STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. Building B. Wing	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aster Creek Nursing and Rehabilitation Center	524 Wardell Road Tinton Falls, NJ 07753

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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	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45209 Based on observation, interview, and record review, it was determined that the facility failed to treat each resident with respect and dignity in a manner that promotes his/her quality of life. This deficient practice was identified for one (1) of 19 residents (Resident #27) reviewed for resident rights. This deficient practice was evidenced by the following: On 8/24/2023 at 10:32 AM, the surveyor observed Resident #27 seated in their wheelchair across from the nurse's station. Resident #27 asked the Acting Licensed Practical Nurse Unit Manager (LPN UM #1) if they can have their medication. LPN UM #1 responded that they would notify their nurse when they returned from break. Resident #27 stated to LPN UM #1 that there was a medication error and they did not receive their medication in the morning and wanted it now. LPN UM #1 sternly directed Resident #27 to go to their room. Resident #27 responded, you don't have a right to speak with me like that. At that time, LPN UM #1 again stated they would notify their nurse and transported the resident from the nursing station to the resident's room. On 8/24/2023 at 10:39 AM, the surveyor interviewed Resident #27 who stated that they wanted their medication at that time and that the interaction between them and LPN UM #1 was always like that. On 8/24/2023 at 11:17 AM, the surveyor interviewed LPN UM #1 regarding their interaction with Resident #27. LPN UM #1 stated that Resident #27 asked for their medication too early and they didn't want Resident #27 to keep speaking about the medication in front of the surveyors, which prompted LPN UM #1 to transport Resident #27 to their room. LPN UM #1 stated Resident #27 had a tendency to ask for medication when it was too early and would threaten the staff. The surveyor reviewed the medical record for Resident #27. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included anxiety disorder, conversion disorder with seizure or convulsions, and schizoaffective disorder. Resident #59 was then readmitted with a diagnoses which included major depressive disorder and insomnia. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 7/1/2023, reflected a brief interview for mental status (BIMS) score of 15 out of 15, which indicated a fully intact cognition. A review of the individualized comprehensive care plan (ICCP) included a focus area revised on 7/5/2023, that the resident had accusatory behaviors towards the staff and was verbally abusive towards the staff. Interventions included: intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. The ICCP also identified another focus area revised on 4/9/23, that the resident was alert, oriented, verbal and able to make decisions as to how the resident spent leisure time, but due to physical limitations, and mood fluctuations, relied on staff support for meeting emotional, intellectual, physical, and social needs. Interventions included: While I am able to self propel my wheelchair on flat surfaces, I will be offered and provided with escort assistance when I need to navigate the ramps. On 8/24/2023 at 11:50 AM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) who confirmed that LPN UM #1's interaction with Resident #27 was not appropriate and they shouldn't have spoken to Resident #27 that way. When asked if Resident #27 had the right to be in the nurses area, the DON stated, I think that [Resident #27] has a right to be there. The DON further stated that LPN UM #'1 had attended the facility's sensitivity training prior. During a follow up interview with the surveyor on 8/25/23 at 11:47 AM Resident #27 stated that they would have liked to stay at the nurses station, and did not feel that LPN UM #1's tone towards the resident was threatening but felt that LPN UM #1 could talk to us [the residents] a little better. A review the facility's Resident Rights policy that was last reviewed April 2023, included .1) Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a) a dignified existence .c)treated with respect, kindness, and dignity .i) be supported by the facility in exercising his or her rights .j) exercise his or her rights without interference, coercion, discrimination or reprisal from the facility . A review the facility's LPN Charge Nurse Position Summary policy with an effective date of October 2019, included .Implement and update care plans as appropriate .direct the delivery of care using sound good judgement while applying the highest standards of care and within the nurse practice act. A review the facility's Staff Sensitivity and Gentleness in Caring for Residents training completed on 6/5/23, included .1) Be conscious of the need to be gentle in all care situations .3) Be aware of the resident's needs and apply those more gentle and cautious applications that show your skill and level of caring for residents. The DON acknowledged LPN UM #1 signature on 6/5/23. NJAC 8:39-4.1(a)(12)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37175 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: a.) store, label, and date potentially hazardous foods to prevent food-borne illness, b.) air dry kitchen equipment in a manner to prevent microbial growth, c.) maintain kitchen equipment in a sanitary manner, d.) maintain proper kitchen sanitation practices. This deficient practice was evidenced by the following. On 08/22/23 at 9:35 AM, the surveyor, in the presence of the Food Service Director (FSD), toured the kitchen and observed the following: 1. In the reach-in refrigerator, sliced yellow American cheese wrapped in clear plastic that was not dated or labeled with a used-by date. The FSD stated that the staff should have labeled and dated when the cheese was sliced. Ten cupcakes in a store-bought plastic container were not labeled or dated. The FSD stated that the cupcakes were from the recreation department and should not have stored them there. The FSD discarded the cupcakes. 