STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315361	A. Building B. Wing	09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Preakness Healthcare Center	305 Oldham Road Wayne, NJ 07470

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on interviews, record review, and facility policy review, the facility failed to ensure that one (Resident (R) 218) of 34 sampled residents were treated with respect and dignity by providing care in a manner to enhance R218's quality of life. Findings include: During an interview with R218 on 09/04/23 at 10:50 AM, she said that on the night shift back in the summer, she had to be changed because she had a bowel movement (BM) in her incontinent brief. R218 said that staff took 30 minutes to answer the call light. R218 said that this made her feel like shit. R218 said that she does not like to sit in her own urine and/or feces. She said that mainly on the 3-11 shift staff do not ask her if she is wet and/or do not offer to change her throughout the shift until 8:30 PM when the staff lay her down for the night. R218 said that this makes her feel not good. R218 said that she would like to be changed more often. Continued interview revealed R218 said this past Friday (09/01/23), an agency nurse worked on the 7-3 shift and forgot to give R218 her allergy relief medication. R218 said that the agency nurse had a nasty attitude, putting her off to another staff member who never gave her the medication. R218 said that this made her feel bad, I am a resident too and I am here to get help also. R218 indicated that these concerns have been addressed with the Administrator. Review of R218's facility provided Face Sheet revealed that R218 was readmitted on [DATE] with a diagnosis including Cerebral palsy (CP), chronic obstructive pulmonary disease (COPD), and diabetes mellitus (DM). Review of R218's Quarterly Minimum Data Set (MDS) assessment, with Assessment Reference Date (ARD) 07/19/23, revealed R218 had a Brief Interview for Mental Status (BIMS) of15 out of 15, which indicated R218 was cognitively intact for interview. Continued review revealed that R218 had no documented behaviors during the seven day look back period. Review of R218's facility provided Progress Notes indicated no evidence of behaviors. Review of R218's facility provided Care Plan indicated no evidence of behaviors. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 09/07/23 at 2:38 PM, said that all residents should be treated with dignity and respect indicating that dignity is taken very seriously at the facility. Review of facility policy titled, Resident Rights, revised 01/30/18, revealed, It is the policy of the facility to protect and promote the rights of each resident, particularly those rights that pertain to a dignified existence, self-determination and communication with an access to persons and services within and outside the facility. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his/her rights. The Social Service Department functions as an advocate in protecting the rights of the residents. These rights mean that the residents should have autonomy and choices, to the extent feasible, in determining how they wish to live their everyday lives. Procedures: 1. Each resident and/or representative is informed during the admission process of his/her rights and responsibilities as defined in the Resident's [NAME] of Rights in accordance with (but not limited to) regulatory requirement which include: -Be informed about what rights and responsibilities he or she has -Exercise his or her rights -Voice grievances/complaints and have the facility respond to those grievances/complaints -Medical care -Freedom from abuse, neglect, exploitation, and restraints -Finances -Physical and personal environment -Receipt of such information will be acknowledged in writing -Visits and activities -Privacy and confidential treatment -Discharges and transfers -Mail and telephones -To personalize their rooms within safety guidelines -Change in room or roommate. NJAC 8:39-4.1(a)12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observations, interviews, and record review, the facility failed to ensure that tube feeding poles were maintained in a sanitary manner for three (Residents (R) 51, R160 and R203) of 34 sampled residents. Findings include: 1. Review of R51's facility provided Face Sheet revealed that R51 was admitted to the facility on [DATE] with a diagnosis including dysphagia, anoxic brain damage, and dysphagia. Review of facility provided Physician Orders for September 2023 revealed R51 was to receive Diabetisource AC 1000 milliliters (ML)/day via gastrostomy (g-tube) using at 75 ml/hour (hr), to start at 6:00 PM until total volume infused. During the initial tour of the facility on 09/05/23 between 10:30 AM-12:00 PM, revealed the tube feeding pole had an unknown cream-colored substance all over the pole. During an observation on 09/06/23 at 09:10 AM, 12:17 PM and 2:30 PM, R51's tube feeding pole had unknown cream-colored unknown substance all over the pole. During an observation on 09/08/23 at 1:00 PM, R51's tube feeding pole had an unknown cream-colored substance all over. During the observation, Registered Nurse (RN) 6 confirmed that the pole was dirty and should be cleaned by housekeeping; however, if the nurses notice them dirty, then the nurses should clean. 2. Review of R160's facility provided Face Sheet revealed that R160 was readmitted with a diagnosis including persistent vegetative state, Alzheimer's disease, and Adult Failure to Thrive (AFTT). Review of R160's facility provided Physician Oder's for September 2023 revealed R160 was to receive Peptamen 1.5 with probiotic 750 ml/day via g-tube using pump at 50 ml/hr start at 6:00 PM until total volume infused. During the initial tour of the facility 09/05/23 between 10:30 AM-12:00 PM, revealed the tube feeding pole had unknown brunt red colored crusty substance all over the pole and cream-colored unknown substance throughout the pole. During an observation on 09/06/23 at 09:00 AM, 12:00 PM, and 2:45 PM, R160's tube feeding pole had unknown burnt red colored crusty substance all over the pole and cream-colored unknown substance throughout the pole. During an observation and interview on 09/08/23 at 1:04 PM, R160's tube feeding pole had unknown burnt red colored crusty substance all over the pole and cream-colored unknown substance throughout the pole. During an interview, RN6 confirmed that the tube feeding pole was dirty, and RN6 indicated that either housekeeping or nursing should clean the poles. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of facility provided Face Sheet for R203 revealed R203 was readmitted to the facility on [DATE] with a diagnosis including encephalopathy, and muscle spasms. Review of facility provided Physician Orders for September 2023 revealed R203 was to receive Diabetisource AC 1200 ml/day via gastrostomy (g-tube) using at 75 ml/hr, start at 6:00 PM, run until total volume infused. During the initial tour of the facility on 09/05/23 between 10:30 AM-12:00 PM, R203's tube feeding pole had gray colored tape in the middle and unknown burnt red colored crusty substance and cream-colored unknown substance all over the pole. During observations on 09/06/23 at 09:12 AM, 12:30 PM, and 2:35 PM, R203's tube feeding pole had gray colored tape in the middle and unknown brunt red colored crusty substance and cream-colored unknown substance all over the pole. During observation on 09/08/23 at 1:01 PM, R203's tube feeding pole had gray colored tape in the middle and unknown brunt red colored crusty substance and cream-colored unknown substance all over the pole. During walking rounds with RN6, at the time of the observation, he confirmed the tube feeding pole was dirty, indicating that either housekeeping and/or nurses should clean the poles. Review of facility provided Housekeeping Cleaning Sheets dated July 2023-present revealed indicated no evidence of tube feeding poles being cleaned. NJAC 8:39-4.1(a)11

