STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315462	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tallwoods Care Center	18 Butler Boulevard Bayville, NJ 08721

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26190 Based on record review, review of facility documents and policy and interviews, the facility failed to ensure one resident (Resident (R) 346) was protected from sexual abuse by another resident (R347). The facility then placed resident (R348) at risk for serious harm by placing R347 in R348's room following the sexual abuse incident. On 04/11/24, a past-noncompliance immediate jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents were safe from sexual abuse. The IJ was determined to exist on 01/23/22 when an act of sexual abuse occurred to R346. The IJ was removed on 01/24/22 when R347 was placed in a private room. The Administrator was informed and provided the IJ template on 04/11/24 at 5:00 PM that the past noncompliance IJ situation existed . The facility provided an IJ Removal Plan that was accepted on 04/11/24 at 6:59 PM. The survey team validated implementation of the Removal Plan through interviews and review of training records on 04/11/24 at 7:15 PM. Based on the facility's implementation of corrective actions, the IJ was determined to be Past Non-Compliance (PNC) and the IJ was removed, with substantial compliance achieved on 04/05/22. The deficient practice was determined to be past noncompliance related to the facility identifying the IJ and implementing interventions to prevent reoccurrence of the situation, completed on 04/05/22. The facility's actions included the following: 1. The perpetrator (R347) was removed from the situation and placed on 30-minute checks. 2. The resident was moved to a private room. 3. Police department was notified, and the situation was investigated. 4. Staff were in-serviced on abuse prevention. 5. The resident was arrested and placed in custody. 6. The judge ordered the facility to readmit the resident. 7. Request sent to the judge regarding R347's continued 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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. The resident was placed on 30-minute checks. 9. Bail was revoked with R347 returning to custody and did not return to the facility. Findings include: Review of the facility's investigation on facility letterhead, dated 01/23/22, indicated .Summary of Incident: On 01/23/22 around 7:00 PM nurse for [R346 and R347] knocked on their room door several times, not getting a response she entered the room and found [R347] kneeling by the side of [R346's] bed with his head between his groin area. [R346's] adult brief was opened and it appeared [R347 had R346's] penis in his mouth .[R346] was assessed .and he had no visible injuries .[R347] was interviewed .and was asked about the incident and he said he was performing oral sex on his roommate without consent. [R347] was put in a room with an alert and oriented resident [R348] as there was not any private room available. His [sic] was placed on 30 minute checks until 01/24/2022 when he was moved to a private room . Review of the facility's undated form titled Individual Statement Form stated, .Where and when did the incident occur? 01/23/2022 7PM room [ROOM NUMBER]. Tell us step by step, in your own words, what happened .I went to give [R347] his HS (at bedtime) sandwich. The door to his room was closed. I knocked a few times but I heard no response. I opened the door and found [R347] on his knees on the floor mat with his head over the groin area of [R346]. Then it was seen that [R347] had his mouth on [R346's] penis. [R346's] adult brief was open and his blankets and sheets were at the end of his bed. [R347] saw me and he got back into his wheelchair and said to me I'm sorry. [R347] was removed from his room .Signature: [Licensed Practical Nurse (LPN) 1] . Review of R347's EMR under the Progress Notes tab from the date of R347's admission (10/16/20) through the day prior to the incident indicated no documentation of R347 attempting or performing sexually inappropriate behavior with the facility's staff or residents. Review of R347's EMR under the Progress Notes tab indicated 01/23/22 around 7:00 PM LPN1 found R347, kneeling by R346. R347 had his head between R346's legs and R346's diaper was open, and his penis was exposed. R347 immediately returned to his wheelchair. R347 was immediately removed from the room and was placed with R348 who was alert and oriented x 4. Resident 347 was placed on 30-minute checks. On 01/24/22 R347 was placed in a private room. Review of facility's policy titled, Abuse Prevention, initiated 03/13, revealed Policy: The facility will not tolerate any form of resident abuse .by another resident. The facility will have an abuse prevention program that protects residents from physical .abuse .Sexual Abuse: Any inappropriate physical contact of a resident in an sexual manner .Key components of systemic approach to prevent abuse .Train .The facility during its orientation program and through an ongoing training program provide all employees with information regarding abuse and neglect and related reporting requirements including prevention, intervention and detection .Protect The facility must protect individuals from abuse .during investigation of any allegations of abuse and neglect .Investigate The facility ensures, in a timely and thorough manner, objective investigation of all allegations of abuse .Report/Respond The facility must assure that any incidents of substantial abuse . are reported and analyzed and the appropriate corrective .action occurs . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R346's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R346 was admitted to the facility on [DATE] with the diagnoses of Alzheimer's disease, Parkinson's disease, major depressive disorder, heart disease, dementia, and functional quadriplegia. Review of R346's EMR under the Minimum Data Set (MDS) tab with an Assessment Reference Date (ARD) of 09/16/22, indicated R346 was total dependence of one person for bed mobility, dressing and toileting; total dependence of two people for transfers; and extensive assist of one person for eating. The MDS showed a Brief Interview for Mental Status (BIMS) score of zero out of 15 indicating R346 was severely cognitively impaired. Review of R347's Face Sheet located under the Profile tab of the EMR revealed R347 was admitted to the facility on [DATE] with the diagnoses of Parkinson's disease, type II diabetes, major depressive disorder, anxiety disorder, heart disease, essential tremor, and muscle weakness. Review of R347's EMR under the MDS tab with an ARD of 01/23/21, indicated R347 was independent with bed mobility, transfers, and locomotion on the unit; supervision of one person for toileting and walking in room; and extensive assist of one person with dressing. The MDS showed a BIMS score of 12 out of 15 indicating R347 was moderately cognitively impaired. Review of R348's Face Sheet located under the Profile tab EMR revealed R348 was admitted to the facility on [DATE] with the diagnosis of schizophrenia. Review of R348's EMR under the MDS tab with an ARD of 01/20/22 indicated R348 was limited assist of one person for transfers, dressing and walking in room; supervision of one person for toileting; supervision of two people for bed mobility; and set up only for eating. The MDS showed a BIMS score of 11 out of 15 indicating R348 was moderately cognitively impaired. Review of the facility's undated form titled, Resident Check for Safety indicated documentation of R347 receiving checks beginning on 01/23/22 at 11:30 PM, 01/24/22 at 12:00 AM, followed by hourly checks through 01/27/22 at 3:00 PM. Review of the facility's in-service sheet titled, Abuse Prevention, dated 01/24/22, indicated 18 Nurses and Certified Nursing Assistants attended the in-service. Review of the R347's EMR under the Progress Notes tab, dated 01/27/22, revealed On 01/27/22 around 2:30 PM [R347] was interrogated by two detectives from Ocean County and [NAME] Township. I was informed he will be arrested tonight . Review of the document from the Superior Court of New Jersey Law Division: Criminal Part Ocean County Complaint #: W-2022-000037-1505 Order Denying Pretrial Detention and Ordering Pretrial Release dated 02/11/22, revealed .Reasons for denial of pretrial detention: Further .the court does not find clear and convincing evidence that pretrial detention is necessary to reasonably assure the defendant's appearance in court when required, the protection of the safety of any other person or the community .The Court fashions a remedy that requires the defendant to be placed in an private room at [Facility Name] or a similarly situated facility that would provide a private room to the defendant .Therefore, the motion for pretrial detention is DENIED .It is ordered, on this date, February 11, 2022, that the defendant be released on Pretrial Monitoring Level III .Next Court Date: You are hereby ordered to return to court on 03/30/22 at 9:00 AM . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated contract titled, [R347] Contract revealed In an effort to ensure the safety of the residents of [Facility Name] Care Center, and to protect [R347's] sexual rights and resident rights, the facility has provided the following contract about sexually appropriate behavior following [R347's] release from Ocean County Jail for a sexual offense. 1. [R347] needs to remain in his room unless escorted by a staff member. 2. When [R347] needs/wants to leave his room, he will use the call bell to ask staff to escort him where he needs to go. 3. [R347] can attend group activities under supervision. 4. [R347] cannot make any sexual advances towards other residents without their consent .I understand that if I violate any aspect of this contract the results will be as follows: 1. The IDT (Interdisciplinary Team) will be in contact with my Public Defender and I am at risk for sentencing. 