STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315404	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Methodist Communities at Collingswood	460 Haddon Ave Collingswood, NJ 08108

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40041 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to develop a comprehensive person-centered care plan for 1 of 2 residents (Resident #36) reviewed for oxygen. This deficient practice was evidenced by the following: On 8/13/24 at 10:11 AM, the surveyor observed Resident #36 in bed receiving oxygen via a nasal canula (tubing that delivers oxygen to the body through the nose). A review of the Admission Record (an admission summary) revealed Resident #36 had diagnoses which included, but were not limited to, presence of cardiac pacemaker, chronic atrial fibrillation (heart arrhythmia), chronic pulmonary edema (lungs fill with fluid), other heart failure, and obstructive sleep apnea (blockage in airway while asleep). A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the managment of care, dated 07/31/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed in Section O: Special Treatments, Procedures and Programs that the resident was on continuous oxygen therapy on admission and while a resident at the facility. A review of the Order Summary Report, as of 08/15/24, included the following active physician's order: Oxygen: 2 L/min (liters per minute) via nasal canula every shift, with a start date of 07/24/24. A review of the individualized comprehensive care plan, initiated 07/25/24, did not include the resident's use of continuous oxygen via nasal canula. On 08/14/24 at 2:02 PM, during an interview with the surveyor, Registered Nurse (RN) #1 stated care plans are initiated upon admission and updated as needed if the resident's condition changes. She continued by stating that if a resident was prescribed oxygen, it should be included on the care plan so that everyone knows the resident's needs. She also stated that it was important that oxygen was on the care plan in the event that the resident needs to leave the unit for an appointment, so he/she doesn't leave the unit without it. She also added that if there was an agency nurse, he/she needs to know the resident's needs. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During that interview, RN #1 reviewed Resident #36's care plan and confirmed that continuous oxygen via nasal canula was not included. The RN stated, No, I don't see it. On 08/15/24 at 9:35 AM, during an interview with the surveyor, the MDS coordinator stated that upon admission, the care plan is initiated and that oxygen should have been included on Resident #36's care plan. On 08/16/24 at 09:00 AM, during an interview with the surveyor, the Director of Nursing (DON) stated oxygen should have been included in Resident #36's care plan and that it was normally included as per the facility's policy and procedure. A review of the facility policy titled, Care Plans, dated 11/9/23, revealed, POLICY The Interdisciplinary Team shall develop a comprehensive, individualized plan of care for each resident that integrate all elements of needed medical, clinical, and community living supports PROCEDURE 1. Development of the Care Plan begins at admission, utilizing information gathered from the resident, family, admission assessments completed by each discipline, and records from the transferring facility or referral source.19. The Care Plan is to be reviewed and updated by all staff providing care or services for the resident. The Care Plan includes a statement of the problem; reasonable, measurable, and time-limited goals; and specific interventions, along with the discipline responsible. NJAC 8:39-11.2(3)h

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41260 Based on interview, record review, and review of facility documents, it was determined that the facility failed to maintain medical records that were complete by not documenting the completion of treatments for 1 of 1 resident (Resident # 42) reviewed for accidents. This deficient practice was evidenced by the following: On 08/13/24 at 10:56 AM, the surveyor observed Resident #42 sitting outside his/her room in a wheelchair. The resident had a wander guard (a device that alarms if the resident attempts to exit the facility) on his/her left wrist. According to the Admission Record, Resident #42 had diagnoses which included, but were not limited to, unspecified dementia and mood disorder. Review of the annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 07/21/24, included the resident had a Brief Interview for Mental Status score of 3, which indicated the resident's cognition was severely impaired. Review of the Elopement Risk Scale assessment, dated 07/16/24, included the resident could move without assistance while in a wheelchair and had a history of wandering. Further review of the assessment revealed the resident was a High Risk to Wander. Review of the Care Plan, initiated 07/21/23, included the resident was at risk for wandering related to impaired safety awareness and a history of wandering with an intervention to ensure that the wander guard is on