STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Moorestown	895 Westfield Road Moorestown, NJ 08057

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 44833 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy by ensuring all newly hired employees were screened for potential abuse by conducting criminal background checks prior to hire. This deficient practice was identified for 1 of 10 staff (Staff #4) reviewed for newly hired employees, and was evidenced by the following: A review of the facility's Abuse Prevention Program policy with an edited date of 4/5/18, included .as part of the resident abuse prevention, administration will: 1. Protect our residents from abuse by anyone, including but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. 2. Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment, by a court of law; b. have had a finding entered into the State nursing aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or c. have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property . On 9/25/24 at 12:10 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) to provide the survey team with the personnel and health files for ten selected newly hired employees (Staff #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10). On 9/26/24 at 9:40 AM, the surveyor reviewed the ten employee health and personnel files requested and provided by the facility which included: Staff #4, a Licensed Practical Nurse (LPN), with a date of hire 12/7/23. A criminal background check was dated entered 1/24/24, and completed 1/26/24, seven weeks after starting employment. On 9/26/24 at 11:35 AM, the surveyor requested the LNHA provide all timecard punches for Staff #4 and all background checks completed for this staff member. A review of Staff #4's timecard punches indicated Staff #4 had their first-time punched at 9:00 AM on 12/7/23, for three hours and a Day shift (7:00 AM) time in punch at 7:00 AM for a 12 hour nursing shift. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 12:37 PM, the [NAME] President of Clinical Services (VPCS) in the presence of the LNHA, Infection Preventionist/Registered Nurse (IP/RN), and survey team stated that criminal background checks were performed on staff prior to being hired. On 9/27/24 at 10:23 AM, the LNHA in the presence of the IP/RN, [NAME] President of Operations Bridge Care (VPO), and survey team confirmed that Staff #4 did not have a background check prior to hire. He further stated that Staff #4 had never had an allegation of abuse against them, and no longer worked at the facility. NJAC 8:39-4.1(a)(5)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 45208 Based on interview and review of pertinent facility documents, it was determined that the facility failed to a.) initiate an investigation at the time a facility acquired pressure ulcer was discovered on 9/18/24, to rule out neglect. The deficient practice was identified for 1 of 2 residents reviewed for skin conditions and pressure ulcers (Resident #402), and was evidenced by the following: Reference: https://www.ncbi.nlm.nih.gov/books/NBK2650/table/ch12.t2/ National Pressure Ulcer Staging System: Deep Tissue Injury: A pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise, and they may herald the subsequent development of a Stage III-IV pressure ulcer, even with optimal treatment. Definition: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. Characteristics: The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler, as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. The area may rapidly evolve to expose additional layers of tissue, even with optimal treatment. On 9/24/24 at 10:10 AM, the surveyor observed Resident #402 lying in bed with their foot elevated on a pillow. The resident stated that they had pain in their heel that they informed their therapist of, so they did not go to therapy today. The surveyor observed the resident had no-skid socks on both feet. On 9/23/24 at 10:40 AM, the surveyor reviewed the medical record for Resident #402. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with medical diagnoses which included but not limited to; unilateral inguinal hernia with obstruction without gangrene (a condition where abdominal contents protrude through the inguinal canal, and the herniated contents are obstructed but not gangrenous). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 9/13/24, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated a fully intact cognition. A review of the Order Summary Report (OSR) dated active orders as of 9/6/24, included a physician's order (PO) dated 9/18/24, for skin prep wipes; to apply one application transdermal two times a day for right heel, red and boggy (abnormal texture of tissues characterized by sponginess usually because of high fluid content). Notify Medical Doctor (MD) if it worsens or gets darker. A review of an additional PO dated 9/18/24, to float heels on pillow every eight hours for boggy heel. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the September 2024 Treatment Administration Record (TAR) included a PO dated 9/13/24, for weekly skin observation every Friday .enter 0 for no skin breakdown, 1 for previously identified wound, 2 for newly identified wound. A review of the corresponding order, revealed that the nurse signed on 9/20/24, a 0, which indicated no skin breakdown. A review of the September 2024 Medication Administration Record (MAR) included a PO dated 9/18/24, to float heels on pillow every eight hours for boggy heel at 8:00 AM, 2:00 PM, and 10:00 PM daily. A review of the corresponding MAR revealed nurses were signing completion with a check mark (which indicated administration) for 9/18/24 through 9/24/24. A review of the Progress Notes included a Physician Practitioner Progress note dated 9/18/24 at 9:09 AM, which included a skin assessment of the right heel as red and boggy. The Advance Practice Nurse documented that they spoke to nurse to make her aware of heel pain and will put an order in for skin prep pads. On 9/24/24 at 11:40 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that the resident complained of heel pain, so she administered the prescribed medication of Tylenol. The surveyor asked the LPN if she assessed the heel prior administering pain medication, and the LPN responded that she had not. At that time, the LPN in the presence of the surveyor assessed the resident's right heel, which was observed as non-blanchable erythema (area of redness that does not disappear with pressure applied; the beginning of a pressure ulcer), boggy, and ankle swelling. The left heel was reddened but blanchable (area of redness that disappears when pressure applied). The surveyor observed the resident's feet and heels were directly on the pillow, and not offloaded (feet and heels should not touch anything including the pillow that would cause pressure). The nurse stated that's he would let the physician know that the right heel was non-blanchable. The the nurse then adjusted the resident's feet to have the heels offloaded from the bed and pillow. On 9/24/24 at 12:22 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN), who stated if the physician made the nurse aware of a pressure injury, the nurse should have completed an assessment, report redness, broken skin, swelling, or something new because it could lead to a breakdown. The UM/LPN stated the nurse should have reported it to the Charge Nurse or Supervisor so an incident report could be completed; family and physician notified. On 9/26/24 at 12:15 PM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with an investigation of Resident #402's wound dated 9/24/24, that was initiated after surveyor inquiry. A review of the incident report indicated that it was determined that the nurses were unaware of proper staging of a wound. During the inservice of wound staging the LPN indicated that I did not do an incident report because the skin was intact without any openings. A review of the facility's Abuse Prevention Program policy dated edited 4/5/18, included policy statement: our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the residents' symptoms . