with unpredictable due to Dementia. 06/19/23 4:20 PM, The Licensed Practical Nurse (LPN) documented, While sitting in the dayroom, Resident #50 attempted to get out of wheelchair and fell . Under observation,the LPN wrote, Resident in dayroom on the ground in front of the wheelchair Root Cause Analysis: Poor safety awareness. Overestimates his/her abilities. When inquired who was in the dayroom to monitor the residents, the DON did not provide any information. 08/27/23 11:30 PM, (Unwitnessed fall) The LPN documented that the Certified Nursing Assistant found Resident #50 on the floor in the room. The bed alarm did not sound. The facility was not aware of how long Resident #50 had been on the floor. Root cause analysis: Poor safety awareness and overestimates his/ her abilities to stand related to Dementia and Parkinson. A review of the fall investigation revealed that Resident #50 was found on the floor with a right front forehead wound and lump measuring 1.5 centimeter x 1.3 and 0.1. The root cause analysis revealed that the bed alarm did not sound at time of the fall. Section (C) of the Supplemental Fall Information included the following question: Were all of the care planned devices applied prior to the fall was checked? No and indicated that Resident #50 did not have the hipsters implemented (10/25/22) and non skid socks on. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section (D) If an alarm was in place was it sounding? According to the documentation, the bed alarm was in place but did not alert alert the staff of the fall. The surveyors also observed that on 3 occasions, 09/08/23 at 9:01 AM, 09/11/23 at 8:35 AM, 09/15/23 8:15 AM, Resident #50 was in bed, when checked with the CNA Resident #50 did not have the hipsters on (padded brief) implemented since 10/25/22 when Resident was observed to have a bruise of unknown origin to the right hip to minimize fall with injury. On 09/19/23 at 08:36 AM, during an interview with the Hospice CNA (HA), stated that when she cared for Resident #50 in the morning, Resident #50 never had the hip protectors on and she reported the issue to the Unit Manager and the CNAs on the unit. On 09/19/23 at 11:19 AM, the surveyor interviewed the DON, in the presence of the survey team and the Licensed Nursing Home Administrator and the Director of Operations. The surveyor asked who is supposed to supervise the residents who are placed in the dayroom. The DON stated, there is staff that floats in and out of the dayroom. The surveyor asked who the staff is, and the DON stated, CNAs, nurses and activity.The surveyor asked the DON who was monitoring Resident #50 when the resident sustained an unwitnessed fall on 06/19/23. The DON reviewed the investigation and stated, it was an unwitnessed fall. The surveyor asked who was monitoring the dayroom, and the LNHA responded that she had just left the dayroom. A statement dated 06/19/23 revealed that the LNHA left the dayroom and heard an alarm sounding and observed Resident #50 rising from the wheelchair and the alarm sounded and the resident fell to the floor. The surveyor asked the DON who can see what is happening in the dayroom if there is no one assigned to monitor, and you are relying on varied staff who float in and out of the dayroom. The DON stated, we had all the safety interventions in place,and if we thought he/she was a fighter risk we would have had someone in the room. The DON further stated, if their behaviors warrant a closer observation we would have a staff member with them. The facility failed to address supervision as a mitigating factor to prevent further falls. The DON confirmed that Resident #50 is a high risk for falls, as are a lot of residents and the resident has had a few falls. The surveyor asked if interventions added preclude supervision of a resident? The DON stated there was distant supervision, and the surveyor asked how the facility would know that was occurring and it is documented. The DON stated, no. The DON confirmed there is no documentation to confirm that there is any supervision from other staff that are around the unit, or going through the unit. On 09/20/23 at 10:28 AM, during an interview with the RN/UM, she stated that the hipsters were to be always on. She was not aware that the staff had not been compliant with the hipsters. On 09/20/23 at 10:33 AM, the RN/UM looked into the room there was no hipsters. She stated that the Resident had 3 hipsters assigned to him. The RN/UM in the presence of the surveyor searched the room and could not find any hip protectors in the room. There was no hipsters on the unit also. The UM stated that Resident #50 was to have 3 hipsters in the room they could have been soiled and sent to the laundry. On 09/20/23 at 12:30 PM, the surveyor reviewed the CNA's Care Plan initiated 09/22/21 and indicated the following: Hip protectors on at all times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/20/23 at 1:30 PM, the surveyor reviewed the facility policy Titled, Falls and Fall Risk Management The policy indicated that Based on the resident's previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Procedure The Interdisciplinary Care Plan Team will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e.; to try one or a few at a time, rather than many at once), # 4 of the procedure indicated the following: If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains irrelevant. The facility indicated on 06/23/23 that Resident #50 had increase confusion with unpredictable behavior due to Dementia. Resident #50 had recurrent falls at the