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20940 Complaint #: NJ157711, NJ159758, NJ162870, NJ162871 Based on interview, record review, and policy review, the facility failed to ensure allegations of abuse / neglect and/or the investigations were submitted to the New Jersey Department of Health (NJDOH) within the time limits of the policy and federal regulation for three of seven residents (Resident (R)18, R409, R458) with NJDOH reportable incidents. Findings include: 1. Review of R18's printed Face Sheet showed a facility admitted [DATE], readmission on 07/14/23, with medical diagnoses (from a printed Diagnosis list) that included acute respiratory failure, multiple sclerosis, polyneuropathy, trigeminal neuralgia, and lower extremity embolism and thrombosis. On 09/06/23 at 4:29 PM, a review of a Facility Reported Event (FRE) showed an incident reported by R18 of a nursing assistant using a full body lift without an assist on 03/22/23, however, the report was not sent to the State Agency until 03/24/23. During an interview on 09/06/23 at 6:42 PM, the Director of Nursing (DON) confirmed the NJDOH report form (AAS45) for R18 was sent in late. 2. R409 a. During an interview with R218 on 09/04/23 at 10:50 AM, R218 said that she witnessed agency staff grab R409's arm to go to the bathroom. R218 said that she let staff know but does not know the staff's name. R218 said that it happened a couple of days ago on the night shift. Attempted to interview R409 on 09/05/23 at 11:30 AM, who was sitting in her bedroom; however, when approached, R409 did not understand English. Review of R409's facility provided Face Sheet revealed R409 was admitted to the facility on [DATE] with a diagnosis including dementia, anxiety, and depression. Review of R409's facility provided Progress Note, dated 08/14/23, revealed, New admission day one hard of hearing (HOH) with periods of confusion. Ambulatory via rollator with slow movements. Patient has some resistance to care. Has false accusatory behavior towards staff. Ate dinner with good appetite. Able to feed self but requires set up assistance. Assisted by [family member] into her pajamas. Toileted wearing pullups. Bilateral hearing aids placed on top medication cart in case. Took medications without difficulties. Fall precautions with bilateral floor alarmed mats to floor, functioning. Eyeglasses placed on bedside table. Review of facility provided Department Health Senior Services (DHSS)/Ombudsman Reportable Incidents dated 01/03/22-present, revealed no evidence of the alleged abuse on 08/14/23 being reported. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/05/23 at 11:40 AM, the Executive Director stated that R409's [family member] had reported an alleged abuse incident to the facility and the facility investigated. She said that she would provide the paperwork to the surveyor. Review of facility provided Employee Statement for Registered Nurse (RN) 2, dated 08/17/23, revealed I noticed patient was trying to sit on chair by bedside. I offered to assist the patient into bed and patient was agreeable. Patient wanted to go to the bathroom for assistant. While instructing patient and giving guidelines during transfer to hold on to handles of rollator. The patient divulged false accusatory behavior and started accusing nurse of pulling her hands and stated that she would report to her [family member] that I grabbed her and pulled her hands. I assisted patient into the bathroom. Patient was not cooperative with the process of assisting into bed. I then went to nurses' station and asked Licensed Practical Nurse (LPN) 1 and RN3 for assistance. Both assisted, slowly to assist patient into bed. Patient was left comfortable with bedside floor alarm in place and functional. During an interview with the Director of Nursing (DON) on 09/05/23 at 12:00 PM, the DON brought one sheet of paper to surveyor that had a hand-written employee statement from RN 2. After reading the employee statement, the DON was asked if this was reported to the State Survey Agency (SSA), and he stated no. He said that it was investigated by him, and he felt it was a language barrier, not abuse. He said that he spoke with R409's family member, and she felt that R409 was having some confusion, and that could have been it. He indicated that he spoke with R409, using a Spanish speaking staff member; however, was unable to produce any evidence of this conversation. The DON said he had not finished his summary of the incident yet. Review of R409's facility provided Care Plan revealed no evidence of making false allegations against staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility provided Email from the DON, dated 09/05/23, revealed, On 08/15/23 at approximately 10:30 AM [RN 2] called to report that [R409's] [family member] reported that [R409] informed her that the CNA who assisted her to bed last night pulled her hands. Undersigned quickly reported to unit [number of unit] to talk to [R409] regarding her complaint. Upon arrival, [R409]'s [family member] was at bedside. After speaking with [family member], I summoned a bilingual Secretary Assistant who is fluent in Spanish to come to [R409]'s room to translate. [R409] stated in Spanish that the aide who assisted her to bed pushed her. I asked [R409] to demonstrate how the aide pushed her. [R409] said she was sitting down in her chair and the aide came to take to the bathroom, she took [R409] by the hands. [R409] pulled her hands from aide and told aide that she will report her to her [family member]. I asked [R409] if the aide pushed or pulled her hands. [R409] did not respond. I asked [R409] if the aide assisted her to the bathroom. [R409] replied yes. I asked [R409] again if the aide pushed or pulled her. [R409] did not respond. [R409] was wearing short sleeves blouse. I assessed her hands and elbows. No redness, bruise or discoloration noted. I check the staffing sheet for the 3-11 shift on 08/14/23 to see who was assigned to [R409].]R409]'s name was noted on the staffing sheet. I interviewed [RN2] who was the assigned nurse to [R409] on 08/14/23 from 3:00 PM to 11:00 PM. According to [RN2], [R409]'s daughter assisted her to put on [R409']s pajamas. [RN2] said, she noticed [R409] looked tired, she noticed [R409] name under [Certified Nursing Assistant (CNA) 1] and instructed [CNA 1] to put [R409] to bed. [RN2] said [CNA1] was busy with another resident, [RN2] offered to assist [R409] to bed. R409 asked to go to the bathroom. RN2 stated that while in the bathroom, she instructed R409 to hold on the grab bar. R409 was not cooperating. RN2 said, she quickly goes to the nursing station and summoned [Licensed Practical