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's Accidents and Incidents - Investigating and Reporting policy dated revised July 2017, included policy statement: all accidents or incidents involving residents, employees, visitors, vendors, [etcetera], occurring on our premises shall be investigated and reported to the administrator .Policy Interpretation and Implementation: 1. the nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident /Accident form: a. the date and time the accident or incident took place; b. the nature of the injury or illness, (example bruising, falls, nausea, etcetera); c. the circumstances surrounding the accident or incident .5. the nurse/supervisor/charge nurse and/or the department director or supervisor shall complete an Report of Incident/Accident form and submit the original to the director of nursing services within 24 hours of the incident or accident . A review of the facility's Investigating Resident Injuries policy dated revised April 2021, included policy statement: all resident injuries are investigated. Policy interpretation and Implementation .3. if an incident/accident is suspected, a nurse or nurse supervisor completes the facility-approved accident/incident forms . A review of the facility's Pressure Ulcer/Skin Breakdown - Clinical Protocol dated revised March 2014, included .2. the nurse shall describe and document/report the following: a. full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. pain assessment; c) resident's mobility status; d. current treatments . A review of the facility's Prevention of Pressure Injuries dated revised April 2020, included purpose: this procedure is to provide information regarding identification of pressure injury risk factors, interventions, or specific risk factors .Skin Assessment: .2. during the skin assessment, inspect: a. the presence of erythema; b. temperature of skin and soft tissue; c. edema. 3. inspect the skin on a daily basis when performing or assisting with personal care of [activities of daily living]. a. identify any signs of developing pressure injuries (i. e. non-blanchable erythema) .Monitoring: 1. evaluate, REPORT, and document potential changes in the skin . NJAC 8:39-4.1(a)5

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40744 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to revise an individual comprehensive care plan for a resident with a history of falls at the facility. This deficient practice was identified for 1 of 2 residents reviewed for accidents (Resident #21), and was evidenced by the following: On 9/23/24 at 7:52 PM, during the initial tour of the facility, the surveyor observed Resident #21 in bed with their eyes closed. The surveyor observed a fall mat on the right side of the bed, and the left side of the bed was against the wall. The surveyor asked the Resident Representative (RR), who was present at the time, if the resident had any falls, and the RR stated that the resident didn't fall but has slid to the floor. On 9/24/24 at 11:00 AM, the surveyor reviewed the medical record for Resident #21. A review of the Admission Record face sheet (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to; cancer of ribs and sternum, infection following procedure, and dementia. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 7/25/24, reflected that the resident had a Brief Interview of Mental Status (BIMS) score of 13 out of 15, which indicated a fully intact cognition. A further review in Section J. health conditions, indicated the resident had a history of falls. On 9/24/24 at 1:02 PM, the surveyor reviewed the resident's incidents and accidents which revealed the resident had the fallowing falls: On 8/29/24, the resident stated I sat on the floor. On 9/4/24, the staff heard a fall, and the resident was kneeling at the foot of the bed. On 9/14/24, the resident was found on the floor sitting near the closet. On 9/21/24, the resident's [name redacted representative] assisted the resident in transfer, lost control, and guided the resident to the floor. Following each fall, the resident had a fall evaluation and a pain evaluation. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 8/24/24 with a revision date of 9/4/24, for a risk for falls related to impaired balance. Interventions included physical therapy; to assist with transfers; and to reinforce safety. The ICCP did not include any specific interventions implemented following each of the resident's falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 10:00 AM, the surveyor interviewed the unit Charge Nurse (CN) regarding the facility's post fall process, who stated that they assessed the resident's vital signs, checked for injuries, notified family and the doctor. The CN stated that the resident's ICCP was updated to prevent future falls. The surveyor asked when the ICCP would be updated, and the CN stated after each fall. On 9/26/24 at 10:28 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN), who was assisting in the Director of Nursing's (DON) absence, who stated the DON was responsible for revising ICCPs or the MDS Coordinator. On 9/26/24 at 10:35 AM, the surveyor interviewed the MDS Coordinator, who stated that they had a big roll with ICCPs, that they helped nursing initiate them, and the IP/RN also completed. The surveyor asked if she was responsible for revisions and she stated no, that it was a nursing measure. The MDS Coordinator stated that falls were reviewed in an Interdisciplinary Team (IDT) meeting, and the ICCP was revised with approval of nursing after reviewing notes and incident reports and that was handled by nursing. On 9/27/24 at 10:33 AM, the IP/RN in the presence of the Licensed Nursing Home Administrator (LNHA), [NAME] President of Operations Bridge Care, and survey team acknowledged that Resident #21's ICCP was revised after the first and second falls, but it was not revised after the third and fourth fall. A review of the facility's Care Plans, Comprehensive Person-Centered policy dated December 2016, did not include care plan revisions. NJAC 8:30-27.