STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315515	A. Building B. Wing	07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium at Navesink Harbor, The	40 Riverside Avenue Red Bank, NJ 07701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48423 Based on observation, interview, and record review, it was determined that the facility failed to complete a fall investigation for 1 of 2 residents (Resident #1) reviewed for falls. This deficient practice was evidenced by the following: On 6/29/23 at 9:59 AM, the surveyor observed Resident #1 ambulating with a walker with a staff member. On that same day at 10:03 AM, the surveyor observed the resident seated a table with another resident. The resident had a wander guard to the left ankle. The surveyor reviewed the medical record for Resident #1. Review of the face sheet (an admission summary) indicated that the resident was admitted to the facility on [DATE], with diagnoses which included but not limited to dementia with behavioral disturbances, paroxysmal atrial fibrillation, Alzheimer's disease and repeated falls. Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 6/16/2023, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severe cognitive impairment. On 06/29/23 at 12:11 PM, the surveyor reviewed the electronic Progress Notes (ePN) which indicated that the resident had falls on the following dates: 11/22/22, 12/6/22, 12/21/22, and 12/24/22. On 7/6/23 at 9:40 AM, the surveyor requested fall investigations for the above corresponding falls from the Director of Nursing (DON). On that same day, the DON provided the surveyor with three fall investigations for 11/22/22, 12/6/22, and 12/21/22. There was no fall investigation provided for the 12/24/22 status post fall. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On that same date, the surveyor reviewed the electronic medical record which indicated a fall progress note titled Fall which indicated that the resident had a fall on 12/24/22 at 10:45 AM. Review of the note narrative indicated, RN [Registered Nurse] notified by activity person that resident was calling for help. Observed resident sitting on floor in front of his/her lounge chair. VSS [vital signs stable], no pain on ROM [range of motion], neuro checks WNL [within normal limits], no skin tears or bruising noted. Resident complaint of hitting head on wall. Bumps noted from previous fall-closed, tender to touch. [medical doctor] recommended evaluation at ER [emergency room], daughter and DON notified. Daughter refused transfer to hospital for evaluation. [medical doctor] and [NAME] notified. Will continue to monitor. Further review of the 12/24/22, Fall progress note indicated that existing interventions such as nonslip socks, rollator, and to encourage activities were implemented and new interventions implemented such as appropriate socks at all times, call bell within reach, use rollator when walking at all times. Activities in dining room. Review of the resident's comprehensive individualized care plans reflected a focus area for risk for fall created 9/14/22, with goal(s) not to have any falls with injury through the next review date. Further review of the care plan indicated that it was updated with new interventions status post the 12/24/22 fall. Review of the Fall Risk assessment dated [DATE], indicated a fall score of 14 which indicates a total score above 10 points represents High Risk for Falls. On 7/6/23 at 10:45 AM, the DON stated that she failed to do an incident report and investigate the 12/24/22 fall. She further stated that an incident report should have been done and she did not know what happened, but she will find out what why it wasn't done. On 7/6/23 at 2:00 PM, the survey team met with the Licensed Nursing Home Administrator and the DON and discussed the above findings. On 7/7/23 at 10:58 AM, the DON stated that the Registered Nurse on duty for 12/24/22 told her I can't believe I didn ' t put it into Risk Watch our tracking tool. Review of the facility's policy for Falls Management Program revised 12/22/22 and provided by the DON included under Post fall that post-fall investigation and incident report would be completed and entered into the Risk Watch Analysis and that all falls are investigated and trended for possible causative factors. There was no additional information provided. NJAC 8:39-27.1(a)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40042 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to develop a person-centered baseline care plan for a resident within 48 hours of admission. This deficient practice was identified for 1 of 15 residents reviewed for person-centered baseline care plans (Resident #8) and was evidenced by the following: The evidence was as follows: On 6/28/23 at 10:55 AM, two surveyors observed Resident #8 in a wheelchair on the third activity room. This resident was noted to require assistance at meals. The surveyor reviewed the medical record for Resident # 8. Review of the resident's Face Sheet (an admission record) reflected the resident was admitted on [DATE], with diagnoses that included but were not limited to; Alzheimer's disease, oropharyngeal dysphagia (difficulty swallowing) and hypothyroidism. Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/22/23 reflected a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated the resident's cognition was severely impaired. It further reflected that the resident was totally dependent and required the physical assistance of one person for the task of eating. Review of the Physician's Orders (POs) from both the electronic medical record (EMR) and the paper chart for May 2023 included a PO dated 5/15/23, to weigh the resident weekly for four weeks. Review of the resident's EMR and paper chart revealed there was no documented evidence that a person-centered baseline care plan was initiated for resident #8. Further review of the Care Plan Report initiated on 5/23/23, included a nutrition care plan which was created on 7/3/23 by the RD. On 7/06/23 at 9:37 AM, the surveyor interviewed the Registered Dietitian (RD) in the presence of the survey team. She stated that she typically initiated a nutrition care plan between five and seven days after admission. The RD acknowledged that there was no documented evidence of a nutrition care plan in the EMR for Resident #8 until 7/3/23. On 7/06/23 at 12:01 PM, the surveyor interviewed the covering Registered Nurse/MDS Coordinator in the presence of the survey team. The MDS Coordinator reviewed the EMR for Resident #8 in the presence of the surveyor and acknowledged that there was no documented evidence of a baseline care plan for Resident #8 and that the nutritional care plan was not initiated until 7/3/23, which was out of the regulatory time frame. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/07/23 at 11:03 AM, the survey team met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The DON presented the surveyor with a copy of a baseline care plan that she then acknowlegded had not been initiated until 7/6/23. In addition, she reviewed the EMR in the presence of the surveyor for Resident #8 and acknowlegded that there was no documented evidence that a baseline care plan had been generated. Review of the facility policy Resident Care Plan with a revised date of 6/29/23, included that it is the policy of the facility to ensure that the care planning process was systematic, comprehensive, interdisciplinary and timely and directed toward achieving and maintaining each residents optimal physical, psychosocial and functional status. It further included that the care plan reflects measurable objectives/goals. It also included that interventions should serve as a care guide. NJAC 8:39 - 27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40042 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to identify and address a significant weight loss of 5.5 pounds (lbs.) which was 5.4% in 20 days from admission on 5/15/23 through 6/5/23 and an additional 0.7 lb. loss from 6/5/23 through 7/1/23. The facility failed to: a.) consistently ascertain and monitor weekly weights for 4 weeks after admission and implement weekly weights for 4 weeks after a significant weight loss occurred, b.) obtain a re-weight to verify a significant weight loss, c.) implement a comprehensive admission nutritional assessment and care plan in a timely manner, d.) consistently record and monitor meal consumption, and e.) ensure a recommended nutritional supplement was prescribed and provided to the resident prior to surveyor inquiry. This deficient practice was identified for 1 of 4 residents reviewed for nutrition and resulted in a significant and avoidable weight loss (Resident #8). The evidence was as follows: On 6/28/23 at 10:55 AM, two surveyors observed Resident #8 in a wheelchair on the third activity room. This resident was noted to require assistance at meals. On 6/29/23 at 9:16 AM, the surveyor observed the resident in bed with the head of the bed elevated and eyes closed. The surveyor then observed a completed breakfast tray on the food truck. The resident completed approximately 25% of a four-ounce bowl of bite sized melon, 50% of a four-ounce yogurt, less than 50% of a two-ounce portion of scrambled eggs, less than 50% of a one-ounce portion of ground ham, a minimal amount of an eight-ounce carton of reduced fat milk, 50% of a four-ounce portion of orange juice, a minimal amount of a four-ounce portion of applesauce, and the mug of the hot beverage appeared unopened. On 7/5/23 at 10:05 AM, the surveyor observed the resident in bed with his/her eyes closed. The resident did not rouse for the surveyor. On 7/07/23 at 8:40 AM, the surveyor observed the resident in bed with the head of the bed elevated. The resident's eyes were opened, and he/she smiled at the surveyor. The residents Certified Nurses' Aides (CNA) opened the residents breakfast tray, sat at the bedside and fed Resident #8. The CNA stated that she was familiar with the resident and had a poor appetite. She stated that on a good day the resident consumed 50% of the breakfast meal which could take up to 40 minutes to complete. The CNA stated that the resident could not feed themselves and was sometimes sleepy at the breakfast meal in addition to being confused. She had to remind the resident to open his/her mouth and introduced small sips of fluids and bites of mechanically altered consistency foods. She stated that items on the breakfast tray were typical and included an eight-ounce carton of reduced fat milk, and eight-ounce mug of coffee, a four-ounce portion of strawberry yogurt, a four-ounce portion of applesauce, a four-ounce portion of orange juice, a package of pancake syrup, a pat of margarine, two banana pancakes cut to bite size pieces and two sausage links cut into bite size pieces. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 7/07/23 at 9:10 AM, the surveyor observed the resident motion to the CNA and clearly stated that he/she did not want any more of the meal. The surveyor observed that the resident consumed approximately two ounces of a four-ounce portion of orange juice, five teaspoons of applesauce, one ounce of the eight-ounce carton of reduced fat milk, two ounces of a four-ounce portion of strawberry yogurt, 50% of the sausage links, and 25% of the banana pancakes. The surveyor reviewed the medical record for Resident # 8. Review of the resident's Face Sheet (an admission record) reflected the resident was admitted with diagnoses that included but were not limited to; Alzheimer's disease, oropharyngeal dysphagia (difficulty swallowing) and hypothyroidism. Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/22/23 reflected a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated the resident's cognition was severely impaired. It further reflected that the resident was totally dependent and required the physical assistance of one person for the task of eating. In addition, it reflected that the resident received a mechanically altered diet. Review of the Care Area Assessment (CAA) Summary reflected the decision to care plan for nutritional status. Review of the Physician's Orders (POs) from both the electronic medical record (EMR) and the paper chart for May, June and July 2023, included a PO dated 5/15/23, to weigh the resident weekly for four weeks, a PO dated 5/15/23, for Mirtazapine (a generic form of Remeron) 15 Milligram (mg) tablet (1/2 Tab =7.5 mg) tablet orally for depression, a PO dated 5/18/23, which indicated the residents diet was changed from a Regular to a Mechanically Soft consistency with thin liquids and a PO dated 6/7/23, to discontinue Remeron 7.5 mg. It further included a PO 7/6/23, to provide Boost Breeze (a nutritional supplement), four ounces twice a day with lunch and dinner after surveyor inquiry. There was no PO for weekly weights for four weeks after Resident #8's significant weight loss on 6/5/23. Review of May and June 2023 electronic Treatment Administration Records (eTAR) reflected the PO to weigh the resident weekly for four weeks to start 5/22/23. There was no documented evidence that a weight was obtained weekly on 5/22/23, 5/29/23 and 6/12/23 as ordered. Review of the July 2023 electronic Medication Administration Record (eMAR) included documented evidence that the nutritional supplement Boost Breeze was provided to the resident on 7/6/23 and 7/7/23 at 12:00 PM and on 7/6/23 at 5:00 PM. The surveyor reviewed the weight record in the EMR. Weights documented were as follows: 5/15/23: 102.8 lbs. 6/1/23: 101 lbs. 6/5/23: 97.3 lbs. 7/1/23: 96.6 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the Registered Dietitian's (RD) Admission Nutritional assessment dated [DATE] at 10:05 AM, reflected that the resident was 102.8 lbs. on admission 5/15/23. It included that the resident's intake was variable but usually consumed 50-100%. The document also included a goal for the resident to consume equal to or more than 75% of meals and have no significant weight changes. In addition, it included nutritional interventions of monitoring weights and intake. There was no documented assessment of the residents usual body weight range, pertinent medications, or pertinent lab values. Review of the RD's Nutrition Miscellaneous Note dated 7/3/23 at 10:11 AM, included the 7/1/23 weight of 96. 6 lbs. She indicated there was a 4.3% weight loss in one month. However, she did not acknowledge and document the 6/5/23 weight of 97.3 lbs. which was a 5.4% significant weight loss. She indicated that the resident's intake remained variable and recommended weekly weights for four weeks as well as a clear nutrition drink with lunch and dinner which would have provided approximately 250 calories and nine grams of protein per eight ounces. She further documented that the staff would continue to monitor the resident's intake and weights. Review of the Monthly Physician Visit note dated and signed 6/13/23 by the resident's primary care physician (PCP), indicated that the resident had not experienced weight loss or a decreased appetite. Furthermore, there was no weight documented by the PCP. Review of Geriatric Psychiatrist Progress Note dated 6/7/23, included that the resident displayed no evidence of depressive symptoms, and that the resident's appetite and sleep were stable. The Psychiatrist included a diagnosis of major depressive disorder, recurrent, in full remission, and discontinued the PO for Remeron 7.5 mg by mouth in the evening. Review of the electronic progress notes from admission to current revealed no documented evidence of edema or fluid concerns. Review of the resident's Care Plan Report initiated on 5/23/23, included a nutrition care plan which was created on 7/3/23 by the RD. The problem area included that the resident had altered nutrition related to variable intake, a modified consistency diet and confusion at times. The RD's goals for the resident included intake to be at or above 75% with no significant weight changes. The RD's interventions included that the resident may need assistance at meals, that staff will monitor his/her weights, intake and labs, and that the resident was on a mechanically soft diet. The clear nutritional drink at lunch and dinner was not included in the care plan until 7/6/23, after surveyor inquiry. The care plan did not reflect weekly weights or the residents actual significant weight loss. On 7/5/23 at 10:35 AM, the surveyor interviewed the third floor Registered Nurse (RN) #1 who stated that the weights were only recorded in the EMR and that there was no weight book. On 7/05/23 at 1:10 PM, the surveyor interviewed the Human Resources Director in the presence of a second surveyor. She stated that the RD worked part time at the facility and that she hurt her foot and thinks she may be out. On 7/05/23 at 1:17 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in presence of the survey team. He stated that the RD broke her toe and has been working remotely. He further stated that it's the first I am hearing of it, he could not state how long she has been out or working remotely. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 7/06/23 at 9:37 AM, the surveyor interviewed the RD in the presence of the survey team. She stated that the Unit Manager (UM) was in charge of assigning the CNA's to weigh residents monthly during the first week of each month. She also stated that through the EMR she could ascertain a weight report for a residents last 10 weights. The RD and surveyor reviewed Resident #8's weights. She stated that she reviewed weights to determine if a re-weight was needed and could not speak to why there was no re-weight after the resident lost weight on 6/5/23. The RD stated that if a resident was over 100 lbs. and there was a five-pound weight change or more from the previous weight she would have requested the nurses get a re-weight for verification. In addition, she would have done the same if a resident was under 100 lbs. and had a three-pound weight change or more from the previous weight. The RD also stated that weekly weights were implemented for four weeks after a resident was newly admitted or readmitted to the facility or if there was another nutritional concern such as a decreased appetite. She stated that if a resident refused to be weighed nursing would record zeros and write a progress note. She stated that UM covered both the second and third floors and was responsible to ensure weights were taken. The RD stated that the UM would have notified her if a resident had a weight