2. [Facility Name] Care Center will issue me a discharge notice and will notify the Department of Health . The contract was completed/signed by R347 on 02/14/22. Review of R347's care plan, initiated on 08/25/21, indicated the Need on 01/23/22 of I inappropriately performed sexual acts on my roommate without his consent .Wishes I'll not have unconsensual [sic] sexual activity with anyone .I understand Interventions 02/28/22 I am aware that I have the right to sexual expression and self pleasure .I can not make sexual advances towards any other resident without their consent .03/28/22 Door alarm on when staff are not present to provide me with one to one . Review of R347's EMR under the Progress Notes tab, dated 02/28/22, indicated the facility Administrator notified R347's Public Defender that R347 was being sexually inappropriate with facility staff, attempting to have male residents come to his room and leaving his room without supervision. The facility's Social Worker and the Public Defender discussed with R347 the rules/guidelines he would have to adhere to remain in the facility. The Public Defender stated he would relay this information to the Judge. Review of the R347's EMR under the Progress Notes tab, dated 04/05/22, indicated R347 attended court and was incarcerated following court. R347 never returned to the facility after that court date. During an interview on 04/09/24 at 2:20 PM the Administrator stated the facility's investigation revealed that R347 had not shown a sexual interest in male staff members or other residents prior to this incident. Administrator confirmed R347 was removed from R346's room to another room immediately following the incident. During an interview on 04/10/24 at 9:31 AM Detective (D) 1, stated he did remember the case. D1 stated he interviewed R347 on 01/27/22, R347 was arrested and taken to jail. D1 confirmed that R347 admitted he committed a sexual act. During an interview on 04/10/24 at 10:03 AM, the Social Services Director (SSD) stated she was not aware of R347 having a sexual abuse history prior to the incident. SSD explained that prior to coming to [Facility Name], R347 was residing at another Long-Term Care facility and had requested to be moved to a facility located closer to where his stepbrother resided. SSD confirmed, at the time of the incident, R346 was nonverbal and had a BIMS of zero. SSD stated R346 did not exhibit any signs of emotional or physical distress following the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/10/24 at 10:33 AM, LPN1 confirmed she entered the room of R346 and R347 and witnessed the sexual abuse occurring. LPN1 stated following the incident R347 was immediately removed from the room. LPN1 stated she did not receive any indication from R347 that he was going to sexually abuse anyone, the incident was a total surprise to her. LPN1 stated she did provide care for R347 prior to and after the incident. During an interview on 01/10/24 at 1:45 PM, Certified Nursing Assistant (CNA) 1 stated she worked for the facility for [AGE] years. CNA1 stated she did not work on the unit where R347 was residing, but remembered the incident and received an in-service regarding sexual abuse following the incident. During an interview on 01/10/24 at 1:51 PM, CNA2 stated she worked for the facility for six years. CNA2 remembered the incident and did provide care for R347 around the time of the incident. CNA2 denied having an indication that R347 was going to sexually abuse a resident. CNA2 stated R347 was moved to another room immediately following the incident, was not allowed to leave his room without someone with him, did recall safety checks being implemented and, at times, a staff member sitting outside R347's room. NJAC 8:39-4.1(a)(5) NJAC 8:39-33.2(c)(12)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on record review, interview, and review of the Resident Assessment Instrument (RAI manual), the facility failed to ensure that two residents (Resident (R) 2 and R65) out of 32 sampled residents' Minimum Data Set (MDS) assessments were completed and transmitted in a timely manner. Findings include: Review of Center for Medicare and Medicaid Services (CMS) Long-term Care Facility Assessment Instrument 3.0 User's Manual, version 1.181, dated 10/23 revealed, Chapter 2: Assessments for the Resident Assessment Instrument, 2.6: Required OBRA Assessments for the MDS .RAI OBRA-required assessment summary for quarterly assessment .MDS completion date (Z0500B) no later than assessment reference date (ARD) + 14 calendar days .Transmission date MDS completion date + 14 calendar days. 1. Review of R2's Face Sheet under the Profile tab in the electronic medical record (EMR) indicated that R2 was admitted to the facility on [DATE] with a diagnosis of traumatic brain injury (TBI) and paraplegia. Review of R2's quarterly MDS assessment under the MDS tab in the EMR with an ARD of 03/02/24 revealed MDS completed on 03/21/24 and submitted on 04/02/24. Review of the MDS Summary under the MDS tab in the EMR, dated 03/02/24, revealed Completed MDS on 03/21/24 and accepted on 04/02/24. Review of the Assessment History under the MDS tab in the EMR, dated 03/02/24, revealed Quarterly assessment batched and accepted on 04/02/24. 