STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315459	A. Building B. Wing	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Jersey Veterans Memorial Home Menlo	132 Evergreen Rd Edison, NJ 08818

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 NJ Complaint #156759 Based on observation, interview, record review, and other pertinent facility documentation, it was determined that the facility failed to ensure residents were free from abuse after a resident (Resident #24) was prevented from leaving an abusive situation by Certified Nursing Aide (CNA #1) who continued to work with other residents following no investigation. This deficient practice was identified for 1 of 5 residents reviewed for abuse (Resident #24). Resident #24, who had diagnoses which included anxiety, depression, and Post Traumatic Stress Disorder (PTSD) (A mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations), reported on 07/30/22 an Agency Nurse (Licensed Practical Nurse (LPN #1) became verbally abusive with him/her when their scheduled Percocet (pain medication) and Xanax (anxiety medication) was requested. The resident reported LPN #1 closed the door to his/her room which triggered the resident's PTSD. The resident indicated that they had a history of imprisonment, which caused the feeling of entrapment with closed doors and feelings of anxiety. Resident #24 reported that when they tried to exit the unit to find help, LPN #1 prevented them from leaving by holding the handlebars of the wheelchair (w/c). He stated that CNA #1 further prevented him/her from escaping the anger that LPN #1 exhibited towards him/her, by blocking the exit doors and preventing him from leaving. The resident reported that this made them angry because all they wanted was to leave, and the resident could not understand why they were not permitted to leave the unit to find help. During a review of video surveillance footage, it was observed that the resident self-propelled in the wheelchair, and LPN #1 moved alongside the resident towards the closed exit doors of the unit. CNA #1 was seen exiting from Resident room [ROOM NUMBER] and stood in front of the resident blocking them from proceeding forward, and then stood in front of the exit door blocking the exit. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of CNA #1's written statement regarding the incident included that she was stopping the resident from leaving the unit. The facility's failure to ensure all residents were free from abuse, including verbal, physical, restraints, and involuntary seclusion by not investigating the actions of CNA #1 after a written statement acknowledged she stopped the resident from leaving the unit as well as video footage confirming she blocked the exit door preventing the resident from leaving the unit posed a serious and immediate threat for abuse which can cause serious physical and emotional harm or impairment. This resulted in an Immediate Jeopardy (IJ) situation that began on 07/30/22 after CNA #1 blocked Resident #24 from leaving the unit and continued to work seven additional shifts until the surveyor inquiry. The facility Administration was notified of the IJ on 08/25/22 at 02:55 PM. The facility submitted an acceptable Removal Plan (RP) on 08/26/22 at 01:55 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 08/26/22. Part A On 08/18/22 at 10:38 AM, the surveyor interviewed Resident #24, who stated on 07/30/22, they received Percocet and Xanax every six hours and asked an aide to find the nurse to administer the medications. An Agency Nurse (LPN #1) entered my room and informed me that they would administer my medications and take my vital signs and proceeded to leave the room and closed the door. The resident stated that they proceeded to use the call bell and LPN #1 came back into the room to tell me to stop pushing the call bell; pulled down her mask and attempted to bite my finger as I pointed at her. The resident continued that he/she got out of bed to get away from LPN #1, LPN #1 lunged her nurse's cart at me three times and hit his/her left foot causing a wound to re-open. The resident stated that he/she was trying to get away from LPN #1 and get to the Registered Nurse Supervisor (RN Supervisor). The resident stated as they were attempting to leave the unit in the hallway, the nurse assaulted them by pulling the wheelchair (w/c) 2-3 times, which positioned the resident on only two back wheels and the two front wheels were lifted off of the floor. The resident stated that there was a (CNA #1) there, but he/she could not recall the name who tried to calm the crazy nurse down. The resident stated that the RN Supervisor escorted LPN #1 out of the building and a State Trooper came last week who viewed the surveillance footage and confirmed LPN #1 assaulted the resident. The resident stated that they had severe PTSD and that this event had triggered an episode. The surveyor reviewed Resident #24's medical record. A review of the Resident Facesheet (an admission summary) reflected that the resident was admitted to the facility in September of 2021 but did not include admitting diagnoses. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 08/10/22, reflected a brief interview of mental status (BIMS) score of 15 out of 15, which indicated the resident was fully cognitively intact. It further reflected the resident had verbal behavioral symptoms directed toward others that occurred four to six days in the last seven days of assessment. Section I Active Diagnoses included the resident had hypertension (high blood pressure), anxiety, depression, psychotic disorder, and PTSD. It further included in a seven-day look back period, the resident received daily antianxiety, antidepressant, and opioid medications. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the individualized comprehensive Care Plan (CP) included a problem area initiated on 04/8/22, for at risk for altercation in mood/behavior; history of major depressive disorder, anxiety, use of Seroquel (antipsychotic medication) for agitation, use of Xanax for anxiety, and Remeron for anxiety/depression/mood with interventions that included to observe for efficiency of medications; monitor for target behaviors or behaviors not easily redirected; refer to nurse if noted behaviors worsening, unable to redirect; keep the room well lit, open blinds for sunlight; and give medications Remeron, Xanax, Seroquel as ordered. A further review of the CP included a diagnosis of PTSD, however, did not include a problem area or interventions pertaining to the resident's diagnosis of PTSD. A review of the Interdisciplinary Progress Notes included a Nursing Note dated 07/30/22 at an illegible time, which reflected at around 05:10 AM; a CNA approached the writer who was on the other side of the unit to report an altercation between an Agency Nurse (LPN #1) and the resident. The writer went over to Resident #24 and brought them back to their room, and conducted a body check. The note reflected that the writer reassured Resident #24 that everything would be okay. On 08/18/22 at 11:49 AM, the surveyor requested from Administration all investigations for Resident #24 from 07/01/22 until present. On 08/18/22 at 12:48 PM, the surveyor interviewed the RN Supervisor via telephone, who stated on 07/30/22, she was called to the unit the Agency Nurse (LPN #1) and Resident #24 were having an argument, and the nurse was very aggressive. The resident had told the CNA that he/she wanted his medications, and LPN #1 came into the room to tell the resident she would get the medications. The RN Supervisor stated that ten minutes had passed and the resident had not received their medications so they pressed the call bell and LPN #1 came into the room and asked why he/she was calling her. LPN #1 then proceeded to close the door, which the resident did not like, and he/she went to call the Supervisor, but LPN #1 took the phone, so the resident could not call. LPN #1 then blocked the resident's room with her medication cart so they could not leave and then pulled the resident's w/c so the resident could not leave the unit. The RN Supervisor stated the aides told LPN #1 to stop, and RN #1, who was on the other side of the unit, called the RN Supervisor, who had LPN #1 leave the facility, and an investigation was initiated. The RN Supervisor stated the resident reported LPN #1 attempted to bite their finger but no injury was observed. There was surveillance video footage reviewed and statements were taken. The RN Supervisor stated Resident #24 gets really upset sometimes due to pain so the nurses usually responded to him/her right away. On 08/18/22 at 01:06 PM, the surveyor requested the Licensed Nursing Home Administrator (LNHA) to provide all investigations conducted for Resident #24 from 07/01/22 to present. On 08/19/22 at 11:25 AM, the surveyor interviewed the Director of Nursing (DON) who stated she had been on vacation for the past two weeks so the Assistant Director of Nursing (ADON) completed the investigation and the final report. The DON confirmed she watched the video surveillance footage which revealed LPN #1 abused Resident #24. On 08/19/22 at 11:31 AM, the surveyor interviewed the ADON who stated that she completed an investigation for the incident on 07/30/22 which she reported to the New Jersey Department of Health (NJDOH), Ombudsman, the Veteran's Affairs [NAME], Office of Inspector General, Physician, family, and later the State Police after the resident alleged LPN #1 assaulted him/her with her medication cart. The ADON stated when she reviewed video footage, it was clear LPN #1 was holding the handlebars on the back of Resident #24's wheelchair as well as a verbal altercation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/19/22 at 11:59 AM, the surveyor interviewed LPN #1 via telephone who stated she was an Agency Nurse assigned to the facility that day (07/30/22) and received no information from the facility prior to the start of her shift. LPN #1 stated to a degree she understood that the resident was right, but the resident made racist remarks to her and weaponized their wheelchair rolling over her feet. LPN #1 stated that the medication cart was in front of his/her room since she was trying to administer the resident's medication and he/she started pushing the medication cart at the nurse. LPN #1 stated a nurse informed her Resident #24 had to receive their medication on time and she apologized that the medication was a few minutes late and she started to prepare the medications. The resident proceeded to press the call bell and started yelling and cursing at her to administer the medications and he/she was going to call administration. LPN #1 stated that she tried to calm the resident down but he/she started making derogatory racial remarks to her telling her that she was yelling at them. The resident then got out of bed and charged in their wheelchair at the medication cart yelling and cursing. LPN #1 stated that she told the aides to get the Supervisor. LPN #1 stated she was unaware if the resident had any behaviors and the two CNAs were telling her to stop the resident from leaving the unit and she had no idea why the resident could not leave the unit; if the unit was a lockdown unit or the resident was on COVID-19 restrictions, but she was the closest staff to the resident so she grabbed the back of the wheelchair to stop the resident. LPN #1 further stated that she did not know the two CNAs' names, but they were yelling at her to stop the resident from leaving the unit, so she grabbed the back of his/her wheelchair. On 08/19/22 at 12:52 PM, the surveyor in the presence of the DON, Employee Relations/Legal Specialist, and survey team observed the surveillance video from 07/30/22 and observed the following: At approximately 05:13 AM, Resident #24 was observed self-propelling in a wheelchair alongside of LPN #1 and proceeded up the hallway in the direction of the closed exit doors; LPN #1 was observed at some point holding her left arm up with their left hand positioned upward in a motion to stop that was directed towards the resident. CNA #1 was observed exiting Resident room [ROOM NUMBER] which was located on the right side directly next to the closed exit doors and proceeded to position herself directly in front of the resident. There was no audio, but it could be determined that there was a verbal exchange between the resident and staff. LPN #1 then grabbed the back of the handlebars of Resident #24's wheelchair, which changed the resident's direction from facing forward towards the exit doors to now facing towards Resident room [ROOM NUMBER]. The resident was trying to get away but was being restrained by LPN #1, who was still holding onto the back of the wheelchair, which caused the front wheels to lift off the ground, causing the resident to recline in the w/c. CNA #1 then stood in front of the exit door and blocked the resident from having access to exit. CNA #2 was observed walking up the hallway towards LPN #1, CNA #1, and the resident and it can be observed CNA #2 was engaging in the conversation. Then, CNA #3 came through the closed exit door and proceeded to wheel the resident away from LPN #1 and CNA #1. RN #1 was seen walking up the hallway towards the resident and CNA #3 and it appeared that they were attempting to calm the resident as they were bringing the resident towards their room. On 08/19/22 at 1:23 PM, the surveyor interviewed CNA #1 via telephone who stated she could not recall the incident but she had provided a statement, so the surveyor should read their statement. On 08/19/22 at 1:31 PM, the surveyor attempted to interview CNA #2 via telephone about the incident, and CNA #2 would only repeat the word yes in response to interview questions and offered nothing further. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/22/22 at 10:00 AM, the surveyor reviewed the facility provided an investigation report for Resident #24's incident which occurred on 07/30/22. A review of the staff statements included a statement provided by CNA #2, which detailed that they were taking care of a resident when they heard a noise in the hallway and came out into the hallway and saw Resident #24 trying to leave the floor. She stated that, I stopped him/her from leaving the floor. CNA #2 stated that both she and another CNA called the charge nurse, but I did not know what was going on. CNA #2's statement appeared to be what the surveyor witnessed CNA #1 do in the surveillance video. There was no statement included from CNA #1 in the investigation report provided. On 08/22/22 at 10:31 AM, the surveyor reviewed the surveillance video with the Assistant Licensed Nursing Home Administrator (ALNHA) #1, Employee Relations/Legal Specialist, and another surveyor, and the Employee Relations/Legal Specialist confirmed CNA #1 was the aide who was blocking the door and CNA #2 was the aide observed later walking up the hallway towards LPN #1, CNA #1, and the resident during the altercation. At this time, the surveyor reviewed the investigation packet with ALNHA #1 who confirmed there should have been a statement from CNA #1 included in the investigation report. On 08/22/22 at 11:28 AM, the surveyor asked the DON if there was any surveillance video footage from the camera by the nurse's station from the incident and the DON reported that the camera was not working during the incident. The surveyor also informed the DON that they attempted to interview the CNAs and was told to read their statements, but there was no statement provided for CNA #1. On 08/23/22 at 10:59 AM, the DON provided the surveyor with CNA #1's statement dated 07/30/22 which was the exact same statement provided by CNA #2. At this time, the surveyor asked the DON to read both CNA #1 and CNA #2's statements, and she confirmed that both statements were the same but was signed by the corresponding CNA. At this time, the surveyor requested to watch the video footage again with the DON. On 08/23/22 at 11:10 AM, the surveyor with the DON, Employee Relations/Legal Specialist, and another surveyor viewed the video footage. The surveyor asked the DON, when comparing the surveillance footage with the statements if the statements clearly reflect what had happened. The DON reported that she completed a three-page reportable to the New Jersey Department of Health (NJDOH) and told RN #1 to watch the video to see if anything should be added to her statement, and then the DON reported she left for vacation. The DON stated that the ADON had watched the video with RN #1 who did not want to change her statement. The DON stated the purpose of an investigation was to determine a root cause analysis and confirmed these statements were not clear. The DON stated when she returned from vacation, the investigation was completed by the ADON and she did not review it even though she was responsible for oversight of all aspects of nursing. The DON confirmed the resident had the right to leave the unit and no staff, including the two CNAs should have stopped the resident from leaving the unit. The surveyor reviewed the video with the DON. The DON acknowledged CNA #1 was standing in front of the exit door blocking Resident #24 from exiting the unit, which was an issue because this was considered a restraint. The DON stated that even if the resident was confused, which Resident #24 was not, staff could not stop the resident from leaving. The DON stated staff had to ensure the resident's safety and could follow the resident from a distance, but staff could not prevent the resident from leaving the unit. The DON stated the ADON was currently on vacation but confirmed the investigation was not complete, and she had to re-open the investigation to clarify the statements and determine why CNA #1 stood in front of the door. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/23/22 at 11:50 AM, the surveyor requested from the LNHA all nursing schedules from 07/31/22 until present. On 08/23/22 at 12:09 PM, the surveyor reviewed the education for CNA #1 and CNA #2, which revealed both aides received abuse training prior to the event on 04/11/22 and 12/20/21 respectively. On 08/23/22 at 01:14 PM, the surveyor re-interviewed Resident #24 who stated CNA #1 was stopping LPN #1 from verbally abusing him/her, but confirmed CNA #1 was preventing him/her from leaving the unit and told them they were not allowed to leave the unit. The resident stated CNA #1 could have done more since she was not letting them leave and he/she did not know why. On 08/24/22 at 10:30 AM, the surveyor reviewed the nursing schedules since 07/31/22, which revealed CNA #1 worked seven shifts at the facility after the incident. On 08/24/22 at 11:35 AM, the surveyor interviewed the DON regarding the process for investigating abuse. The DON stated that for abuse, you take the person off the floor immediately and get their statement. When asked why you removed them from the floor, the DON responded that you have to remove them from the floor because it was a concern of abuse, you would not leave the residents with that person until you determined it was not abuse. When asked what constitutes abuse, the DON stated there were different types of abuse including physical, verbal, monetary, emotional, sexual, seclusion, and restraining against ones will. The DON stated she called CNA #1 yesterday and spoke to her over the phone regarding her statement that she stopped the resident from leaving, and CNA #1 stated after everything was done, the RN Supervisor gave an in-service that if a resident wanted to leave, they cannot stop anyone from leaving the floor, and they can follow them from afar. The DON stated that the situation was looked at initially that CNA #1 was trying to calm the resident down and not by the statement which the video confirmed that CNA #1 was trying to prevent the resident from leaving the unit. An additional review of the investigation report included an in-service/education attendance sheet dated 07/31/22, the day after the incident, with a program topic of the resident should be allowed to leave the unit if [they] wish. Do not stop the resident from leaving the unit by holding [their] chair, re-direct verbally. If they insist on going leaving the unit allow them to leave, and can follow behind to make sure the resident is safe. The in-service was presented by RN Supervisor to four staff members CNA #1, CNA #3, LPN #2, and RN #2. The in-service was not given to CNA #2 or RN #1, who were both present at the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the investigation report included in the Final Investigation dated 08/11/22, for actions taken: staff intervened separating the Agency Nurse (LPN #1) from [resident]; provided emotional support and notified Nursing Supervisor (RN Supervisor) immediately of their observations and [resident's] allegations; Agency Nurse was removed from the nursing unit and asked to provide a statement. She was subsequently dismissed from the remainder of her shift; [Agency] was notified of incident and request was made for the staff member not to return to facility; MD (Physician) was notified with order for body check every shift for five days and vital signs every shift for five days; [resident] reported that the nurse did not make physical contact with [his/her] person, only restricted [him/her] by holding [his/her] wheelchair; Social Worker will continue to provide emotional support. The summary included: the ADON reviewed the footage, which showed [Resident #24] was near the end of the door of the unit, the Agency staff was holding [their] wheelchair handle preventing [them] from leaving the unit. It was apparent on the video that staff members intervened and came to diffuse the situation. Hand gestures were made by Charge Nurse noted to put her hand up in a stop motion to Agency Nurse (LPN #1) as she appeared to follow [Resident #24] up the hall making verbalizations. Conclusion: evidence of verbal abuse and intent to involuntarily seclude a resident was consistent in staff members' statements and observations made by the ADON on the video footage. Verbal abuse and attempt to involuntarily seclude were substantiated. The Final Investigation summary did not include that CNA #1 involuntarily secluded the resident or that any action was taken towards CNA #1. On 08/24/22 at 12:33 PM, the DON informed the survey team that in light of CNA #1 blocking door, she was reporting it to the NJDOH. On 08/25/22 at 09:51 AM, the surveyor interviewed Resident #24 who stated he/she was imprisoned for twenty months and preferred the door to their room remain open because the closed door triggered their PTSD causing anxiety. The resident stated on 07/30/22, they were waiting for LPN #1 to administer their routine Percocet and Xanax medication so they could go back to sleep. LPN #1 closed his/her room door and then started yelling at him/her, and the resident reported they just wanted to escape LPN #1 who grabbed their wheelchair almost tipping the chair over. Resident #24 stated that he/she remembered the aide (CNA #1) saying their name and that he/she knew her and he/she could not leave but Resident #24 stated they could not determine who the aide was at the time. Resident #24 stated they just wanted the RN Supervisor, which made them feel angry because they were being prevented from escaping from LPN #1, and CNA #1 was not helping the situation. CNA #1 could have opened the door to let me leave but she would not let me leave which made me mad. The resident stated he/she had never been prevented from leaving the unit before so they could not understand why that was happening. The facility's failure to ensure all residents were free from abuse, including verbal, physical, restraints, and involuntary seclusion by not investigating the actions of CNA #1 after a written statement acknowledged she stopped the resident from leaving the unit as well as video footage confirming she blocked the exit door preventing the resident from leaving the unit posed a serious and immediate threat for abuse which can cause serious physical and emotional harm or impairment. This resulted in an Immediate Jeopardy situation. The IJ was identified on 08/25/22, and the LNHA, ALNHA #1, ALNHA #2, DON, and Director of Veterans Health Care Services were notified of the IJ at 02:55 PM. A written Removal Plan was accepted and verified on-site on 08/26/22, which included staff members will be immediately relieved from their duties; to ensure safety of the residents a comprehensive investigation will commence at the time of the event to ensure a thorough and complete review of all contributing factors have been conducted; all staff in-serviced on the Abuse and Neglect Policy. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/26/22 at 10:34 AM, the surveyor interviewed the DON who confirmed that the investigation regarding CNA #1 should have started upon review of the CNA's statement and video footage. The DON stated that after surveyor inquiry, she had called on the telephone both CNA #1 and CNA #2 to clarify their identical written statements. The DON stated CNA #1 had better English than CNA #2 so CNA #2 copied CNA #1's statement. The DON acknowledged that CNA #2 should not have copied CNA #1's statement and CNA #2 provided the DON with a new written statement and the DON received a verbal statement over the phone from CNA #1. On 08/26/22 at 11:00 AM, the DON provided the surveyor with a copy of the Statement of Clarification dated 08/23/22. A review of this statement included a revised statement of CNA #1 given via telephone to the DON and the MDS Coordinator. The statement indicated CNA #1 was taking care of a resident in room [ROOM NUMBER] when she heard Resident #24 and the nurse's voices in the hallway. When she came out, she observed the nurse holding the resident's wheelchair while he/she was trying to leave the floor. I stayed in front of the door, and tried to talk to him/her and said, You cannot leave the floor so we are going to get the charge nurse for you. This statement contradicts video footage of LPN #1 grabbing the back of the resident's wheelchair after CNA #1 had exited Resident room [ROOM NUMBER]. On 09/06/22 at 02:35 PM, the surveyor conducted an interview via telephone with the DON. The surveyor asked the DON to review the Statement of Clarification dated 08/23/22. The DON read the statement and the surveyor asked if the statement confirmed what the video footage revealed. The DON stated she watched the video three times with the surveyor and the video confirmed that CNA #1 was blocking the door preventing the resident from leaving which was the part she was focused on. When asked if LPN #1 grabbed the back of Resident #24's wheelchair before CNA #1 exited Resident room [ROOM NUMBER] or after, and the DON stated she could not speak to that. The DON confirmed she did not review the video again after receiving the statement because it was the CNA's statement and she admitted to blocking the resident from leaving the room. When asked if it was important to verify the written statement matched the video footage, the DON confirmed yes. On 09/06/22 at 02:50 PM, the DON, in the presence of two surveyors, watched the video surveillance footage which showed CNA #1 stepped out of Resident room [ROOM NUMBER] before LPN #1 and Resident #24 reached the closed exit doors, and CNA #1 stood in front of the exit doors. The video then revealed after CNA #1 was in front of the doors, LPN #1 grabbed the back of Resident #24's wheelchair in the presence of CNA #1. This contradicted CNA #1's revised statement that she walked out of Resident room [ROOM NUMBER] and observed LPN #1 was holding the back of Resident #24's wheelchair at that time. On 09/06/22 at 03:15 PM, the DON followed-up with the surveyor via telephone and confirmed that she watched the video footage again. The DON confirmed that the video footage showed that LPN #1 did not grab the back of Resident #24's wheelchair until after CNA #1 was outside of Resident room [ROOM NUMBER] in front of the door which contradicted the CNA's statement. The DON continued the statement taken was what CNA #1 informed her of what had happened. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Jersey Veterans Memorial Home Menlo	132 Evergreen Rd Edison, NJ 08818

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's Resident Safety Policy and Procedure Resident Abuse Certification dated 06/08/22, included it is policy to promote and maintain a work and living environment that is professional and free from threat, and/or occurrences of harassment, mistreatment, abuse (verbal, physical, mental or sexual), neglect, corporal punishment, involuntary seclusion and misappropriation of property .Residents must not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals . Procedure . identify, correct and intervene in situations in which mistreatment, abuse, neglect and/or misappropriation of resident property [in] more likely to occur. This shall include but is not limited to: the supervision of staff to identify inappropriate behaviors such as using derogatory language, rough handling, ignoring residents while giving care, speaking to a resident in a scolding manner, etc. A review of the facility's Abuse Investigation policy, includes the facility will investigate all alleged and/or suspected events, occurrences, patterns, or trends that may constitute abuse. An investigative report of the findings, disposition of the victim, conclusions, and subsequent administrative actions filed as a matter of record . Procedure . Investigations pertaining to employee to resident . incidents involving employees shall require the employee be assigned to another work area or released from duty with pay pending on the outcome of the investigation. The employee shall not have contact with the resident throughout the course of the Administrative Investigation . NJAC 4.1(a)(5) F600 remains a deficiency at a scope and severity level of a D based on the following: Part B Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure an Agency Nurse received abuse training according to facility policy prior to working in the facility. This was identified for 1 of 3 staff members (LPN #1) reviewed for an abuse investigation of 1 of 5 residents (Resident #24) and was evidenced by the following: On 08/18/22 at 10:38 AM, the surveyor interviewed Resident #24 who stated on 07/30/22, he/she received Percocet (pain management medication) and Xanax (anxiety medication) every six hours and asked an aide to find the nurse to administer the medications. An Agency Nurse (Licensed Practical Nurse (LPN #1)) entered my room and informed me that they would administer my medications and take my vital signs and proceeded to leave the room and closed the door. The resident stated that he/she proceeded to use the callbell and LPN #1 came back into the room, to tell me to stop pushing the callbell; pulled down her mask and attempted to bite my finger as I pointed at her. The resident continued that they got out of bed to get away from her and LPN #1 lunged her nurse's cart at me three times and hit my left foot that reopened a wound. The resident stated that he/she was trying to get away from LPN #1 and get to the Registered Nurse Supervisor (RN Supervisor). The resident stated as he/she was attempting to leave the unit in the hallway, the nurse assaulted me by pulling my wheelchair 2-3 times which caused my wheelchair's (w/c) two front wheels to be in the air which positioned me only on the two back wheels. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The resident stated that there was a Certified Nursing Aide (CNA #1) there but he/she cannot recall their name who tried to calm the crazy nurse down. The resident stated that the RN Supervisor escorted LPN #1 out of the building and a State Trooper came last week who viewed the surveillance footage and confirmed LPN #1 assaulted me. The resident stated that he/she had severe Post Traumatic Stress Disorder (PTSD) and this event had triggered an episode. The surveyor reviewed the medical record for Resident #24. A review of the Resident Facesheet (an admission summary) reflected that the resident was admitted to the facility in September of 2021 but the document did not include admitting diagnoses. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 08/10/22, refl [TRUNCATED]

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 27193 Complaint # NJ00157129 B. Based on interviews, and record review, it was determined that the facility failed to ensure that care plan interventions were being followed and that direct care staff were consistently following the person-centered care plan. This deficient practice was identified for Resident #29 one of 2 residents reviewed for abuse and was evidenced by the following: On 08/16/22 at 11:45 AM the surveyor observed Resident #29 in bed. The head of the bed was elevated, Resident #29 was alert and able to answer some simple questions. On 08/19/22 at 11:00 AM, the surveyor conducted an interview with the Certified Nursing Assistant (CNA) assigned to Resident # 29. The CNA stated that Resident #29 was a total care, does not get out of the bed by choice, had behavior of being accusatory toward staff. She further stated that Resident #29 must have two staff in the room at all times to provide care. The CNA showed the daily assignment to the surveyor. The surveyor reviewed Resident #29's medical record on 08/19/22. The Admission Face sheet revealed that Resident #29 had diagnoses which included but not limited to: Major depressive disorder, cardiac dysrhythmias, atrial flutter, muscle weakness essential hypertension. The Minimum Data Set (MDS) an assessment tool to prioritize care dated 08/01/22 revealed that Resident #29 was able to make his needs/ her needs known. Resident #29 scored 11 on the Brief Interview for Mental Status (BIMS.) normal score 15. A care plan dated 05/10/21 last revised 08/24/22, identified the following problem :I have a habit of accusing others of misconduct towards me The Goal was for Resident #29 to not accusing others of misconduct for the next 90 days. The intervention implemented was for two staff to care for Resident #29 at all times. On 08/23/22 at 12:30 PM an interview was conducted with the Director of Nursing. The surveyor requested all investigative reports for Resident #29. The DON provided a reportable incident dated 08/10/29 regarding an allegation of abuse. 08/24/22 02:30 PM, the surveyor conducted an interview with the (Registered Nurse Unit Manager) RNUM. The RNUM confirmed that Resident # 29 had behavior of being accusatory toward staff, and the behavior was addressed in the care plan. The surveyor reviewed the care plan with the RNUM and noted that the behavior was not addressed on the current care plan. However the behavior was addressed on the CNA's daily assignment. The CNA daily assignment read, two staff members during care at all times. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the incident provided and noted that on 08/10/22 Resident #29 reported an allegation of verbal abuse to the Nursing Supervisor. The facility suspended the CNA pending investigation. 08/25/22 at 11:48 AM, the surveyor entered the room with the RNUM . Resident #29 in the presence of the RNUM agreed to an interview. The resident stated that he had been residing at the facility for 5 years and had a supportive family. Resident #29 stated that something happened and he/she reported it to the Social worker. (SW) Resident #29 stated a female CNA referring to him/her as a black bastard, when he/she inquired about what was going to be served for dinner. Resident #29 stated, I did not like it, I reported it. On 08/25/22 at 12:45 PM, an interview with the RNUM confirmed that 2 staff were to care for Resident #29 at all times. The RNUM stated that a prior allegation of abuse prompted the facility to revise the care plan and implemented that two staff would care for and answer Resident #29's call light all times. On 08/25/22 at 1:30 PM, the surveyor requested all investigative reports regarding Resident #29 for review. The following documentation were provided: 03/31/21 12:18 PM, Resident #29 stated that S staff member was verbally abusive. 04/06/21 4:08 PM, Resident #29 alleged verbal abuse from a staff member. 05/03/21 4:36 PM, reported alleged physical abuse. Resident #29 reported that an aid slapped him in the face. 05/10/21 1:48 PM, alleged verbal and physical abuse. 11/24/21 2:06 PM, Resident #29 stated that a Certified Nursing Assistant (CNA) called him a damn pig 11/24/21 The intervention implemented again for 2 CNAs to be present when entering Resident #29's room. 2 staff will be present when care was rendered. 08/10/22 at 23:08 PM Resident stated that the staff who provided care was verbally abusive. The CNA was suspended, pending an investigation. The surveyor obtained the CNA's file. The CNA received in-service education on abuse and neglect on 09/24/21. The CNA had been working at the facility since 2015. There was no disciplinary action or written warning on the file. On 08/25/22 at 12:06 PM, the surveyor interviewed the Licensed Social Worker (SW) who confirmed that Resident #29 reported the alleged abuse. The SW stated that she met with Resident #29 and completed the investigation. Resident #29 was able to describe the time and described the staff involved. The resident indicated that he/she was not afraid and felt comfortable. On 08/30/22 at 09:30 AM, the DON provided the incident report pertaining to the above allegation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was statement from one staff only. On 08/30/22 at 10:58 AM, two surveyors conducted a telephone interview with the CNA who provided care to Resident #29 on 08/10/22. The CNA stated, that she was aware of the plan of care, she could not find any staff to assist. She stated, that night the facility was short handed. One of the CNA on duty that could assist her,was not allowed to enter Resident #29's room due a prior allegation of abuse. On 08/30/22 at 12:30 PM, the surveyor conducted an interview with the DON. The surveyor reviewed the Care Plan with the DON, the DON stated that the CNA did not follow the plan of care. The surveyor reviewed the Interdisciplinary Progress Notes dated 08/10/22, with the RNUM, the RNUM stated, that she was told that only documentation of clinical relevance should be entered in the medical record. The RN stated that Resident #29 made appropriate remarks . The appropriate remark was not entered in the medical record. 37547 NJ Complaint #156759 Based on observation, interviews, and record review, it was determined that the facility failed to develop a comprehensive, person-centered care plan for a resident who had known triggers for Post-Traumatic Stress Disorder (PTSD). This deficient practice was identified for 1 of 47 residents sampled for comprehensive care plans (Resident #24). This deficient practice was based on the following: Refer to F600 J On 08/18/22 at 10:28 AM, the surveyor observed Resident #24 seated in a wheelchair at the bedside. When interviewed, the resident informed the surveyor that on 07/30/22, he/she pressed the call light to request scheduled pain and anxiety medications and the call light was answered by the Certified Nursing Assistant (CNA) who reportedly informed the resident's assigned nurse. The resident stated the nurse walked in the room and stated that she would obtain the resident's vital signs and medications simultaneously and then proceeded to walk out of the resident's room and closed the door behind her. The resident reportedly pressed the call light in an effort to call the nurse back to the room. The resident stated that the nurse walked back into the room and yelled at the resident to, Stop buzzing. The resident stated that a verbal exchange ensued between the two and when the resident pointed his/her finger into the nurse's face, she pulled down her mask and attempted to bite the resident's finger. The resident stated the nurse continued to scream and the resident got out of bed at that point and attempted to get away from her. The resident alleged that the nurse lunged the medication cart towards him/her three times and hit the resident's left foot. The resident reportedly tried to call for a nursing supervisor and the nurse pulled the wheelchair two or three times and caused the resident to do a wheelie in the wheelchair and the nurse continued along side the resident as the resident attempted to leave the nursing unit. The resident confirmed that the nurse was an agency nurse who had never provided care to him/her before and was not permitted to return to the facility. The resident further stated that the nursing supervisor responded and escorted the crazy nurse off of the unit, and the resident was assured that the nurse was not permitted to return to the facility. The resident further stated that he/she had severe PTSD and was visibly upset during the recount of the event. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's medical record reflected the following: Review of Resident #24's Resident Facesheet revealed that the resident was admitted to the facility in September of 2021, with a single diagnosis of Post-traumatic stress disorder. Review of the Quarterly Minimum Data Set (MDS), an assessment tool dated 08/10/22, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was fully cognitively intact. Further review of the MDS indicated that the resident was independent with bed mobility, required limited assistance of one person for transfers, required set up for meals and required extensive assistance of one person for toileting and personal hygiene. Active Diagnoses that were identified in the assessment included but were not limited to: anxiety, depression, psychotic disorder (not specified) and PTSD. Review of Resident #24's Plan of Care (POC) revealed that a single diagnosis of Post-traumatic stress disorder (PTSD) was identified on every page of the 33-page document. Further review of the POC revealed that there was an entry dated 07/30/22, which confirmed the resident's account of the incident that occurred between the resident and the agency nurse. The problem identified that the resident had an altercation with a nurse, reported that the agency nurse yelled at the resident, pointed her finger at the resident, and blocked the resident with the medication cart in his/her room. Goals included that were effective on 08/11/22, included that the resident would feel safe and would be allowed to move freely around the facility. Interventions included: Staff to treat resident with dignity, respect, not raise their voices or yell at the resident, staff to allow the resident to leave his/her room as long as environment was safe, encourage resident to engage in care, staff to encourage resident to move about the facility at will, if resident asserts themselves verbally, staff to actively listen, validate, and respond to resident in an intentionally calm or low voice and lastly, staff to engage with resident and provide support. Further review POC revealed that there was no entry related to the resident's primary diagnoses of PTSD, triggers, and related goals and interventions. On 09/01/22 at 9:04 AM, the surveyor interviewed the Supervisor of Nursing/MDS Coordinator (SON/MDSC), who stated that each unit was assigned it's own MDS Nurse. She stated that she bore the responsibility to sign that the MDS was completed prior to submission. The SON/MDSC stated that the facility held Interdisciplinary Team Meetings/Care Planning MDS meetings. She remarked that it was identified in meetings that Resident #24 had a lot of pain. When the surveyor asked if she would expect to see a POC entry related to PTSD, she stated, Yes, especially with some of the resident's behaviors that I have heard about. The SON/MDS described the resident behaviors which included: yelling at staff, dressing change refusal and room mate refusal. She stated that a PTSD POC should have been there in the POC with specific triggers which may provoke the resident's behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/02/22 at 9:52 AM the surveyor interviewed the 7 AM - 3 PM Supervisor, who reportedly worked on another unit. The surveyor asked her to review Resident #24's Care Plan which was kept in a binder on the counter at the nurse's station with the surveyor. The 7 AM - 3 PM Supervisor stated that the MDS Nurse who was assigned to the unit was responsible to generate and update the resident's POC. The 7 AM - 3 PM Supervisor stated that the resident's POC should have included a PTSD entry and how to handle the resident's behaviors when they come up. The 7 AM - 3 PM Supervisor stated, Like what just happened now. The 7 AM - 3 PM Supervisor stated that the Unit Clerk phoned her unit and requested that she come over and address a concern with Resident #24. The 7 AM - 3 PM Supervisor stated that the resident complained that he/she requested a topical medication to treat foot pain that was no longer ordered and the resident hollered at the the nurse to, Do it now! The 7 AM - 3 PM Supervisor stated that she phoned the doctor and obtained an order and the doctor advised her to send the resident to the hospital if no relief. The 7 AM - 3 PM Supervisor stated, The POC was very important and that was why it was left on the desk. That is why it is here. On 09/02/22 at 10:02 AM, the surveyor interviewed Resident #24's assigned MDS nurse who stated that she was unsure if she initiated the resident's POC. She stated that the resident had behaviors, but not PTSD. She stated that the POC was generalized with behaviors, not specifically PTSD. She further stated that maybe we have not connected the behaviors and the diagnosis together. On 09/02/22 at 9:31 AM the surveyor interviewed the Social Worker (SW), who stated that Resident #24 had spoken to her about their diagnosis of PTSD and informed her that loud noises upset the resident and set off their PTSD such as with bed alarms and floor mats used by the facility. The SW stated that we suggested that we kept the resident's door closed a little bit, and the resident informed her that the resident did not want the door closed, because it was the resident's preference to keep the door open. The SW stated that the resident also referred to stuff that happened during war time. The SW further stated that, The POC should have addressed the resident's PTSD and included interventions and goals to include triggers such as loud noises and closing the door. On 09/02/22 at 12:13 PM the surveyor interview the Director of Nursing (DON), who stated that she would review Resident #24's POC because PTSD was the big problem. She stated she would have expected that the POC would have included an entry for the diagnosis of PTSD and related behaviors. The DON further stated that if staff were aware that the resident had PTSD, it should have been care planned to help alleviate the resident's behaviors. Review of the facility policy titled, Care Plans-Comprehensive (undated) revealed the following: Purpose: An individual comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Each resident's comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Each