Nurse (LPN1)] and [RN3] to assist her to finish toileting [R409] and assisted her back to bed. [RN2] stated the process was slow, but they were able to calm [R409] down and assisted her back to bed. I spoke with [LPN1], who confirmed that [RN2] called him to assist with [R409]. [LPN1] stated that he is not fluent in Spanish, but he managed to direct [R409] from the bathroom to her bed. [RN3] also confirmed that [RN2] summoned her to [R409]'s room to assist her with [R409] on 08/14/23. [R409] was provided with a communication binder. I spoke with [R409]'s family member after the investigation explaining the resolution. [name of family member] said [R409] used to live alone in an apartment, she thinks her [R409] needs a little time to adjust. When I told her that it was the nurse who assisted [R409] to bed, she said that she spoke with the nurse before she left, she told the nurse about [R409]'s routines. In an interview with R409's family member on 09/07/23 at 12:26 PM, she stated that R409's first night there was very traumatic for me. The family member said that R409 reported to her (the family member) when she visited in the morning, that during the night shift someone pushed R409. The family member said that she reported this to the DON and thought it had been forgotten about because she had not heard anything else about it. Attempts were made to contact RN2 via phone on 09/07/23 at 12:53 PM, 1:17 PM and 2:30 PM; however, the call went straight to a voice message that said the voicemail box has not been set up as of yet. Attempted another call on 09/08/23 at 3:11 PM, without any answer and the same message as before. There was no contact prior to exiting the facility. During a phone interview on 09/07/23 at 12:54 PM, CNA1 stated that she does not remember anything about the 08/14/23 incident. Attempts were made to contact RN3 via phone on 09/07/23 at 1:04 PM; and a message was left; however, there was no return call prior to exiting the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/07/23 at 2:07 PM, LPN1 said that RN2 did come and get him to assist with getting R409 back to bed. He said that when he arrived in R409's bedroom, R409 was on her bed, with her foot on the floor. He indicated that he speaks a little Spanish but was able to speak enough to assist R409's position in bed without any issues. During an interview on 09/07/23 at 2:38 PM, the DON stated that the email he provided was his summary of the investigation. The DON stated that he concluded that it was a misunderstanding because of the language barrier. The DON stated that he could not substantiate that abuse occurred, and that was the reason he did not report to the state survey agency (SSA). He stated he was unaware of the timeframes for reporting and/or sending in the final summary after investigation, and that the facility put different interventions into place, such as a communication board with common pictures written in Spanish for R409 and/or the staff to point to ensure that R409's needs were met. Also, the DON said that he has a Spanish speaking staff member work with R409 when possible. The DON denied any further incidents. The DON, when asked, said that he reports to the SSA as soon as possible. He said if abuse is reported to the supervisors, then they contact him and the Administrator, the supervisors make a file and indicate on the inside of the file the date and time that the SSA and Ombudsman were notified, and they that file on his desk, so that he can began the investigation the next morning. He indicated that sometimes the supervisors will begin the interviews with the resident and staff involved and place them in the folder too. He said that if the resident is interviewable, he will speak with that resident, and then speak with nurses and CNAs. The DON stated if other residents were directly involved, he will speak with them; however, if no other resident was involved, he did not speak with other interviewable residents. The DON stated that after he finishes his investigation, he sends an email summary to the Administrator who faxes to the SSA and Ombudsman. The DON stated that he tries to get the investigation done as soon as possible, but sometimes due to staff being off or on vacation, he completes it as fast as he can. The DON confirmed in the 08/14/23 incident with R409 that he did not speak with other residents and indicated that he spoke with only R409. The DON indicated that while speaking with RN2, RN2 confirmed that she was assisting R409 to the bathroom when R409 pushed her away. b. During an interview on 09/07/23 at 12:26 PM, R409's family member stated that a few days ago, in the middle of the night, R409 reported to her that the staff was verbally aggressive with R409. The family member stated reported this to the aide and the nurse who said that she reported this event. The family member was unable to recall staff names that she reported the incident to. Review of facility provided Progress Note dated 09/04/23, revealed Alert responsive confused with accusatory behavior towards staff, keep saying somebody push me. RN8 notified. R409 is not compliant with rolling walker and toileting, R409 walking in her room going to the toilet by herself. Reminded R409 to call for help when she needs help. Eyeglasses and bilateral hearing aid on in morning, denies pain. There was no indication of the alleged abuse. Review of facility provided Department Health Senior Services (DHSS)/Ombudsman Reportable Incidents, dated 01/03/22-present, revealed no evidence of the alleged abuse on 09/04/23 being reported. Review of R409's facility provided Care Plan revealed no evidence of R409 making false allegations against staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/07/23 at 2:38 PM, the DON revealed that he was unaware of the 09/04/23 progress note in R409's medical record. After reading the progress note, he said that R409 should have become a two person assist for care to prevent further incidents. The DON said that he would investigate, and then if he felt it was concrete, he would report to SSA. At 4:00 PM, the DON stated that he was going to report the 09/04/23 incident to the SSA since he was just informed of this concern. Attempts were made to contact RN8 via phone on 09/08/23 at 5:55 PM; however, there was no answer and/or answering machine. 3. Review of R458's printed Face Sheet showed a facility admitted [DATE], readmission on 04/03/23, with medical diagnoses (from a printed Diagnosis list) that included internal device hemorrhage, dementia, unspecified stomach/duodenal disease, atherosclerotic heart disease, atrial fibrillation, hypotension, and deep tissue injury. On 09/06/23 at 12:19 PM, a FRE was reviewed that R458 reported to the physician a fear of a nursing assistant on 03/22/23 (there was a date discrepancy in part of the report that stated 03/21/23; the date was verified by the physician's notes) and the report was sent to the NJDOH on 03/24/23. During an interview on 09/06/23 at 6:42 PM, the Director of Nursing (DON) confirmed the State Agency report form (AAS45) for R458 was sent in late. Review of the facility's policy titled Resident Abuse, revised 02/07/17, revealed, Every resident has the right to be free from all types of abuse, neglect, misappropriation of resident property exploitation. [name of facility] will protect the health and safety of every resident including those that are incapable of perception or who are unable to express themselves in a manner that can convey their intent .G. Reporting 1. All allegations involving mistreatment, neglect, exploitation, or abuse, including injuries of unknown source and misappropriation of resident property must be reported to the Executive Director and to other officials in accordance with the state law through established procedures and local law enforcement: New Jersey Department of Health Office of the Ombudsman for the Institutionalized Elderly (for residents age 60 or older). 2. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, must be reported immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the Executive Director of [name of facility] and to other officials (including to the SSA and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures. 3. Allegations of crime are reported in accordance with section 1150B of the Social Security Act (the Elder Justice Act reporting requirements). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The results of abuse investigations must be reported to the Executive Director within five working days. 5. The Executive Director will forward the results of all abuse investigations within five working days of the incident to all officials in accordance with State Law (including state survey and certification agency). If the allegation is verified, appropriate corrective action must be taken. 6. The Executive Director will send the completed Mandatory Reporting of Abuse, Neglect and or Misappropriation of Resident Property by (Certified) Medication Aides, Nurses' Aides and Personal Care Assistant form and a copy of the entire investigative report to the program manager of the certification program at the [name of state] Department of Health within 15 calendar days from the date of the incident. 7. The Director of Human Resources shall report to the State Nurse Aide Registry or Licensing Authorities/Board any knowledge it has of any actions by a court of law or findings, which would indicate an employee is unfit for service or has a history of resident abuse. NJAC 8:39-5.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on record review, interview, review of Facility Reported Incidents (FRI), and policy review, the facility failed to ensure that a thorough investigation was conducted regarding staff-to-resident abuse allegations involving one (Resident (R) 409) of 34 sampled residents. There was no evidence that the facility interviewed other current residents regarding the allegations. Findings include: 1. During an interview with R218 on 09/04/23 at 10:50 AM, R218 said that she witnessed agency staff grab R409's arm to go to the bathroom. R218 said that she let staff know but does not know the staff's name. R218 said that it happened a couple of days ago on the night shift. Review of R409's facility provided Face Sheet revealed R409 was admitted to the facility on [DATE] with a diagnosis including dementia, anxiety, and depression. Review of R409's facility provided Progress Note dated 08/14/23 revealed New admission day one hard of hearing (HOH) with periods of confusion. Ambulatory via rollator with slow movements. Patient has some resistance to care. Has false accusatory behavior towards staff. Ate dinner with good appetite. Able to feed self but requires set up assistance. Assisted by [family member] into her pajamas. Toileted wearing pullups. Bilateral hearing aids placed on top medication cart in case. Took medications without difficulties. Fall precautions with bilateral floor alarmed mats to floor, functioning. Eyeglasses placed on bedside table. During an interview on 09/05/23 at 11:40 AM, the Executive Director stated that R409's [family member] had reported an alleged abuse incident to the facility and the facility investigated. She said that she would provide the paperwork to the surveyor. During an interview with the Director of Nursing (DON) on 09/05/23 at 12:00 PM, the DON brought one sheet of paper to surveyor that had a hand-written employee statement from RN 2. The DON stated he investigated the allegation, and he felt it was a language barrier, not abuse. He said that he spoke with R409's family member, and she felt that R409 was having some confusion, and that could have been it. He indicated that he spoke with R409, using a Spanish speaking staff member; however, was unable to produce any evidence of this conversation. The DON said he had not finished his summary of the incident yet. Review of facility provided Employee Statement for Registered Nurse (RN) 2, dated 08/17/23, revealed I noticed patient was trying to sit on chair by bedside. I offered to assist the patient into bed and patient was agreeable. Patient wanted to go to the bathroom for assistant. While instructing patient and giving guidelines during transfer to hold on to handles of rollator. The patient divulged false accusatory behavior and started accusing nurse of pulling her hands and stated that she would report to her [family member] that I grabbed her and pulled her hands. I assisted patient into the bathroom. Patient was not cooperative with the process of assisting into bed. I then went to nurses' station and asked Licensed Practical Nurse (LPN) 1 and RN3 for assistance. Both assisted, slowly to assist patient into bed. Patient was left comfortable with bedside floor alarm in place and functional. (continued on next page)

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	315361	A. Building B. Wing	09/08/2023

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility provided Email from the DON, dated 09/05/23, revealed, On 08/15/23 at approximately 10:30 AM [RN 2] called to report that [R409's] [family member] reported that [R409] informed her that the CNA who assisted her to bed last night pulled her hands. Undersigned quickly reported to unit [number of unit] to talk to [R409] regarding her complaint. Upon arrival, [R409]'s [family member] was at bedside. After speaking with [family member], I summoned a bilingual Secretary Assistant who is fluent in Spanish to come to [R409]'s room to translate. [R409] stated in Spanish that the aide who assisted her to bed pushed her. I asked [R409] to demonstrate how the aide pushed her. [R409] said she was sitting down in her chair and the aide came to take to the bathroom, she took [R409] by the hands. [R409] pulled her hands from aide and told aide that she will report her to her [family member]. I asked [R409] if the aide pushed or pulled her hands. [R409] did not respond. I asked [R409] if the aide assisted her to the bathroom. [R409] replied yes. I asked [R409] again if the aide pushed or pulled her. [R409] did not respond. [R409] was wearing short sleeves blouse. I assessed her hands and elbows. No redness, bruise or discoloration noted. I check the staffing sheet for the 3-11 shift on 08/14/23 to see who was assigned to [R409].]R409]'s name was noted on the staffing sheet. I interviewed [RN2] who was the assigned nurse to [R409] on 08/14/23 from 3:00 PM to 11:00 PM. According to [RN2], [R409]'s daughter assisted her to put on [R409']s pajamas. [RN2] said, she noticed [R409] looked tired, she noticed [R409] name under [Certified Nursing Assistant (CNA) 1] and instructed [CNA 1] to put [R409] to bed. [RN2] said [CNA1] was busy with another resident, [RN2] offered to assist [R409] to bed. R409 asked to go to the bathroom. RN2 stated that while in the bathroom, she instructed R409 to hold on the grab bar. R409 was not cooperating. RN2 said, she quickly goes to the nursing station and summoned [Licensed Practical Nurse (LPN1)] and [RN3] to assist her to finish toileting [R409] and assisted her back to bed. [RN2] stated the process was slow, but they were able to calm [R409] down and assisted her back to bed. I spoke with [LPN1], who confirmed that [RN2] called him to assist with [R409]. [LPN1] stated that he is not fluent in Spanish, but he managed to direct [R409] from the bathroom to her bed. [RN3] also confirmed that [RN2] summoned her to [R409]'s room to assist her with [R409] on 08/14/23. [R409] was provided with a communication binder. I spoke with [R409]'s family member after the investigation explaining the resolution. [name of family member] said [R409] used to live alone in an apartment, she thinks her [R409] needs a little time to adjust. When I told her that it was the nurse who assisted [R409] to bed, she said that she spoke with the nurse before she left, she told the nurse about [R409]'s routines. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/07/23 at 2:38 PM, the DON stated that the email he provided was his summary of the investigation. The DON stated that he concluded that it was a misunderstanding because of the language barrier. The DON stated that he could not substantiate that abuse occurred, and that was the reason he did not report to the state survey agency (SSA). He stated he was unaware of the timeframes for reporting and/or sending in the final summary after investigation, and that the facility put different interventions into place, such as a communication board with common pictures written in Spanish for R409 and/or the staff to point to ensure that R409's needs were met. Also, the DON said that he has a Spanish speaking staff member work with R409 when possible. The DON denied any further incidents. The DON, when asked, said that he reports to the SSA as soon as possible. He said if abuse is reported to the supervisors, then they contact him and the Administrator, the supervisors make a file and indicate on the inside of the file the date and time that the SSA and Ombudsman were notified, and they that file on his desk, so that he can began the investigation the next morning. He indicated that sometimes the supervisors will begin the interviews with the resident and staff involved and place them in the folder too. He said that if the resident is interviewable, he will speak with that resident, and then speak with nurses and CNAs. The DON stated if other residents were directly involved, he will speak with them; however, if no other resident was involved, he did not speak with other interviewable residents. The DON stated that after he finishes his investigation, he sends an email summary to the Administrator who faxes to the SSA and Ombudsman. The DON stated that he tries to get the investigation done as soon as possible, but sometimes due to staff being off or on vacation, he completes it as fast as he can. The DON confirmed in the 08/14/23 incident with R409 that he did not speak with other residents and indicated that he spoke with only R409. The DON indicated that while speaking with RN2, RN2 confirmed that she was assisting R409 to the bathroom when R409 pushed her away. Review of the facility policy titled Resident Abuse, revised 02/07/17, revealed, Every resident has the right to be free from all types of abuse, neglect, misappropriation of resident property exploitation. [name of facility] will protect the health and safety of every resident including those that are incapable of perception or who are unable to express themselves in a manner that can convey their intent .E. Investigation 1. [name of facility] will investigate all incidents with injuries of unknown origin and all alleged violations. Allegations of abuse must be investigated by a professional, and, if applicable, in the primary language of the resident. The report will include: a. Name of the resident who is the subject of the suspected abuse/exploitation. b. Name of the person suspected or accused of committing the alleged violation. c. Description of the nature of the suspected violation. d. Date, time and specific location of the occurrence. e. Name (s) of all witnesses to the suspected abuse/exploitation f. Written statements from the resident (if able), possible suspect, eyewitnesses, and any circumstantial witnesses. g. Information on injuries that require medical treatment and photographs if applicable. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Any other information which may be helpful in the investigation as well as the protection of the residents. i. Social Service representative to encourage resident to express the incident and monitor the resident's feelings. j. Steps taken to protect the alleged victim from further abuse. 2. A resident incident checklist and supervisory investigatory summary report will be completed 3. The alleged victim will be promptly examined if applicable, and findings documented in the investigation report. 4. Original investigation report of the alleged violation will be forwarded to the Executive Director's office within 24 hours of the incident. 5. All phases of the investigations are to be kept with the Executive Director and remain confidential. NJAC 8:39-9.4(f)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20940 Based on record review and interview, the facility failed to provide to the resident and/or their representative, a written notice of the reason for transfer for two (Residents (R) 191 and R98) of three residents transferred to the hospital and provided that notice to the Ombudsman. Findings include: 1.Review of R191's paper chart revealed an admitted [DATE] with diagnoses including dementia, depression, and schizophrenia. R191 experienced a change in condition on 08/12/23 and was transferred to the hospital. The paper record lacked evidence the facility provided the resident and/or representative, in writing, of the reason R#191 was transferred to the hospital. The record also lacked evidence the Ombudsman was notified of R#191's transfer. 2. Review of R98's paper chart revealed an admitted [DATE] with diagnoses including diabetes, respiratory failure, and dependence on a ventilator for respiratory support. R98 was transferred to the hospital for a change in condition on 04/05/23. The paper record lacked evidence the facility provided the resident and/or representative, in writing, of the reason R98 was transferred to the hospital. The record also lacked evidence the Ombudsman was notified of R98's transfer. R98 was readmitted [DATE]. R98 was transferred to the hospital for a change in condition on 05/02/23. The paper record lacked evidence the facility provided the resident and/or representative, in writing, of the reason R98 was transferred to the hospital. The record also lacked evidence the Ombudsman was notified of R98's transfer. R98 was readmitted to the facility on [DATE] and was again transferred to the hospital due to a change in condition on 06/28/23. The paper record lacked evidence the facility provided the resident and/or representative, in writing, of the reason R98 was transferred to the hospital. The record also lacked evidence the Ombudsman was notified of R98's transfer. Interview with the Director of Nursing (DON) on 09/06/23 at 4:19 PM confirmed the facility failed to develop and implement policies and procedures for the notification of resident and/or their representatives of the reason the resident was transferred to the hospital and notification to the Ombudsman. NJAC 8:39-4.1(a)32 NJAC 8:39-5.3(b)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20940 Based on record review and interview, the facility failed to provide to the resident and/or their representative, a bed hold policy to two (Residents (R) 191 and R98) of three residents transferred to the hospital. Findings include: 1.Review of R191's paper chart revealed an admitted [DATE] with diagnoses including dementia, depression, and schizophrenia. R191 experienced a change in condition on 08/12/23 and was transferred to the hospital. The paper record lacked evidence the facility provided the facility's bed hold policy. 