2. On the front of the stove, underneath the grill top, there was a buildup of brownish-dried substance. The FSD stated that this is from grease catcher where the grease collects, spills out, and runs down the front of the oven. When the FSD opened the double oven doors, the right and left side doors dropped simultaneously. The FSD stated that the hinges were bad, and the oven doors would not stay closed. The FSD stated he had temporarily placed latches on both sides of the oven to keep the oven doors closed until the oven was fixed. The FSD stated there is a cleaning schedule for the kitchen, including the stove. 3. On a metal rack, four hotel pans were wet nested, and the FDS removed the pans and placed them near the sink to be washed. 4. During a tour of the dry storage area, there was an opened box of taco shells with three opened packages wrapped in clear plastic that were not labeled or dated. The FSD removed and discarded them. There was a 20-pound box of spaghetti with an opened package of spaghetti wrapped in plastic that was not labeled or dated. A 5-gallon plastic container, identified as panko by the FSD, was not labeled or dated. 5. At 10:00 AM, the surveyor observed the cook enter the kitchen without a hair net. The cook stated that he should have had a hair net on because it is very unsanitary as hair could get into the food. The FSD was made aware at that time. On 8/23/23 at 9:19 AM, the surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and were informed of the findings. The LNHA stated the cook should have put a hair net on before he walked into the kitchen, the stove is on the list to be replaced, and the staff will have a schedule to keep the stove clean. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy, Food Brought in from the Outside, dated 1/6/23, included a designated pantry space and refrigerators for residents' outside foods. A review of the facility's policy Use of Hair Nets and [NAME] Nets dated 3/10/23 included that hair nets and beard nets are necessary items required by the FDA and USDA in food handling settings .When entering the kitchen, always wearing a hair net and beard net when handling food .or any duty in the kitchen area is mandatory. They are an effective tool for preventing the spread of hair in food processing and food service. A review of the facility's policy Food Labeling and Dating for Kitchen, dated 6/10/23, included all food .should be labeled with the common name of the food, the date the food was made, and a use-by date. NJAC 8:39-17.2(g)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 37175 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris. This deficient practice was evidenced by the following: On 8/22/23 at 9:35 AM, the surveyor, in the presence of the Food Service Director (FSD), toured the kitchen and the designated garbage area and observed the following: There were three dumpsters in the designated area for the facility's garbage. All three lids were opened and several garbage bags were filled with trash on the ground near the dumpsters. There was debris around all the dumpsters, and behind one of the dumpsters, there was furniture such as mattresses, frames for the beds, overbed tables, and dressers. The Food Service Director (FSD) stated that the housekeeping department was responsible for keeping the area clean. On 8/23/23 at 8:55 AM, the surveyor toured the garbage area in the presence of the FSD. The furniture was in one of the dumpsters, and there were piles of debris around the dumpsters. During an interview with the surveyor on 8/23/23 at 9:25 AM, the Director of Housekeeping, stated that there was construction at the facility that finished approximately two months ago, and the furniture was left behind the dumpsters. He said that he was unsure of where the furniture would go. He further stated that the garbage around the dumpsters was the responsibility of both maintenance and housekeeping to keep the area clean and that the area should not have been left like that. On 8/23/23 at 9:19 AM, the surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and were informed of the findings. The LNHA stated that the garbage area did have furniture in the area and that the area had become a mess. Review of the facility policy titled Housekeeping-Outdoor Trash Area with a revised date of 2/2023, indicating that the housekeeping staff are responsible for regular cleaning and maintaining the outdoor trash. They will ensure that the area is free of litter and debris. The Maintenance team will ensure that the trash bins are in good condition and are adequately covered to prevent odors and pests. N.J.A.C. 8:39-19.3(c)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 33106 Based on observation, interview, review of medical records and other pertinent facility documentation it was determined that the facility failed to maintain medical records accurately and completely in accordance with acceptable standards and practice by not documenting pertinent clinical documentation on the resident's medical record for a resident who had a change in condition. This was identified for 1 of 18 residents (Resident #68) reviewed and was evidenced by the following. a.) According to Resident #68's medical record, the resident was admitted to the facility with the diagnoses which included but not limited to hypertension (high blood