2. Review of R65's Face Sheet under the Profile tab in the EMR indicated that R65 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease, major depressive disorder (MDD), and mood disorder. Review of R65's quarterly MDS assessment under the MDS tab in the EMR with an ARD of 03/01/24 revealed MDS completed on 03/20/24 and submitted on 04/02/24. Review of the MDS Summary under the MDS tab in the EMR, dated 03/01/24, revealed Completed MDS on 03/20/24 and accepted on 04/02/24. Review of the Assessment History under the MDS tab in the EMR, dated 03/01/24, revealed Quarterly assessment batched and accepted on 04/02/24. During an interview on 04/11/24 at 1:40 PM, the MDS Assistant (MDSA) confirmed that neither assessments were completed and submitted within the appropriate timeframe. NJAC 8:39-11.2

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observations, record review, interviews, and facility policy review, the facility failed to ensure that five of 12 residents (Resident (R) 17, R19, R61, R128 and R297) reviewed for side rails had a comprehensive care plan developed that addressed the use of side rails of 32 sampled residents. Findings include: Review of facility's undated policy titled, Comprehensive Person-Centered Care Plans, revealed [name of the facility] will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. A plan of care is something that describes in an easily accessible way the services and support being provided and should be put together and agreed with the person through the process of care planning and review. 1. Review of R17's Face Sheet under the Profile tab in the electronic medical record (EMR) indicated that R17 was admitted to the facility on [DATE] with a diagnosis including multiple sclerosis (MS), generalized muscle weakness, and ataxia (impaired balance or coordination). During an observation and interview on 04/08/24 at 10:30 AM, R17 was sitting up in her bed with bilateral half side rails in the up position. During this observation, R17 stated that she used the side rails for turning. At 12:15 PM, R17 was sitting up in bed eating lunch with upper half bilateral side rails in the up position. During further observation on 04/10/24 at 6:30 PM, R17 was in bed with upper half bilateral side rails in the up position. Review of R17's annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/25/24 indicated a Brief Interview for Mental Status (BIMS) was 15 out of 15, which indicated R17 was cognitively intact. Review of R17's Care Plan's under the EMR Care Plan tab, dated 09/09/22, revealed no evidence of a side rail care plan or side rails as an intervention. 2. Review of R19's Face Sheet under the Profile tab in the EMR indicated that R19 was readmitted to the facility on [DATE], with a diagnosis including difficulty walking, muscle weakness, arthritis, fracture of right humerus, and unsteady gait/balance. During initial tour observation on 04/08/24 at 10:00 AM, R19 was in bed asleep with her upper half bilateral side rails in the raised position. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R19's undated Care Plan under the EMR Care Plan tab, revealed no evidence of a side rail care plan or side rails as an intervention. 3. Review of R61's Face Sheet under the Profile tab in the EMR indicated that R61 was admitted to the facility on [DATE] with a diagnosis of dementia, pain in left shoulder, and history of falling. During an observation on 04/08/24 at 10:05 AM, R61 was sitting up in her bed with bilateral half side rails in the up position. Further observation on 04/11/24 at 9:00 AM, R61 was sitting up in her bed with bilateral half side rails in the up position. Review of R61's Care Plan under the EMR Care Plan tab, dated 05/31/21, indicated no evidence of a side rail care plan or side rails as an intervention. 4. Review of R128's Face Sheet under the Profile tab in the EMR indicated that R128 was readmitted to the facility on [DATE] with a diagnosis of generalized muscle weakness, restless leg syndrome (RLS), dementia, and difficulty walking. During the initial observational tour of the facility on 04/08/24 at 10:00 AM, R128 was laying in her bed with bilateral half side rails in the up position. At 12:00 PM, R128 was sitting up in her bed with bilateral half side rails in the up position. Review of R128's Care Plan under the Care Plan tab in the EMR, dated 07/11/23, indicated no evidence of a side rail care plan or side rails as an intervention. 