facility when he /she was not being supervised, the facility did not indicate the line of supervision required to prevent falls. On 09/21/23 at 8:30 AM, the surveyor interviewed by phone, the CNA assigned to the 11:00 AM-7:00 PM shift regarding the residents placed in the dayroom. The CNA confirmed prior to leaving the facility at 7:15 AM she would cared for some residents including Resident #49 and placed him/her in the dayroom. When inquired about who was responsible to monitor the residents at risk for falls who were observed early morning in the dayroom. The CNA stated, she could not be at the facility to monitor the dayroom when her shift was over. She stated that she reported to work timely every day when she was assigned to work. The CNA further added, that the administrative staff needed to reinforce the rule and ensure that the 7:00- 3:00 PM shift reported to work on time. On 09/21/23 at 9:39 AM, during a pre-exit conference with the administrative staff which included the LNHA, DON, Regional staff and the Chief Executive Officer (CEO). When the surveyor presented multiple observations where both residents were observed in the dayroom and the alcove unsupervised, she replied, noted. The facility did not provided further information regarding the lack of supervision for the residents who sustained multiple unwitnessed falls, including falls with injury. NJAC 8:39-27.1 (a)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Complaint # NJ 165178 Based on observation, interview and review of pertinent documents it was determined that the facility failed to ensure sufficient staff were available to: a) provide supervision for resident's who were at risk for falls, who sustained multiple unwitnessed falls, b) consistently provide resident's with assistance to get out of bed, and c) provide appropriate incontinence care. The deficient practice occurred on two of two resident units and was evidenced by the following: Refer to 689E Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes, indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. a. On 09/06/23 at 12:30 PM, Surveyor #1 observed Resident #49 in the dayroom with six other residents. The residents were unsupervised and there was no staff observed in the dayroom, or at the nursing station at that time. On 09/08/23 at 8:43 AM, Surveyor #1 toured the East unit and interviewed a Certified Nursing Aide (CNA #1) who stated she was the only CNA for 25 residents and that most of the time there were two CNAs. Surveyor #1 asked CNA #1 if she were able to complete her assigned tasks daily. CNA #1 stated that she usually finished her assignment, but 12:00 PM or 1:00 PM and not all of the residents would be out of bed due to staffing. CNA #1 stated she focused on getting the residents who were at risk for falls out of bed. Surveyor #1 inquired to CNA #1 regarding if the management staff were aware of the staffing concerns. CNA #1 stated that they make the schedule and they know about it. On 09/11/23 at 9:39 AM, Surveyor #1 observed Resident #49 sitting in the dayroom with three other residents. The residents were unsupervised as there was no staff in attendance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. Building B. Wing	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Haven Rehab and Nursing Center	350 Oxford Road Oxford, NJ 07863

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the medical record revealed: a fall risk assessment completed by the facility on 08/11/23 indicated that Resident #49 was at a high risk for falls. Resident #49 received a score of 90 on the Morse Fall Scale; Scoring: High Risk 45 and higher. A nurse Progress Note dated 08/11/23, timed 12:45 PM, revealed that Resident # 49 was found lying on the floor with feet inside the bathroom and head was near the bed. Upon assessment, it was noted a circular skin tear to the left forearm measuring three centimeters was identified. Another entry in the nurse Progress Note dated 08/29/23, timed 6:30 PM, revealed that Resident #49 had another unwitnessed fall that occurred in the dayroom. According to the description of Facts and Event, the [CNA] heard a thud and found Resident #49 sitting on the ground with no apparent injury. Interventions added: 15 minutes monitoring, rehabilitation screen, rule out infection. The CNA's statement revealed that she was at the nursing station and heard the thud and then observed Resident #49 on the floor. The root cause analysis of the event provided by the facility revealed that Resident #49 had poor safety awareness, required assistance with transfer and ambulation. b. On 09/06/23 at 10:33 AM, Surveyor #1 observed Resident #50 sitting in a high back chair in the dayroom, unsupervised, and not respond to the surveyor's greeting. There was no staff observed in the dayroom. On 09/11/23 at 9:58 AM, Surveyor #1 observed Resident #50, unsupervised, and sitting in the dayroom with three other residents. There was no staff observed in the dayroom or at the nursing station. On 09/14/23 at 12:05 PM, the surveyor observed Resident #50 sitting, unsupervised, in the alcove area with two other residents. There was no staff present in the hallway. On 09/15/23 at 11:15 AM, the surveyor further reviewed the medical record and noted the following entries: On 10/13/22 at 7:10 AM, Resident #50 was found on the floor with an abrasion to the forearm. On 09/19/23 at 11:19 AM, the surveyor interviewed the Director of Nursing (DON), in the presence of the survey team along with the Licensed Nursing Home Administrator (LNHA) and Director of