the left wrist. Review of the Order Summary Report, as of 08/15/24, included physician's orders for Wander guard function check every shift, and Wander guard placement check left wrist every shift for elopement precaution. Review of the May 2024 Treatment Administration Record (TAR) revealed the two wander guard treatment orders were not signed out, and left blank, on the following dates: -05/09/24 Evening Shift -05/22/24 Evening Shift -05/23/24 Evening Shift Review of the June 2024 TAR revealed the two wander guard treatment orders were not signed out, and left blank, on the following dates: -06/05/24 Evening Shift (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the August 2024 TAR, revealed the two wander guard treatment orders were not signed out, and left blank on the following dates: -08/01/24 Evening Shift -08/02/24 Evening Shift -08/16/24 Evening Shift During an interview with the surveyor on 08/15/24 at 10:53 AM, the Certified Nursing Assistant (CNA) stated that the facility used wander guard devices and that everyone was responsible for checking to ensure they were in place. The CNA further stated that it was important to check the wander guards to prevent confused residents from leaving the facility. During an interview with the surveyor on 08/15/24 at 10:55 AM, the Licensed Practical Nurse (LPN) stated Resident #42 had a wander guard. The LPN further stated that the nurses check the placement and function of the wander guard every shift and document completion of the treatment on the TAR. The LPN added that if there is a blank on the TAR it meant the treatment was not completed, and that it was important to ensure the TAR was signed so everyone knows the treatment was completed. The LPN also stated the importance of checking the wander guard for placement and function was to prevent residents from eloping. During an interview with the surveyor on 08/15/24 at 11:01 AM, Registered Nurse (RN) #1 stated the nurses were responsible for checking the placement and function of wander guards every shift and documenting the treatment in the TAR. The RN further stated that it was important to document the wander guard checks so everyone knows the wander guard is on and functioning. The RN further stated that a blank on the TAR meant the nurse did not document the completion of the treatment. During an interview with the surveyor on 08/15/24 at 11:13 AM, the Director of Nursing (DON) stated the nurses were responsible for checking the placement and function of the wander guards every shift and documenting the completion of the treatment in the TAR. The DON further stated that a blank on the TAR meant the nurse did not sign the treatment as completed. When notified of the blanks in Resident #42's TAR, the DON stated the nurses should have signed the TAR and not left it blank. The facility was unable to provide a policy related to medical documentation or documenting in the TAR. Review of the RN Job Description, modified 03/29/22, included, Administers and documents administration of medications, enteral nutrition, and treatments per the physician's order and accurately records all care provided in the EHR [electronic health record]. NJAC 8:39-35.2 (d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Based on observations, interviews, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide a safe and sanitary environment to prevent the potential spread of infection and cross-contamination to both residents and staff by failing to: adhere to proper handwashing techniques, clean and sanitize medical equipment in accordance with the facility policy and manufacturer's recommendation and maintain appropriate infection control practices during the medication administration observation for 1 of 2 nurses observed on 1 of 3 nursing units ([NAME] Unit). This deficient practice was evidenced by the following: On 08/14/24 at 8:20 AM, the surveyor met with Registered Nurse (RN) #2 at the medication cart. RN #2 wore gloves as she swept debris from the top of the medication cart with her gloved hands. RN #2 then doffed (removed) her gloves and failed to perform hand hygiene before she reached into her pocket and obtained the keys to the medication cart, unlocked the cart, and then returned an unsampled resident's eye drops into the medication cart. RN #2 then proceeded to access the computer that was mounted on top of the medication cart and after medication review, she stated that she needed to obtain vital signs (blood pressure, heart rate and pulse oximetry reading (the amount of oxygen circulating in the blood determined by placing a pulse oximeter probe on a finger) from Resident #23. At 8:22 AM, RN #2 wheeled the blood pressure machine into Resident #23's room. RN #2 greeted the resident and the resident complained of an aching sensation in the fingers of their right hand. RN #2 placed a blood pressure cuff on the resident's left upper arm, and placed a pulse oximeter probe on the resident's left index finger. RN #2 wore a surgical mask and pulled the mask out and away from her face when she spoke with the resident. RN #2 then proceeded to remove the blood pressure cuff and pulse