loss, but the UM was out right now. She stated, I do not check every day but once a week, I will look at weekly weights. During that same interview, the RD stated that if she was unable to observe the resident herself, she would ask staff how the resident was eating in addition to viewing the percentage of meals consumed which was documented by the CNA's. She stated that the CNA documentation was not always filled out. In addition, she stated that in the EMR she utilized a nutritional assessment form to document for new admissions, annual assessments and significant changes. She also stated that she utilized a miscellaneous note for follow up documentation. She stated that it was the facility policy to have a nutritional assessment completed by day 13 from the admitted , but her goal was to complete the nutritional assessment between five and seven days, at which time she also generated the care plan. She stated that she initiated nutritional care plans. The RD further stated that she would consider a resident at nutritional risk if they experienced a significant weight change. She stated that if a resident's weight was trending down, she would look more closely at weights and she considered a weight loss of five percent within one month and 10% within six months to be considered significant. The RD stated that if a resident had a significant weight loss she would intervene immediately and also stated as soon as I know. She stated that if she made nutritional recommendations, she would fill out a form and email it to nursing, the Director of Nursing (DON), and food service (FS). The RD further stated that Boost Breeze was one of the supplements that the facility had available and was a non-milky juice-like beverage. The RD acknowledged that there was no documented evidence of a nutrition assessment or care plan in the EMR for Resident #8 until 7/3/23. She stated that the facility contacted her about this and stated, I don't know what happened, maybe it got deleted. On that same date and time, the RD reviewed the active POs in the presence of the surveyor and acknowledged that there was no PO for Boost Breeze or weekly weights for Resident #8. She acknowledged that the weekly weights for four weeks after admission were not completed and stated, as per protocol and that there should have been a re-weight after the 6/5/23 weight of 97.3 lbs, but was not done. She could not speak to why the protocol wasn't followed and a re-weight was not obtained. The RD stated that she inquired if the Food Service Director (FSD) received the diet slip for the Boost Breeze two days ago and he had not. She stated that Resident #8 was supposed to be a trial stay here maybe that's why they didn't weigh her according to protocol but that's no excuse. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 7/06/23 at 10:41 AM, the RD provided the surveyor with a printout of the EMR CNA worksheet for Resident #8's meal intake accountability from 5/16/23 dinner through 7/6/23. Review of this document revealed inconsistent documentation for percentages of meals consumed. During this time frame, there were 154 opportunities (meals) to record percentage consumed, there was only documented evidence for 35 meals. On 7/06/23 at 11:01 AM, the surveyor interviewed the RD in the presence of the survey team who stated that if meal accountability was not filled out properly, I can't use it. She stated that she was not at the facility daily and that she expected the CNA's to fill out the document consistently and properly. She acknowledged that the goal she developed for the resident was for his/her intake to be at or above 75%. The RD reviewed the EMR in the presence of the survey team and acknowledged that there was no documentation from nursing for Resident #8's meal intake. She further acknowledged that she needed to know how much the resident was consuming to monitor if goals were met and to determine how many calories needed to be supplemented. She stated that if she noticed the intake worksheet was not being filled out consistently, she would have reported this to the UM and/or DON and stated, I don't know if I told anyone. She also stated that she could not speak to why she did not notice the residents weight loss since she reviewed the weights every week and stated that it did not fall into the one month change time frame. In addition, the RD stated that there was a weight loss and that she wanted to put supplements in place quickly. She also stated that nursing usually alerted her when a resident had a significant change in an email. She reviewed her emails in the presence of the surveyor and acknowledged she had not received an email from nursing regarding Resident #8. During this interview, the RD provided the surveyor with a copy of an email communication with the Food Service Department dated 7/3/23 at 9:53 AM. She requested that Boost Breeze be added to Resident #8. On 7/4/23 at 9:46 AM the Healthcare/Independent Living Supervisor replied to the email, We sure can, no problem. In addition, the RD provided the surveyor a copy of an email communication she sent to the DON regarding Resident #8, which included a recommendation for weekly weights for four weeks and Boost Breeze for lunch and dinner. The RD asked if the DON could add that to the PO's. No documentation was provided that the DON acknowledged the email. On 7/06/23 at 11:19 AM, the Food Service Department provided copies of three Dining Service Communication Forms for Resident #8 dated 5/15/23 and two dated 5/18/23. No communication was provided that verified Boost Breeze was ordered by the physician for Resident #8. The Food Service Department provided a copy of the third floor Diet List at this time yet dated 7/3/23. It indicated that Resident #8 was supposed to receive Boost Breeze at lunch and dinner. On 7/06/23 at 11:49 AM, the surveyor conducted a telephone interview with RN #1. RN #1 was the nurse who entered Resident #8's weight of 97.3 lbs. on 6/5/23 into the EMR. She stated that she did not recall if the resident was on weekly weights or if the resident should have been placed on weekly weights for four weeks after admission. She stated that weekly weights required a PO. The surveyor reviewed the residents' weights with RN #1, who stated that she would have reported a weight loss of 102.8 lbs. to 97.3 lbs. to the DON but could not recall if she did or not. She also stated that she did not think she notified the physician. She further stated that she would not have written a note about the weight loss. RN #1 stated that the resident's intake varied and that she needed to be fed. She further stated that someone discussed starting a supplement for Resident #8 due to poor intake at times but could not recall who discussed this with her, or if a supplement was started and if it should have been recorded on the eMAR/eTAR. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 7/06/23 at 12:01 PM, the surveyor interviewed the covering RN/MDS Coordinator in the presence of the survey team. She stated that the RD was responsible to fill out Section K of the MDS Swallowing/Nutritional Status. She stated that the MDS opened on the day of admission and the facility had up to 14 days to complete the MDS and up to 21 days to complete the Care Plan. She stated that if the CAA summary section indicated to proceed to care plan for nutritional status that it should have been completed by the 21st day after admission. She further stated that each discipline was responsible to initiate their own care plan. She also stated that it was the MDS Coordinator's responsibility to ensure that all triggered CAA's were addressed in the comprehensive care plan. The MDS Coordinator reviewed the EMR care plan in the presence of the surveyor and acknowledged that the nutritional care plan was not initiated until 7/3/23, which was out of the regulatory time frame. On 7/06/23 at 12:34 PM, the surveyor interviewed RN #2 who was the covering the UM in the presence of the survey team. She stated that she was mainly on the second floor but also covered the third floor. She stated that she trained with the previous UM for two weeks prior to taking the position and that the agency she worked for provided her with a job description for the UM position for this facility. She stated that the previous UM provided her with a list of tasks to complete each day. RN #2 stated that if the eTAR indicated a weight should be taken she ensured it was done. She stated that weekly weights were completed on Mondays and that she did not work on Monday. She further stated that if a weekly weight was not completed on Monday, I would follow up myself. She stated that weekly weights were done for four weeks for newly admitted and readmitted residents and required a PO. She stated that she was instructed to obtain a re-weight for a resident who had a two or more pound weight change from the previous weight. She stated that she was instructed to oversee weights for the second floor and only bigger things like falls for the third. RN #2 stated that Resident #8 was briefly admitted to the second floor and was transferred to the third floor. She reviewed the resident's weights in the EMR in the presence of the surveyor. She stated that she was unaware of the significant weight loss and acknowledged that the weekly weights were not consistently recorded and that a re-weight should have been done for the 6/5/23 weight of 97.3 lbs. In addition, she stated that she does not interact with the RD. At that same time, RN #2 reviewed the EMR PO's and acknowledged that there was no PO for weekly weights. On 7/06/23 at 1:02 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) for the third floor in the presence of the survey team. She stated that she supervised the weight processes. She stated that weekly weights were done on Mondays and that she did not work on Monday's. She stated that it was protocol to weigh residents weekly for four weeks after admission. She further stated that weekly weights required a PO and would have been documented on the eMAR or eTAR which would have been flagged to get done. The LPN stated that if a resident had a five-pound weight change that she would have obtained a re-weight and if that weight was verified it would be considered a significant weight loss. She stated that she would have notified the RD who then makes recommendations to start supplements and would have determined the cause of the weight loss. The LPN reviewed Resident #8's weights in the EMR in the presence of the surveyor. She acknowledged that weekly weights were not consistently obtained and recorded and that there was a significant weight loss on 6/5/23. She acknowledged that she recorded the next weight of 96.6 lbs. on 7/1/23, which was a further weight loss (.7 lbs) and could not speak to why she did not notify the RD, DON or physician. She stated that when a resident had a weight loss the RD, DON, physician and family should have been notified and it should have been documented on the 24-hour report. The LPN then reviewed the PO's in the presence of the surveyor, which indicated that she transcribed the PO for Boost Breeze on 7/6/23, after surveyor inquiry. She further acknowledged that the resident enjoyed and consumed the entire carton of Boost Breeze at lunch. In addition, she acknowledged that currently there was no PO for weekly weights. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 7/06/23 at 1:22 PM, the surveyor interviewed the FSD and the Healthcare/Independent Living FS supervisor in the presence of the survey team. The FSD stated that once they received a diet slip (a communication tool) from nursing, which provided FS with a verified record that it's been signed off on and it's ok to serve that [the nutritional supplement] to the resident that they would have provided it. He stated that the diet slip ensured that there was a PO for that supplement. He further stated that Resident #8 typically consumed breakfast in his/her room and lunch and dinner in the dining room. He stated that FS would have provided the supplement on the tray for breakfast and that the nurses would have provided the supplement to the resident for lunch and dinner. The FSD stated that the RD sent an email on Monday 7/3/23, which indicated that she recommended Boost Breeze be given at lunch and dinner