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 Complaint NJ #: 175738 Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) obtain weekly weights as ordered; and b.) obtain a physician's order to hold a tube feeding (therapeutic nutrition) in accordance with professional standards of practices. This deficient practice was identified for 2 of 18 residents reviewed for professional standards of practice (Resident #103 and Resident #301). Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The deficient practice was evidenced by the following: 1. On 9/23/24 at 7:24 PM, the surveyor reviewed the closed medical record for Resident #103. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included but not limited to; fracture of left femur (thigh bone), left knee osteoarthritis, generalized muscle weakness, and anemia (low iron). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 5/28/24, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated a moderately impaired cognition. A review of the Order Summary Report dated active orders as of 5/21/24, included a physician's order (PO) dated 5/21/24, for weekly weights every Tuesday. A review of the corresponding May and June 2024 Medication Administration Records (MAR) revealed the weekly weights were blank on 5/28/24 and 6/6/24. A review of the Weights and Vitals Summary included one weight for 5/22/24, of 195 pounds. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 11:49 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN), who stated when a resident was admitted to the facility, their weight was taken upon admission, then a weekly weight was obtained. The IP/RN stated that the Certified Nursing Aides (CNA) obtained the weight, wrote the weight on a list and gave it to the nurse to enter the weight in the Electronic Health Record (EHR). The IP/RN stated that the weight was either recorded in the Weights and Vitals or on the MAR. On 9/26/24 at 12:06 PM, the surveyor interviewed the Registered Dietitian (RD), who stated that orders were put in for weekly weights, and the staff was expected to obtain weekly weights and document on the MAR. The RD stated that the facility was aware that the nurses were either not obtaining or not documenting weekly weights for residents, since there were blanks on the MAR. On 9/27/24 at 10:23 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the IP/RN, [NAME] President of Operations Bridge Care (VPO), and survey team, confirmed that Resident #103's weights were not obtained weekly as ordered. The LNHA acknowledged that the weights should have been obtained weekly as ordered. A review of the facility provided Weight Assessment and Intervention policy dated revised March 2022, included residents are weighed upon admission and at intervals established by the interdisciplinary team such as: weekly for four, then weekly for four weeks, then monthly unless otherwise indicated, or as ordered . weights are recorded in each individual's medical record . 49094 2. On 9/23/24 at 7:05 PM, during initial tour of the facility, the surveyor observed Resident #301 sleeping in bed with the Resident Representative (RR) by their bed side. The RR stated that the resident had not been eating well and a feeding tube (a tube surgically inserted into the stomach to provide nutrition; FT) was inserted to provide supplemental nutrition. The surveyor observed the FT pump located on a pole near the resident's bed. There was no formula being administered at that time. On 9/24/24 at 11:10 AM, the surveyor reviewed the medical record for Resident #301. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses including but not limited to; dysphagia (difficulty with swallowing), gastrostomy (FT) malfunction, and adult failure to thrive (weight loss, decreased appetite, poor nutrition, and inactivity). A review of the most recent MDS dated [DATE], reflected the resident had a BIMS score of 6 of out of 15, indicating a severe impairment in cognition. A review of Section K indicated Resident #301 had a FT and received mechanically altered diet. A review of the Physician Order Summary Report reflected a physician's order (PO) with a start date of 9/19/24, for Osmolite 1.5 calorie (nutrition formula) with a start start time of 6:00 PM (6 PM), to administer 40 milliliters (ml) per hour until 800 ml has been infused. There was also a PO with a start date of 9/14/24, to administer water flushes every six hours 150 ml every shift for water flushes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 11:40 AM, the surveyor observed Resident #301 lying in bed awake. The surveyor asked the resident if they ate breakfast that morning, and the resident, who seemed confused, replied yes. The surveyor observed a 1000 ml bottle of Osmolite 1.5 calorie and a water flush bag hanging on the FT pole near the resident's bed. The pump was turned off and the tube feeding was not connected to the resident. The bottle of Osmolite had 600 ml remaining in the bottle, and was dated for 9/23/24, and timed for 10:00 PM. On 9/24/24 at 11:53 AM, the surveyor observed Resident #301 in their wheelchair being escorted by the Certified Nursing Aide (CNA) to a common area where Resident #301 started watching television. Resident #301 was not receiving any tube feeding at that time. On 9/24/24 at 12:01 PM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that Resident #301's tube feeding started at 6 PM, and ran until the resident received a total volume of 800 ml. The LPN and surveyor proceeded to the resident's room where the LPN confirmed that the tube feeding was hanging on the feeding pole and not being infused at that time. The LPN confirmed that there was only 400 ml missing from the Osmolite. The LPN acknowledged that the resident's tube feeding at a rate of 40 ml per hour would take until 2:00 PM (2 PM) to reach a total volume of 800 ml infused. The LPN then stated that they may be holding the tube feeding because Resident #301 was scheduled for a kidney, ureter, and bladder (KUB) X-ray (imaging test that examines the urinary and gastrointestinal system) today. The LPN stated there should be an order to hold the tube feeding. At that time, the surveyor and LPN reviewed the resident's EHR, and the LPN confirmed there was no physician's order to hold the tube feeding and said she was going to call Resident #301's physician to clarify if the tube feeding should be held. On 9/24/24 at 12:36 PM, the surveyor interviewed the LPN, who stated that she spoke with the resident's Nurse Practitioner (NP) who was aware of the tube feeding being held due to the KUB X-ray scheduled for today. The LPN stated that the NP was going to put in an order to hold the tube feeding. On 9/26/24 at 9:57 AM, the surveyor reviewed the physician order's which revealed a PO dated 9/24/24 at 12:41 PM, to hold tube feeding until KUB results. On 9/26/24 at 10:09 AM, the surveyor reviewed the Progress Notes which included a Physician/Practitioner Progress Note created on 9/24/24 at 3:21 PM, that documented the KUB X-ray was ordered and the tube feeding was on hold until KUB was obtained. The LPN created a progress note on 9/24/24 at 4:28 PM, which indicated that the tube feeding was on hold until KUB results were returned. The doctor and nutritionist were notified. On 9/26/24 at 10:40 AM, the surveyor interviewed the Charge Nurse (CN), who acknowledged that there should have been a physician's order to hold the tube feeding. The CN also stated the physician's order should have been obtained prior to holding the resident's feeding. On 9/27/24 at 10:24 AM, the IP/RN in the presence of the LNHA, VPO, and survey team, stated there should have been a physician's order to hold the tube feeding. The IP/RN acknowledged that the physician's order to hold the tube feeding should have been obtained at the time the KUB X-ray was ordered to ensure the nurses were aware to hold the tube feeding. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Licensed Practical (Vocational) Nurse (LPN)/(LVN) job description with a revision date of May 2022, included to transcribe telephone, verbal, and telemedicine orders from providers as appropriate . A review of the facility's Charting and Documentation policy with a revision date of 2001, included all services provided to the resident, progress toward the care plan goals, or any changes in the residents medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315482	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Moorestown	895 Westfield Road Moorestown, NJ 08057

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 49094 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to obtain daily weights for 7 out of 20 daily weights ordered for a resident with congestive heart failure that required daily weights to monitor fluid retention. This deficient practice was identified for 1 of 1 resident reviewed for respiratory care (Resident #302), and was evidenced by the following: On 9/23/24 at 7:39 PM, during initial tour of the facility, the surveyor observed Resident #302 in their bedroom lying in bed watching television. Resident #302 was receiving oxygen via a nasal cannula (tubing that administers oxygen through the nose). On 9/25/24 at 11:16 AM, the surveyor reviewed the medical record for Resident #302. A review of the Admission Record face sheet (an admission record) reflected that the resident was admitted to the facility with diagnoses including but not limited to; acute and chronic respiratory failure with hypercapnia (body cannot get rid of carbon dioxide which prevents blood cells from carrying oxygen), asthma (inflammation and narrowing of the airways), chronic kidney disease (damaged kidneys that cannot filter the blood properly), and acute on chronic diastolic (congestive) heart failure (heart muscle does not pump blood as well as it should). A review of the most recent Minimum Data Set (MDS), an assessment tool dated 9/10/24, reflected the resident had a brief interview for mental status score of 10 of out of 15, which indicated a moderately impaired cognition. A review of Section I indicated that the resident had an active diagnosis of heart failure. A review of the Physician Order Summary Report reflected a physician's order (PO) dated 9/5/24, for weight daily in the morning for congestive heart failure (CHF). A review of the Weights and Vital Summary from 9/5/24 to 9/25/24, reflected there were no daily weights taken on 9/5/24, 9/6/24, 9/7/24, 9/8/24, 9/9/24, 9/14/24, and 9/18/24. A review of the individualized comprehensive care plan (ICCP) initiated on 9/5/24, indicated a focus area for edema/excess fluid volume related to cardiac disease, peripheral vascular disease, and renal disease. Interventions included to report signs and symptoms of edema/fluid overload such as change in mental status; weight gain; neck vein distention; abnormal lung sounds; and extremity swelling. On 9/25/24 at 12:36 PM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated the resident was weighed daily because they had a diagnosis CHF, so it was important to monitor their weights daily to ensure they were not retaining fluid and going into fluid overload (occurs when the heart is unable to pump enough blood, causing fluid to build up in the body). At that time, the surveyor and the LPN reviewed the resident's Electronic Medical Record (EMR), and the LPN confirmed that there were no daily weights obtained on 9/5/24 to 9/9/24, 9/14/24, and 9/18/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 12:55 PM, the surveyor interviewed the Charge Nurse (CN), who stated that the resident had an order for daily weights as of 9/5/24, because they have CHF. The CN reviewed the EMR, and confirmed that daily weights did not start until 9/10/24, and that no weights were obtained on 9/14/24 and 9/18/24. The CN stated that the importance of weighing the resident daily was to determine if they were retaining fluid, because if they were retaining fluids, it could mean the resident's CHF was worsening. The CN stated if the resident had a weight gain, we notified the physician. On 9/27/24 at 10:24 AM, the Infection Preventionist/Registered Nurse (IP/RN) in the presence of the Licensed Nursing Home Administrator (LNHA), [NAME] President Operations Bridge Care, and survey team, acknowledged the facility did not obtain daily weights as ordered for Resident #302. The IP/RN confirmed the resident was being monitored daily to ensure their weight was being maintained and not fluctuating to ensure no extra weight gain. The IP/RN stated that if there was any extra weight, it could lead to fluid overload. A review of the facility's Licensed Practical (Vocational) Nurse (LPN)/(LVN) job description with a revision date of May 2022, included monitor resident weight and intake of food and fluids; notify the practitioner of significant weight loss or gain or changes in consumption . A review of the facility's Certified Nursing Assistant job description with a revision date of 2003, included weigh and measure residents as instructed . A review of the facility provided Weight Assessment and Intervention policy dated revised March 2022, included residents are weighed upon admission and at intervals established by the interdisciplinary team such as: weekly for four, then weekly for four weeks, then monthly unless otherwise indicated, or as ordered . weights are recorded in each individual's medical record . NJAC 8:39-27.1(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40744 Based on observations, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure catheter care was performed and documented every shift in accordance with a physician's order. This deficient practice was identified in 1 of 2 residents reviewed for urinary catheters (Resident #44), and was evidenced by the following: On 9/23/24 at 7:05 PM, during the initial tour of the facility, Resident #44 was in the bed with their eyes closed. The surveyor did not observe a urinary catheter. On 9/24/24 at 9:00 AM, the surveyor reviewed the medical record for Resident #44. A review of the Admission Record face sheet (an admission summary) reflected the resident had medical diagnoses which included but were not limited to; acute kidney failure, obstructive uropathy (structural or functional hindrance of normal urine flow), and repeated falls. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 9/2/24, reflected the resident had a Brief Interview of Mental Status of 11 of 15, which indicated moderately impaired cognition. A review of section H, bladder and bowel indicated the resident had an indwelling urinary catheter (a tube inserted into the bladder to allow urine to drain). A review of the physician orders (PO) included a PO dated 8/27/24, for urinary catheter care every shift. On 9/24/24 at 9:00 AM, the surveyor reviewed the facility's Charting and Documentation policy dated July 2017, which included all services provided to the resident or changes in the residents' condition shall be documented in the resident's medical record. At that time, the surveyor reviewed the facility's Urinary Catheter Care policy dated August 2022, which included insertion and maintenance of the urinary catheter and assessing for complications . On 9/24/24 at 10:12 AM, the surveyor observed the resident in the bed. There was a urinary drainage bag hanging on the right side of the bed, and the drainage bag was in a light grey privacy bag. The resident told the surveyor they had the catheter for awhile. The surveyor asked if they used a machine to check the bladder, and the resident responded yes. On 9/24/24 at 11:01 AM, the surveyor reviewed the resident's individualized comprehensive care plan (ICCP) which included a focus area dated 8/27/24, for the use of an indwelling urinary catheter related to obstructive uropathy, urinary retention. Interventions included change catheter per physician order, change collection bag as needed and report signs of infection to the physician. On 9/24/24 at 11:30 AM, the surveyor reviewed the September 2024 Treatment Administration Record (TAR) which included the PO for catheter care every shift (three times daily). The TAR revealed that from 9/1/24 through 9/23/24, catheter care was not documented as rendered eleven times. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 10:35 AM, the Licensed Nursing Home Administrator (LNHA) and [NAME] President of Operations Bridge Care (VPO), in the presence of the Infection Preventionist/Registered Nurse (IP/RN) and survey team, both stated that if it was not documented, it was not done in reference to Resident #44's missing documentation for catheter care in the TAR. NJAC 8:39-27.1 (a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49094 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to a.) store nebulizer equipment in a manner to prevent the spread of infection for 1 of 1 residents reviewed for respiratory care (Resident #302); and b.) administer and accurately document breathing exercises using an incentive spirometer tool as ordered by the physician for 3 of 4 residents reviewed for incentive spirometry therapy (Resident #5, Resident #401, and Resident #402). This deficient practice was evidenced by the following: 1. On 9/23/24 at 7:39 PM, during initial tour of the facility, the surveyor observed Resident #302 in their bedroom lying in bed watching television. The surveyor observed the nebulizer machine with attached face mask and tubing lying directly on the resident's nightstand. The nebulizer tubing and face mask were not in use, and not placed in a bag which exposed both to air and contamination. On 9/25/24 at 11:16 AM, the surveyor reviewed the medical record for Resident #302. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses including but not limited to; acute and chronic respiratory failure with hypercapnia (body cannot get rid of carbon dioxide which prevents blood cells from carrying oxygen), asthma (inflammation and narrowing of the airways), chronic kidney disease (damaged kidneys that cannot filter the blood properly), and acute on chronic diastolic (congestive) heart failure (heart muscle does not pump blood as well as it should). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 9/10/24, reflected the resident had a brief interview for mental status (BIMS) score of 10 of out of 15, indicating a moderately impaired cognition. A further review indicated the resident received continuous oxygen therapy. A review of the Physician Order Summary Report reflected a physician's order dated 9/13/24, for albuterol sulfate nebulization solution 2.5 milligram per 3 milliliter (2.5 mg/3 ml) 0.083%; inhale one vial orally via nebulizer every six hours for shortness of breath (SOB). On 9/26/24 at 10:25 AM, Resident #302 was observed sitting in their wheelchair watching television in their bedroom. The resident stated that they received a nebulizer treatment that morning. The surveyor observed the nebulizer mask in the opened top drawer of the nightstand. The mask was uncovered and exposed to air. On 9/26/24 at 10:35 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that when a resident completed a nebulizer treatment, the nebulizer mask should be stored in a plastic bag to keep it clean. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/26/24 at 10:38 AM, the surveyor accompanied by the LPN went to Resident #302's room and the LPN confirmed that the resident's nebulizer mask was in the nightstand drawer, not in a bag and exposed to air. The LPN stated that it should not be stored in the drawer like that, it should be stored in a plastic bag. On 9/26/24 at 10:45 AM, the surveyor interviewed the Charge Nurse (CN) who stated when the nebulizer treatment was completed, the mask was cleaned, dried, and placed in the clear plastic bag to help prevent infection. On 9/27/24 at 10:24 AM, the Infection Preventionist/Registered Nurse (IP/RN) in the presence of the Licensed Nursing Home Administrator (LNHA), [NAME] President Operations Bridge Care (VPO), and survey team, stated that it was important to store the nebulizer mask in a bag to keep it clean, dust free, and for infection control purposes. A review of the facility's Administering Medications through a Small Volume (handheld) Nebulizer with a revision date of October 2010, included the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Steps in the procedure .when equipment is completely dry, store in a plastic bag with the resident's name and the date on it . 45208 2. On 9/24/24 at 12:00 PM, the surveyor reviewed the medical record for Resident #5. A review of the Admission Record face sheet reflected the resident was admitted to the facility with medical diagnoses which included but not limited to; displaced fracture of base of neck of left femur and the presence of left artificial hip. A review of the most recent quarterly MDS dated [DATE], reflected the resident had a BIMS score of 13 of 15, which indicated a fully intact cognition. A review of the September 2024 Order Summary Report (OSR) included a PO dated 7/27/24, for a incentive spirometry (a device used for breathing exercise; IS); do five sets of five repetitions, cough between sets. On 9/24/24 at 1:44 PM, the surveyor observed Resident #5 lying in bed and did not see an IS in the room. The surveyor asked the resident if they used an IS, and the resident stated that they had never received an IS, and they were never taught how to use one since their admission to the facility. On 9/24/24 at 2:15 PM, the surveyor continued to review the resident's medical record. A review of the July 2024, August 2024, and September 2024 Medication Administration Records (MAR) revealed that the nurses were signing that the resident used the IS for times a day at 9:00 AM (9 AM), 1:00 PM (1 PM), 5:00 PM (5 PM), and 9:00 PM (9 PM). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 10:11 AM, surveyor interviewed the IP/RN, who acknowledged that Resident #5 did not have an IS, and the nurses should not have been signing off that the resident used one four times a day. The IP/RN stated that the IS should be used as ordered to prevent pneumonia and respiratory complications for post-surgical residents. On 9/25/24 at 12:25 PM, surveyor accompanied by the Unit Manager/Licensed Practical Nurse (UM/LPN), showed Resident #5 an IS, and the resident confirmed they did not have one and were not taught how to use on. On 9/25/24 at 12:36 PM, the surveyor interviewed the UM/LPN, who stated that she expected staff to train the resident how to use an IS, watch the resident use the IS to ensure the proper use, and then sign the MAR after the resident used it. The UM/LPN acknowledged that Resident #5 was cognitively intact so if they stated they were not given an IS, they would know. On 9/26/24 at 12:34 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that he expected all staff to follow all facility policies. 3. On 9/23/24 at 7:00 PM, the surveyor reviewed Resident #401's medical record. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with medical diagnoses which included but not limited to; nontraumatic subarachnoid hemorrhage (intracranial bleeding within the subarachnoid space, which lies between the arachnoid and [NAME] mater overlying the brain). A review of the most recent comprehensive MDS dated [DATE], reflected the resident had a BIMS score of 13 out of 15, which indicated a fully intact cognition. A review of the September 2024 OSR included a PO dated 9/13/24, for IS, do five sets of five repetitions four times a day for prevention of pneumonia due to deconditioning. On 9/23/24 at 7:52 PM, the surveyor observed Resident #401 sitting in a wheelchair conversing with another resident. The resident stated they never received an IS or was taught how to use one. On 9/24/24 at 9:00 AM, the surveyor continued to review the medical record. A review of the September 2024 MAR reflected that the nurses were signing daily that the resident used the IS at 9 AM, 1 PM, 5 PM, and 9 PM. On 9/25/24 at 10:11 AM, the surveyor interviewed the IP/RN, who acknowledged that Resident #401 did not have an IS, and the nurses should not have been signing off that the resident used one four times a day. The IP/RN stated that the IS should be used as ordered to prevent pneumonia and respiratory complications for post-surgical residents. On 9/25/24 at 12:25 PM, surveyor accompanied by the UM/LPN, showed Resident #401 an IS, and the resident confirmed they did not have one and were not taught how to use on. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 12:36 PM, the surveyor interviewed the UM/LPN, who stated that she expected staff to train the resident how to use an IS, watch the resident use the IS to ensure the proper use, and then sign the MAR after the resident used it. The UM/LPN acknowledged that Resident #401 was cognitively intact so if they stated they were not given an IS, they would know. On 9/26/24 at 12:34 PM, the surveyor interviewed the LNHA, who stated that he expected all staff to follow all facility policies. 4. On 9/23/24 at 7:10 PM, the surveyor reviewed the medical record for Resident #402. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with medical diagnoses which included but not limited to; unilateral inguinal hernia with obstruction without gangrene (a condition where abdominal contents protrude through the inguinal canal, and the herniated contents are obstructed but not gangrenous). A review of the most recent comprehensive MDS dated [DATE], reflected the resident had a BIMS score of 14 out of 15, which indicated a fully intact cognition. A review of September 2024 OSR included a PO dated 9/6/24, for IS, do five sets of five repetitions four times a day for lung expansion. On 9/23/24 at 8:10 PM, the surveyor observed Resident #402 who was sitting in a wheelchair conversing with another resident. The resident stated that they did not have an IS and were not trained on how to use it. On 9/24/24 at 9:30 AM, the surveyor continued to review the resident's medical record. A review of the September 2024 MAR which revealed the nurses were signing daily that the resident used the IS at 9 AM, 1 PM, 5 PM, and 9 PM. On 9/25/24 at 10:11 AM, the surveyor interviewed the IP/RN, who acknowledged that Resident #402 did not have an IS, and the nurses should not have been signing off that the resident used one four times a day. The IP/RN stated that the IS should be used as ordered to prevent pneumonia and respiratory complications for post-surgical residents. On 9/25/24 at 12:25 PM, surveyor accompanied by the UM/LPN, showed Resident #402 an IS, and the resident confirmed they did not have one and were not taught how to use on. On 9/25/24 at 12:36 PM, the surveyor interviewed the UM/LPN, who stated that she expected staff to train the resident how to use an IS, watch the resident use the IS to ensure the proper use, and then sign the MAR after the resident used it. The UM/LPN acknowledged that Resident #402 was cognitively intact so if they stated they were not given an IS, they would know. On 9/26/24 at 12:34 PM, the surveyor interviewed the LNHA, who stated that he expected all staff to follow all facility policies. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated Incentive Spirometry policy included policy statement: Patients who have had recent operative procedures will be taught deep breathing exercises with an IS to encourage lung expansion and reduce post operative respiratory complications. Purpose statement: to optimize lung inflation, cough mechanism, improve inspiratory muscle performance, prevent and/or correct atelectasis and promote bronchial hygiene. IS can be cost-effective way to avoid more aggressive bronchial hygiene modalities. General Purpose statement: IS shall be performed by a licensed caregiver that has demonstrated the required competencies. Direct supervision is required until the resident has demonstrated mastery of the technique, understands the modality and realistic volume goals. Optimal results achieved when the patient is given pretreatment instruction. Process: 1) Verify physicians order, 2) obtain disposable IS and label with resident's name and date, 9) assess residents heart rate, breath sounds and cough, 11) provide instruction to resident . A review of the facility's Charting and Documentation, dated July 2017, included .the following information is to be documented in the resident's medical record; b) medications administered, c) treatments and services performed . NJAC 8:39-27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 40744 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure a resident who received hemodialysis was being assessed in accordance with their hemodialysis access site and professional standards of practice every shift; and b.) complete dialysis communication forms on return to the facility from dialysis treatment. This