5. Review of R297's Face Sheet under the Profile tab in the EMR indicated that R297 was admitted to the facility on [DATE] with a diagnosis of fracture left femur. During observation on 04/08/24 at 10:20 AM, R297 was in bed, with bilateral half side rails in the up position. At 12:20 PM, R297 was sitting up in her bed, eating lunch with bilateral half side rails in the up position. During further observation on 04/10/24 at 10:00 AM and 6:37 PM, R297 was in her bed with bilateral half side rails in the up position. Review of R297's Care Plan under the Care Plan tab in the EMR, dated 01/10/24, indicated no evidence of a side rail care plan or side rails as an intervention. During an interview on 04/10/24 at 3:45 PM, the Assistant Director of Nursing (ADON) confirmed that R17, R19, R61, R128, and R297 did not have a side rail care plan. NJAC 8:39-11.2(e) thru (i) NJAC 8:39-27.1(a)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 25232 Based on observation, record review, interviews, and facility policy review, the facility failed to attempt to use appropriate alternatives prior to installing bed rails; failed to assess the residents for the risk of entrapment from the bed rails; failed to review the risks and benefits of the bed rails with the resident or resident representative; and failed to obtain informed consent prior to installation or use of the side rails of 11 of 11 residents (Resident (R) 17, R19, R61, R128, R297, R6, R23, R54, R57, R196, and R197) reviewed for accident hazards of 32 sampled residents. Findings include: Review of facility's undated policy titled, Side Rail Assessment, revealed Purpose: 1. Every resident will be assessed for the need for side rails upon admission or re-admission. 2. When side rail usage is determined to be necessary and side rails meet the definition of a restraint whether to restrict movement for safety, a physician's order should be obtained, and the side rail should be addresses as an approach to a problem/need on the resident's plan of care. 3. The need for side rails will initially be determined upon admission by the admitting nurse, conferring with the resident and family members. Physical and mental status, resident wishes and history will all assist in determining initial side rail usage. 4. A screening form will be used to assist in determining the need of rationale for side rail usage. A new screen may be indicated by functional ability changes as noted by the Minimum Data Set (MDS). 5. The resident or family representative will be asked to sign a consent form upon admission. If after the screening process, bed rail usage changes or at any time thereafter, the family representative will be notified. Review of facility provided documentation titled, Side Rail Screen, revised 08/15, revealed Patient Name: __Unit: __Room number: __1. Is the patient ambulatory? 2. Is the patient comatose or semi-comatose? 3. Does the patient have alteration in safety awareness? 4. Does the patient have a history of frequent falls? 5. Does the patient have difficulty moving in bed? 6. Does the patient have difficulty sitting on or moving to the side of the bed? 7. Does the patient have difficulty with balance or poor trunk control? 8. Does the patent take any medication that would require an increase in safety precautions? 9. Is the patient currently using side rails for independent positioning or to assist with positioning? 10. Has the patient asked to have the side rails raised while in bed? Alternate to Side Rails: 1. Frequent toileting 2. Reminders to use call bell 3. Restorative care to enhance independence 4. Other: Yes/No (circle) Side rails are indicated to: 1. Provide safety 2. Promote independence of positioning of transfers 3. Fulfill resident's request Yes/No (circle) Side Rails are not indicated at the present time. Yes/No (circle) Evaluation will continue to determine the appropriateness. Comments: __Side Rails Utilization: __One __Both __1/2 Rail __3/4 Rails Signature: __ Date: __ 1. Review of R17's Face Sheet under the Profile tab in the electronic medical record (EMR) indicated that R17 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (MS), generalized muscle weakness, and ataxia (impaired balance or coordination). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R17's annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/25/24 indicated a Brief Interview for Mental Status (BIMS) was 15 out of 15, which indicated R17 cognitively intact. During an observation and interview on 04/08/24 at 10:30 AM, R17 was sitting up in her bed with bilateral half side rails in the up position. During this observation, R17 stated that she used the side rails for turning. At 12:15 PM, R17 was sitting up in bed eating lunch with upper half bilateral side rails in the up position. During further observation on 04/10/24 at 6:30 PM, R17 was in bed with upper half bilateral side rails in the up position. Review of Order Summary Report under the Orders tab in the EMR, dated 04/10/24, indicated Side rails: 1/3 left and right. Review of Assessments under the Evaluation tab in the EMR indicated no evidence of a side rail assessment. Review of Consent under the Miscellaneous tab in the EMR indicated no evidence of a side rail consent and/or alternatives prior to side rail use. 2. Review of R19's Face