for Resident #8. However, food service had not received a diet slip. The FSD stated that the resident should have started to receive the supplement on Tuesday 7/4/23. He further stated that the RD should have communicated that to the DON. The FSD stated that the supplement came in an eight-ounce carton and was started today because he had not previously received a diet slip. On 7/07/23 at 9:16 AM, the surveyor reviewed the physician's documentation in Resident #8's paper chart with the LPN. The LPN acknowledged that the resident's Monthly Physician's Visit note dated 6/13/23, did not address the resident's weights or appetite. On 7/07/23 at 10:00 AM, the surveyor interviewed the DON in the presence of the survey team and LNHA. She stated that the facility did not conduct official weight meetings. She further stated that if the RD made a recommendation for a supplement that the nurse would call the physician for approval to implement the PO, the nurse would send a communication slip to FS, and this would be documented on the 24-hour report which would then be discussed in the morning meeting the next day with the team. On 7/07/23 at 10:19 AM, the surveyor conducted a telephone interview with the resident's representative in the presence of the survey team. She stated that the resident's usual body weight was 106 lbs. and that she was aware of the resident's weight loss from 102 lbs. to 96 lbs. and was concerned. She stated that the resident was confused, required feeding and took a long time to eat. She stated that the resident required reminders to open his/her mouth and seemed to prefer sweets. She stated that a juice like supplement was started for the resident yesterday and he/she loved it and consumed 100 percent of the carton. On 7/07/23 at 10:37 AM, the surveyor attempted to conduct a telephone interview with the resident's primary care physician. The receptionist stated that the physician was away until Monday and stated that she would provide him with the message. On 7/07/23 at 11:03 AM, the survey team met with the DON and LNHA. The DON stated that Resident #8 was admitted to the facility as a trial to see how [he/she] would adjust. She further stated that the resident was only supposed to be at the facility for a week and once the resident went to long term care weekly weights should have been implemented. She stated, that's the reason they probably did not do weekly weights. She acknowledged that weekly weights were not consistently obtained and documented and that a re-weight should have been obtained after the 6/5/23 significant weight loss. In addition, she stated that she had not received the email sent to her by the RD regarding the supplement and weekly weights. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy Resident Weights and Weight Changes with a revised date of 11/7/17, included that regular monitoring of weights was necessary in order to screen residents for significant weight changes, which may indicate a resident was at nutritional risk. It further included that significant weight changes would be reviewed by the DON or designee and referred to the RD and physician if indicated. It also included that residents would be weighed on admission and weekly for four weekly thereafter or more frequently per PO or RD recommendation. It included that a re-weight must be obtained within 48 hours if a weight change was considered significant or if there was a three-pound loss for residents under 100 lbs. In addition, it included that DON/designee, or the RD would assess and document the weight changes, plan of action and any recommendations in the medical record; the care plan should be adjusted to include the dietary recommendations. If indicated the RD would discuss the weight change with the DON/designee and a nutritional, follow up would be conducted as indicated. Review of the facility policy Nutrition Screening, Assessment and Monitoring with a revised date of 1/22, included that the RD will complete a comprehensive nutrition assessment according to the admitted and MDS schedule and clinical nutrition need. It further included that the individualized plan of care should be written and reviewed regularly when changes were noted. It further included that the nutrition assessment will include the following, but not limited to .usual body weight (UBW) . It also included that residents with a confirmed significant change in weight should receive a reassessment as soon as possible but no longer than five days after notification, and a follow up note should be done a minimum of weekly until the weight has stabilized. Review of the facility policy Nutrition Interventions with a revised date of 1/22, included that the RD should identify residents who are at risk and/or potential risk for nutrition-related problems due to insufficient/inappropriate intake of food and recommend interventions to improve the resident's intake based on resident preference and tolerance. It further included that the Rd should request a PO for additional monitoring parameters such as weekly weights. It also included that the RD should communicate the residents needs and progress to the interdisciplinary care team as well as monitor the resident's acceptance of nutritional interventions and outcomes on a regular basis. Review of the facility policy Resident Care Plan with a revised date of 6/29/23, included that it is the policy of the facility to ensure that the care planning process was systematic, comprehensive, interdisciplinary and timely and directed toward achieving and maintaining each residents optimal physical, psychosocial and functional status. It further included that the care plan reflects measurable objectives/goals. It also included that interventions should serve as a care guide. Review of the facility's job description for Clinical Nutrition Manager or Director Food & Nutrition Services dated 2019, included that the position was responsible to provide clinical nutrition services, including nutrition assessment and nutrition interventions. The position is required to ensure resident satisfaction, quality of care and regulatory agency compliance. The RD is responsible for