2. Review of R98's paper chart revealed an admitted [DATE] with diagnoses including diabetes, respiratory failure, and dependence on a ventilator for respiratory support. R98 was transferred to the hospital for a change in condition on 04/05/23. The paper record lacked evidence the facility provided R98 and/or representative the bed hold policy. R98 was readmitted [DATE]. R98 was transferred to the hospital for a change in condition on 05/02/23. The paper record lacked evidence the facility provided R98 and/or representative the facility's bed hold policy. R98 was readmitted to the facility on [DATE] and was again transferred to the hospital due to a change in condition on 06/28/23. The paper record lacked evidence the facility provided the resident and/or representative the facility's bed hold policy. Interview with the Director of Nursing (DON) on 09/06/23 at 4:19 PM confirmed the facility failed to develop and implement bed hold policies and procedures for the notification of resident and/or their representatives of the facility's bed hold process. The DON confirmed the facility did not give a bed policy notice to R191, R98 or to the representative. NJAC 8:39-5.4(c)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on observation, interview, record review, and facility policy review, the facility failed to ensure that three of three residents (Resident (R) 18, R140, and R232) and/or Resident Representative (RR) reviewed for bed rail use had documented safety assessment for the use of bed rails and were advised of the risks and/or benefits of rail use. This failure had the potential for residents with bed rails to be uninformed of the risk of severe injury and/or death associated with bed rail use. Findings include: 1. Review of R18's printed Face Sheet showed a facility admitted [DATE], readmission on 07/14/23, with medical diagnoses (from a printed Diagnosis list) that included acute respiratory failure, multiple sclerosis, polyneuropathy, trigeminal neuralgia, and lower extremity embolism and thrombosis. During an interview on 09/04/23 at 12:04 PM, it was noted R18 had bilateral assist bars, or bed rails. When asked about them, R18 stated his wife and he had to fight to get them and thought his wife had to sign something. In response to a request for a bed rail assessment (for need and safety), risk/benefit notification, and consent for R18 on 09/06/23 at 2:05 PM, the Director of Nursing (DON) provided a Fall Risk Assessment. When asked about the rail assessment, the DON stated, We only do that for side rails, we don't do the assessment for assist bars. The DON explained they have been going by the Minimum Data Set (MDS) physical restraint definition but after reading the regulation confirmed the practice did not meet the regulation. 2. Review of R140's printed Face Sheet showed a facility admitted on 02/26/21, readmission on 07/28/21, with medical diagnoses (from a printed Diagnosis list) that included rheumatoid arthritis, anemia, hemiplegia, type II diabetes, major depressive disorder, ataxia, and long-term steroidal use. During an observation on 09/05/23 at 10:23 AM it was noted that R140 had bilateral assist bars on the bed. In response to a request for a bed rail assessment, risk/benefit notification, and consent on 09/06/23 at 12:05 PM, the DON provided printed progress notes for R140 dated 02/26/21 and 03/10/21 that revealed, requested for b/l [bilateral] grab assist bars for positioning and [R140] has bilateral grab bars. respectively. In an interview on 09/06/23 at 2:05 PM, the DON confirmed no bed rail assessment was completed. 3. Review of R232's printed Face Sheet showed a facility admitted [DATE], readmission on 01/19/23, with medical diagnoses (from a printed Diagnosis list) that included hip pain, right femur fracture, hypertension, bradycardia, atherosclerotic heart disease, and cancer. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/04/23 at 4:00 PM, R232 was asked about the observed bilateral assist bars on the bed. R232 responded that they had been on the bed for a long time. When asked if he used them, R232 stated he did not. When queried if R232 had been advised of the risks / benefits of bed rails, he did not remember. In response to a request for a bed rail assessment (for need and safety), risk/benefit notification, and consent for R232 on 09/06/23 at 2:05 PM, the Director of Nursing (DON) provided a Fall Risk Assessment. When asked about the rail assessment, the DON stated, We only do that for side rails, we don't do the assessment for assist bars. The DON explained they have been going by the Minimum Data Set (MDS) physical restraint definition but after reading the regulation confirmed the practice does not meet the regulation. Review of the facility policy titled, Bed Side Rails, reviewed 01/10/18, showed: .2. Upon admission, readmission, change of condition, or request of the resident and/or resident representative, residents will be assessed using the Assessment for Side Rail(s) Use Form by staff indicated on the form to: -Assess the resident to identify appropriate alternatives prior to installing side rails. Alternatives must be attempted and evaluated based on clinical assessment with the findings documented in the medical record. -Assess the resident for risk of entrapment from side rails prior to installation. -Assess the resident to determine if the use of a side rail is a restraint using the CMS definition of restraints as outlined in Federal regulations and the MOS RAI Manual. -Assess the resident to determine if the use of a side rail may enhance a resident's ability to move independently in bed or when transferring in or out of bed. 4. Based upon the Resident Assessment if it is determined that the side rail is the least restrictive alternative for the least amount of time, the Nursing Supervisor will review the risk and benefits with the resident and/or resident representative and obtain the written informed consent from the resident and/or resident representative. NJAC 8:39-5.1(a) NJAC 8:39-27.1(a)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on observation and interviews, the facility failed to ensure the daily nursing staffing hours were included in the prominently displayed nurse staffing for residents, visitors, and/or staff. This failure could