Sheet under the Profile tab in the EMR indicated that R19 was readmitted to the facility on [DATE], with diagnoses including difficulty walking, muscle weakness, arthritis, fracture of right humerus, and unsteady gait/balance. During initial tour observation on 04/08/24 at 10:00 AM, R19 was in bed asleep with her upper half bilateral side rails in the raised position. Review of Order Summary Report under the Orders tab in the EMR, dated 04/10/24, indicated Side rails as enabler 1/3 to left and right. Review of Assessments under the Evaluations tab in the EMR indicated no evidence that R19 had an assessment for side rails. Review of Consent under the Miscellaneous tab in the EMR indicated no evidence of a side rail consent and/or alternatives prior to side rails being used. 3. Review of R61's Face Sheet under the Profile tab in the EMR indicated that R61 was admitted to the facility on [DATE] with diagnoses of dementia, pain in left shoulder, and history of falling. During an observation on 04/08/24 at 10:05 AM, R61 was sitting up in her bed with bilateral half side rails in the up position. During further observation on 04/11/24 at 09:00 AM, R61 was sitting up in her bed with bilateral half side rails in the up position. Review of Order Summary Report under the Orders tab in the EMR, dated 04/10/24, indicated Side rails 1/3 to left and right. (continued on next page)

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	315462	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tallwoods Care Center	18 Butler Boulevard Bayville, NJ 08721

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Assessments under the Evaluations tab in the EMR indicated no evidence of a side rail assessment. Review of Consent under the Miscellaneous tab in the EMR indicated no evidence of a side rail consent and/or alternatives prior to side rails being used. 4. Review of R128's Face Sheet under the Profile tab in the EMR indicated that R128 was readmitted to the facility on [DATE] with diagnoses of generalized muscle weakness, restless leg syndrome (RLS), dementia, and difficulty walking. During the initial observational tour of the facility on 04/08/24 at 10:00 AM, R128 was lying in her bed with bilateral half side rails in the up position. At 12:00 PM, R128 was sitting up in her bed with bilateral half side rails in the up position. Review of Order Summary Report under the Orders tab in the EMR, dated 04/10/24, indicated Side rails: 1/3 as enabler for left and right. Review of Assessments under the Evaluations tab in the EMR indicated no evidence of a side rail assessment. Review of Consent under the Miscellaneous tab in the EMR indicated no evidence of a side rail consent and/or no evidence of alternatives completed prior to side rails applied. 5. Review of R297's Face Sheet under the Profile tab in the EMR, indicated that R297 was admitted to the facility on [DATE] with a diagnosis of a fracture left femur. During observation on 04/08/24 at 10:20 AM, R297 was in bed, with bilateral half side rails in the up position. At 12:20 PM, R297 was sitting up in her bed, eating lunch with bilateral half side rails in the up position. During further observation on 04/10/24 at 10:00 AM and 6:37 PM, R297 was in her bed with bilateral half side rails in the up position. Review of Order Summary Report under the Orders tab in the EMR, dated 04/10/24, indicated Side rails 1/3 as enabler to left and right. Review of Admit/Readmit Screener under the Evaluations tab in the EMR, dated 01/09/24, indicated both side rails were used; however, no evidence of an indication why the side rails were being used. Further review revealed no evidence of alternatives prior to side rails being applied. Review of Consent under the Miscellaneous tab in the EMR indicated no consent and/or alternatives prior to side rails being applied. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/24 at 3:45 PM, the Assistant Director of Nursing (ADON) indicated that all beds had 1/3 side rails, and these side rails were built into the bed. She stated that side rails were used for bed mobility and/or positioning. She indicated that side rails should have been assessed quarterly during the care conference; however, they were only being assessed upon admission and/or re-admission. The ADON confirmed that R17, R19, R61, R128, and R297 did not have side rail consent, quarterly side rail assessments, and/or alternatives prior to side rail usage. 