oximeter probe from the resident, and then rubbed the resident's right hand and arm in an effort to comfort the resident. RN #2 then obtained the blood pressure machine and left the resident's room without first performing hand hygiene. At 8:29 AM, RN #2 failed to clean the blood pressure machine and pulse oximeter after use and placed it in the hallway. RN #2 then returned to the medication cart, accessed the computer, reached into her pocket and obtained the keys to the medication cart and opened it. RN #2 then performed hand hygiene using alcohol based hand rub (ABHR) before she prepared medications for Resident #23. At 8:39 AM, after RN #2 administered medications to Resident #23 with a spoon, she proceeded to wash her hands under the stream of running water for 22 seconds. At 8:43 AM, RN #2 obtained the blood pressure machine and proceeded into Resident #111's room. At that time, RN #2 adjusted the resident's oxygen cannula (plastic prongs that are placed in the nostrils to deliver oxygen) to ensure that the tubing made contact with both of the resident's nostrils. RN #2 then placed the blood pressure cuff on the resident's left upper arm and placed the pulse oximeter probe on the resident's right middle finger. RN #2 then removed the blood pressure cuff and pulse oximeter from the resident, touched the resident's blankets and patted the resident's legs and exited the resident's room without first performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 8:49 AM, RN #2 stated that Resident #111 had a new order to have their blood sugar checked and proceeded to remove a glucometer from the medication cart. At 8:50 AM, RN #2 donned (put on) gloves before she placed a test strip into the glucose meter (device to measure blood sugar levels of persons with diabetes). RN #2 then cleaned Resident #111's right middle finger with an alcohol prep pad, then used a lancet to pierce the resident's finger and drew a drop of blood which was placed on the test strip within the glucose meter. RN #2 then placed pressure on the resident's right middle finger to stop the bleeding and cleansed the area. At 8:52 AM, RN #2 doffed her gloves and removed the used test strip from the glucometer with her bare hand. RN #2 then proceeded to dispose of her gloves. At 8:53 AM, RN #2 went into Resident #111's bathroom and laid the lancet and test strip on the bathroom counter while she washed her hands under the stream of running water for 20 seconds. RN #2 then returned to the medication cart and disposed of the used lancet and test strip into the sharps disposal system (device used to contain needles and sharp instruments until disposal) on the side of the medication cart. RN #2 failed to clean the blood pressure machine, pulse oximeter, and glucometer after usage. RN #2 then began to prepare medications for Resident #111 which included but were not limited to: a single dose vial of Budesonide Suspension 0.5 mg (milligrams) per two milliliters (nebulizer (inhaled respiratory treatment), and Ueclidinium-Vilanterol (hand held inhaler) and glycolax powder 3350 17 grams (a powder that is mixed with water treat constipation). At 9:08 AM, RN #2 returned to Resident #111's room and donned gloves. The resident's breakfast tray was present on the overbed table in front of the resident. RN #2 placed the single dose vial of Budesonide and the Ueclidinium-Vilanterol (hand held inhaler) on the resident's overbed table while she administered the oral medications to the resident. The resident declined to take the glycolax and requested to take both the budesonide nebulizer treatment and the Ueclidinium-Vilanterol hand held inhaler after breakfast. At that time, RN #2 proceeded to take Resident #111's budesonide nebulizer treatment and the Ueclidinium-Vilanterol hand held inhaler into the resident's bathroom and placed the medications directly on the resident's bathroom counter that surrounded the sink while she washed her hands under the stream of running water for 21 seconds. At 9:14 AM, RN #2 returned to the medication cart and returned the budesomide to a multi-foil pack container and returned the Ueclidinium-Vilanterol hand held inhaler into the drawer of the medication cart. RN #2 then proceeded to sign out Resident #111's medications in the computer and then proceeded to review medications for the next resident. At 10:11 AM, during an interview with the surveyor, RN #2 stated that she had not performed any additional blood sugars with the glucose meter after the medication pass observation and had wiped it down with an approved disinfectant wipe. RN #2 then stated that she still had to wipe the glucometer down again with a disinfectant wipe since it was placed in the case during the observation prior to being cleaned. RN #2 stated, I am supposed to wipe it down before I placed it in the case, because the case might get bacteria on it. RN #2 then stated, I still have to wipe it down and get a new one. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, the surveyor asked RN #2 to describe the process for handwashing. RN #2 stated, I wash my hands under running water for 15 to 20 seconds. RN #2 stated that if the proper handwashing technique were not followed, it may attract microorganisms and the hands were not cleaned. RN #2 further stated that if the handwashing policy were not followed, it could spread infection and viruses. At that time, the surveyor asked RN #2 to describe the process for cleaning the blood pressure machine and pulse oximeter. RN #2 stated it was ideal to clean between residents with a disinfectant wipe. RN #2 stated if the blood pressure machine and pulse oximeter were not cleaned between residents, it might transfer microorganisms and can spread bacteria. At that time, the surveyor asked RN #2 what could happen if she handled a used glucometer test strip without gloves and RN #2 stated that the blood or bacteria could get on the skin and be transferred onto her. At that time, RN #2 stated that she should have cleaned the tip of the nebulizer treatment and inhaler before she returned it to the multi-use package in the medication cart. At that time, RN #2 stated that if she touched her mask while speaking with a resident and then touched the resident, medication cart, and computer there could be problems because, my hands could have been contaminated. At 10:24 AM, RN #3 approached the surveyor and RN #2 at the medication cart as the surveyor began to interview RN #2 about the proper technique for cleaning both the glucose meter and the glucose meter case. RN #3 stated, we can get a new case or attempt to replace the whole unit. At 10:29 AM, the surveyor interviewed RN #3 who stated, we are required to wipe the blood pressure machine down between residents with a disinfectant wipe. RN #3 stated, we were stricter during COVID, but there is a potential for contamination if it were not cleaned. At that time, RN #3 stated that either hand sanitizer or handwashing should have occurred after gloves were doffed. RN #3 stated that there was a risk of spreading anything infectious if hand hygiene was not performed after each resident. RN #3 stated that hands must be washed for 20 to 30 seconds out of the stream of running water. At 10:47 AM, the surveyor interviewed the Director of Nursing (DON) who stated she recently served in the role of the previous Infection Preventionist (IP) prior to becoming the DON three weeks ago. The DON stated that the current IP was not available for interview. The DON stated that once gloves were doffed, staff were supposed to wash their hands, because if it were not done, it was an infection control breach. At that time, the DON stated, we informed the staff that they were not supposed to touch the outside of their masks because it was not clean. At that time, the DON stated the blood pressure machine and pulse oximeter were supposed to be cleaned between residents with a disinfectant wipe or it was an infection control issue if it were not done. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, the DON stated that, RN #2 shared with us after your observation that she did not clean the glucose meter after she used it. The DON explained that she asked RN #2 what was observed by the surveyor, and, she told me that she did not do it. The DON stated, it was a problem and against our policy. The DON stated that RN #2 should not have handled the test strip and lancet without gloves and should not have placed them or the inhaler and nebulizer on the bathroom counter. The DON stated that it was an infection control issue if the glucose meter, nebulizer, and inhaler were returned to the medication cart without cleaning them first. The DON stated it was her expectation that nursing cleaned the glucometer after use and RN #2 did not properly clean the glucometer after use as required. At that time, the DON stated that hands were require to be washed outside the stream of water for 30 seconds. The DON stated, If hands were washed under the stream of water, then you are not lathering and ensuring that all surfaces were washed. At 12:12 PM, the surveyor interviewed the Staff Educator (SE) who stated that hand sanitizer should be used both before and after glove use per facility policy. The SE stated that hands were required to be lathered with soap for 20 seconds outside of the stream of running water. The SE stated that hands were not effectively washed if they were washed under the stream of water and could infect anyone because that was not effective handwashing. The SE stated it was unacceptable to touch the outside of your mask, because the outside was the dirtiest. The SE stated staff should wash their hands after they touched equipment. The SE stated that there could be contamination if the medication cart was accessed and hand hygiene was not completed prior to use. The SE stated that the medication cart and the keys to the cart were the dirtiest part, because everyone touched them. At that time, the SE stated the blood pressure and pulse oximeter should be cleaned before and after use and were considered contaminated if they were not cleaned between residents. At that time, the SE stated RN #2 should have cleaned the glucose meter, blood pressure cuff, and pulse oximeter with the approved disinfectant wipes which have a kill time (contact