deficient practice was identified for 1 of 1 resident reviewed for hemodialysis (Resident #48) and was evidenced by the following: A review of the facility's Hemodialysis Pre and Post Care, the policy dated revised March 2010, included .the routes of dialysis treatments are to be monitored for complications, treatment sites are to be assessed regularly including pre and post dialysis treatment, and the access arm should not be used for venipuncture or blood pressures .the graft should be assessed upon return to the facility for patency and any unusual redness or swelling . On 9/23/24 at 7:01 PM, during initial tour of the facility, Resident #48 was observed sitting on the side of the bed. The resident stated that they went to dialysis (removes waste products and excess fluid from the blood when the kidneys no longer function properly) on Mondays, Wednesdays, and Fridays. The resident then told the surveyor that they had an access site (a surgically created entry point into the bloodstream that allows blood to be removed and returned during dialysis treatment) for dialysis in the left arm. On 9/24/24 at 9:15 AM, the surveyor reviewed the medical record for Resident #48. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included but were not limited to; end stage renal disease (ESRD), heart failure, and dependence on renal dialysis. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 9/9/24, reflected that the resident had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, meaning the resident was cognitively intact. A further review indicated that the resident received dialysis treatments. A review of the September 2024 Order Summary Report included the following physician's orders (PO) related to dialysis: a PO dated 9/2/24, for ESRD dialysis every Monday, Wednesday, and Friday with a 10:00 AM pick-up time. There were no orders related to the dialysis access site or orders to check for a bruit or thrill (a nursing assessment which shows the arteriovenous (AV) graft (surgically placed shunt that connects an artery to a vein in preparation for dialysis) is functioning). A review of the individualized comprehensive care plan (ICCP) included a focus area dated 9/4/24, that the resident had the potential complications related to left arm fistula (vessel formed by joining a vein to an artery in your arm during an operation to form an accessible blood vessel that gives increased flows of blood that are adequate for dialysis). Interventions included to change dressing site per physician orders and as needed; and to report signs and symptoms of infection such as redness, swelling, drainage, tenderness to touch, and fever. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 10:55 AM, the surveyor reviewed the dialysis communication book (a tool used for the facility to communicate with the dialysis center). A review of the Dialysis Center Communication Record revealed that the section Post-treatment, which was completed by the facility after the resident returned from dialysis, was not completed on 9/4/24, 9/9/24, 9/11/24, 9/13/24, 9/18/24, and 9/20/24. On 9/24/24 at 11:05 AM, the surveyor interviewed the Charge Nurse (CN), who stated that it was the facility's responsibility to assess the resident upon return to the facility from dialysis which included but not limited to; obtaining vital signs, assessing for injuries, assessing for pain, provide a meal, and complete the Dialysis Communication Record. At that time, the surveyor and the CN reviewed the resident's dialysis communication book, and the CN confirmed that the six forms were not completed upon return from dialysis, and she could not speak to why. On 9/25/24 at 11:30 AM, the surveyor reviewed Resident #48's Electronic Medical Record (EMR) blood pressure documentation for the month of September 2024. The resident had their blood pressure checked a total of 50 times. Out ff the 50 times, it was documented that the blood pressure was checked 18 times for the resident's left arm which contained their AV fistula. On 9/25/24 at 11:45 AM, the surveyor interviewed the Registered Nurse (RN), who stated that the resident had a left arm AV graft. The surveyor asked what that would mean for the staff caring for the resident, and the RN replied, No blood pressures in that arm, the AV graft could clot, and we check it for function. The surveyor then asked the RN to review the blood pressures in the EMR, who confirmed the resident's blood pressures were documented as obtained from both the left and right arms. The RN stated maybe it was a mistake the documented blood pressures in the left arm. The RN acknowledged that there was no documentation that the nurses were checking the resident's bruit and thrill. On 9/27/24 at 10:38 AM, the Infection Preventionist/RN (IP/RN), in the presence of the Licensed Nursing Home Administrator (LNHA), [NAME] President of Operations Bridge Care, and survey team stated that physician added an order to check the dialysis access for bruit and thrill after surveyor inquiry, and confirmed staff should have completed the dialysis communication forms upon the resident's return from dialysis. The IP/RN stated that the nurses should be aware not take blood pressure from the arm with the dialysis access site but sometimes they were rushing. NJAC 8:39-27.1(a)

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	315482	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Moorestown	895 Westfield Road Moorestown, NJ 08057

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 44833 Based on interview and review of pertinent facility documents, it was determined that the facility failed to conduct yearly performance reviews of Certified Nursing Aides (CNA) to provide specific education based on the outcomes of the reviews. This deficient practice was identified for 4 of 5 CNAs reviewed for education (CNA #1, #2, #3, and #4), and was evidenced by the following: During entrance conference on 9/23/24 at 6:55 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to provide a list of all the facility's CNAs with their date of hire. On 9/25/24 at 12:10 PM, the surveyor requested from the LNHA to provide all education from 2023 and the most recent performance evaluation for five selected CNAs (CNA #1, #2, #3, #4, and #5). On 9/26/24 at 9:40 AM, the surveyor reviewed the performance evaluations provided by the LNHA which revealed the following: CNA #1 was hired on 9/23/20. The last performance evaluation was completed 2022, and signed by the employee with no date of signature documented. CNA #2 was hired on 10/30/19. The last performance evaluation was completed September 2021, and signed by the employee on 11/12/21. CNA #3 was listed as hired on 11/7/22. The facility did not provide the surveyor with a performance evaluation for this CNA. CNA #4 was listed as hired on 10/10/22. The facility did not provide the surveyor with a performance evaluation for this CNA. On 9/26/24 at 10:54 AM, the surveyor interviewed the LNHA who stated that the most recent evaluations and performance reviews he could find were provided. The LNHA further stated that CNA #3 and #4 were re-hired, but he was unable to provide any documentation. At that time, the surveyor requested a performance evaluation policy. On 9/26/24 at 12:37 PM, [NAME] President of Operations Bridge Care (VPO), in the presence of the LNHA, Infection Preventionist/Registered Nurse (IP/RN), and survey team confirmed that performance evaluations should be completed annually. At that time, the surveyor requested for a second time, that the facility provide documentation that CNA #3 and CNA #4 were not hired on 11/7/22 and 10/10/22, respectively as documented on the list provided, or their last performance evaluations. On 9/26/24 at 10:23 AM, the LNHA, in the presence of the VPO, IP/RN, and survey team stated that the importance of performance evaluations was for staff improvement and education to identify areas of concern. The facility did not provide any additional information or policies. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-43.17(b)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44833 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: a.) ensure the accountability of the narcotic shift count logs were completed; b.) accurately account for and document the administration of controlled medications; and c.) ensure medications were stored appropriately in accordance with professional standards of practice. This deficient practice was identified on 2 of 2 medication carts reviewed for medication storage, and was evidenced by the following: 1. During medication storage review on 9/24/24 at 10:08 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN #1), reviewed the [NAME] nursing unit's medication cart's August and September 2024 New Jersey Control Drug Index (a shift-to-shift controlled substance and narcotics (narc) count sheet signed by the incoming and outgoing nurses each shift) which revealed the following: The narcotic counts Cards, Packs, Bottles and nursing signatures were blank for the incoming nurse for the following shifts: For the day shift (7:00 AM to 3:00 PM) on: 8/2, 8/11, 8/25, 9/4, and 9/10. For the evening shift (3:00 PM to 11:00 PM) on: 8/2, 8/10, 8/11, 8/16, 8/25, 9/1, 9/2, 9/4, 9/5, 9/6, and 9/22. For the overnight shift (11:00 PM to 7:00 AM) on: 8/10, 8/11, 9/3, 9/5, and 9/22. The narcotic counts Cards, Packs, Bottles and nursing signatures were blank for the outgoing nurse for the following shifts: For the day shift on: 8/2, 9/4, 9/6, and 9/10. For the evening shift on: 8/2, 8/3, 8/4, 8/11, 8/25, 9/4, and 9/5. For the overnight shift on: 8/2, 8/10, 8/11, 8/15, 9/1, 9/2, 9/3, 9/5, 9/6, 9/15, and 9/22. Further review of cart revealed the individual resident Controlled Drug Administration Record logs (declining inventory) indicated the 9:00 AM (9 AM) doses of clonazepam (a controlled medication used to treat anxiety or seizures) 1 milligram (mg) tablet for Resident #204 and alprazolam (a controlled medication used to treat anxiety) for Resident #21 were not signed out on the residents' individual medication administration records corresponding with those medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At the time of observation, the surveyor interviewed LPN #1, who stated she did not sign the declining inventory sheets for Resident #21 and Resident #204's 9 AM controlled medications because she got distracted. LPN # 1 showed the surveyor that those doses were signed out as being administered in the electronic Medication Administration Record (MAR), but were not accounted for on the declining inventory sheets. LPN #1 further acknowledged that there should be no missing documentation on the narcotic or controlled substance logs, including the shift-to-shift count sheets; that the incoming and outgoing nurses should be counting the narcotics together and signing the log together to acknowledge the count was correct and accurate. On 9/24/24 at 10:58 AM, the surveyor, in the presence of LPN #2, reviewed the Maple Shade nursing unit's medication cart's August and September 2024 New Jersey Control Drug Index logs which revealed the following: The narcotic counts Cards, Packs, Bottles and nursing signatures were blank for the incoming nurse for the following shifts: For the day shift on: 8/4. For the evening shift on: 8/2, 8/4, 8/6, 8/11, and 8/31. For the overnight shift on: 8/6, 8/23, and 9/8. The narcotic counts Cards, Packs, Bottles and nursing signatures were blank for the outgoing nurse for the following shifts: For the day shift on: 8/7, 9/9, 9/22, and 9/23. For the evening shift on: 8/12, 8/17, and 8/31. For the overnight shift on: 8/2, 8/4, and 8/6. At the time of observation, LPN #2 stated that the shift-to-shift count sheets should be completed at the time of shift change and the count was done by the incoming and outgoing nurses. She further acknowledged that there should be no missing documentation on the narcotic count sheets. On 9/24/24 at 11:39 AM, the surveyor interviewed the LPN/Charge Nurse (LPN/CN) who stated narcotic count shift-to-shift logs should be completed and should have no missing documentation. The LPN/CN stated that individual declining inventory sheets should be completed at the time the controlled medication was removed from inventory, and there should be no missing documentation. On 9/24/24 at 12:01 PM, the surveyor interviewed the Director of Nursing (DON), who stated that the shift-to-shift narcotic count log should have been completed by the incoming and outgoing nurses at the time the count was performed at shift change. The DON stated there should be no missing documentation or signatures on the narcotic count logs because it was for accountability. The DON further acknowledged that the declining inventory logs should be completed and filled out for each narcotic dose dispensed immediately at the time the medication was removed from inventory. The DON acknowledged that if it was not documented it's not done. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 9/24/24 at 10:08 AM, the surveyor, in the presence of LPN #1 reviewed the [NAME] nursing unit's medication cart. The surveyor observed four unidentifiable, loose medication pills of varying shapes, colors, and sizes in the medication cart drawer. At that time, LPN #1 stated there should be no loose pills in the medication cart. On 9/24/24 at 12:01 PM, the surveyor interviewed the DON who stated that there should be no loose pills in the medication carts and that it was the nurse's responsibility to ensure the cart was organized and clean. A review of the facility's Controlled Substance policy with a revision date November 2022, included .1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: A. Records of personnel access and usage. B. Medication administration records. C. Declining inventory records, and D. Destruction, waste and return to pharmacy records. 3. Staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to their director of nursing services . A review of the facility's undated Medication Labeling and Storage policy included .1. medications and biologicals are stored in the packaging containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff is responsible for maintaining medication storage and preparation areas. In a clean, safe and sanitary manner . NJAC 8:39-29.4, 29.7(c)