6. Review of R6's quarterly MDS with an ARD of 12/20/23 revealed she had a BIMS score of 9 out of 15 indicating she had moderately impaired cognition and she required substantial assistance with bed mobility. Review of R6's physician orders located in the Orders tab of the electronic medical record (EMR) revealed she had a physician's order for 1/3 side rails as enabler with a start date of 07/28/23. Review of the Admit/Readmit screener, dated 07/27/23, under the Evaluation tab of the EMR revealed she used half side rails on both sides of the bed to promote independence with bed mobility. R6's EMR was reviewed in its entirety and was absent documentation to show what alternatives were attempted prior to the use of the side rails, documentation to show the risks and benefits of bed rails was reviewed with the resident or resident representative, or that informed consent was obtained prior to installation of the 1/3 side rails. During an observation on 04/09/24 at 8:57 AM and on 04/11/24 at 7:37 AM, R6 was observed in bed with one-third side rails in the up position on the top of the bed. 7. Review of R23's quarterly MDS with an ARD of 03/04/24 revealed she had a BIMS score of 15 out of 15 indicating she was cognitively intact. Review of R23's physician's orders in the Orders tab of the EMR revealed she had a physician's order for 1/3 side rails as enabler with a start date of 10/20/23. Review of the Admit/Readmit screener, dated 07/27/23, under the Evaluation tab of the EMR revealed she used half side rails on both sides of the bed. R23's EMR was reviewed in its entirety and was absent documentation to show what alternatives were attempted prior to the use of the side rails, documentation to show the risks and benefits of bed rails was reviewed with the resident or resident representative, or that informed consent was obtained prior to installation of the 1/3 side rails. During an observation on 04/09/24 at 8:58 AM, 9:54 AM, and 5:05 PM and on 04/11/24 at 7:37 AM, R23 was observed in bed with one-third side rails in the up position on the top of the bed. 8. Review of R54's admission MDS with an ARD of 03/07/24 revealed she had a BIMS score of 6 out of 15 indicating she was severely cognitively impaired and required substantial/maximal assistance with bed mobility. Review of R54's physician's orders in the Orders tab of the EMR revealed she had a physician's order for 1/3 side rails as enabler with a start date of 09/29/24. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admit/Readmit screener, dated 2/29/24, under the Evaluation tab of the EMR revealed the resident used half side rails on both sides of the bed for safety and to promote independence with bed mobility. R54's EMR was reviewed in its entirety and was absent documentation to show what alternatives were attempted prior to the use of the side rails, documentation to show the risks and benefits of bed rails was reviewed with the resident or resident representative, or that informed consent was obtained prior to installation of the 1/3 side rails. During observations on 04/08/24 at 10:45 AM, 1:33 PM; on 04/09/24 at 6:53 PM; on 04/10/24 at 10:26 AM; and on 04/11/24 at 6:15 AM and 7:39 AM, R54 was observed in bed with one-third side rails in the up position on the top of the bed. 9. Review of R57's quarterly MDS with an ARD of 02/07/24 revealed she had a BIMS score of 14 out of 15 indicating she was cognitively intact, and she required partial assistance with bed mobility. Review of R57's physician's orders in the Orders tab of the EMR revealed she had a physician's order for 1/3 side rails as enabler with a start date of 12/22/23. Review of the Admit/Readmit screener, dated 12/21/23, under the Evaluation tab of the EMR was blank for the use of the side rails. R57's EMR was reviewed in its entirety and was absent documentation to show what alternatives were attempted prior to the use of the side rails, documentation to show the risks and benefits of bed rails was reviewed with the resident or resident representative, or that informed consent was obtained prior to installation of the 1/3 side rails. During observation on 04/09/24 at 8:58 AM and on 04/11/24 at 7:38 AM, R57 was observed in bed with one-third side rails in the up position on the top of the bed. 10. Review of R196's admission MDS with an ARD of 03/29/24 stated she had a BIMS score of 10 out of 15 indicating she had moderate cognitive impairment and she required supervision or touch assistance with bed mobility. Review of R196's physician's orders in the Orders tab of the EMR revealed she had a physician's order for 1/3 side rails as enabler with a start date of 03/24/24. Review of the Admit/Readmit screener, dated 03/23/24, under the evaluation tab of the EMR revealed she used two half side rails to promote independence with bed mobility. R196's EMR was reviewed in its entirety and was absent documentation to show what alternatives were attempted prior to the use of the side rails, documentation to show the risks and benefits of bed rails was reviewed with the resident or resident representative, or that informed consent was obtained prior to installation of the 1/3 side rails. During observation on 04/09/24 at 6:52 PM, R196 was observed in bed with one-third side rails in the up position on the top portion of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. Review of R197's admission MDS with an ARD of 03/25/24 revealed she had a BIMS score of 15 out of 15 indicating she was cognitively intact, and she required supervision or touch assistance with bed mobility. Review