pressure), obstructive uropathy (retention of urine), and cerebral infarction (stroke). The significant change Minimum Data Set (MDS-a assessment that facilitates a resident's care) dated 06/12/23, indicated that the resident had moderate cognitive impairment and required expensive assistance with activities of daily living (ADL's) On 08/23/23/ at 10:00 AM, the surveyor was unable to interview Resident #68 because the resident was in the hospital. On 08/23/23 at 10:44 AM, the surveyor reviewed Resident #68's progress notes which revealed the following information: The nurses note date 08/19/2023 at 7:09 AM reflected the following documentation: Note Text: Resident is alert slept well F/C [foley catheter] intact urine output 800 cc yellow color, no behavior problems penis noted swelling continue to monitor and offer fluids. The nurses' notes dated 08/19/2023 at 8:31 AM reflected the following documentation: Note Text: Resident has a change of mental status, and F/C not draining, penis is swollen, Dr is made aware. Ambulance is waiting for transport to ER, family contact is notified, resident is aware going to ER. Report pass on to 7-3 nurse. The nurses' notes dated on 8/19/2023 at 10:44 AM reflected the following documentation: Note Text: Medical transportation in to transport to ER for eval. The nurses' notes dated on 8/19/2023 at 18:02 (6:02 PM) reflected the following documentation. Note Text: Resident admitted to JSMU for sepsis (infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever). The surveyor reviewed the subsequent nurses' notes regarding Resident #68's change of condition on 08/19/23 which did not contain information regarding what the resident's vital signs were or type of mental status change the resident was experiencing at the time that the resident had a change in condition. The surveyor reviewed the Weights and Vitals Summary dated for the month 08/2023 and there was no documentation that the resident had vital signs taken when the resident had a change in condition on 08/19/23 at 8:31 AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/23/23 at 11:11 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#2). LPN #2 stated that if a resident had a change in condition that the nurse would perform an assessment. She stated that an assessment would include a full set of vital signs (VS) to include a pulse Oximeter reading, blood pressure, pulse, temperature, and examination of all body symptoms. She confirmed that all assessments performed would be documented in the resident's medical record. She continued to explain that the nurse would be required to fill out a Universal Transfer Form (UTF). She stated that a UTF was a communication form that was utilized between the facility and the hospital and would provide the hospital with information regarding the resident's medical condition, code status, resident information, vital signs and how to care for the resident. LPN #2 added the UTF was an important communication tool between the facility and the hospital. On 08/23/23 at 11:19 AM, the surveyor interviewed the acting LPN Unit Manager who stated that the nurse was responsible to assess the resident and to obtain a full set of vital signs if a resident had a change in condition. He added that the nurse would be responsible to complete a UTF. The LPN/UM confirmed that there was no VS documented in Resident #68's medical record when the resident had a change in condition on 08/19/23. He stated that this would have been important as the resident was admitted to the hospital with the diagnose of sepsis. He stated, There is no documentation that the resident even had a temperature. On 08/23/23 at 12:09 PM, the surveyor interviewed the DON in the presence of the survey team. The DON explained that if a resident had a change in condition, the nurse would immediately physically assess the resident and obtain a full set of VS which would include pulse Ox (checks O@ level of the blood), level of conscience, evaluate for pain etc. He stated that if VS were taken during the assessment, then it should be documented under the weights and VS section of the electronic medical record and in the nursing progress notes. The surveyor reviewed the progress notes that were written on 08/19/23 at 8:31 AM when Resident #68 had a change of condition and the DON confirmed that the documentation was not specific regarding what type of mental status change the resident was experiencing or any VS. The DON could not explain why the RN did not document that she had taken the residents VS when the resident had a change in condition. On 08/28/23 at 10:26 AM, the surveyor interviewed LPN who stated that that on 08/19/23, she arrived at the Unit 3 late. She indicated that the 11:00 PM-07:00 AM shift Registered Nurse (RN) gave her report that Resident #68's penis area was swollen and that she was going to assess the resident before she left. She then explained that the RN then went back to assess the resident and she went back to performing her medication pass for other residents. She then added that the RN did not report to her that the resident had a change in mental status. She stated that the RN only reported to her that the resident's penis was swollen and that the RN would notify the MD. LPN #1 then stated the RN told her that the MD ordered the resident to be sent to the hospital for evaluation. LPN #1 and the surveyor reviewed the resident's progress notes. LPN #1 confirmed that the 11:00 PM-07:00 AM RN documented that Resident #68 had a change of condition at 8:31 AM and confirmed that there was no further documentation or progress notes written until 10:44 AM when LPN #1 documented that the resident was transferred to the hospital. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 stated that she did check on Resident #68 between 08:31 AM and 10:44 AM she and the resident gave her a thumbs up. LPN #1 stated that she did not document the resident's condition in the resident's medical record while the resident was waiting for transport to the hospital from 8:31 AM till 10:44 AM (approximately 2 1/2 hours). The surveyor reviewed the resident medical records and there was no documentation regarding the resident's medical condition from 8:31 AM till 10:44 AM while the resident was waiting to be transferred to the hospital for evaluation. She stated that it would have been important to document on a resident who had a change in condition, but that she was passing out medications to other residents and didn't have the time to perform the documentation until after the resident was already transferred to the hospital. The LPN admitted that she did not document in Resident #68's medical record any resident assessments subjective or objective that she performed for Resident #68 that was reported to have a change in condition. On 08/28/23 at 11:05 AM, the surveyor interviewed the RN who worked on 08/19/23 11:00 PM-07:00 AM shift on Unit 3 and sent the resident to the hospital to be evaluated for a change in mental status and swollen penis 08/19/2023 at 8:31 AM. The RN described Resident #68 as being hard of hearing and unable to verbalize. The RN added that Resident #68 communicated with the use of a communication board, IPAD and sign language. She also indicated that the resident was alert and oriented and could communicate his needs and wants. She explained that Resident #68 had a chronic curvature catheter (tube that facilitated the draining of urine from the bladder) utilized for blockages associated with the resident's anatomy. She stated that on 08/19/23 during the 11:00 PM-07:00 AM shift, the resident slept well and had 800 cc of urinary output. She stated that at the end of her shift and the beginning of the day shift the resident was noted to be tugging at the urinary catheter and had appeared to be in discomfort. She explained that when she asked the resident if he/she was in pain that the resident shook his/her head no indicating that he did not have pain. The RN then explained that she took the resident's vital signs in the middle of the shift and prior to noticing that the resident's penis head was swollen. She then added that she did not recall writing the resident's VS to include the resident's temperature in the medical record, but recall did recall writing them on the UTF. The surveyor explained to the RN that upon the surveyor's review of the UTF, there were two sets of vital signs on the form and that one set of VS were typed and the other set of VS were handwritten. The RN confirmed that the typed VS were not the VS that she took and did not know how that set of VS got on the UTF. She then confirmed that the handwritten blood pressure and pulse were the VS that she had written on the UTF. The RN could not explain to the surveyor why the resident's temperature was not documented by her on the UTF. The RN also confirmed that it would have been important to have documented the full set vital signs to include temperature, pulse, blood pressure, and pain in the resident's medical records and on the UTF that was sent to the hospital. The RN stated that it was the change of shift and that the other nurse that came on duty was also involved with the resident's change in condition and was surprised that the other oncoming nurse did not document her assessments of the resident in the medical record. The surveyor reviewed the physician discharge summary dated 08/19/2023 at 06:55 PM, which indicated that Resident #68 was noted to have a fever and unstable vital signs and was sent to the hospital for evaluation for sepsis. The surveyor was unable to locate any evidence in the medical record that indicated that the resident had unstable vital signs or fever at the time that the resident was had a change of condition on 08/19/2023. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/29/23 at 10:07 AM, the surveyor interviewed the primary care physician (PCP) who stated that the VS that were documented on the resident's discharge summary dated 08/19/2023 at 6:55 PM, were not accurate and not updated since his last assessment of the resident. He stated that the VS that were documented on the discharge summary were not the VS that were exhibited by Resident #68 at the time the resident had a change in condition and was sent to the hospital for evaluation. On 09/01/23 at 09:24 AM, the Administrator and DON provided progress notes for Resident #68 titled, late entry for 8/19/13 which was dated 9/1/23 at 07:10 AM by the RN. Review of the progress note included documentation of the resident's VS and assessment. The Administrator confirmed that the nurses should have documented their assessment and VS prior to the late entry. The surveyor reviewed the facility policy titled, Change in Condition with a revised date 04/2023 which indicated the clinical nurse will recognize and appropriately intervene in the event of a change in resident condition. The policy indicated that with a change in condition, the clinical nurse will gather all subjective and objective assessment information. The nurse was responsible to complete an assessment of the resident's condition to include vital signs, level of conscience and any other symptoms related to the resident's condition. The surveyor reviewed the facility policy titled, Nursing Documentation with a revised date of 04/2023 which indicated that pertinent information should be documented in the individual's record in an accurate, timely and legible manner. It also indicated that the individual's record is a permanent legal document that provides a comprehensive account of information about the individuals health care status. NJAC 8:39-35.2 (d)6, 16(e)