Operations. When the facility was interviewed regarding any staff supervision for residients left unnatended in the day room, the DON stated there was distant supervision. The surveyor asked how the facility would know that was occurring and was it documented. The DON stated, no. The DON confirmed there was no documentation to confirm that there was any supervision from other staff that were around the unit, or going through the unit. c. On 09/08/23 at 9:15 AM, Surveyor #2 observed a call bell system blinking at the un-manned nursing station. At that time, the surveyor conducted an interview with a Licensed Practical Nurse (LPN) and a CNA. The LPN stated there were 35 Residents on both the short and long hall, that she had eleven residents and that there were two CNA's for 35 residents. The surveyor asked the CNA and LPN how they managed to get all of the residents out of bed and the LPN stated, sometimes they don't, and the CNA stated sometimes we can't get everyone up, and with the machine [mechanical lift] it is not easy. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/11/23 at 8:52 AM, Surveyor #2 was seated at the unoccupied [NAME] nursing desk and observed a blinking call bell unit with a screen that displayed 8 min, 9 min, and 11 min and a red light was observed blinking outside of the door to room [ROOM NUMBER]. Surveyor #2 observed a nurse standing at a medication cart positioned outside of the room and a staff member was observed going into the room at 8:58 AM. On 09/11/23 at 8:56 AM, Surveyor #2 interviewed the LHNA regarding the current staffing level for CNAs. The LNHA confirmed that she was aware of the New Jersey minimum staffing ratios for CNAs and stated staffing was a concern and during the day shift we don't make it. Surveyor #2 asked the LNHA how does she ensure that residents are getting out of bed and provided with the necessary care required due to the staffing concerns. The LNHA stated that the facility prioritized the residents who get out of bed by ensuring that resident's identified as fall risks get out of bed daily. The LNHA shared the CNA recruitment incentives with Surveyor #2 and strategies, including qualified management staff who help. c. On 09/06/23 at 10:22 AM, the Surveyor #1 observed Resident #49 lying in bed and a strong urine odor permeated throughout the room. On 09/06/23 at 10:35 AM, while in the hallway of the East Unit, Surveyor #1 heard an alarm sounding in Resident #49's room. The surveyor observed the Resident attempting to get out of the bed, a blue incontinent brief was observed soaked with urine and was bulging from the back. The CNA was observed emerging from the adjacent bathroom and then escorted the resident back to bed. The CNA told the resident to wait until she could complete care for the other resident that was observed in the bathroom. The CNA informed the surveyor that whenever Resident #49 was wet he/she would try to get out of bed and disrobed. On 09/15/23 at 8:15 AM, Surveyor #1 performed an incontinence tour with CNA #2, and also in the presence of the facility Infection Preventionist Nurse (IPN). Resident #49 was observed wearing two incontinent briefs and was saturated with urine. At that time, CNA #1 stated that wearing two incontinent briefs was not the protocol and Resident #49 should have been wearing one brief. At 9:06 AM, Surveyor #1, in the presence of Surveyor #2 conducted a follow-up interview with CNA #2 regarding the double incontinent briefs. CNA #2 stated staffing was a concern and that it might take all day to complete her assignment, but she would complete it. CNA #2 stated she was trained to only use one incontinent brief and that Resident #49 should have had one incontinent brief on because it was a dignity issue and could affect resident's skin. CNA #2 stated she has observed two briefs on Resident #49 in the past and she always alerted the supervisor who informed her that it would be addressed. CNA #2 stated Resident #49 was suppose to be taken by the staff to use the toilet not be wearing two briefs. CNA #2 stated there were two CNA's at present, and a third CNA was due to start at 11:00 AM and typically she had twelve residents on any given day. A review of the Facility Assessment 2023, Sufficiency Analysis Summary revealed a daily meeting reviews the staffing for the day as well as projected needs over the next several days to ensure appropriate, sufficient staffing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/19/23 at 10:55 AM, Surveyor #2 interviewed the LNHA, in the presence of the survey team and with a Corporate Manager regarding the purpose of the Facility Assessment. The LNHA stated to identify our strength and weaknesses annually or more than annually if something changed. Surveyor #2 inquired as to how the staffing had been completed. The LNHA stated a computer program was used to assist with CNA staffing and what areas of the facility would be short. The LNHA stated she and the DON would be made aware of when staffing would be short and when asked if there were days that were short she stated, yes. When asked if there was a system to monitor call bell response, the LNHA stated no. A reivew of the Promoting/Maintaining Resident Dignity Policy, Effective 09/02/15 was reviewed by Surveyor #2 and revealed the following: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recogniting each resident's individuality. Compliance Guidelines included 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights, 4. Respond to requests for assistance in a timely manner. NJAC 8:39- 4.1(a)11; 27.1(a)