nutrition screening, assessment, diagnosis, intervention, monitoring, evaluation and plan of care . Complies with regulatory standards, including federal, state and accrediting agencies . NJAC 8:39 - 11.2(e)(1)(f), 17.1(c), 17.2(c)(d), 27.1(a)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 40042 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure the physician a.) addressed a significant weight loss of 5.5 pounds (lbs.) which was 5.4% in 20 days from admission on 5/15/23 through 6/5/23, b.) monitored weekly weights, and c.) implemented nutritional interventions in a timely manner for 1 of 4 residents (Resident #8) reviewed for nutrition. The deficient practice was evidenced by the following: On 6/28/23 at 10:55 AM, two surveyors observed Resident #8 in a wheelchair on the third activity room. This resident was noted to require assistance at meals. On 7/07/23 at 8:40 AM, the surveyor observed the resident in bed with the head of the bed elevated. The resident's eyes were opened, and he/she smiled, appeared to be missing his/her top two teeth. The residents Certified Nurses' Aides (CNA) opened the residents breakfast tray, sat at the bedside and fed Resident #8. The CNA stated that she was familiar with the resident who had a poor appetite. She stated that on a good day the resident consumed 50% of the breakfast meal which could take up to 40 minutes to complete. The CNA stated that the resident could not feed themselves and was sometimes sleepy at the breakfast meal in addition to being confused. She had to remind the resident to open his/her mouth and introduced small sips of fluids and bites of mechanically altered consistency foods. She stated that items on the breakfast tray were typical and included an eight-ounce carton of reduced fat milk, and eight-ounce mug of coffee, a four-ounce portion of strawberry yogurt, a four-ounce portion of applesauce, a four-ounce portion of orange juice, a package of pancake syrup, a pat of margarine, two banana pancakes cut to bite size pieces and two sausage links cut into bite size pieces. On 7/07/23 at 9:10 AM, the surveyor observed the resident motion to the CNA and clearly stated that he/she did not want any more of the meal. The surveyor observed that the resident consumed approximately two ounces of a four-ounce portion of orange juice, five teaspoons of applesauce, one ounce of the eight-ounce carton of reduced fat milk, two ounces of a four-ounce portion of strawberry yogurt, 50% of the sausage links, and 25% of the banana pancakes. The surveyor reviewed the medical record for Resident # 8. Review of the resident's Face Sheet (an admission record) reflected the resident was admitted with diagnoses that included but were not limited to; Alzheimer's disease, oropharyngeal dysphagia (difficulty swallowing) and hypothyroidism. Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/22/23 reflected a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated the resident's cognition was severely impaired. It further reflected that the resident was totally dependent and required the physical assistance of one person for the task of eating. In addition, it reflected that the resident received a mechanically altered diet. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders (POs) from both the electronic medical record (EMR) and the paper chart for May, June and July 2023, included a PO dated 5/15/23, to weigh the resident weekly for four weeks, and a PO dated 5/18/23, which indicated the residents diet was changed from a Regular to a Mechanically Soft consistency with thin liquids. It further included a PO dated 7/6/23, to provide Boost Breeze (a nutritional supplement), four ounces twice a day with lunch and dinner after surveyor inquiry. There was no PO for weekly weights for four weeks after Resident #8's significant weight loss on 6/5/23. Review of May and June 2023 electronic Treatment Records (eTAR) reflected the PO to weigh the resident weekly for four weeks to start 5/22/23. There was no documented evidence that a weight was obtained for 5/22/23, 5/29/23 and 6/12/23. The surveyor reviewed the weight record in the EMR). Weights documented were as follows: 5/15/23 102.8 6/1/23 101 6/5/23 97.3 7/1/23 96.6 Review of the Monthly Physician Visit note dated and signed 6/13/23 by the resident's primary care physician (PCP), indicated that the resident had not experienced weight loss or a decreased appetite. Furthermore, there was no weight documented by the PCP. On 7/06/23 at 9:37 AM, the surveyor interviewed the Registered Dietitian (RD)in the presence of the survey team. During this interview the RD acknowledged that the resident had a significant weight loss and did not notify the physician. On 7/06/23 at 11:49 AM, the surveyor conducted a telephone interview with the Registered Nurse (RN) #1. RN #1 was the nurse who entered Resident #8's weight of 97.3 lbs. on 6/5/23. She stated that weekly weights required a PO. The surveyor reviewed the residents' weights with RN #1, who stated that she would have reported a weight loss of 102.8 lbs. to 97.3 lbs. to the Director of Nursing (DON) but could not recall if she did or not. She also stated that she did not think she notified the physician. On 7/06/23 at 1:02 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) for the third floor in the presence of the survey team. The LPN reviewed Resident #8's weights in the EMR in the presence of the surveyor. She acknowledged that weekly weights were not consistently recorded and that there was a significant weight loss on 6/5/23. She could not speak to whether or not the RN that recorded that weight notified anyone. She then acknowledged that she recorded the next weight of 96.6 lbs. on 7/1/23 which was a further weight loss and could not speak to why she did not notify the RD, DON or physician. She stated that when a resident has a weight loss the RD, DON, physician and family should have been notified and it should have been documented on the 24-hour report. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/07/23 at 9:16 AM, the surveyor reviewed the physician's documentation in Resident #8's paper chart with the LPN. The LPN acknowledged that the resident's Monthly Physician's Visit note dated 6/13/23, did not address the resident's weights or appetite. On 7/07/23 at 10:37 AM, the surveyor attempted to conduct a telephone interview with the resident's primary care physician. The receptionist stated that the physician was away until Monday and stated that she would provide him with the message. On 7/07/23 at 11:03 AM, the survey team met with the DON and Licensed Nursing Home Administrator (LNHA). The DON acknowledged that weekly weights were not consistently recorded and that the resident experienced a significant weight loss on 6/5/23. Review of the facility policy Resident Weights and Weight Changes with a revised date of 11/7/17, included that regular monitoring of weights was necessary in order to screen residents for significant weight changes, which may indicate a resident was at nutritional risk. It further included that significant weight changes would be reviewed by the DON or designee and referred to the RD and physician if indicated. It also included that residents would be weighed on admission and weekly for four weekly thereafter or more frequently per PO or RD recommendation. Review of the facility policy Resident Care Plan with a revised date of 6/29/23, included that it is the policy of the facility to ensure that the care planning process was systematic, comprehensive, interdisciplinary and timely and directed toward achieving and maintaining each residents optimal physical, psychosocial and functional status. It further included that the care plan should be developed by the interdisciplinary team, which included but would not be limited to the resident's attending physician, the RN, RD, and DON. NJAC 8:39-23.2 (b)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37791 Based on observation, interview, and record review, it was determined that the facility failed to ensure that a medication was administered according to physician orders and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice was identified in 1 (one) of 9 (nine) residents (Resident #9) observed during the medication observation pass. The deficient practice was evidenced by the following: 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. On 07/05/23 at 8:40 AM, during the medication administration observation, the surveyor observed the Registered Nurse (RN#1) in the room of Resident #9. The surveyor observed RN #1 checking the resident's identification bracelet and informing Resident #9 that she would be administering the resident's medications. The surveyor observed the resident seated in their bed and just finished eating breakfast. On 07/05/23 at 8:45 AM, the surveyor observed RN #1 preparing to administer three (3) medications to Resident #9 which included Norvasc 5 mg tablet (medication for lowering blood pressure), Simethicone 80 mg tablet (medication for gas), and enteric-coated aspirin 81 mg tablet (secondary prevention of cardiovascular disease). The surveyor observed RN #1 crush each medication separately and then adding the crush contents of each medication into a medication cup and then mixing the contents with apple sauce. The surveyor then observed RN #1 administer the medications to Resident #9. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to hypertension (elevated blood pressure), Alzheimer's disease (disease that cause the brain to shrink and for brain cells to die), and cerebral infarction due to thrombosis (a brain lesion in which a cluster of brain cells die when they don't get enough blood). A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated 5/30/23, reflected that the resident's cognitive skills for daily decision-making score was 4 out of 15, which indicated that the resident's cognition was severely impaired. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the July 2023 Physician Order Sheet (POS) revealed a physician order (PO) dated 3/6/23, for Crush Meds (by mouth medications) oral with the following note: May crush medication as per manufacture or pharmacy guidelines may administer crush medications together in apple sauce. Further review of the July 2023 POS revealed a PO dated 3/6/23, for Ecotrin Low Strength 8l mg tablet enteric coated (aspirin) (1) tablet, Delayed release (Enteric Coated) oral. Notes: CVA (cardiovascular accident) instructions: May increase the risk of bleeding, please monitor for bruising, dark urine, and tarry stools. Aspirin-administer with plenty of water. Do not crush enteric coated, swallow whole. Take with meals. A review of the July 2023 electronic Medication Administration Record (eMAR) revealed an order dated 3/6/23, for Ecotrin Low Strength 81 mg, enteric coated 1 tablet one time daily starting 3/6/23. Notes: CVA Instructions: May increase the risk of bleeding, please monitor for bruising, dark urine, tarry stools Aspirin-Administer with plenty of water. Do not crush enteric coated, swallow whole. Take with meals. On 7/5/23 at 9:30 AM, the surveyor in the presence of RN #1 reviewed the July 2023 eMAR. After reviewing the eMAR, the surveyor interviewed RN #1, who acknowledge that the resident had an order to crush and administer all their PO [by mouth] medications with apple sauce. She further stated that the resident's Ecotrin low Strength tablet was an enteric coated tablet, and it should not have been crushed and that the medication should have been administered whole. RN #1 further acknowledge that the eMAR and the POS for the Ecotrin had instructions to not crush and to administer whole and that she should have administer the medication whole. On 7/6/23 at 1:30 PM, the surveyor discussed the above observations and findings with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). There was no additional information provided. A review of the facility's policy for Administering Medication dated 6/19/23, which was provided by the DON included the following: The individual administering the medication must ensure that the right medication, the right dosage, the right time, and the right method of administration are verified before the medication is administered (e.g., review of the drug label, physician orders, etc.). NJAC 8:39-11.2 (b), 29.2 (d)