affect the knowledge of the availability of staff to care for the 50 residents, their family members, or their representatives. Findings include: During an observation of the nursing staff posting on 09/08/23 at 11:45 AM, the 09/08/23 day shift posting was observed in a locked glass case next to the elevator. The posting included the census, the number of the different types of nursing staff, and the total number of hours for each category. During an interview on 09/08/23 at 11:45 AM regarding who was responsible for changing the posting, the Director of Nursing (DON) stated [Name] does it. and proceeded to contact her to come to the elevators. During an interview on 09/08/23 at 11:48 AM regarding who was responsible for changing the posting, the Nursing Secretary Assistant (NSA) responded that she changed it out for evening shift. When questioned who posts the night shifts, NSA stated, We don't do it for nights. When asked who was responsible for posting on weekends, NSA responded, I do Saturday morning because I'm here, but it is not done the rest of the weekend. During an interview on 09/08/23 at 12:09 PM, NSA stated, There is no policy regarding the staff posting. NJAC 8:39-41.2(a)(b)(c)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observations, document review, interviews, and facility policy review, the facility failed to ensure a medication error rate of less than five percent. During observation of medication pass, there were eight errors observed out of 29 opportunities, resulting in a 27.59% error rate. This had the potential to place one (Residents (R) 410) at risk of not receiving the full benefit of their medication therapy. Findings include: Observation on 09/08/23 at 12:18 PM, Registered Nurse (RN) 1 prepared medications for R410, which included vitamin B-12 extended release (ER) 1000 micrograms (mcg) one tablet, vitamin D-3 25 mcg one tablet, Depakote 125 milligrams (mg) one tablet, Eliquis 2.5 mg one tablet, Cozaar 25 mg one tablet, Memantine 10 mg one tablet, Oxybutynin 15 mg one tablet at 08:30 AM, and Pot Citrate 10 milliequivalent (mEq) one tablet. After RN1 obtained all the medications needed for R410, he administered the medications. During medication pass, RN1 said that these medications were R410's morning medication that should have been given at 08:30 AM. R410 did not swallow her Pot Citrate, vitamin B-12 ER and vitamin D-3. RN1 did obtain the three medications from R410's mouth and did not attempt to give R410 these three medications. RN1 said since the medication was late already, he was not going to attempt them again; however, said if it was earlier, he would have offered them again. Review of R410's facility provided Face Sheet revealed R410 was admitted to the facility on [DATE] with a diagnosis that includes hypertension (HTN), dementia, overactive bladder, mood disorder, Alzheimer's, hypokalemia, vitamin B-12 deficiency, and vitamin D deficiency. Review of R410's facility provided September 2023 Physician Orders revealed vitamin B-12 (medication for vitamin B-12 deficiency) ER 1000 mcg one tablet orally daily, vitamin D-3 (medication for vitamin D deficiency) 25 mcg one tablet orally daily, Depakote (mood stabilizer medication) 125 mg one tablet orally daily, Eliquis (anti-coagulant medication) 2.5 mg one tablet twice a day (BID), Cozaar (high blood pressure medication) 25 mg one tablet orally daily, Memantine (dementia medication) 10 mg one tablet BID, Oxybutynin (overactive medication) 15 mg one tablet daily, and Pot Citrate (medication for hypokalemia)10 mEq one tablet BID. Review of facility provided September 2023 Medication Administration Record (MAR) revealed vitamin B-12 ER 1000 mcg one tablet at 08:30 AM, vitamin D-3 25 mcg one tablet at 08:30 AM, Depakote 125 mg one tablet at 08:30 AM, Eliquis 2.5 mg one tablet at 08:30 AM and 4:30 PM, Cozaar 25 mg one tablet at 08:30 AM, Memantine 10 mg one tablet at 08:30 AM and 4:30 PM, Oxybutynin 15 mg one tablet at 08:30 AM, and Pot Citrate 10 milliequivalent (mEq) one tablet at 08:30 AM and 4:30 PM. Interview with RN6, on 09/08/23 at 1:05 PM, revealed that medications were given one hour before to one hour after the medication was ordered. He confirmed that morning medications should not be given in the afternoon. Interview with the Director of Nursing (DON), on 09/08/23 at 1:28 PM, revealed he confirmed that medications are given as the physician ordered. If ordered in the morning, then should be given in the morning. Said that medications could be given one hour before and one hour afterwards. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Administering Medications, revised 04/19, read in pertinent part, Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation .7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. NJAC 8:39-29.2(d)

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	315361	A. Building B. Wing	09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Preakness Healthcare Center	305 Oldham Road Wayne, NJ 07470

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 25232 Based on observations, interviews, and facility policy review, the facility failed to ensure medications were administered in a manner that prevented cross-contamination for one (Resident (R) 410) of 34 sampled residents. Findings include: During an observation on 09/08/23 at 12:18 PM, Registered Nurse (RN) 1, without performing hand hygiene, prepared medications for R410, which included vitamin B-12 extended release (ER) 1000 micrograms (mcg) one tablet, vitamin D-3 25 mcg one tablet, Depakote 125 milligrams (mg) one tablet, Eliquis 2.5 mg one tablet, Cozaar 25 mg one tablet, Memantine 10 mg one tablet, Oxybutynin 15 mg one tablet at 08:30 AM, and Pot Citrate 10 milliequivalent (mEq) one tablet. After RN1 obtained all the medications needed for R410, he administered the medications. R410 did not swallow Pot Citrate, vitamin B-12 ER and vitamin D-3 pills. At 12:30 PM, RN1 placed on a pair of gloves, and had R410 spit the medications in his gloved left hand, while cleaning R410's mouth with a 4x4 gauze square with his gloved right-hand. Then he threw the gauze square into the trash, and RN1 started opening drawers on the medication cart without removing his right glove, while he continued to hold the medications in his gloved left hand. At 12:36 PM, RN1 removed his gloved right hand, and went to another medication cart on the hall to destroy the three medications in his gloved left hand. Upon returning to the medication cart, RN1 removed his gloved left hand, and did not perform hand hygiene. RN1 picked up his pen and started signing off the medication in the Medication Administration Record (MAR). RN1 had not performed hand hygiene by the time surveyor left the medication cart. Interview with RN6, on 09/08/23 at 1:05 PM, revealed that hand hygiene should have been performed before and after medications, and after removing gloves. Interview with the Director of Nursing (DON), on 09/08/23 at 1:28 PM, revealed hand hygiene should have been performed before and after preparing and/or administering medication, and after removal of gloves. Review of facility policy Handwashing/Hand Hygiene, revised 11/17/17, revealed, [name of facility] policy considers hand hygiene the primary means to prevent the spread of infections and healthcare associated infections (HAI) .2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies .4. Hand sanitizer is the preferred method of hand hygiene. Use soap and water for hand hygiene if hands are visibly soiled or after caring for a resident with known or suspected C. Deficile (C. Diff), or Norovirus infection, or hands are visibly soiled from blood and body fluids .6. Perform hand hygiene when: .After contact with a resident .Before and after direct contact with residents .After removing gloves. NJAC 8:39-19.4(a)1 NJAC 8:39-19.4(n)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on observation, interview, and review of manufacturer's instructions, the facility failed to ensure bed frames and rails, if present, were inspected and serviced per the Manufacturer's Instructions for Use (MIFU) for three of three residents (Resident (R) 18, R140, and R232) to minimize the risks of bed malfunction or resident injury. This failure had the potential to affect 267 of 267 residents who reside at the facility. Findings include: 1. Review of R18's printed Face Sheet showed a facility admitted [DATE], readmission on 07/14/23, with medical diagnoses (from a printed Diagnosis list) that included acute respiratory failure, multiple sclerosis, polyneuropathy, trigeminal neuralgia, and lower extremity embolism and thrombosis. During an interview on 09/04/23 at 12:04 PM, it was noted R18 had bilateral assist bars, or bed rails. When asked about them, R18 stated his wife and he had to fight to get them and thought his wife had to sign something. 2. Review of R140's printed Face Sheet showed a facility admitted on 02/26/21, readmission on 07/28/21, with medical diagnoses (from a printed Diagnosis list) that included rheumatoid arthritis, anemia, hemiplegia, type II diabetes, major depressive disorder, ataxia, and long-term steroidal use. During an observation on 09/05/23 at 10:23 AM it was noted that R140 had bilateral assist bars on the bed. 3. Review of R232's printed Face Sheet showed a facility admitted [DATE], readmission on 01/19/23, with medical diagnoses (from a printed Diagnosis list) that included hip pain, right femur fracture, hypertension, bradycardia, atherosclerotic heart disease, and cancer. During an interview on 09/04/23 at 4:00 PM, R232 was asked about the observed bilateral assist bars on the bed; R232 responded that they had been on the bed for a long time. When asked if he used them, R232 stated he did not. When queried if R232 had been advised of the risks / benefits of bed rails, he did not remember. In response to a request for bed MIFUs and maintenance/inspection logs on 09/08/23 at 2:35 PM the Director of Nursing provided: Zenith bed, on page six through eight showed Inspection /Maintenance Plan /Packaging /Handling Inspection Notice that showed the side rail assembly was to be inspected every three months, three other elements to be inspected every six months, and two elements to be inspected annually. Zenith II bed, on page D7 showed a Recommended Maintenance/Inspection that specified four elements that should be inspected at six-month intervals and the mechanical inspection of casters annually. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Zenith III bed, on page P52 showed Recommended Maintenance & Inspection Schedules that had the same six month and annual elements as the Zenith II. The inspection/maintenance logbook provided showed the last inspections were completed in June of 2022, and the Director of Nursing (DON) stated, When [name of the prior Maintenance Director] retired and [name of the current Maintenance Director] took over it [bed inspections] got dropped. Review of the facility policy titled, Bed Side Rails, reviewed 01/10/18, showed: .Equipment Management and Maintenance 1. When installing or maintaining bed rails, the Facilities staff will follow the manufacturer's recommendations and specifications. The bed, mattress, side rails will be inspected by the Facilities staff prior to use to identify and remove potential fall and entrapment hazards and appropriately match the equipment to resident needs, considering all relevant risk factors. 2. The Facilities staff will conduct semi-annual inspections of all bed frames, mattresses, and bed rails, as part of a regular maintenance program to identify areas of possible entrapment. NJAC 8:39-31.8(e)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 28154 Based on record review and interview, the facility failed to ensure six of six Certified Nurse Aides (CNA), two of two Licensed Practical Nurses (LPN), and two of two Registered Nurse's (RN) reviewed had received behavioral health training to care for residents diagnosed with mental health illnesses indicated as admittable in the facility assessment. This failure had the potential for direct care staff to lack current knowledge to work with the unique challenges mental health illnesses present. Findings include: Review of the Facility Assessment, reviewed 01/09/23, showed: .Preakness Healthcare Center accepts residents with the following diseases/conditions, physical and cognitive disabilities or combinations of these conditions that require complex medical care and management. Under the category of Psychiatric/Mood Disorders stated: If not a danger to self or others: Psychosis, Impaired Cognition, Mental Disorder, Depression, Bipolar, Schizophrenia, PTSD, Anxiety, Behavior that Needs Interventions . Review of the facility completed Resident Census and Conditions of Residents form showed the facility had 71 residents with psychiatric diagnoses and 93 residents with behavioral healthcare needs. Review of the personnel files requesting abuse training, dementia care training, and behavioral health training revealed: CNA1: Date of Hire (DOH) 06/05/17 had documented dementia and abuse training, however, no documented behavioral health training. CNA4: DOH 05/01/13, had documented dementia and abuse training, however, no documented behavioral health training. CNA5: DOH 09/24/18, had documented dementia and abuse training, however, no documented behavioral health training. CNA6: DOH 11/16/15, had documented dementia and abuse training, however, no documented behavioral health training. CNA7: DOH 10/12/20, had documented dementia and abuse training, however, no documented behavioral health training. CNA8: DOH 11/23/21, had documented dementia and abuse training, however, no documented behavioral health training. LPN1: DOH 04/16/07, had documented dementia and abuse training, however, no documented behavioral health training. LPN2: an agency nurse started 06/28/23 and received an orientation for agency nurses that included abuse and dementia training, however, no behavioral health training was documented. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN3: DOH 06/13/18, had documented dementia and abuse training, however, no documented behavioral health training. RN10: agency nurse with first trainings documented on 07/24/23, however, no documented behavioral health training. After clarification of behavioral health training not being equivalent to behaviors of dementia training, on 09/08/23 at 2:20 PM the Director of Nursing (DON) provided the same training records and stated that there was no behavior training other than for dementia. The DON stated there was no policy regarding staff behavioral health training. NJAC 8:39-Appendix B XI.5