time required to kill germs) of two minutes. The SE stated the test strip for the glucometer should have been placed in a glove when doffed, then discarded in the trash and the lancet should have been discarded in the sharps container. The SE stated gloves should have been donned before the glucose meter was sanitized with disinfectant wipes. The SE stated, test strips should never have been handled with bare hands, because you could have blood transmission or an infection waiting to happen. The SE stated when RN #2 placed the glucometer back in the case after use, she contaminated the whole case. The SE stated RN #2 should have cleaned the glucose meter per protocol prior to returning it to the storage case. At that time, the SE stated when RN #2 placed the nebulizer container and the inhaler on the sink it would have contaminated them, as well as everything in the cart where the medications were stored. The SE stated RN #2 should have wasted the inhaler and nebulizer and reordered both of the medications. The SE provided the surveyor with RN #2's Hand Hygiene Competency dated 01/24/24, Medication Pass Observation Tool dated 01/31/24, and a Glucometer Competency Checklist dated 01/30/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/15/24 at 10:15 AM, the DON provided the surveyor with the Manufacturer Technical Brief (Reviewed 10/23) for the glucose meter used by the facility which was reviewed by the surveyor and revealed the following: To minimize the risk of transmitting bloodborne pathogens, the cleaning and disinfecting procedures should be performed as recommended in the instructions below .The [trademark] glucometer (glucose meter) may only be used for testing multiple patients when standard precautions and manufacturer's disinfecting procedures are followed . -The meter should be cleaned and disinfected after use on each patient. -The cleaning procedure is needed to clean dirt, blood and other bodily fluids off of the exterior of the meter before performing the disinfecting procedure. -The disinfecting procedure is needed to prevent the transmission of bloodborne pathogens. Cleaning and Disinfecting FAQ: -Why is cleaning and disinfecting of blood glucose monitors a high priority? Blood glucose meters are at high risk of becoming contaminated with blood borne pathogens such as Hepatitis B Virus (HBV, a serious liver infection), Hepatitis C Virus (HCV, an infection caused by a virus that attacks the liver) and Human Immunodeficiency Virus (HIV, the virus that causes acquired immunodeficiency syndrome (AIDS). Transmission of these viruses from resident to resident has been documented due to contaminated blood glucose devices. According to the Centers for Disease Control and Prevention, cleaning and disinfecting of meters between resident use can prevent the transmission of these viruses through indirect contact. Review of the facility policy, Medication Management Program Guidelines (RS-10) (11/6/23) revealed the following: Cleanse hands using antimicrobial soap and water or community-approved hand sanitizer before beginning a med pass, before handling medication, and before and after contact with resident. Hand hygiene is performed before putting on examination gloves and upon removal for administration of topical, ophthalmic (relating to the eye), injectable, enteral (passing through the intestine either naturally through the mouth or through an artificial opening), rectal and vaginal medications. Review of the Hand Hygiene (RS-26) Policy (Effective 03/19/18) revealed the following: Purpose: To prevent the transmission of pathogenic micro-organism from resident to resident and from inanimate surfaces to residents by the hands of all healthcare providers. Hand hygiene procedure with soap and water: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Turn on water, adjust temperature. Wet hands and wrists with running water before applying soap. Keep hands with fingers downward so water will run into sink and not down arms. Apply soap to hands, use only community approved liquid soap, rub the soap on all surfaces of the hands and wrists using friction, friction can be obtained by rubbing hands rapidly and firmly together, wash all surfaces for at least 20-30 seconds: back of hands palms, wrists, between fingers, including thumbs, under fingernails and around cuticles, rinse hands thoroughly under running water keeping hand downward, avoid touching the sink. Dry hands thoroughly with paper towel(s) .Turn off faucet with a clean paper towel. Discard Paper towel. Hand hygiene should be done (even when gloves are used): At the beginning of work. Before and after contact with each resident. After contact with blood, bodily fluids, mucous membranes, secretions, excretions . Before administering medication. After body fluid exposure. Review of the facility policy, Cleaning & Disinfecting Resident Equipment (RS-29) (Last approved 03/23/23) revealed the following: Blood Pressure Cuffs/machines .Before use on each resident .with a low level disinfectant. Glucose monitors .Before use on each resident and before going into storage .with a low level disinfectant. NJAC 8:39-19.4 (n)