of R197's physician's orders in the Orders tab of the EMR, revealed she had a physician's order for 1/3 side rails as enabler with a start date of 03/21/24. Review of the Admit/Readmit screener, dated 03/21/24 and located under the Evaluation tab of the EMR revealed she used two half side rails to promote independence with bed mobility. R197's EMR was reviewed in its entirety and was silent for documentation to show what alternatives were attempted prior to the use of the side rails and for documentation to show the risks and benefits of bed rails was reviewed with the resident or resident representative, or that informed consent was obtained prior to installation of the 1/3 side rails. During observations on 04/08/24 at 10:51 AM and on 04/09/24 at 5:01 PM, R197 was observed in bed with one-third side rails in the up position on the top of the bed. On 04/08/24 at 10:51 AM the resident stated she only used the side rails to attach her phone cords and call cord to so she could reach them. During an interview on 04/10/24 at 4:00 PM, the ADON was interviewed, and the above records were reviewed with her. She was unable to find any information related to alternatives attempted prior to putting the side rails in place; or documentation to show the residents and/or the residents' representatives were informed of the risk and benefits prior to using the side rails. She stated they did not have consent for the use of the side rails for the above residents. 03115 NJAC 8:39-27.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03115 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the dish washer sanitizer level was maintained at a level required to sanitize the dishes. This had the potential to affect 146 of 146 residents in the facility. Findings include: Review of the undated facility's policy titled, Dish Machine Policy and Procedure revealed it was the facility policy to test the chlorine level using test strips. According to the policy the chlorine level should be 50 to 100 PPM and should be tested at the start of running the dish machine. During an observation and interview on 04/08/24 at 9:52 AM, the Dietary Manager (DM) stated the dish washer was being used as a low temperature dish machine because the booster went out on 03/28/24. He stated the employee was using it to wash breakfast dishes. He tested the chlorine sanitizer level of the dish washer rinse water, and it tested zero (0) parts per million (ppm). He stated it was supposed to be testing at 50 to 100 ppm. The dish washer was ran and tested two additional times and each time the sanitizer level of the rinse water was zero ppm. The hose running from the bottle of sanitizer was examined while the dish washer was running, and the sanitizer was not running through the hose. During an observation and interview on 04/08/24 at 10:10 AM, Dietary Aide (DA) 1 was asked what he did prior to washing the breakfast dishes and he stated he checked the temperatures on the two thermometers located on the top of the machine and wrote the temperatures on the log that was hanging on the wall across from the dish washer. The log was examined and did not contain an area to document the chemical level of the chlorine. The DM was present and verified the chlorine level was not being documented. DA1 was asked if he checked the chemical level, and he did not appear to understand so the container of test strips was handed to him, and he opened the container took out half the strips and threw them into the dishwasher tank. The strips did not change color again indicating there was no chlorine in the rinse water. The DM was present during the observation and verified the employee did not understand how to check the chlorine level of the sanitizer. Review of the manufacturer's information posted on the back of the gallon bottle of Santec Three sanitizer used to sanitize the dishes for the dish washer stated to prepare sanitizing solution to an initial concentration of 100 ppm available chlorine. The instructions stated the chlorine level must be tested and adjusted periodically to ensure the available chlorine did not drop below 50 ppm. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 04/09/24 at 9:15 AM the level of the chlorine sanitizer was checked in the rinse water of the dish washer, and it was 50 ppm. The DM provided documentation titled Cleanslate Kitchen Service Report, dated 04/08/23 and timed 2:30 PM. According to the report the professional technician came to the facility to complete a preventative maintenance call. The report revealed he recalibrated the sanitizer on the dish machine and made sure chemicals were at the right levels. The DM stated that the service technician from Cleanslate told him the tubing was clogged and he replaced the tubing and rearranged/recalibrated the sanitizer and now it was running at 50 to 100 PPM. He stated that he retrained staff, and he produced a new log for them to record the chemical level of the sanitizer. NJAC 8:39-17.2(g) NJAC 8:39-19.7(d)