resident's comprehensive care plan is designed to: Incorporate identified problem areas, Incorporate risk factors associated with identified problems, Build on the resident's strengths, Reflect the resident's expressed wishes regarding care and treatment goals, Reflect treatment goals, timetables and objectives in measurable outcomes, Identify the professional services that are responsible for each element of care, Aid in preventing or reducing declines in the resident's functional status and/or functional levels, .Reflect currently recognized standards of practice for problem areas and conditions . The Care Planning/Interdisciplinary Team is responsible for the periodic review and updating of care plans: When there has been a significant change in the resident's condition, When the desired outcome is not met, When the resident has been readmitted to the facility from a hospital stay; and at least quarterly . NJAC 8:39-11.2 (e)(1)(2)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint #NJ00156516 Part A Based on interviews, record review, and review of other facility documentation, it was determined that the facility failed to ensure nursing staff appropriately removed an indwelling urinary catheter (soft plastic or rubber tube that is inserted into the bladder to drain urine) in accordance with professional standards of nursing practice which necessitated a transfer to the hospital for treatment, and a urinary tract infection. This deficient practice was identified for 1 of 3 Residents reviewed for indwelling urinary catheter care (Resident #179) and 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 or 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 well-being, and executing medical regimes 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 facility's failure to have a system in place to ensure that nursing staff appropriately removed an indwelling catheter posed a serious and immediate threat to the health, and welfare of all residents who required catheter care. An adverse outcome had occurred and was likely to occur as the identified non-compliance resulted in an immediate Jeopardy (IJ) situation that began on [DATE] at 2:50 PM when the Registered Nurse (RN) improperly removed the indwelling catheter. The RN used scissors to cut through Resident #179's indwelling catheter, which then caused the remaining catheter to retract into the bladder. The Immediate Jeopardy (IJ) situation was identified during an onsite survey conducted on [DATE], and the facility was notified of the IJ, on the same day, at 3:20 PM. The facility submitted an acceptable removal plan on [DATE] at 2:55 PM. The team verified the removal plan during an onsite visit conducted on [DATE]. Findings included: (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 10:30 AM, the surveyor toured the 200 Unit of the facility and observed that Resident #179's door was closed. On the door, the surveyor observed signage posted which identified the required PPE (Personal Protective Equipment) to enter the room. The surveyor observed staff donning (putting on) and doffing (removing) with the required PPE before entering and exiting the room. An interview with the Registered Nurse/Unit Manager (RN/UM) revealed that Resident #179 was on isolation for Extended Spectrum Beta Lactamase (ESBL, antibiotic-resistant bacteria) and Methicillin Resistant Staphylococcus Aureus (MRSA, antibiotic-resistant bacteria) in the urine. On [DATE] at 11:29 AM, the surveyor donned the appropriate PPE, knocked at the door, waited for Resident #179 to answer, and entered the room. The surveyor observed Resident #179 in bed, awake with eyes open, and the surveyor observed a splint to the left arm. The surveyor explained the purpose of the visit, and Resident #179 agreed to be interviewed. Resident #179 was alert and stated that he could not move their left arm. Resident #179 answered all questions appropriately. The surveyor observed an indwelling urinary catheter covered with a catheter drainage bag hung on the bed frame. On [DATE] at 09:30 AM, the surveyor returned to the 200 Unit, the door was open, and Resident #179 was not inside the room. Upon inquiry, the RN/UM informed the surveyor that Resident #179 had tested + for COVID-19 in the evening during routine testing and was transferred to the 700 Unit. On [DATE] at 08:30 AM, the surveyor observed Resident #179 on the 700 Unit. The door was closed. Signage with the required PPE was posted on the door. The surveyor reviewed the medical record for Resident #179 on [DATE]. According to the Admission Face Sheet (an admission summary), Resident #179 was readmitted to the facility on [DATE] following a hospitalization for urinary retention. Resident #179 had diagnoses which included, but were not limited to, hypertension, diabetes mellitus, depression, hyperlipidemia, and End Stage Renal Disease. A review of Resident #179's Plan of Care, updated on [DATE] and [DATE], revealed that Resident #179 had decreased range of motion (ROM) and muscle strength related to co-existing chronic medical conditions. Resident #179 also was at risk for infection due to urinary retention. The care plan goal was for Resident #179 to not have a urinary tract infection and to receive the care needed to maintain their current functional status. The Annual Minimum Data Set Assessment (MDS), an assessment tool used by the facility to prioritize care, dated [DATE], revealed that Resident #179 scored ,d+[DATE] on the Brief Interview for Mental Status (BIMS), which indicated intact cognition. The section H of the MDS, which addressed Bladder and Bowel, Resident #179 received a score of 9 for H 0300. The score was indicative of the presence of an indwelling catheter in the bladder. The Interdisciplinary Progress Notes (IDPN) revealed that on [DATE] at 3:00 PM, a Registered Nurse documented in the IDPN, Per assigned desk nurse statement, in the process of removing resident catheter. She cut it and put a towel under it to prevent the urine from draining into the resident's pants. Before she could pull the catheter out part of the catheter retracted. It was reported to the writer. Director of Nursing (DON) and Assistant Director of Nursing (ADON) made aware. NP (Nurse Practitioner) made aware and gave order to transfer Resident #179 to the Emergency Department (ED) for retracted [indwelling urinary] catheter . Resident #179 was picked up at 2:55 PM by 911 crew. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A late IDPN entry dated [DATE], timed 3:30 PM, read, Dc' d [indwelling urinary] catheter retracted in the process of removing it. Resident transferred to ED. On [DATE] at 11:52 AM, the surveyor interviewed the RN/UM regarding the IDPN dated [DATE]. The RN/UM stated that the Registered Nurse (RN #1), who oversaw the unit on [DATE], cut the indwelling urinary catheter in the process of removing the indwelling urinary catheter. She stated that there was an order to remove the indwelling urinary catheter on [DATE]. RN #1 proceeded to execute the order to remove the urinary catheter. The RN/UM stated that RN #1 reportedly had never removed a urinary catheter before. She cut the urinary catheter with a pair of scissors instead of using a syringe to remove the water to deflate the balloon. The remaining urinary catheter then retracted into the bladder. Resident #179 was transferred to the ED for evaluation and treatment the same day. The hospital discharge summary was requested and was not available for review by the surveyor. The RN/UM stated she would inform the DON of the request for the hospital discharge summary. On [DATE] at 12:30 PM, the surveyor interviewed the Director of Nursing (DON). The DON confirmed that she was aware of the above incident and informed the surveyor that RN #1 was currently suspended pending disciplinary action. The surveyor requested the investigation and the employee file for review. The surveyor also requested RN #1's telephone contact to conduct an interview. On [DATE] at 9:23 AM, the surveyor interviewed a random Registered Nurse (RN) assigned to the 200 unit regarding nursing resource materials available to the staff. The RN directed the surveyor to the binder outside the nursing station that contained all the policies and procedures. The surveyor located in the binder policy # 4:035 B titled, Indwelling Catheter Replacement, dated [DATE], which outlined the following: Indwelling Catheter replacement must have a physician order indicating size and schedule. Indwelling catheter replacement must be done by a registered nurse whose clinical skill has been checked by the instructor of nursing. If the physician and/or registered nurse, who has demonstrated clinical competence for this procedure is not available, send Resident to the emergency room for indwelling Catheter. The policy did not include a procedure to remove an indwelling urinary catheter. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 11:00 AM, the surveyor conducted a telephone interview with RN#1, who confirmed she was the nurse who received the order to remove the indwelling urinary catheter on [DATE]. RN #1 stated that she was overwhelmed that day and did not want to leave the procedure for the next shift. RN #1 stated she went to Resident #179's room with the Certified Nurse Aide (CNA), and she then used a pair of scissors from the treatment cart, cut the indwelling urinary catheter, and urine was splashing all over. She stated she then looked for the indwelling urinary catheter but could not locate it on the bed. RN #1 stated she realized that the indwelling urinary catheter retracted into the bladder. She stated she applied a towel to protect the resident's clothing, informed the RN/UM what had happened, and went to the desk and called and reported the incident to the Nurse Practitioner (NP). The NP then gave an order to transfer Resident #179 to Emergency Department for evaluation and treatment, and she reported the incident to the DON and initiated the 911 call for transfer. She stated that the DON informed her to leave the floor once she completed her statement. RN #1 stated that she had not received any in-service education on how to remove an indwelling urinary catheter at the facility. She stated she was aware that besides deflating the balloon, another simple way was to cut the indwelling urinary catheter. She stated, I made a mistake. RN #1 stated that she met with the DON in the office and explained what had happened. The DON informed her that she was suspended. The surveyor then asked RN #1 to elaborate on her work history prior to being employed by the facility. RN #1 stated that she worked as a floor nurse for a long-term care facility and a psychiatric hospital before working at the current facility. She stated she had been a Registered Nurse for [AGE] years. RN #1 stated after being hired by the facility, during orientation, she was able to demonstrate and was evaluated on the skill sets of inserting an indwelling urinary catheter. However, she was not evaluated on indwelling urinary catheter removal. A review of RN #1's orientation file provided by the Nurse Educator (NE) confirmed that she received in-service education on inserting a urinary drainage catheter on [DATE] during orientation. The surveyor requested RN #1's employee file from the DON. RN #1's employee file contained three written warnings, one for a medication error, the second for not donning the proper PPE during an outbreak, and the most recent was for an allegation of verbal abuse toward a family member. RN #1 also stated that she was informed during her hearing with the Employee Relation Officer ([NAME]) that she did not document all the required information on the hospital transfer form prior to sending Resident #179 to the ED. The surveyor then asked RN #1 if there were any resource materials on the floor that she could have used prior to removing the indwelling urinary catheter. She stated that she did not review any indwelling urinary catheter removal procedure before cutting the urinary catheter with scissors. She stated that she was provided with a form titled Wisconsin Technical College (Nursing Skills 21.13 Checklist for [indwelling urinary catheter Removal] during her hearing with [NAME] on [DATE]. On [DATE] at 10:15 AM, the surveyor reviewed the Facility assessment dated [DATE]. According to the documentation provided, the Facility Assessment had to identify and analyze the facility's resident population, which must be considered when determining staffing and resources needed to care for the residents. Understaffing training, it is revealed, Licensed nursing staff receive training and demonstrate competencies in areas of responsibility related to providing skilled nursing care to residents of the facility. Nurses receive updated and additional training as necessary to meet the changing needs of our residents. Training and competencies include, but not limited to: (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Licensed nurse training and/ or competencies. Oxygen set up Oxygen masks . Nasal cannula / Non-Rebreather /Simple face mask Wound care / Dressing Change Suctioning skill/ Trach care Glucometer Medication Pass Indwelling catheter replacement CPR The facility's Indwelling Catheter Replacement policy did not cover Foley Catheter Removal. On [DATE] at 10:37 AM, the surveyor conducted an interview with the NP responsible for Resident #179's care. The NP stated that she wrote an order to remove the indwelling urinary catheter and initiate a voiding trial. She received a call from the nurse, who stated that something had happened. The nurse stated she cut the indwelling urinary catheter to remove it, and the catheter retracted. The NP stated, I came on the unit, examined the Resident, the resident was not in pain. I gave an order to transfer Resident #179 to the ED for evaluation and treatment. The NP stated, I had never heard of such a procedure. The NP further stated that she was not informed of any follow-up or recommendations from the ED. The NP stated that she reviewed the After Visit Summary the next day and could not identify what treatment was provided. She said she called the hospital and spoke to the staff, but the hospital staff could not comment on what treatment was provided. The NP stated she asked for the Urology report and was informed that the Urologist was not called in to see Resident #179. The NP then explained to the ED, what had happened, and that the issue needed to be addressed immediately. The NP stated the Urologist was then made aware that Resident #179 had the retracted catheter in the bladder. On [DATE] at 12:03 PM, the surveyor interviewed the NE in charge of orientation and staff competencies. The surveyor inquired about specific competencies and skill sets necessary to care for resident needs. The NE provided the surveyor with the orientation package. A review of the orientation package confirmed that indwelling urinary catheter removal was not included in the competencies. RN #1 did not receive in-service training for indwelling urinary catheter removal. The NE stated that Licensed Staff had to go to general orientation classes for two days and then work with a mentor on the floor for 14 days (for full time) employees. Mandatory training was scheduled yearly, and skill sets for competencies were completed every two years. Based on the orientation package provided, the facility staff did not receive competency training for indwelling urinary catheter removal. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The NE stated that he was aware of the adverse outcome with the Foley catheter on the [DATE] incident. He was informed that Resident #179 was transferred to ED for treatment because the indwelling urinary catheter was improperly removed. The surveyor requested in-service education training provided after the incident, but none had been provided. When asked how nursing staff competency education was being tracked, the NE added the DON would inform him of any needed in-service education training. The Orientation package provided by the facility was reviewed with the NE on [DATE] and did not include Foley Catheter Removal. The current policy revealed how to insert an indwelling urinary catheter only. The facility was unable to provide the rationale for nursing staff not being trained or assessed for competency on how to remove an indwelling urinary catheter. On [DATE] at 4:40 PM, the surveyor conducted a second interview with RN #1. She stated that she had performed the skill to remove an indwelling urinary catheter before deflating the balloon. She stated that cutting the indwelling urinary catheter was a simple procedure that she had not used prior. She stated that she overheard nurses saying that you could cut the indwelling urinary catheter to remove it, and that was why she cut the indwelling urinary catheter. She stated that after the incident, she went to the internet, watched a video, and realized that she did not follow the proper technique. RN #1 stated that she cut the catheter 4 to 5 inches below the insertion site, not by the port, to evacuate the water. The surveyor then asked RN #1 to elaborate on the procedure for indwelling urinary catheter removal. She stated: 1. Verify the order, identify the patient, explain the procedure, provide privacy, use a syringe to deflate the balloon by aspirating the water, and gently pull the indwelling urinary catheter. She stated she was very concerned regarding the resident's well-being. She kept calling every day to inquire regarding Resident #179's status. RN #1 was able to elaborate on the process of properly removing an indwelling urinary catheter. She could not provide the rationale for cutting the indwelling urinary catheter, which caused Resident #179 to be transferred to the ED for treatment. On [DATE] at 09:30 AM, The DON provided the Investigation Report for review. The surveyor reviewed the final report, which revealed the following: Physical Evidence On [DATE], the charge nurse reported that in the process of removing Resident #179's indwelling urinary catheter, she cut the catheter and part of it retracted into the bladder. Resident #179 was immediately discharged to the hospital for intervention. CT urogram (used to examine the kidneys and bladder) without contrast was performed in the hospital with the impression there is significant bladder wall thickening with peri cystic inflammation suggesting cystitis (inflammation of the urinary bladder), no hydronephrosis or renal calculi identified, a note is made of small bilateral pleural effusion (abnormal fluid collection between thin layers of tissue lining the lung and the wall of the chest cavity), and urinary bladder is partially collapsed around Foley catheter. No further intervention was taken at the hospital. Recommendations: [DATE] Urology consult by ___, with recommendation for bladder ultrasound. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	[DATE] Bladder ultrasound taken on with conclusion of bladder not visualized, to consider ST scan not ordered. On [DATE] resident was seen by the Cardiology group and cleared for cystoscopy. On [DATE], cystoscopy was performed for removal, and a new Foley catheter was placed. The resident was referred for follow-up with Urologist. Resident's care plan revision: Bladders scan every shift Monitor for signs and symptoms of infection Observe Resident for any abdominal pain Encourage fluids Refer to MD if no urinary output Staff Education All nurses were given competency for Foley catheters. Conclusion A Cystoscopy was performed on Resident #179; the retracted piece of the indwelling urinary catheter was removed, and a new indwelling urinary catheter was re-inserted. The resident is being monitored for any signs and symptoms of infection. A bladder scan is being performed every shift to monitor for bladder retention. Resident #179 will be seen by a urologist on [DATE] at the facility. The RN who cut the Foley catheter remains on suspension pending investigation. On [DATE] at 9:51 AM, an interview was conducted with the DON, who stated that she made her last rounds at 2:50 PM and was informed that Resident #179 had to be sent out because the nurse cut the indwelling urinary catheter. When asked if the nurse provided the rationale for cutting the indwelling urinary catheter, the DON added that the indwelling urinary catheter removal was a skill set that was taught in school, and all licensed staff should know how to remove an indwelling urinary catheter. The DON did not interview RN #1 to identify the causal factor, implement corrective action, or prevent recurrence. The DON stated that during her career, she had never heard of cutting the indwelling urinary catheter as a skill set to remove the indwelling urinary catheter. The DON stated that RN #1 was suspended pending disciplinary action, and the incident had been reported to the Department of Health. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 11:17 AM, a second surveyor interviewed the Physician Assistant (PA) covering for the Urologist. He stated they had been assigned to the facility for about 1 ,d+[DATE] to 2 years. Their responsibilities consisted of reviewing all urology consults and changing all indwelling urinary catheters monthly. Resident #179 was seen at the hospital for urinary retention ([DATE]- [DATE]), and an indwelling urinary catheter was inserted prior to discharge to the facility. He was made aware of the adverse outcome of the indwelling urinary catheter removal by the NP. Resident #179 had to have a scheduled cystoscopy to remove the remaining catheter in the bladder. He stated if the resident had a cardiac history, medical clearance had to be obtained to ensure that the resident was stable to sustain the procedure under anesthesia. The PA stated that based on the report obtained from the facility, Resident #179 was able to void and did not develop signs/ symptoms of infection. The PA was unaware that Resident #179's urine culture and sensitivity tested positive for E Coli, ESBL, and MRSA on [DATE] and that Resident #179 had to be placed on Macrobid (antibiotic) to treat the urinary tract infection. On [DATE] at 12:06 PM, the surveyor interviewed the CNA who assisted the RN #1 on [DATE]. The CNA stated that Resident #179 got out of bed three times weekly. It was almost 3:00 PM, and Resident #179 had been dressed and was up and sitting in a wheelchair. The nurse asked her to assist with removal of the indwelling urinary catheter. She stated, she went to the room, pulled Resident #179's pants down just enough to see the indwelling urinary catheter. The CNA stated the catheter was long, the nurse retrieved a pair of scissors from her packet and cut the yellow part that goes into the penis. The nurse then told me to pull out the long part from the pants. The CNA stated that the nurse asked her, What happened to the other part? The CNA stated, I do not know, and the RN #1 stated, It went back inside. The RN #1 then attempted to retract the penis to see if she could visualize the other part of the catheter and she could not. RN #1 then called the UM, explained what had happened, and I was told to return Resident #179 to bed. Upon further inquiry, the CNA stated, I never assisted any other staff at the facility to remove an [indwelling urinary catheter]. I worked in the ED before, and I know when you insert an [indwelling urinary catheter], you have to put water into the port to inflate the balloon and when you had to remove them, [indwelling urinary catheter] you have to take the water out. The surveyor then asked why she did not offer any guidance to RN #1. The CNA replied, She is an RN. She is supposed to know. On [DATE] at 09:43 AM, the surveyor interviewed RN #1 with another surveyor present. RN #1 stated that she attended and graduated from one of the State Colleges. During her academic years, she was taught how to remove an indwelling urinary catheter, but the skill sets were not demonstrated. She stated that in nursing school, she was not evaluated on the skill sets to remove an indwelling urinary catheter. RN #1's failure to remove the Foley catheter in accordance with professional standards of nursing practice resulted in harm, unnecessary transfer to the hospital for treatment and a urinary tract infection. Resident #179 had to have a Cystoscopy (procedure to look inside the bladder with a camera) to remove the retracted indwelling urinary catheter. RN #1 did not seek assistance from other nursing staff to remove the indwelling urinary catheter. She did not inform the Nurse Educator that she needed assistance with the indwelling urinary catheter removal. Part B (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Based on interview and document review, it was determined that the facility failed to ensure: a.) the facility policy was followed to document all pertinent information on a universal transfer form prior to a resident being transferred to the hospital, and b.) thoroughly review instructions/recommendations on the After Visit Summary (hospital discharge summary) to facilitate continuation of care. This deficient practice was identified for 1of 3 Residents reviewed for indwelling urinary catheter care (Resident #179) and was evidenced by the following: 2. On [DATE] at 11:30 AM, the DON provided a copy of the reportable event forwarded to the Department of Health. The surveyor reviewed the report and observed that the facility did not include the New Jersey Universal Transfer Form (NJUTF) that was identified as not completed. Pertinent information regarding the reason for transfer was not entered to inform the ED of the reason for transfer. On the NJUTF the following information was documented, Tube/catheter. Resident # 179 was sent back to the facility with the remaining catheter in the bladder. The Urologist was not called and informed that the nurse cut the indwelling urinary catheter and the remaining catheter was still inside Resident #179's bladder. The ED was informed of the retracted catheter remaining in the bladder on [DATE], one day after the resident was transferred to the ED, by the NP. On [DATE] at 11:34 AM, the DON provided the surveyor a copy of the undated facility's policy Resident Transfer Form. The policy revealed: Purpose: The purpose of this procedure is to ensure continuity of care in transfer from the facility to the hospital or other extended care facility. Procedure: 1. In the event a resident needs to be transferred to a hospital or other long-term care facilities, the charge nurse is responsible for filling out a Resident Transfer Form. 2. The form must be completed totally, and all information must be up-to-date and accurate. 3. The attached copy of the completed transfer form is to be placed in the resident's chart. 4. Information received in reference to resident transfers will be forwarded to the units by the nursing office. 5. The Nursing Services Clerk will transcribe the information to the Universal Transfer Form and date and sign the form. The form will be placed in a sheet protector and placed in the front of the chart. The facility failed to enter all the pertinent information on the NJUTF to facilitate continuity of care. The reason for the transfer was not documented, and the ED had not been informed that Resident #179's indwelling urinary catheter was cut. The remaining catheter remained in the resident's bladder. The Urologist was not called and informed of the incident. Resident #179 returned to the facility with the remaining catheter not being removed from the bladder. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. The surveyor reviewed the After Visit Summary dated [DATE], which revealed that during the ED visit, Resident #179 received Rocephin [a broad spectrum antibiotic] 1 gram (gm), intravenously at the hospital for preventive measure of UTI. Please give Cephalexin (Keflex; antibiotic) 500 mg (milligrams) every 12 hours for the next 7 days for treatment of Urinary Tract Infection. The physician, or the NP was not made aware of the recommended continued medication order. The surveyor reviewed the [DATE] Medication Administration Record (MAR) and the order was not transcribed. On [DATE] at 10:23 AM, in the presence of the survey team the surveyor conducted an interview with the Assistant Director of Nursing (ADON). The ADON confirmed that staff missed the instructions on the After Visit Summary for the Keflex order. The ADON stated, on [DATE] during the final investigation regarding the adverse outcome with the Foley Catheter Removal, she discovered that Resident #179 did not receive the Antibiotic ordered on [DATE]. She reported the incident to the DON, and the administrator. She stated, she consulted with the (MD) who ordered Urine analysis, urine culture and sensitivity, Keflex 500 mg twice daily for 10 days for preventive measure. The facility received the urine culture result on [DATE] and the final report revealed the following: Urine Culture Colony Count Source: Colony Count: 100, 000 + Grams-Negative Rods Gram-Positive Cocci in clusters Extended Spectrum Beta Lactamase (ESBL)- Positive ESBL is an enzyme that causes an organism to become resistant to extended-Spectrum cephalosporins, monobactams and extended-spectrum penicillins. Contact precautions indicated. Positive for MRSA. Contact precautions indicated. The NP was informed of the result on [DATE]. Resident #179 was placed on contact isolation. Keflex was discontinued and Macrobid 100 mg was ordered twice daily for 5 days. On [DATE] at 10:05 AM, the surveyor conducted an interview with the Medical Director (MD) in the presence of the team. The MD confirmed that the facility discussed with him the adverse outcome with the urinary catheter removal. He stated he was consulted by both the DON and the Assistant Director of Nursing regarding Resident #179's not receiving the Antibiotic ordered at the hospital since [DATE]. He gave a verbal order to obtain Urine Analysis, urine culture and sensitivity and ordered Keflex 500 milligrams every 12 hours for 10 days for UTI. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The surveyor observed a signed verbal order in the clinical record dated [DATE]. The MD stated, apparently this nurse had heard that cutting the [indwelling urinary catheter] was the easiest way to take the [indwelling urinary catheter] out. She opted for the easiest way. I am not sure where the education came from. I just do not know how it happened; the nurse needed to be suspended. The MD further stated, he started in July and identified that staff education, lack of oversight from the physician, infection control, mishandling of patient's care, policies and standards procedure needed to be addressed. He added the facility needed a system to track significant issues. [DATE] at 3:02 PM, the surveyor conducted a telephone interview with the Registered Nurse (RN #2) who received Resident #179's After Visit Summary on [DATE]. The RN #2 confirmed that she was assigned to Resident #179 on the third shift (11:00 PM-07:00 AM) She stated that she did not see the instructions for the Keflex order and did not inform the NP. RN #2 stated that she reviewed the After Visit Summary with the Supervisor of Nursing (SON) and they both missed the instructions to administer Keflex. The Keflex order was not documented on the After Visit Summary dated [DATE], and Resident #179 received the Keflex 15 days later ([DATE]). RN #2 stated, she was made aware of the mistake by the ADON, and DON. The RN stated, I do not know how I missed the order. I reviewed the After Visit Summary that day and did not see the order. The SON and the NP both reviewed the After Visit Summary and missed the order. Resident #179 did not receive the antibiotic for 15 days. Resident #179's UA and C&S result was positive for E.Coli, ESBL and MRSA on [DATE]. The facility was unable to provide a rationale for the nurses failing to thoroughly review the After Visit Summary and then failing to communicate the recommendations to the physician/NP. On [DATE] at 12:32 PM, during an additional interview with the NP in the presence of the survey team.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 27193 Complaint #NJ156886 Based on interview, record review, and review of other facility documents, it was determined that the facility failed to ensure a resident who sustained a fall with a possible fractured arm received a timely recommended medical follow-up by failing to: a.) thoroughly review the After Visit Summary (discharge hospital summary) and communicate the recommendations to the physician, and b.) thoroughly review an X-Ray report received on 07/13/22, and alert the physician of the recommended follow-up with more films to confirm the possible fracture detected on the X-Ray. This deficient practice occurred for 1 of 47 sampled residents reviewed (Resident #44) who sustained a fall with a hematoma (collection of blood outside of blood vessels) on the forehead on 07/12/22. There was a 12 day delay from 07/13/22 to 07/25/22. The recommended follow-up was as soon as possible for a visit in 2 days (around 07/14/22), and was evidenced by the following: Reference: New Jersey Statutes, 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 or 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 regimes as prescribed by a licensed or otherwise legally authorized physician or dentist: On 08/16/22 at 10:52 AM, during the initial tour of the facility, the surveyor observed Resident #44, who had a yellow cast on the right forearm. The resident was sitting in a chair in the room close to the nursing station and did not respond to the surveyor's greetings. On 08/17/22 at 1:16 PM, the surveyor observed Resident #44 in the room eating lunch. Resident #44 consumed approximately twenty-five percent of the lunch tray. On 08/18/22 at 1:28 PM, the surveyor observed Resident #44 sitting quietly in the resident's room and wearing non-skid socks on both feet. The yellow cast was observed on the right forearm. On 08/19/22 at 8:51 AM, Resident #44 was observed sitting in the room eating breakfast. The yellow cast was observed on the right forearm. On 08/23/22 at 9:22 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who cared for Resident #44. The CNA stated that Resident #44 was totally dependent upon staff for care but was able to feed themself after set-up. The CNA stated that Resident #44 could be combative with care. However, she had developed a trusting relationship with the resident, and the resident was not very combative with her during care. The CNA also stated that the family was very involved. The surveyor reviewed Resident #44's medical record on 08/17/22. According to the Admission Face Sheet, Resident #44 was admitted to the facility with diagnoses which included, but were not limited to: hypertension (high blood pressure), pernicious anemia (a condition in which not enough red blood cells are produced due to deficiency of vitamin B12 in the body) and Dementia (a group of symptoms that affects memory, thinking and interfered with daily life) with behavioral disturbances. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The quarterly Minimum Data Set Assessment (MDS), an assessment tool used by the facility to prioritize care, dated 05/22/22 and 08/22/22, revealed that Resident #44 was severely cognitively impaired. Resident #44 scored 99 on the Brief Interview for mental status (Normal score 8-15). Further review of the MDS revealed that Resident #44 was unable to make their needs known. A Care Plan (CP) dated 10/29/20 revealed the following problems: Cognitive- Resident #44 was impaired in decision making ability related to Depression, Dementia, and anxiety as evidenced by difficulty making decisions in new situations, poor decision ability, and needs cues and supervision. The fall care plan dated 12/27/17, last revised 07/28/22 included the following: Keep my surroundings safe and free from clutter. Keep my bed at the lowest safe position. Apply non-skid strips on the floor. Assist me to wear non-skid socks when I am not wearing shoes . A Progress Note dated 07/12/22 revealed that Resident #44 sustained a fall with injury. Resident #44 was observed lying on the floor in the room with a hematoma (collection of blood) on the forehead measuring 3.5 centimeters (cm) x 3.5 cm. Resident #44 was transferred to the Emergency Department (ED) for evaluation and treatment. CT Scan (Computed Tomography) of the spine and head performed at the hospital was negative for fracture. The nurse documented upon return to the facility the following: Scalp hematoma still persists, no signs and symptoms of distress noted. The recommendations to follow up as soon as possible for a visit in 2 days was not depicted on the After Visit Summary dated 07/12/22. The following entries were documented in the clinical record: On 07/13/22 - 07:00 AM. Received resident in bed sleeping, hematoma still persists on right forehead slept in the night. Neuro checks (assess an individual's neurological functions, motor and sensory response, and level of consciousness) within normal limits . will continue to monitor. On 07/13/22, the surveyor reviewed the medical record which lacked evidence of a post fall nursing assessment completed for the 7:00 AM - 3:00 PM shift. On 07/13/22 at 4:00 PM, the resident (referring t Resident #44) received in bed, sleeping, and the patient spit out Tylenol offered. Upon assessment, swelling was noted on the right wrist. When assessing the right hip, the resident was guarding. MD (Medical Doctor) made aware and ordered stat X-Ray of the right side of the upper body, forearm, femur, right pelvis, right humerus, right tibia/ fibula. The resident remained in bed. Will continue to monitor. On 07/14/22, there was no evidence of a documented post fall assessment for the 7:00 AM - 3:00 PM shift. On 07/14/22, 11:00 PM - 7:00 AM shift, revealed that Resident #44 refused vital signs, all care rendered, no delayed injury noted from past fall. On 07/14/22 at 5:40 PM, the following entries were noted, Received resident in bed, X-Ray of the body was done. No fracture noted. Meals and meds well tolerated. No delayed injury. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The surveyor reviewed the X-Ray result, dated 07/13/22, timed 5:38:22 PM, and observed the word Alert was stamped on the X-Ray result. Under the section Forearm AP [(Antero Posterior) and lateral, Right. The following were documented: The study is significantly limited. No fracture or bone destruction are seen in the forearm. However, there is a possible subtle nondisplaced fracture in the right distal right radius. No soft tissue masses are seen. Conclusion: Limited study. There is a possible nondisplaced fracture in the distal right radius. Follow-up more complete wrist films are recommended along with clinical correlation. The above recommendations were not communicated to the physician/Nurse Practitioner in charge of Resident #44's care. On 08/29/22 at 9:20 AM, the surveyor interviewed the Registered Nurse (RN) who received the X-Ray report on 07/13/22. The RN stated that she reviewed the X-Ray result along with the Unit Manager and did not see the recommendations. The surveyor inquired about the word Alert observed on the report. The RN stated, alert means abnormal The RN further stated that she reviewed the first page only and did not see the second page with the recommendation. The RN stated it was only on 07/25/22 that she was made aware of the second page. The RN confirmed that she did not contact the nurse practitioner or physician with the recommendations documented on the X-Ray report that the resident had a right wrist fracture. The RN stated that she met with the Director of Nursing (DON), and the DON had not informed her that she had to provide a statement pertaining to this incident. The RN stated she was not provided with any education either. The RN elaborated that on 07/25/22, a change of condition was reported by the CNA who cared for Resident #44, and the nurse then assessed the resident. At that time, it was noted that Resident #44 was limping, guarding the right side, and appeared to have pain in the right arm. The physician was called and ordered an X-Ray of the right side of the body. The X-Ray report dated 07/25/22 timed 11:46:33 PM, confirmed the fracture identified on the report dated 07/13/22 and indicated the following: Comparison is dated 07/13/22. As was suspected on the previous examination (07/13/22), there is a nondisplaced distal radius fracture without significant interval healing. No additional fractures are observed. There is no destructive bony process. The surrounding soft tissues have a normal appearance. The NP gave an order to transfer Resident #44 to the hospital for evaluation and treatment. Imaging Tests[X-Ray forearm two views Right] confirmed a closed fracture of the distal end of the right radius with delayed healing. During the second ED visit dated 07/26/22, a second X-Ray confirmed the fracture detected since 07/13/22. Resident #44 returned with a splint to the right arm. On 08/10/22, during a visit to the orthopedist, Resident #44 had a cast applied to the right hand to facilitate healing of the fracture. The cast was removed on 08/23/22. The Nurse Practitioner signed the X-Ray report on 07/19/22 and missed the recommendations on the X-Ray report. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/29/22 at 10:05 AM, an interview with the Director of Nursing (DON) in the presence of another surveyor revealed that during the investigation, she noted that the nurse failed to pick up on the recommendations both on the After Visit Summary and on the X-Ray report; therefore, there was a delay in treatment. The DON stated, When a consult comes in, there should be a follow-up. The DON confirmed that the recommendations were not detected during the 24 hours chart check. The DON added, There is going to be a write-up for the nurses and the supervisors as well. An entry dated 07/26/22, timed 10:15 AM, revealed that the son was made aware of the fracture on 07/26/22. He indicated, I still want my (Resident #44) to go to the hospital in case she fell and sustained an injury or serious medical condition. The family was not informed of the fracture on 07/13/22. On 08/29/22 at 10:33 AM, an interview with the Registered Nurse/Unit Manager (RN/UM) revealed that she was unaware of the follow-up required as documented on the After Visit Summary until 07/25/22. The RN/UM confirmed that she reviewed the X-Ray report also and missed the recommendations. On 08/30/22 at 09:30 AM, the surveyor requested all investigative reports for Resident #44 from the DON. The facility provided a Reportable Incident dated 07/25/22. The report revealed the final investigation indicated that Resident #44 was observed with swelling. X-Ray done, result was positive for fracture of the right distal radius. MD (physician) notified of result and ordered for Resident #44 to be transferred to the hospital for further evaluation and treatment. Resident #44 returned from the hospital with a splint to the right arm. On 08/30/22 at 12:13 PM, conducted a second interview with the regularly assigned CNA assigned to Resident #44. The CNA stated that the bruises had been present since last week. The CNA stated that she did not report it to the nurse because the bruise had been there since the fall, and she thought the nurse knew about it. Conclusion: Resident (referring to resident #44) was noted with swelling of the right wrist region on 07/29/22. resident did have an X-Ray of the same area on 07/12/12, which the radiologist reported as inconclusive for fracture. However, based on clinical record provided by the facility and reviewed on site, Resident #44 was noted with swelling of the right wrist on 07/13/22. An X-ray was ordered and carried out on that same day, 07/13/22. The X-Ray report dated 07/13/22 came with an Alert as there was a possible nondisplaced fracture seen, and the facility was to order more films to correlate. The facility missed the recommendations. The physician or the nurse practitioner was not made aware until 07/25/22, when a change of condition was reported. On 08/31/22 at 10:09 AM, during a second interview with the DON, she indicated that the Nursing Supervisor informed her on 07/25/22 that she needed to schedule an orthopedic appointment that had been missed on 07/12/22. She did not have any prior knowledge of the incident. On 08/31/22 at 11:18 AM, the surveyor observed Resident #44 sitting in the room with the left hand holding the right wrist. On 08/31/22 at 12:30 PM, an interview with the Physical Therapy (PT) Director revealed that Resident #44 was not referred to PT immediately after the fall. He received a referral on 07/29/22. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/31/22 at 1:43 PM, an interview was conducted with the NP in charge of Resident #44's care. The NP was asked if she was aware of the fracture when she signed the report on 07/19/22. She stated that she did not know exactly what she did. When asked to elaborate on the process if a fracture was detected on the X-Ray report, she said she would usually follow up immediately and notify the family right away. The NP stated, I could not remember. I don't know. There was no documented evidence that the fracture was detected and discussed with the family on 07/13/22. The RN who reviewed the report did not inform the NP. On 09/01/22 at 8:55 AM, the surveyor conducted a second interview with the RN. The RN stated that she had been aware of the After Visit Summary recommendations. She added that she had discussed the recommendations with the NP, and the NP then informed the son, and the NP indicated that there was no need to follow up. On 09/01/22 at 11:21 AM, during a second interview with the RN/UM, she confirmed that she reviewed the X-Ray result with the Charge Nurse. The UM stated, We both saw the word Alert, and we don't know how we missed it. When asked if the radiology department was called to clarify the Alert, the RN/UM stated that she did not contact radiology to clarify the Alert. On 09/01/22 at 11:21 AM, during a third interview with the RN, who initially received the X-Ray report, she maintained that she did not review the whole report. She stated, If I was aware, I would call the MD/NP immediately., and we did not follow up with the care that needed to be provided. The RN stated, This is a delay in treatment. I learned my lesson and need to review the whole report to the end. The RN further stated that she had not received any education yet regarding the incident. The surveyor then asked the RN to elaborate on the facility's documentation post-fall. The RN stated that the staff was to perform a daily head-to-toe assessment for 5 days after a fall. When asked if body check was done or the protocol was being followed, she replied that Resident #44 was always combative with care. There was no documented evidence that assessment was carried out post fall on all three shifts for five days. On 09/01/22 at 9:07 AM, the surveyor observed Resident #44 in bed. Resident #44 was not dressed. On 09/01/22 at 2:13 PM, an interview with the Nursing Supervisor on duty that day revealed that she did not review the After Visit Summary or the X-Ray result. The nurse told her there was no fracture. She did not assess the resident as the resident returned the same day. She was not aware of the recommendations. She added that the Nursing Supervisor on the day shift was to follow on the next day. On 09/02/22 at 9:37 AM, the regular CNA assigned to Resident #44 retired. Throughout the survey until 09/01/22, the surveyor would observe Resident #44 sitting in the room eating breakfast early in the morning. On 09/02/22 at 9:37 AM, the surveyor observed Resident #44 in bed. The side rails were elevated on both sides. The breakfast tray was untouched. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 09/02/22 at 10:20 AM, an interview with the Charge Nurse revealed that the breakfast tray was served around 7:30-08:00 AM. Care was not provided to Resident #44 until the surveyor inquired about the breakfast tray at 10:30 AM. The nurse stated that the resident was left in bed due to a cardiologist visit. There was no rationale provided for the breakfast tray left at the bedside with the side rails up and the breakfast tray, not within the resident's reach. The Charge Nurse also acknowledged that since the fall, the resident had not been able to ambulate and confirmed that Resident #44 could not reach the breakfast tray. That same day the Charge Nurse had to use a transport chair to transfer Resident #44 from the room to the hallway to be weighed. No weight loss was noted. On 09/02/22 at 10:25 AM, an interview with the CNA who cared for the resident that day revealed that he worked the 3:00-11:00 PM shift and was unfamiliar with Resident #44's routine. He was aware that Resident #44 was combative with care. The CNA added that he did not provide care yet to Resident #44. Resident #44 was a high risk for falls. Resident #44 received a score of 16 on the Fall Risk Assessment. A care plan to prevent falls was in place prior to the fall. After the fall, dated 07/12/22, the care plan was revised to include non-skid strips on the fall care plan. However, the facility did not follow up with: a) recommendations on the After Visit Summary. b) recommendations on the X-Ray report, which came with an Alert. Resident #44's clinical record lacked evidence that the physician or nurse practitioner was consulted with all the recommendations dated 07/12/22 and 07/13/22 and that a head to toe assessment was done on all three shifts following the fall. The clinical record lacked evidence of any steps taken to address Resident #44's health status in a timely manner. The facility lacked evidence of a system to ensure that all recommendations and consults were thoroughly reviewed, documented, and communicated to the physician or the nurse practitioner in a timely manner. Although the nurse practitioner confirmed that she signed the X-Ray report on 07/19/22, the clinical record lacked evidence that she was aware of the possible fracture, acted upon the recommendations, and consulted with Resident #44's family before 07/26/22. An undated facility policy entitled Guidelines for Charting and Documentation included: The purpose of charting and documentation is to provide : 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, and the progress of the resident's care. 2. Guidance to the physician in prescribing appropriate medications and treatments. 3. The facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident. The above findings were reviewed with the facility administrative staff on 09/01/22 and again during the Exit Conference. No further information was provided. NJAC 8:39-27.1 (a)

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F 0692 Level of Harm - Minimal harm or potential for 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** 33106 Based on observations, interviews, review of clinical records and other facility documentation, it was determined that the facility failed to: a) provide nutritional supplements recommended by a Registered Dietician (RD) to address a weight loss b) obtain resident re-weights in accordance with the facility policy for a resident with a weight change of three or more pounds c) administer enteral tube feeding (allows food to enter the stomach or intestine through a tube) at the prescribed rate. This deficient practice was identified for 2 of 6 residents reviewed (Resident #152, Resident #59) for nutrition and was evidenced by the following: 1. On 08/16/22 at 11:05 AM during tour, Surveyor #1 observed Resident #152 who was seated in a wheelchair in the dayroom and appeared both thin and frail. The resident was not able to provide the surveyor with any history due to cognitive loss and was not able to be interviewed. The resident Face Sheet indicated that Resident #152 was admitted to the facility in April of 2022. The Resident Nursing Evaluation/Data Collection form dated 04/08/22 at 11:45 AM, indicated that Resident #152 had the diagnoses that included but was not limited to dementia (a group of symptoms that affects memory, thinking and interferes with daily life), hypertension (HTN), macular degeneration (vision impairment resulting from deterioration of the central part of retina), enlarged prostate and gastroesophageal reflux disease (occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach). The resident's functional status indicated that the resident was highly involved in the activity, but that staff provided guided maneuvering of limbs or other non-weight bearing assistance for bed mobility, transfers, ambulation, dressing, personal hygiene, and toilet use. The admission Minimum Data Set (MDS) an assessment tool dated 04/14/2022 indicated that the resident's weight was 147. The quarterly MDS dated [DATE], reflected that the resident weighed 136. The Physician's Order form dated 08/01/2022 to 08/31/2022, reflected that Resident # 152 was ordered a regular diet. The dietician interdisciplinary (IDT) note dated 07/18/22 at 03:30 PM, indicated that Resident #152 had a weight loss. The Registered Dietician (RD) #1 recommended for the resident to receive Boost Plus BID (twice a day) as a supplement. Surveyor #1 reviewed Resident #152's medical record and did not find a physician order for Boost plus supplement BID. Further review of the medical record revealed that there was no documentation on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) that the resident was receiving the nutritional supplement Boost Plus. On 08/22/22 at 10:15 AM, Surveyor #1 interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that Resident #152 was on weekly weights in August for weight loss. The surveyor reviewed the dietician notes dated 07/18/22 at 03:30 PM with the RN/UM who acknowledged the RD #1's recommendations for Boost Plus BID (twice a day) as a supplement. The RN/UM did not have an explanation as to why physician orders were not obtained for the RD #1's recommendations. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RM/UM then stated that the kitchen sent up the supplements and a physician's order was not required for the supplement Boost Plus. The surveyor asked how the nursing staff tracked how much the resident consumed of the recommended supplement and the RN/UM replied, you would just ask the CNA (Certified Nursing Assistant) how much the resident drank. When the surveyor asked the RN/UN how the nurse or CNA would know which residents received a supplement the RN/UM could not provide the surveyor with a response. On 08/22/22 10:30 AM, Surveyor #1 interviewed the Registered Dietician Director (RDD) who stated that if a dietician recommended a supplement such as Boost Plus that a physician order would have to be obtained and it would be documented in the MAR. She also stated that the nurse would be required to document how much of the supplement the resident consumed in the MAR. The RDD stated that a physician's order was not needed for calorie dense foods and that they could be added to the meal trays to include foods such as super cereal, extra butter, extra milk, mighty shakes, ice cream etc. She stated that calorie dense foods would be on the meal ticket. The RDD stated that the RD for the Eagle Unit who followed Resident #152, was in the facility and that she would have her explain the dietician note dated 07/18/22 at 03:30 PM, because she was the one who wrote it. The RDD confirmed that there was not a physician's order in Resident #152's medical record for Boost Plus BID. On 08/22/22 at 10:47 AM, Surveyor #1 interviewed the Food Service Director (FSD) who stated that supplements such as Ensure, or Boost were kept on the nursing units and were not sent from the dietary department. The FSD stated that the nurses were responsible to hand the supplement out. He stated, I think you would need a physician's order for those type of supplements. The FSD also added that the dietary department did not have the capability to change any information on the resident dietary ticket, and that only the dietician could change the dietary tickets. The FSD provided the surveyor with a copy of Resident #152's food ticket which indicated that the resident was being provided with calorie dense food items. On 08/22/22 at 11:24 AM, Surveyor #1 interviewed the CNA who stated that Resident #152 did not have a very good appetite, did not always complete his/her meals and needed encouragement to eat. The CNA stated that the resident had been on weekly weights since July and that she documented the weight on the 24-hour report. She also stated that she did not know if the resident was receiving supplements. On 08/22/22 at 11:33 AM, Surveyor #1 interviewed RD #1 for the Eagle Unit who confirmed that she documented the nutritional note dated 07/18/2022 at 03:30 PM. She explained that she put Resident #152 on weekly weights in July and continued weekly weights in August. She stated that in July the resident had a weight loss and that she recommended Boost Plus BID as supplement and that she put the recommendation on the Advisement to the Physician form. The RD provided the surveyor with a copy of this form which included the RD's recommendation for the Boost Plus supplement to be given to Resident #152 BID. According to the facility form titled, Advisement to the Physician dated 07/19/22, the physician signed the recommendation for Boost Plus BID. RD #1 did not have any explanation as to why there was not a physician's order for the supplement Boost Plus to be given to Resident #152. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Jersey Veterans Memorial Home Menlo	132 Evergreen Rd Edison, NJ 08818

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RD #1 stated that she monitored Resident #152 approximately three times a week visually and the resident ate very slow. She stated, In my clinical judgement I did not feel the resident needed a calorie count because I was watching him/her, and the calorie count would not give me any additional information that I already didn't know. She further stated that for the month of August the resident was on her list to review the weekly weights and at that point she would have noticed that the resident was not receiving the supplements that she recommended. On 08/23/22 at 08:48 AM, RD #1 from Eagle Unit provided the surveyor with a Timeline of Resident #152's weights. The timeline included the following information: Weight History: -04/2022-147.6 pounds (lbs.) -05/2022-151.4 lbs. -06/2022-142.7 lbs. reweight 145 lbs. -07/2022-140.8 lbs. reweight 135.6 lbs. -Weekly weights in July- 07/13/2022-140.2 lbs., 07/20/2022-139.6 lbs., 07/27/2022- weight not available -Weekly weights in August-08/2022-132.0 lbs./ reweight 133.6 lbs., 08/10/2022-137.4 lbs., 08/17/2022-130.9 lbs. The timeline indicated that the resident had a 6-pound weight loss which reflected a 3.6% loss in 30 days. The resident had an 11.4-pound weight loss which reflected an 8% decline in 90 days and a 14-pound weight loss in 150 days which reflected a 10% decline in weight since admission. On 08/23/22 at 09:39 AM, Surveyor #1, and Surveyor #2 interviewed RD #1 from the Eagle Unit and RD #1 stated that when weight loss occurred for a resident in the facility that most times she would increase the resident's calories in meals such as with double portions, ice cream, pudding, whole milk. She stated that she would evaluate the patient and if she thought the resident needed increase in calories, she would adjust the resident's diet. She stated that physician orders were not needed to increase calories and adjust the meal plan for the residents. She further stated that if a nutritional supplement was recommended that a physician's order was needed for that supplement. She stated that when she would recommend a supplement such as Boost Plus and that the Dieticians in the facility had two ways of ordering supplements for the residents. The first way was to flag a dietary recommendation or prepare a Physician Verification Form (PVF) and flag it in the clinical record for the physician to review and order the supplements that were recommended. RD #1 stated that she was not allowed to write orders for supplements and if she noticed that the dietary supplement was not ordered for whatever reason she would talk to the physician again to find out why it was not ordered. She stated that she was not sure why the Boost supplement was not ordered when she recommended it because the physician signed the PVF that it was approved. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/23/22 at 12:41 PM, Surveyor #1 interviewed the Registered Nurse (RN) regarding the process for administration of supplements to the residents. He stated that supplements had to be ordered by a physician and the order was written in the MAR and the nurse was responsible to document the percentage of supplement a resident ingested. He stated that information was also documented in the Interdisciplinary Progress Notes (IDT) note. On 08/23/22 at 12:55 PM, Surveyor #1 and Surveyor #2 interviewed RD #1 regarding Resident #152's weight loss. RD #1 stated that the resident was eating well and then declined. She stated that in May, Resident #152 was placed on Lasix (diuretic) for 7 days for edema (swelling due to fluid) and Congestive Heart Failure (CHF) (progressive heart disease that affects pumping action of the heart muscles) which could have contributed to resident's weight loss. She stated that a nutritional assessment was done with the family on admission. She added that the resident had fluctuations in weight in June and lost 4% which was not a significant loss. She stated that the resident had some decline in appetite and was seen in July for quarterly assessment. She stated that at that time she recommended: calorie dense foods, and Boost Plus BID. Surveyor #2 asked RD #1, from 07/19/22 until 8/22/22, was the resident receiving the Boost supplements? RD #1 stated, No, unfortunately he/she was not receiving the supplements during that time. RD #1 stated that she wrote new recommendations, and Resident #152 would now receive Boost three times per day. Surveyor #2 asked, why wasn't there any follow up with the resident, to see if he/she was receiving or enjoying the supplement? RD #1 stated, I should have followed up, but I have a lot of patients and I did go on vacation. The Care Plan (CP) was reviewed and reflected that on 4/22/22 the resident had a problem that he/she was at a nutritional risk due to recent decline in appetite and weight (low BMI [body mass index] (a weight to height ratio) and abnormal labs). The goal indicated that the resident would have an improvement in intake and would not have a further decline in weight. Interventions included: Please provide calorie dense foods and Boost Plus BID supplement, assess change and adjust diet as needed. 37547 2. On 08/16/22 at 11:52 AM during the initial tour of the facility, Surveyor #2 observed Resident #59 who was lying in bed and appeared thin. The resident did not respond to the surveyor when spoken to. The surveyor observed that there was a feeding tube pump that hung on a pole beside the resident's bed which was not in use at that time. The resident's left hand was noted to be contracted and the resident wore a splint on the affected extremity. On 08/18/22 at 11:02 AM, the surveyor observed Resident #59 lying in bed awake with the head of the bed elevated. A bottle of Iso Source 1.5 Cal infused via a tube feeding (TF) pump and the digital display on the pump indicated that the feeding was set to infuse at a rate of 65 ml/hr. (milliliters per hour) and that 1107 ml had already infused. Review of the Resident Facesheet revealed that Resident #59 was admitted to the facility in July of 2021 with diagnoses which included but were not limited to: dysphagia (difficulty swallowing), essential hypertension (high blood pressure), and adult failure to thrive. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #59's quarterly MDS dated [DATE], reflected that the resident was unable to complete the Brief Interview for Mental Status (BIMS) and was determined to be severely cognitively impaired, and required total dependence of two persons for bed mobility, transfers, and one person assist for dressing, eating (tube feeding), toileting and personal hygiene. Further review of the MDS revealed that Resident #59 was 69 inches tall, weighed 125 pounds (lbs). Review of a Significant Change MDS dated [DATE], revealed that the resident's weight was recorded as 124 lbs. Both the quarterly and significant change MDS indicated that the resident received 51% or more of total calories through tube feeding. Review of Resident #59's CP revealed an entry dated 10/19/21, which demonstrated that the resident was at nutritional risk related to dysphagia/failure to thrive/aspiration pneumonia (occurs when food or liquid is breathed into the airways or lungs instead of being swallowed), the goal that was included at that time was for the resident to tolerate tube feedings (TF) and the related interventions included that the RD will monitor resident tolerance to the TF, weights, labs & skin integrity. Review of an Initial Clinical Nutrition assessment dated [DATE] at 10:15 AM, documented by RD #1 revealed that Resident #59 was five (5) foot nine (9) inches tall and weighed 141.8 lbs. on 07/29/21 and the BMI (Body Mass Index) was 21 (<22.9 Underweight). Diagnosis included CVA (cerebral vascular accident, stroke), hypertension (high blood pressure), muscle weakness, pressure ulcer and malignant neoplasm of the prostate (prostate cancer). The assessment indicated that resident required total assistance with meals and was ordered a pureed diet with thin liquids. The resident's oral intake was estimated to between 100-75% and was rated as Good. Review of a Clinical Nutrition assessment dated [DATE], identified as a Significant Change Assessment that was written by RD #2, revealed that a new PEG (Percutaneous endoscopic gastrostomy, a tube inserted through the wall of the abdomen directly into the stomach to deliver liquid food, liquids, and medications) was inserted on 10/12/21, secondary to multifactoral pneumonia and failed swallow evaluation. RD #2 documented that Resident #59 weighed 150.8 pounds on 10/18/21 and the resident's BMI was 22.3. Further review of the assessment revealed that RD #2 documented that resident was s/p (status post) PEG placement on 10/12 secondary to multifactoral pneumonia and failed swallowing evaluation. RD #2 specified that the resident's current weight/BMI indicated nutritional risk. RD #2 also noted a questionable 20-pound weight decrease and increased fluctuations since admission. Review of an Interdisciplinary Progress Note (IPN) dated 11/12/21 at 12:25 PM, revealed that RD #2 documented that Resident #59 remained on Isosource 1.5 at 65 ml/hr. x 18 hrs. Further review of the IPN revealed that the resident's weights were: 11/3/21-129.4 lbs., 10/1/21-127 lbs., 09/13/21-161.2 pounds with beneficial weight gain x 30 days. She noted that based on the resident's weight history since admission the resident's weight for September was questionable as the resident had a 12-pound weight loss since admission (6 months) secondary to declining health, functional status indicating 8% weight change x 6 months. Review of an IPN dated 11/24/21 at 11:00 AM, revealed that RD #2 documented that Resident #59 was hospitalized from 11/18/21 through 11/23/21, with diagnosis of NSTEMI (non-ST elevated myocardial infarction, heart attack), and UTI (urinary tract infection). RD #2 noted that the resident remained on Isosource 1.5 at 65 ml/her x 18 hrs. and a re-admit weight was ordered and result was 124.2 lbs, indicating five-pound weight loss x 2 weeks. RD #2 documented that the weight change may have been fluid related as the resident received intravenous fluids while hospitalized . Weekly weights were ordered x 4 weeks and RD #2 was to monitor tolerance, weights, labs, and skin integrity. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the IPN dated 12/2/21 at 1:00 PM, revealed that the Nurse Practitioner (NP) documented that Resident #59 was bony and frail with loose muscle mass and fat stores with cachexia (weakness and wasting of the body due to severe chronic illness) noted over entire body. Patient on G (gastric)-tube feeding but food not being absorbed which could be the reason for frequent hospitalization with the last hospitalization [DATE], noted with pressure on sacral area and buttock stage 2. The NP documented that the resident's responsible party (RP) was made aware and an order for DNR (Do not resuscitate) and DNH (Do not hospitalize) was placed with discussion related to Hospice (end of life care) versus Palliative Care (comfort measures). The NP documented that she informed the RD about reducing the feeding to help disease progression. Review of an IPN note dated 12/6/21 at 12:00 PM, revealed that Resident #59 was placed on Palliative Care on 12/2/21. Surveyor #3 reviewed the Record Of Monthly Vital Signs Weights and Weekly Weights which revealed the following: 07/29/21 141.8 lbs, 7/1/21 (charted on first week of August 2021) 145.5 lbs, 08/03/21 150.4 lbs, 08/11/21 150.8 lbs, 08/18/21 152.4 lbs, 08/23/21 146.4 lbs, 08/28/21 148.8 lbs, 09/03/21 161.2 lbs, (12.4 pound weight gain), 10/1/21 127 lbs, (34.2 pound weight loss), 11/03/21 129.4 lbs, Re-admit weight 11/23/21 124.2 lbs (5.2 pound weight loss), 12/08/21 115.4 lbs (8.8 pound weight loss), 01/07/22 124.2 lbs with Re-weight 119 lbs (5.2 pound weight loss), 2/1/22 121 lbs, 03/04/22 112.5 lbs, 04/07/22 124.8 lbs, 05/04/22 125.2 lbs, 06/02/22 125.8 lbs, 07/05/22 124.2 lbs and 8/9/22 124.4 lbs. On 08/25/22 at 12:19 PM, Surveyor #3 interviewed the Registered Nurse Supervisor (RN/S) for Independence Unit who stated that the weight process was to weigh the resident upon admission, weekly for four weeks and then monthly. RN/S stated that if a weight discrepancy was identified, then the resident was reweighed the next day. RN/S stated that the Certified Nursing Assistants (CNA) obtained the weights in the presence of the nurse and documented it on the weight sheet in the presence of the nurse to confirm completion. RN/S stated that if staff identified a weight discrepancy greater or less than three pounds, then a reweight was done and the scale should be questioned for accuracy. RN/S stated that the facility had problems with every scale in the building which required service at one point. RN/S was unable to specify when the scales were last serviced. She further stated that the RD assessed resident weights weekly and would intervene to assess the feeding for a resident with TF who lost weight. On 08/25/22 at 12:40 PM, Surveyor #3 interviewed RD #2 who stated that the facility policy was that if a resident's weight was obtained and was greater or less than three pounds then a reweight was required. Surveyor #3 reviewed Resident #59's Record of Monthly Vital Signs and Weights and Weekly Weights with RD #2 who stated that when Resident #59's weight dropped from 152.4 lbs. to 148.8 lbs. on 08/28/21, there should have been a reweight documented on the weight book on the unit and on the monthly vitals. RD #2 stated that the RD kept their own records. RD #2 stated that on 09/03/21, when the resident's weight was 161.2 lbs, she did not know if there was a medical reason for that. RD #2 further stated that she did not think that the weight was accurate, but the reweight was not recorded and should have been. RD #2 stated that it was in the facility Policy and Procedure for the RD or delegate to put the reweight on the 24-hour Report and we hand the request to the Charge Nurse. RD #2 stated that on 10/01/21, the resident weighed 127 lbs. RD #2 stated that the resident did appear to weigh less than the initial admission weight, as evidenced by the resident's thin appearance. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RD #2 further explained that on 11/3/21, Resident #59 weighed 129.4 lbs. and on 11/23/21, the resident's readmit weight was 124.2 lbs. RD #2 stated that the resident was not reweighed until 12/8/21 and was 115.4 lbs. at that time. RD #2 stated that she did not recall an issue with the scale, and probably asked for a reweight. RD #2 stated that in October 2021, a Significant Change was done in the MDS related to the resident's compromised medical status, a new PEG tube, Failure to thrive and a significant weight loss that was greater than 5% monthly and 10% over six months. RD #2 stated that the resident was started on TF and weekly weights. She stated that, If the admission weight was accurate, and I do not think it was accurate, the resident's weight would never reach what it was due to muscle loss and skin break down. RD #2 further stated that the resident's weight had been steady at 124.4 lbs. On 08/30/22 at 10:19 AM, Surveyor #3 interviewed RD #2 who stated that when she placed a request in the 24-Hour Report for reweight, she usually followed up in one to two days to see if the reweight was obtained. RD #2 stated that on 10/01/21, the resident's weight dropped to 127 lbs. and a reweight should have been done when a 32-pound weight loss occurred, and a reweight was requested, but was not done. She stated she requested weekly weights because there was such a big jump to determine the accuracy of the weights. RD #2 stated that on 10/08/21, the resident was hospitalized , and a PEG was placed during that period. RD #2 further stated that when the resident was hospitalized on [DATE], then readmitted to the facility on [DATE], and a readmit weight was obtained the weekly weights should have been done on 12/01/21 and the resident was not weighed as required. RD #2 stated that usually both she and nursing ensured that weights were done. RD #2 stated that getting weights could be a challenge sometimes. RD #2 further stated that resident went on monthly weights on 12/08/21, and weighed 115.4 lbs. RD #2 stated that she reached out to the Maintenance Department via work order requests to check the accuracy of the Hoyer scale used to weigh the resident. RD #2 was unable to provide documented evidence of the work order request. RD #2 further stated that the lapse in reweights could have factored into Resident #59's weight loss. RD #2 stated that she requested the 24-Hour Reports to validate requests at reweights but was informed that the documents had been shredded. The surveyor requested copies of the 24-Hour Reports from Administration and when reviewed, there was no documented evidence that the reweights were requested by RD #2. On 08/31/22 at 11:58 AM, Surveyor #3 phoned the Assistant Engineer of Maintenance who agreed to furnish the surveyor with work order requests for scale evaluation and calibration from July of 2021 to present for Independence Unit. He agreed to furnish the documentation by the next morning but failed to do so. On 08/31/22 at 12:03 PM, Surveyor #3 interviewed the Health Services Technician (HST) who stated that she did not normally work on the unit. She stated that when she was required to obtain a resident weight, the nurse went with the aide or HST to watch you weigh the resident. She stated that the nurse documented the weight. The HST stated that you had to obtain the weight when assigned the duty regardless of whether there was enough staff available to do it. The HST further stated that she had not seen any problems with the scales function, but if she did, she would call Maintenance and they would fix it right away. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/01/22 at 9:32 AM, Surveyor #3 interviewed the Supervisor of Nursing/MDS Coordinator, who stated that for a weight gain or loss of three pounds a reweight was required. She stated that the RD placed the request for reweight on the 24-Hour Report and the Charge Nurse was responsible to assign the weight to the CNA on the assignment sheet. She stated the aide should call the nurse to come and watch the weight being done. She stated that the 24-Hour Report was a carbon copy, and the copy remained in the book and the original was filed in the nursing office. On 09/06/22 at 3:16 PM, Surveyor #3 informed Assistant Nursing Home Administrator (ANHA #1) for a policy that pertained to scale calibration. He was also informed that Assistant Engineer of Maintenance failed to provide proof of a work order requests for scale evaluation and or calibration. ANHA #1 stated that there were concerns expressed regarding scale accuracy during a Quality Assurance Meeting. ANHA #1 stated at that point, he decided to have all scales checked on all units. ANHA #1 showed the surveyor one work order dated 06/03/21. ANHA #1 stated that the weight of the lift scale used on Independence Unit was determined to be accurate after scale calibration was performed. ANHA #1 also showed the surveyor receipts that he had for facility scales that were dated from December 2021 through March 2022 which were contained within a binder. The scale calibration policy was again requested at that time and a Preventative Maintenance policy was provided instead which was not specific to scale calibration. On 09/02/22 at 12:27 PM, Surveyor #3 interviewed the Director of Nursing (DON) who stated that the reweights should have been reviewed by the Charge Nurse and Supervisor should have been on top of it. The DON stated as the supervisor, you ought to know what was going on. She stated that they should then have delegated the weight request to the CNA to do and follow through to be sure that it was done. The DON explained that the desk nurse was responsible for monthly weights and should review the base weight and when it was realized that there was a weight gain or a weight loss the RD, Medical Doctor and Power of Attorney should have been notified. 3. On 08/18/22 at 11:02 AM, Surveyor #3 observed Resident #59 lying awake in bed. The TF was in progress and Isosource 1.5 Cal was infusing by way of TF at 65 ml/hr and 1107 ml had infused according to the digital display on the TF pump. The surveyor reviewed Resident #59's August 2022 Physician's Order Sheet (POS) which revealed that Resident #59 was ordered Isosource 1.5 via PEG Tube at 65 ml/hr. x 18 hours for Total Volume of 1170 ml. On 08/23/22 at 11:55 AM, Surveyor #3 observed Resident #59 observe lying asleep in bed. Isosource 1.5 cal infused at 66 ml/hr with 1152 ml infused according to the digital display on the TF pump. The surveyor observed the label that was on the front of the feeding bag which indicated that the feeding was hung on 8/22/22 at 4:00 PM. On 08/24/22 at 11:20 AM, Surveyor #2 observed Resident #59 lying in bed. The resident's enteral feeding was completed but was not disconnected at that time. The TF pump was observed by Surveyor #2, the TF rate was set at 66 ml/hr. and the total volume completed was 1170 ml. The TF bag label was reviewed and indicated that the correct enteral formula, IsoSource 1.5, was hung but not at prescribed rate that was listed on the formula bag which was 65 ml/hr. and total volume 1170 ml. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:25 AM, Surveyor #2 interviewed Resident #59's assigned nurse. When Surveyor #2 asked the Licensed Practical Nurse (LPN) about the resident's enteral feeding the LPN stated, I really don't know these patients, I was pulled from my normal unit, Eagle unit. I can look at the chart to answer any questions. Surveyor #2 asked if the LPN knew or if she could tell surveyor #2 what the TF rate was for the resident? The LPN looked at the Treatment Administration Record (TAR) record which showed that the TF rate should have been set at 65 ml/hr. The LPN and the surveyor then entered the resident's room. The LPN acknowledged the TF rate was set at 66 ml/hr. and the formula bag listed the TF rate indicated that it should have been set at 65 ml/hr. The LPN was unable to explain why or who set the TF rate incorrectly. The LPN stated, Since this is not my normal unit or patients, the unit manager would be able to answer any additional questions more accurately. On 08/25/22 at 12:19 PM, Surveyor #3 interviewed the 7-3 Supervisor, who stated that TF was hung on evening shift. The 7-3 Supervisor stated that the process was as follows: The nurse gathered needed supplies, checked the order, then went into the room with the required supplies. The 7-3 Supervisor stated that the feeding was hung, and placement was checked. The 7-3 Supervisor stated that the nurse was required to zero out the pump and re-set the rate and the volume to be infused. The 7-3 Supervisor stated that the Volume to be infused (VTBI) was documented in the Medication Administration Record (MAR). The 7:00 AM-3:00 PM nursing Supervisor stated that on every shift, the assigned nurse was expected to check the TF rate for accuracy. The 7-3 Supervisor stated that the nurse should have corrected the rate if it were not set at the correct rate upon assessment. She further stated that she was made aware by the LPN that Resident #59's TF rate was set at the wrong rate for two consecutive days. The 7-3 Supervisor further stated that the assigned nursing staff should have noted that the resident's TF was set at the wrong rate. On 09/07/22 at 12:10 PM, in the presence of the survey team, surveyor #3 interviewed the NP, who stated that she regulated the rate of the TF because of the possibility of the resident getting pneumonia due to past history of aspiration pneumonia. The NP stated that if the TF ran at the wrong rate of 66 ml/hr for three to four days, or for a long time at the wrong rate, it would have been a problem. The NP further stated that she did not want for the resident to contract aspiration pneumonia, which could be deadly. According to the facility policy dated November 23, 2021, and titled Weights Loss/Gain Policy: the facility interventions for undesirable weight loss shall be based on the use of supplementation. Purpose: To assure weights are taken timely, accurately, and recorded to maintain control of weight changes. .If there is a 3-pound weight change (loss or gain) noted from the previous weight, a reweigh will be done on the following day . The Dietician will review weights daily from 1st to 7th day of the month to assess individual weight trends over time. Negative trends will be evaluated by the Dietician to determine whether the criteria for significant change have been met. The Dietician will document on the 24-Hour report those residents requiring weekly weights and provide the list to the Unit Manager/Charge or Desk Nurse. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Charge Nurse/Unit Manager will enter those residents requiring weekly weights onto the daily calendar. The Dietician will monitor and document on readmission weight changes . According to the facility policy titled, Enteral Nutrition (undated): Purpose: Adequate nutritional support through enteral feeding will be provided to residents as ordered NJAC: 8:39-11.2(e), 27.2(a)(e)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41858 Based on observation, interviews, and record review, it was determined that the facility failed to a.) ensure that the physician responsible for supervising the care of residents conducted face-to-face visits and wrote progress notes at least every thirty days for the first ninety days of admission. b.) Ensure all residents were seen by the physician or nurse practitioner every thirty days with a physician visit at least every sixty days. This deficient practice was observed for 14 of 47 residents (Resident #8, #24, #50, #59, #64, #83, #84, #78, #87, #92, #106, #122, #125 and #187) reviewed. Reference: Centers for Medicare and Medicaid Services (CMS) memo QSO-,d+[DATE]-NH & NTC & LSC, dated [DATE], Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers indicated the Emergency Declaration Blanket Waivers Ending for SNF/NFs 30 Days from Publication of this Memorandum including Physician Visits-42 CFR 483.30 (c) (3): CMS waived the requirements that all required physician visits (not already exempted in 483.30 (C) (4) and (f) must be made by the physician personally. The waiver modified this provision to permit physicians to delegate any required physician visit to a nurse practitioner, physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the State and performing within the state's scope-of-practice laws. This deficient practice was evidenced by the following: 1. On [DATE] at 9:39 AM, a review of Resident #64's chart by Surveyor # 1 revealed the Primary Physician 30 Day Assessment and Medical Plan of Care forms were signed by Nurse Practitioner (NP) #1 for [DATE], [DATE], and [DATE]. Surveyor #1 was unable to locate a June visit by the PCP or NP at that time. On [DATE] 9:38 AM, Registered Nurse/Unit Manager (RN/UM #1) reviewed Resident #64's chart with the surveyor. He was unable to show documentation for when the resident was last seen by the Primary Care Physician (PCP). He asked the unit clerk to review Resident #64's thinned chart records for PCP documentation. At 09:42 AM, the RN/UM #1 stated that they were unable to find documentation that Resident #64's PCP #2 had conducted a face-to-face visit. He stated that PCP #1, PCP #2 and NP#1 were from the same medical practice. He then stated that the PCP would do the assessments after an admission for 3 months and then the NPs would take over the resident's care. On [DATE] at 10:08 AM, a review of Resident #187's chart by Surveyor #1 revealed the Primary Physician 30 Day Assessment and Medical Plan of Care forms were signed by NP #1 for [DATE] and [DATE]. The Annual/Readmit Examination & Plan of Care form dated [DATE] was signed by NP #1. Further review of the chart revealed that Resident #187 was hospitalized in July and was readmitted to the facility [DATE]. On [DATE] at 10:16 AM, Surveyor # 1 interviewed Registered Nurse Supervisor (RNS) #1 who stated that the PCP and the NP should alternate seeing the resident every other month, but the PCP would see a new admission for the first 3 months. RNS #1 reviewed Resident #187's chart with the surveyor and was unable to find documentation that the PCP had seen the resident since [DATE]. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:23 AM, Surveyor #1 interviewed Unit Clerk (UC)#1 who stated that the PCP should see the resident for the first 3 months after admission and then the NP would take over the care. On [DATE] at 10:13 AM, during an interview with the survey team, Assistant Nursing Home Administrator (ANHA #1) stated that the PCP should see the residents at least every other month, but there was an executive order in place which allowed the NPs to continue to see the residents each month instead of the PCP. He further stated, he was not sure if the waiver had expired. On [DATE] at 12:00 PM, ANHA #1 provided the survey team with a copy of the QSO-,d+[DATE]-NH & NTC & LSC memo, dated [DATE]. He confirmed that the PCP waiver expired as of [DATE], which meant that the physician should have seen the resident at least once since May. On [DATE] at 09:03 AM, Surveyor #1 requested documentation that the PCP or NP had seen Resident #64 for [DATE] and Resident #187 for [DATE] from ANHA #1. On [DATE] at 12:48 PM, ANHA #1 confirmed that they were unable to provide documentation that the PCP or NP had seen Resident #64 in [DATE] or Resident # 187 for [DATE]. On [DATE] at 11:37 AM, during a phone interview with the survey team the Medical Director (MD) stated that the long-term residents should be seen once a month by the PCP and NP. They could alternate monthly visits, but the PCP must see the resident at least every other month. He further stated that the PCP would see a new admission for the first 3 months and then NP can alternate with the PCP. On [DATE] at 11:21 AM, in the presence of the surveyor and ANHA#2, the Director of Nursing (DON) reviewed the Interdisciplinary Progress Notes and confirmed that there was not documentation that the PCP or NP had seen Resident # 187 for [DATE]. The DON stated the PCP should have seen Resident #187 within 48 hours of readmission in [DATE] and then again in [DATE]. At 11:58 AM, ANHA #2 confirmed that they were unable to find documentation that the PCP had seen the resident since readmission to the facility. 43308 2. On [DATE] at 11:43 AM, Surveyor #2 interviewed RN/UM #1 who stated the PCPs came to the facility based on the need of the residents. He stated that they came monthly to complete their assessments and for all new admissions they came within 72 hours to complete the admission assessment. He further stated the PCPs came for the first three (3) months then the NP came to visit the residents three to four times a week. The RN/UM #1 stated PCP #3 had not been to the facility, but that PCP #4 worked with PCP #3, and she came to the facility often. A review of the Primary Physician 30-day Assessment and Medical Plan Care for Residents #8, #50, #87 and #122 reflected the physician's NPs had completed the monthly physician visits as followed: NP #1 completed and signed the form for Residents #8, #50 and #122 on [DATE], [DATE], and [DATE]. NP #2 completed and signed the form for Resident #87 on [DATE], [DATE] and [DATE]. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:08 AM, Registered Nurse/Charge Nurse (RN/CN #1) stated NP #2 came to the facility every day and PCP #4 came to the facility twice a week. She stated to be honest she was unsure of the last time PCP #1 and #3 came to the facility. She further stated PCP #2 came on admission and followed the residents for three (3) months and PCP #2 also came into the facility for any cardiology consults. On [DATE] at 10:08 AM, ANHA #1 stated the [DATE] monthly physician visits for Residents #8, #50 and #122 were not done yet but the residents would be seen by NP #1 today ([DATE]) or tomorrow ([DATE]). The ANHA #1 further stated the physicians normally sees the residents at admission, the first three (3) months, and then every other month. He stated there was an executive order in place which allowed the NPs to continue to see the residents each month instead of the PCP, but he was not sure if the waiver had expired. On [DATE] at 10:44 AM, Surveyor #2 observed PCP #4 on the Eagle unit and interviewed her regarding the physician visits. PCP #4 stated she came to the facility twice a week but decreased it to once a week since May of 2022 but emphasized that NP #2 came to the facility every day. She stated each week she visits a set number of residents which included any residents that staff mentioned had recent changes. PCP #4 stated that there was a certain criteria which warranted a physician visit. She explained the criteria included all new admissions/readmissions and the first three (3) months after an admission. She further stated the NP would take over the monthly physician visits as long as the resident was stable and had no issues. PCP #4 stated if the resident wasn't stable then the PCP would visit the resident. On [DATE] at 12:09 PM, NP #1 stated in the presence of Surveyors #1 and #2 that she came into the facility twice a week on Tuesdays and Wednesdays and sometimes on Thursdays for a few hours. She further stated she was not sure of how often the PCPs came as sometimes they preferred to complete their rounds on the residents at night. NP #1 stated her role was to see residents and complete their assessments and confirmed she was at the facility today ([DATE]) to complete the monthly assessments for Residents #8, #50, and #122. She stated the requirements for the physician visits were once a month unless they are sick. NP #1 explained it was either herself or PCPs #1 or #2 that were to complete the monthly physician assessments. When asked was the PCPs and NPs required to alternate the monthly physician visits, NP #1 stated they were supposed to alternate each month but acknowledged that does not happen. AHNA #1 provided the Primary Physician 30 Day Assessment and Medical Plan of Care for August of 2022 which reflected that NP #1 completed the form on [DATE] for Residents #8, #50, and #122. 44605 3. On [DATE] at 9:30 AM, during record review for Resident # 59, the surveyor observed the Primary Physician 30 Day Assessment and medical Plan of Care forms were not signed by the Physician for May, June, July of 2022. [DATE] form was not available. The forms were signed by Nurse Practitioner (NP #1). On [DATE] at 10:50 AM, during record review of Resident # 24's chart, the surveyor observed the Primary Physician 30 Day Assessment and Medical Plan of Care was not signed by the Physician for May, June, July and August of 2022. The forms were signed by NP #2. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43307 4. A review of the Annual/Readmit Examination and Plan of Care for Resident #84 reflected the physician's NP #1 had completed and signed the form on [DATE]. A review of the Primary Physician 30-day Assessment and Medical Plan of Care for Resident #84 reflected the physician's NP #1 had completed and signed the monthly physician visits form on [DATE]. A review of the Primary Physician 30-day Assessment and Medical Plan of Care for Resident #78 reflected the physician's NP #2 had completed and signed the monthly physician visits form on [DATE], [DATE], and [DATE]. On [DATE] at 09:22 AM, Surveyor #4 interviewed Licensed Practical Nurse (LPN #1) who stated she was unsure which doctor visited the facility because NP #1 was the staff member she saw on the unit and the staff member she called for the residents. LPN #1 further stated she did not know how often the doctor was supposed to visit the residents and that NP #1 covers for the doctor. On [DATE] at 11:17 AM, Surveyor #4 interviewed Resident #78 who stated PCP #3 was his/her doctor and that he/she only saw him by request and that he does not come in regularly. On [DATE] at 10:34 AM, Surveyor #4 requested from ANHA #1 the physician notes for the last four months on Residents #84 and #78. On [DATE] at 01:33 PM, ANHA #2 provided Resident #78's Primary Physician 30-day Assessment and Medical Plan of Care dated [DATE], [DATE], and [DATE] which revealed to have all been completed and signed by NP #2. On [DATE] at 01:50 PM, ANHA #1 provided Resident #84's Annual/Readmit Examination and Plan of Care dated [DATE] that was completed and signed by NP #1, and Primary Physician 30-Day Assessment and Medical Plan of Care dated [DATE] that was completed and signed by NP #1. ANHA #1 stated that they were the only two notes available. 39460 5. On [DATE] at 12:27 PM, the surveyor interviewed the Registered Nurse/Charge Nurse (RN/CN #2) for Freedom Unit who stated the residents were usually assessed monthly by the NP #1 who comes to the facility nearly every day. The RN/CN #2 was not sure how often the physician made rounds or came to the facility to assess the residents, that she mostly saw the NP. A review of the Primary Physician 30-Day Assessment and Medical Plan of Care forms for Residents #106, and #125 reflected NP #1 had conducted the monthly physician's assessment as followed: NP #1 completed and signed the form for Resident #106 on [DATE], [DATE], and [DATE]. NP #1 completed and signed the form for Resident #125 on [DATE], [DATE], and [DATE]. On [DATE] at 11:30 AM, The surveyor interviewed the ANHA #1 who stated he was unable to locate a Primary Physician 30 Day Assessment and Medical Plan of Care form for [DATE] for Resident #106. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility was unable to provide documentation that a physician responsible for supervising the care of residents conducted face to face visits, wrote and signed progress notes at least every 60 days. 39885 6. On [DATE] at 12:29 PM, during record review for Resident #92, Surveyor #6 observed that the physician visit dated [DATE] was documented on a Primary Physician 30 Day Assessment and medical Plan of Care form and was not signed by the Physician. The form was signed by NP #1. The surveyor observed that the physician visits dated [DATE] and [DATE] were documented on an Annual/Readmit Examination & Plan of Care form and were not signed by the Physician. The form was signed by NP #1. Surveyor #6 did not observe a physician visit for [DATE]. On [DATE] at 10:20 AM, the surveyor requested information from the ANHA #1 if a physician visit was done in July. The facility did not provide documentation that a physician visit was done during [DATE] by either a physician or NP. The facility did not provide documentation that a physician responsible for supervising the care of residents conducted face to face visits, wrote and signed progress notes at least every 60 days. 36419 7. On [DATE] at 9:45 AM, Surveyor #7 reviewed Resident #83's hybrid chart which revealed Resident #83 was admitted to the facility on ,d+[DATE]. A further review reflected the Primary Physician 30 Day Assessment and Medical Plan of Care form was not completed or signed by PCP #1 for ,d+[DATE] or , d+[DATE]. Surveyor #7 was not able to locate any documentation that PCP #1 had conducted a face-to-face visit with Resident #83. On [DATE] at 10:23 AM, Surveyor #7 interviewed UC #2 who stated that the attending physician should see the resident for the first 3 months after admission, and then the NP could see the resident after the initial 3 months. Unit Clerk #2 further stated that Resident #83 must not have been seen by PCP #1 since the Primary Physician 30 Day Assessment and Medical Plan of Care Form was not filled out. On [DATE] at 10:31 AM, Surveyor #7 interviewed RNS #1 who stated that the Primary Care Physician should see the resident on admission, readmission, and then every ,d+[DATE] months. Surveyor #7 asked RNS #1 for the documentation that Resident #83 had been seen by PCP #1. RNS #1 replied, it should be in the chart. The RNS #1 was unable to provide Surveyor #7 with documentation that Resident #83 had been seen by PCP #1. On [DATE] at 11:03 AM, Surveyor #7 interviewed Resident #83 who stated that he/she would like to see their physician but had not seen him since they were admitted . (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated policy Physician Services revealed Interpretation and Implementation: 5. Physician visits .are provided in accordance with current OBRA regulations. The regulation states that the physician (or his/her delegate) must visit the resident at least every 30 to 60 days. Physician will visit resident for 3 months following admission and every other month to alternate with NP/PA if applicable. NJAC 8:,d+[DATE].2 (D)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint #NJ156516 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to ensure that licensed nursing staff had the specific competency and education on the removal of a resident's (Resident #179) indwelling urinary catheter. This deficient practice was identified for 1 of 1 Registered Nurse (RN) reviewed and was evidenced by the following: Refer to F658 L The clinical record of Resident #179 was reviewed on [DATE]. According to the Admission Face Sheet, Resident #179 was readmitted to the facility on [DATE] following hospitalization for urinary retention. Review of Resident #179's care plan updated on [DATE] and [DATE], revealed that Resident #179 was at risk for infection due to urinary retention. The care plan goal was for Resident #179 not to have a Urinary Tract Infection and to receive the care needed to maintain his/her current functional status. The Annual Minimum Data Set Assessment (MDS) an assessment tool used by the facility to prioritize care dated [DATE], revealed in section H which addressed Bladder and Bowel, that Resident #179 had an indwelling urinary catheter in the bladder. A review of the Interdisciplinary Progress Notes (IDPN) dated [DATE] at 3:00 PM, revealed that the Registered Nurse (RN) caring for Resident #179 had used an improper procedure in attempts to remove the indwelling urinary catheter which caused part of the catheter to retract into the resident's bladder. It was noted that the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Nurse Practitioner (NP) were made aware. Orders were given to transfer Resident #179 to the emergency room for retracted indwelling urinary catheter removal. Resident #179 was transferred via 911. On [DATE] at 11:52 AM, the surveyor interviewed the RN Unit Manager (RN/UM) regarding the IDPN dated [DATE]. The RN/UM revealed that the RN caring for Resident #179 had cut the indwelling urinary catheter. The RN/UM stated reportedly the RN had never removed an indwelling urinary catheter before, so the RN cut the catheter with a pair of scissors instead of using a syringe to remove the water to deflate the balloon. The remaining portion of the catheter retracted into the bladder. On [DATE] at 9:23 AM, the surveyor interviewed a RN assigned to the 200 unit regarding resource materials available on the floor. The RN directed the surveyor to the binder located outside the Nursing Station that contained all the facility policies and procedures. A review of the facility policy, # 4:035 B titled, Indwelling Catheter Replacement dated [DATE] revealed: Indwelling Catheter replacement must have a physician order indicating size and schedule. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Indwelling catheter replacement must be done by a registered nurse whose clinical skill has been checked by the instructor of nursing. If the physician and/or registered nurse, who has demonstrated clinical competence for this procedure is not available, send Resident to the emergency room for indwelling Catheter. The binder and the policy did not include the procedure for the removal of an indwelling urinary catheter. On [DATE] at 11:00 AM, the surveyor conducted a telephone interview with the RN. The RN stated that she had not received any in-service or education on how to remove an indwelling urinary catheter at the facility. The RN stated that after being hired by the facility and during orientation, she was able to demonstrate and be evaluated on the skill sets of inserting an indwelling urinary catheter but was not evaluated on the removal of an indwelling urinary catheter. The surveyor then asked the RN if there were any resource materials on the nursing unit that she could have referenced prior to removal of the indwelling urinary catheter. The RN stated that she did not review any procedure on indwelling urinary catheters but that she was provided with a form titled, [redacted -out of state form] Nursing Skills 21.13 Checklist for [redacted] (indwelling urinary catheter) Removal from a facility representative on [DATE]. A review of the RN's orientation file provided by the Nurse Educator (NE) confirmed that the RN received in-service education on how to insert an indwelling urinary catheter on [DATE] during orientation. On [DATE] at 11:15 AM, the surveyor reviewed the Facility assessment dated [DATE]. According to the documentation provided, the facility had to identify and analyze the resident population that must be considered when determining staffing and resources needed to care for the residents. Under staff training it is noted, Licensed nursing staff receive training and demonstrate competencies in areas of responsibility related to providing skilled nursing care to residents of the facility. Nurses receive updated and additional training as necessary to meet the changing needs of our residents. Training and competencies include, but were not limited to: Licensed nurse training and/ or competencies. Oxygen set up Oxygen masks . Nasal cannula / Non-Rebreather /Simple face mask Wound care / Dressing Change Suctioning skill/ Tracheostomy care Glucometer Medication Pass (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Indwelling catheter replacement Cardiopulmonary resuscitation (CPR) The Facility's policy for Indwelling Catheter Replacement did not cover indwelling urinary catheter removal. On [DATE] at 12:03 PM, the surveyor interviewed the NE in charge of orientation and staff competencies. The surveyor inquired about specific competencies and skill sets necessary to care for resident's needs. The NE provided the surveyor with the orientation package used by the facility. A review of the orientation package confirmed that indwelling urinary catheter removal was not included in the competency. The RN had not received any in-service training for indwelling urinary catheter removal. The NE stated that licensed staff had to go to general orientation classes for 2 days, then they had to work with a mentor on the nursing unit for 14 days. The NE stated mandatory training was scheduled yearly and skill sets for competencies every two years. Based on the orientation package provided, the facility staff did not receive competency training for indwelling urinary catheter removal. The NE stated that he was aware of the adverse outcome with the attempted indwelling urinary catheter removal on [DATE] and that Resident #179 had to endure emergency care because the indwelling urinary catheter was improperly removed. The surveyor requested in-service or education training that was provided after the incident, none was provided. A review of the facility provided policy revealed it had not been revised to include indwelling urinary catheter removal. When asked how licensed staff competency education was being tracked, the NE added he would be informed by the DON of any needed in-services or educational training. The facility could not provide the rationale for licensed staff not being trained or provided competency on how to remove an indwelling urinary catheter. NJAC 8:,d+[DATE].3(a), 27.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43307 Based on observation, interviews and review of facility documentation it was determined that the facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses and b.) maintain equipment in a manner to prevent microbial growth and cross contamination. This deficient practice was observed and evidenced by the following: On 08/16/22 from 10:29 AM to 12:43 PM, the surveyor toured the kitchen in the presence of the Assistant Food Service Director (AFSD) and observed the following: 1. In refrigerator #2, there was a wheeled metal cart that was covered with an unlabeled and undated clear plastic bag, that the AFSD identified as the breakfast cart, which contained: On the top shelf was one metal 4 inch half pan that was covered with clear plastic wrap, that contained a solid yellow substance with black specks, that the cook identified as garlic butter, with no label and no use by date. The AFSD acknowledged that the garlic butter should have been dated. On the second shelf was one metal 4 inch half pan that was covered with clear plastic wrap, that the AFSD identified as pieces of lettuce, sliced tomato, and sliced turkey, with no label and no use by dates. On the third shelf was one metal 4-inch pan that was covered with clear plastic wrap, that contained six circular light brown patties, that the AFSD identified as pancakes, with no label and no use by dates. On the fourth shelf was one metal tray containing 43 circular tan patties, that the AFSD identified as 2- ounce sausage patties, with no covering, no label and no use by dates. On the fifth shelf was one metal tray containing 60 circular tan patties, that the AFSD identified as 2-ounce sausage patties, with no covering, no label and no use by dates. The AFSD acknowledged there was no covering or label on the sausage patties and stated that they should have been covered with plastic then labeled and dated so everyone would know exactly what the food was and when the food was prepared. The AFSD discarded the patties. 2. On the bottom shelf of a metal rack there was an unlabeled metal roasting pan which contained four sealed, defrosted, five pound individual packages marked mechanically separated turkey, which were resting in a large amount of red liquid. One package was marked with a sticker that stated, dated pull 08/08, thaw 08/08, use by 08/18, one package was marked with a sticker that stated PM, with no pull or use by date, and two packages were not marked with pull or use by dates. The AFSD acknowledged there were no dates on three of the packages of turkey and discarded the meat. The AFSD stated all of the meat should have been marked with the date so that everyone would know it was not bad. 3. In refrigerator #3, on a wheeled metal cart, was a one quarter half inch pan covered with clear plastic wrap and foil that contained several circular slices of pink meat, that the AFSD identified as 3-4 pounds of sliced pork roll, with no label or use by dates. The AFSD acknowledged that the pork roll should have been labeled and should have had a use by date. The AFSD discarded the meat. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. In freezer #1 there was one tied, clear bag containing four tan rectangular meat patties, that the AFSD identified as breaded fish, with an opening in the bottom of the bag with the meat exposed to air, with no label and no use by date. The AFSD acknowledged that the fish should have been labeled and stored in the original box and he discarded the bag. There was one tied, clear bag marked breaded scallops with no open or use by date. The AFSD acknowledged that the scallops should have been dated and discarded the bag. There was one box marked salmon patty that contained an unsealed white plastic bag with the meat exposed, with a manufacturer sticker dated 07/07/22, with no open or use by dates. The AFSD acknowledged the bag should have been closed and discarded the salmon. There was one sealed clear bag containing small tan squares, that the AFSD identified as tater tots, with no label or use by dates. The AFSD stated there should have been a label and the tater tots should have been stored in the original box. There was one sealed four pound package marked liverwurst with a manufacturer stamp marked sell by [DATE] with no use by date. On a rolling metal cart, there was a metal tray covered with clear plastic wrap marked roast beef and dated 07/31, with the side of the tray uncovered with the meat exposed. There was white frost observed on all three pieces of meat. The AFSD acknowledged that the meat was not sealed correctly and discarded the meat. There was one metal tray marked pancakes that was dated 08/12, that was partially covered with clear plastic wrap with the pancakes exposed to air. The AFSD acknowledged the pancakes were not sealed correctly. On the bottom shelf of a metal rack there was one sealed 10 pound package of ground beef with manufacturer stamp marked best before or freeze by 08/08/22, with no received or use by date. The AFSD acknowledged there was no received date and stated that the meat should have had a sticker with the date it was received. The AFSD then discarded the meat. On the top shelf of a rolling metal cart, there was a metal tray with five, unwrapped, red oblong shaped pieces of meat wrapped in dough with no label or dates. The AFSD identified them as pigs in a blanket and discarded the meat. On the second shelf there was one metal tray marked pigs in blanket, dated [DATE], that was partially covered with clear plastic wrap, the meat was exposed to air, and white crystals were observed on the meat. The AFSD stated that the meat was freezer burnt and discarded it. On a metal tray was one brown piece of meat marked filet [NAME] that was dated 05/21/22, with the clear plastic wrap partially covering the meat and the end of the meat exposed. The AFSD acknowledged the meat was exposed and stated that the meat should have been covered then discarded the meat. There was one metal tray marked breaded eggplant that was dated 08/11/22, that was partially covered with clear plastic wrap with the side of the tray open and the eggplant exposed. The AFSD acknowledged the opening in the covering then discarded the food. 5. In the dry storage room, there was one sealed plastic container labeled orzo with no open or use by date. The AFSD acknowledged he did not know how old the orzo was and stated it should have had a dated sticker on it. On a metal rack was one 111 ounce can of three bean salad with a large dent, one 106 ounce can of tomato puree with a large dent, one 106 ounce can of fruit cocktail with a large dent, one 6 pound 10 ounce can of mandarin oranges with a large dent, and one 6 pound 10 ounce can of cut yams with a large dent. The AFSD acknowledged the dented cans and discarded them in the trash. The AFSD stated that all of the employees were inserviced and know to remove dented cans to the milk crate for them to be discarded. During an interview at that time, the AFSD stated that it was important to not serve food from dented cans because the food could be compromised. The AFSD further stated that if the residents ate compromised food from a dented can, or food that was old, undated or uncovered, that the residents could get sick or die. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. There was one large free standing white covered bin containing a white powder, marked flour, with no open or use by date. There was one large free standing white covered bin containing white granules, marked sugar, with no open or use by date. The AFSD stated the bins have never been dated. There was a large black hair resting on the sugar. The AFSD acknowledged the hair and stated it should not have been there. The AFSD removed the bin and instructed the cook to dump the sugar and clean the bin. 7. On the top convection oven, there was a brown greasy residue on the inside of the doors and black debris on the oven floor. On the bottom convection oven, there was a brown greasy residue on the inside of the doors and black debris on the oven floor. The AFSD acknowledged they were dirty and stated they were cleaned biweekly. 8. On the spice rack, over a prep table, there was: one opened 16 ounce jar of garlic powder with no open, use by, or expiration date; one opened 1 pound jar ground sage with no open, use by, or expiration date; and two 3 ounce jars of marjoram with no open, use by or expiration dates. The AFSD acknowledged the undated spices and discarded them. The surveyor reviewed the facility's policy, Food Storage, Date of Issue/Revision 08/22/22, which revealed Procedure: 5. All food products will be identified and must show date of receipt. 6.All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. 7. Any cans that are bulging, crushed, have deep or sharply pointed dents, have holes, and/or are heavily rusted must be separated from stock and discarded. Per the USDA, cans with small dents do not need to be discarded. A deep dent is one that you can lay your finger into. The surveyor reviewed the facility's policy, Labeling of Foods/Food Products, Date of Issues/Revision 08/22/22, which revealed Protocol: 3. Pull/Thaw/Use By labels are for pulling food from the freezer. Each item pulled from the freezer must be labeled, along with the received date. 4. Prep Date/Use By labels are for food that has been prepped for use. 5. [NAME] labels, dry good storage (which includes, but is not limited to such items as potato flakes, spice type products, canned items). The surveyor reviewed the facility's policy, Storage of Prepared Food Items, undated, which revealed Procedure: 1. Foods prepared and held for over 24 hours under refrigeration need to be labeled with a preparation date. 2. Once prepared, food, including sliced deli meats, is not to be held for longer than five days. 3. Any food more than five days old is to be discarded. The surveyor reviewed the facility's policy, Cleaning/Preventive Maintenance of [NAME] Ovens, Date of Issue 12 [DATE], which revealed Purpose: To maintain ovens properly. Procedure: 3. Wash interior sides, bottom and top with mild detergent and water. A stainless steel cleaner should be used for the interior. Rinse and dry. 4. Wash doors using a stainless steel cleaner. Rinse and dry. NJAC 8:39 17.2(g)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Based on observation, interview, and review of clinical medical records it was determined that the facility failed to ensure that a resident received therapy services based on a physical therapy and occupational therapy resident screening that was done on 04/21/22, for a period of four (4) months. This deficient practice was identified for 1 of 1 resident (Resident #152) reviewed for rehabilitation and was evidenced by the following: The Resident Face Sheet indicated that Resident #152 was admitted to the facility in April of 2022. The Resident Nursing Evaluation/Data Collection form dated 04/08/22 at 11:45 AM, indicated that Resident #152 had diagnoses that included but were not limited to dementia, hypertension (HTN), macular degeneration (is a medical condition which may result in blurred or no vision in the center of the visual field), enlarged prostate and gastroesophageal reflux disease (occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach). The resident's functional status indicated that the resident was highly involved in the activity, but that staff provided guided maneuvering of limbs or other non-weight bearing assistance for bed mobility, transfers, ambulation, dressing, personal hygiene, and toilet use. On 08/16/22 at 11:05 AM, Surveyor #1 observed Resident #152 seated in a wheelchair in the dayroom and the resident appeared thin and frail. The resident was not able to provide the surveyor with any history or interview due to cognitive loss. On 08/22/22 at 11:24 AM, Surveyor #1 interviewed the Certified Nursing Assistant (CNA) who stated that Resident #152 did not have a very good appetite, needed encouragement to eat and did not always complete his/her meals. She also stated that the resident was able to move all extremities and required assistance with transfers to the wheelchair. She stated that the resident was unable to ambulate and used a wheelchair that staff propelled. On 08/23/22 at 11:15 AM, Surveyor #2 conducted a telephone interview with Resident # 152's responsible party (RP). The RP stated that Resident #152 was using a rolling walker at home, but since admitted to the facility, he/she was put into a wheelchair and has not walked. Surveyor #1 reviewed Resident # 152's medical record which revealed the following information: The admission Interdisciplinary Note (IDT) dated 04/08/2022 and untimed, indicated that Resident # 152 was admitted to the facility with the family present. The note indicated that the family relayed the resident's history and medical information to the nurse performing the admission assessment. The IDT note indicated that the resident had a history of falls and the diagnoses of Dementia. The family also relayed that the resident used a walker at home and complained of weakness at times. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admission Minimum Data Set (MDS) used to facilitate the management of care dated 04/14/22, reflected that Resident #152 had severe cognitive impairment and required extensive assistance with one staff member for bed mobility, transfers, and toilet use. The MDS also indicated that the resident did not ambulate and was dependent for dressing, personal hygiene, and bathing. The MDS further indicated that the resident was not stable for moving from a seated to standing position unless assisted by staff and was not able to ambulate. The quarterly MDS dated [DATE], reflected that the resident required extensive assistance with one staff member for bed mobility, transfers, and toilet use. The MDS further indicated that the resident was not stable for moving from a seated to standing position unless assisted by staff and was not able to ambulate. On 08/24/2022 at 11:06 AM, Surveyor #1 interviewed the MDS Coordinator (MDSC) who stated that Resident # 152 was not walking on admission, but that resident was evaluated by therapy (Physical Therapy (PT) and Occupational Therapy (OT)) to see if he/she needed therapy. She stated that Resident #152 was weak on admission according to the information that was provided by the family. She then revealed that the resident was evaluated by PT and OT on 04/21/22 at 01:15 PM and that the therapy evaluation reflected that Resident #152 would benefit from therapy services however they were waiting for insurance approval. She further stated, I can't find any evidence that the resident received skilled therapy as recommended. The IDT note dated 04/21/22 at 01:15 PM, reflected that a PT and OT screen was done for Resident #152. The note indicated that the resident could benefit from skilled therapy services to improve overall strength, balance and endurance for functional transfers and activities. The note also revealed that therapy would evaluate upon insurance clearance and Power of Attorney (POA) clearance. On 08/24/2022 at 11:30 AM, Surveyor #1 interviewed the Director of Rehabilitation (DOR) who was also an Occupational Therapist by trade, who stated that Resident # 152 had a screening for skilled PT and OT on 04/21/22. He then stated that physician orders were obtained for skilled PT and OT on 04/22/22. He added that therapy evaluated Resident #152 on 04/22/22, however the resident refused therapy. The DOR could not provide the surveyor with any documented evidence that there was a physician order for skilled PT and OT on 04/22/2022 or documentation that the resident refused therapy. The only documentation that the DOR could provide to the surveyor was an occupational therapy screen that was done on 04/21/2022. The facility form titled Therapy Services Screening dated 04/21/2022, indicated that PT and OT performed a new admission therapy screen for Resident #152 and determined that the resident could benefit for skilled OT and PT services to impact strength, range of motion (ROM) and balance for functional transfers/activities. It also indicated that OT and PT would evaluate upon insurance clearance and POA (power of attorney) approval. The facility provided Surveyor #1 with an IDT note dated 08/25/22 at 07:45 AM, that indicated that Resident #152 was admitted to the facility on [DATE] accompanied by the family. The note indicated that Resident #152 was non-ambulatory secondary to weakness and was not able to stand or pivot for transfer. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/25/22 at 10:30 AM, after Surveyor #1 inquiry regarding if Resident #152 receiving skilled therapy, the facility provided Surveyor #1 with an untimed facility Incident Report dated 08/24/22, which indicated that on 04/22/22, OT attempted to evaluate the resident and the resident declined the evaluation. The form further revealed that the resident's refusal was not documented in the resident's medial record because the resident's medical chart was unavailable. On 08/25/22 at 10:30 AM, after Surveyor #1 inquiry regarding if Resident #152 receiving skilled therapy, the facility provided Surveyor #1 with an untimed facility Incident Report dated 08/24/22 which indicated that on 04/22/22, PT attempted to evaluate the resident and the resident declined the evaluation. The form further revealed that the resident's refusal was not documented in the resident's medical record because the resident's medical chart was unavailable. Surveyor #1 could not find any further documentation that the resident received PT or OT services in the medical record even though there was documentation on 04/21/22 that the resident would benefit from skilled therapy services to improve overall strength, balance and endurance for functional transfers and activities. Surveyor #1 reviewed the resident's Care Plan (CP) dated 04/08/22, which reflected that Resident #152 had a history of falls, impaired balance and was at risk for falls with related interventions. The interventions included that the resident would be encouraged to participate/attend physical therapy as recommended so that he/she could get stronger. On 08/25/22 at 11:08 AM, the surveyor interviewed the MDS Coordinator, who explained to the surveyor the process of when a resident care conference was conducted. The MDS coordinator stated that care conferences were done on admission, quarterly, annually or if there was a significant change in a resident's condition. She stated that staff attendance included the MDS coordinator, supervisor of nursing or charge nurse, primary care certified nursing assistant (CNA), Social Worker (SW), the Recreation Assistance (RA), and Registered Dietician (RD). She added that if the resident was on restorative nursing, then the restorative nursing aide would attend. If the resident was on therapy, then the therapist would also attend the meeting. She further stated that both the resident and family were also invited to attend. She stated that therapy was usually ordered for every resident that was admitted to the facility and that therapy screens were done for every resident. She stated that during care conferences the residents care was discussed and that the care plan was updated or revised to reflect specific interventions and care the resident received. The surveyor reviewed Resident # 152's Care Plan (CP) with the MDS Coordinator, and she acknowledged that there was documentation and interventions on the CP that indicated Resident #152 was to be encouraged to participate/attend physical therapy as recommended so that he/she could get stronger. The MDS coordinator could not speak to as why this intervention was on the CP when the resident was not receiving therapy. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/25/22 at 11:27 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) who stated that he attended care conferences which were held on admission, quarterly and for significant changes. She stated that care conference was held every 90 days and included review of the residents CP. The RN/UM stated that attendance at the care conference included the following disciplines: RD, RA, SW, CNA, MDS coordinator and unit manager. He stated that the team reviewed the CP to make sure it was accurate in relation to the resident's care and revised any resolved interventions that were not relevant to the resident's care and updated the interventions that were relevant to the resident's care. He revealed that when the CP was revised or reviewed, the staff that attended the meeting were required to sign the back of the care plan on the sign out sheet. He stated that it was important to sign the sheet to keep track of staff that were present at the meeting and to make sure that the CP was accurate. He further added that the MDS coordinator was responsible to update the CP during the quarterly reviews. He stated that the RN/UM only updated the CP during change in status and incidents. He stated that he did not know how it written on the CP that the resident was to receive PT, and the resident was not receiving therapy to address the resident's weakness. The facility provided the surveyor with an in-service form dated 08/24/2022 (untimed), the topic was titled, How and what to document when a resident refused therapy. The form indicated that if a resident refused therapy, then the therapy should: -Inform nursing. -The interventions offered. -The reason for the intervention. -The potential risks and benefits of the intervention. -Note that the resident has been informed of the risk in not accepting the interventions. -If the patient does not understand contact the power of attorney (POA) or family and document accordingly. The in-service form contained the signature(s) of the Physical Therapist and Occupational Therapist who completed Resident #152's initial Therapy Screen which indicated that they received education related to the process the therapist should take when a resident refused therapy. The facility provided Surveyor #1 with a policy from the therapy department dated July 1, 2014, and titled, Patient Care Policies. The policy indicated that the therapy company was committed to seeing that patients receive the quality healthcare they deserve and expect. Evaluation and Management: -Upon receipt of the therapy referral we would contact the patient for needed information, conduct insurance verification, and contact the patient with information to allow the patient to make an informed decision for their healthcare needs. NJAC 8:39-27.1 (a)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Reference F 600, F 658, F 880 and F 886 Based on observations, interviews, review of medical records and review of facility documents, it was determined that the facility Licensed Nursing Home Administrator (LNHA) failed to ensure: a) that an alert and oriented resident (Resident #24) who was being verbally abused by an Agency Nurse was not prevented from leaving the unit to seek help by a Certified Nurses Aide (CNA) on [DATE], who was permitted to work for seven shifts without any additional abuse training or investigation to rule out possible abuse until surveyor inquiry b) that a resident's (Resident #179) Foley urinary catheter was removed in accordance with professional standards of practice which resulted in transfer to an acute care hospital on [DATE] and the resident returned to the facility on [DATE] with a portion of the severed catheter which remained in the bladder and the resident was consequently ordered a prophylactic antibiotic to prevent infection to be administered at the facility that the resident did not receive, prior to a required urological surgical procedure after awaiting cardiac clearance to extract the foreign body that remained in the bladder and later resulted in the resident receiving additional antibiotic treatment for ESBL (Extended-spectrum beta lactamases, a bacterium with antibiotic resistance) and MRSA (methicillin-resistant Staphylococcus aureus, a bacterium with antibiotic resistance) in the urine c) that immediate contact tracing was completed in response to to newly identified COVID-19 staff and residents in accordance with local health department guidance provided on [DATE] d) that immediate action was taken to prevent the spread of COVID-19 during an outbreak which began on [DATE] by failing to complete contact tracing and complete immediate follow-up resident and staff testing upon identification of COVID-19 positive staff and residents to prevent the continued spread of infection. This posed a serious and immediate threat to the safety and well-being of all residents who resided at the facility, were made subject and vulnerable to abuse, had foley urinary catheters, and were placed at risk for contracting COVID-19, which is a harmful and deadly virus. The failure of the LNHA to ensure the facility operated in a manner that ensured residents were cared for in a manner and an environment that enabled residents to maintain or attain their highest practicable physical, mental, and psychosocial well-being posed a serious and immediate threat to the health, safety, and welfare of all residents who resided at the facility in compliance with federal, state and local requirements as outlined in the Administrator Job Description, resulted in an immediate jeopardy (IJ) that was identified on [DATE] at 4:16 PM, and was sent to the facility via e-mail at 4:18 PM. A Removal Plan was received on [DATE] at 9:37 AM, and the survey team verified the implementation of the Removal Plan on [DATE] at 9:26 AM. This deficient practice was evidenced by the following: A review of the facility's Job Specification 60293, Chief Executive Officer, Care Facility ([DATE]), revealed that the duties of the CEO/LNHA included but were not limited to: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Oversees the development, implementation, and monitoring of clinical programs designed to meet the level of functioning and/or care needs of clients. Ensures the implementation of department policies and statutes applicable to the operation of the care facility. Oversees the development and management of a quality assurance system to comply with standards promulgated by accrediting and certifying agencies; .Federal Department of Health and Human Services and NJ Department of Health and Senior Services. Provides protection of clients' civil and legal rights . Findings included: Refer F600 On [DATE], the LNHA failed to ensure residents were free from abuse after a resident (Resident #24) was prevented from leaving an abusive situation by Certified Nursing Aide (CNA #1), who continued to work with other residents following no investigation. This deficient practice was identified for 1 of 5 residents reviewed for abuse (Resident #24). On [DATE] at 10:38 AM, the surveyor interviewed Resident #24, who stated on [DATE], they received Percocet and Xanax every six hours and asked an aide to find the nurse to administer the medications. An Agency Nurse (LPN #1) entered my room and informed me that they would administer my medications and take my vital signs and proceeded to leave the room and closed the door. The resident stated that they proceeded to use the call bell, and LPN #1 came back into the room to tell me to stop pushing the call bell; she pulled down her mask and attempted to bite my finger as I pointed at her. The resident continued that they got out of bed to get away from LPN #1. LPN #1 lunged her nurse's cart at me three times and hit their left foot, causing a wound to re-open. The resident stated that they were trying to get away from LPN #1 and get to the Registered Nurse Supervisor (RN Supervisor). The resident stated as they were attempting to leave the unit in the hallway, the nurse assaulted them by pulling the wheelchair (w/c) ,d+[DATE] times, which positioned the resident on only two back wheels, and the two front wheels were lifted off of the floor. The resident stated that there was a (CNA #1) there, but they could not recall the name of who tried to calm the crazy nurse down. A review of the Resident Facesheet (an admission summary) reflected that the resident was admitted to the facility in September of 2021 but did not include admitting diagnoses. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [DATE], reflected a brief interview of mental status (BIMS) score of 15 out of 15, which indicated the resident was fully cognitively intact. It further reflected the resident had verbal and behavioral symptoms directed toward others that occurred four to six days in the last seven days of assessment. Section I Active Diagnoses included the resident having hypertension (high blood pressure), anxiety, depression, psychotic disorder, and PTSD. It further included a seven-day look back period. The resident received daily antianxiety, antidepressant, and opioid medications. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the individualized comprehensive Care Plan (CP) included a problem area initiated on [DATE], for at risk for altercation in mood/behavior; history of major depressive disorder, anxiety, use of Seroquel (antipsychotic medication) for agitation, use of Xanax for anxiety, and Remeron for anxiety/depression/mood with interventions that included to observe for efficiency of medications; monitor for target behaviors or behaviors not easily redirected; refer to nurse if noted behaviors worsening, unable to redirect; keep the room well lit, open blinds for sunlight; and give medications Remeron, Xanax, Seroquel as ordered. A further review of the CP included a diagnosis of PTSD, however, did not include a problem area or interventions pertaining to the resident's diagnosis of PTSD. On [DATE] at 10:00 AM, the surveyor reviewed the facility provided investigation report for Resident #24's incident which occurred on [DATE]. A review of the staff statements included a statement provided by CNA #2, which detailed that they were taking care of a resident when they heard a noise in the hallway and came out into the hallway and saw Resident #24 trying to leave the floor. She stated that, I stopped them from leaving the floor. CNA #2 stated that both she and another CNA called the charge nurse, but I did not know what was going on. CNA #2's statement appeared to be what the surveyor witnessed CNA #1 do in the surveillance video. No statement from CNA #1 in the investigation report was provided. On [DATE] at 10:31 AM, the surveyor reviewed the surveillance video with the Assistant Licensed Nursing Home Administrator (ALNHA) #1, Employee Relations/Legal Specialist, another surveyor, and the Employee Relations/Legal Specialist confirmed CNA #1 was the aide who was blocking the door. CNA #2 was the aide observed later walking up the hallway towards LPN #1, CNA #1, and the resident during the altercation. At this time, the surveyor reviewed the investigation packet with ALNHA #1, who confirmed there should have been a statement from CNA #1 included in the investigation report. On [DATE] at 10:59 AM, the DON provided the surveyor with CNA #1's statement dated [DATE], which was the exact same statement provided by CNA #2. At this time, the surveyor asked the DON to read both CNA #1 and CNA #2's statements, and she confirmed that both statements were the same but was signed by the corresponding CNA. At this time, the surveyor requested to watch the video footage again with the DON. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 11:10 AM, the surveyor with the DON, Employee Relations/Legal Specialist, and another surveyor viewed the video footage. When comparing the surveillance footage with the statements, the surveyor asked the DON if the statements clearly reflected what had happened. The DON reported that she completed a three-page reportable to the New Jersey Department of Health (NJDOH) and told RN #1 to watch the video to see if anything should be added to her statement. Then the DON reported she had left for vacation. The DON stated that the ADON had watched the video with RN #1, who did not want to change her statement. The DON stated the purpose of an investigation was to determine a root cause analysis and confirmed these statements were not clear. The DON stated when she returned from vacation, the investigation was completed by the ADON, and she did not review it even though she was responsible for oversight of all aspects of nursing. The DON confirmed the resident had the right to leave the unit, and no staff, including the two CNAs, should have stopped the resident from leaving the unit. The surveyor reviewed the video with the DON. The DON acknowledged CNA #1 was standing in front of the exit door blocking Resident #24 from exiting the unit, which was an issue because this was considered a restraint. The DON stated that even if the resident was confused, which Resident #24 was not, staff could not stop the resident from leaving. The DON stated staff had to ensure the resident's safety and could follow the resident from a distance, but staff could not prevent the resident from leaving the unit. The DON stated the ADON was on vacation but confirmed the investigation was incomplete. She had to re-open the investigation to clarify the statements and determine why CNA #1 stood in front of the door. On [DATE] at 01:14 PM, the surveyor re-interviewed Resident #24, who stated CNA #1 was stopping LPN #1 from verbally abusing them, but confirmed CNA #1 was preventing them from leaving the unit and told them they were not allowed to leave the unit. The resident stated CNA #1 could have done more since she was not letting them leave, and they did not know why. On [DATE] at 10:30 AM, the surveyor reviewed the nursing schedules since [DATE], which revealed CNA #1 worked seven shifts at the facility after the incident. On [DATE] at 09:51 AM, the surveyor interviewed Resident #24, who stated they were imprisoned for twenty months and preferred the door to their room remain open because the closed door triggered their PTSD, causing anxiety. The resident stated on [DATE]; they were waiting for LPN #1 to administer their routine Percocet and Xanax medication so they could go back to sleep. LPN #1 closed their room door and started yelling at them, and the resident reported they just wanted to escape LPN #1, who grabbed their wheelchair and almost tipped the chair over. Resident #24 stated that they remembered the aide (CNA #1) saying their name and that they knew her and they could not leave, but Resident #24 stated they could not determine who the aide was at the time. Resident #24 stated they just wanted the RN Supervisor, which made them feel angry because they were being prevented from escaping from LPN #1, and CNA #1 was not helping the situation. CNA #1 could have opened the door to let me leave, but she would not let me leave, which made me mad. The resident stated they had never been prevented from leaving the unit before, so they could not understand why that was happening. The facility's failure to ensure all residents were free from abuse, including verbal, physical, restraints, and involuntary seclusion by not investigating the actions of CNA #1 after a written statement acknowledged she stopped the resident from leaving the unit as well as video footage confirming she blocked the exit door preventing the resident from leaving the unit posed a serious and immediate threat for abuse which can cause serious physical and emotional harm or impairment. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	This resulted in an Immediate Jeopardy situation. The IJ was identified on [DATE], and the LNHA, ALNHA #1, ALNHA #2, DON, and Director of Veterans Health Care Services were notified of the IJ at 02:55 PM. A written Removal Plan was accepted and verified onsite on [DATE], which included staff members will be immediately relieved from their duties; to ensure the safety of the residents, a comprehensive investigation will commence at the time of the event to ensure a thorough and complete review of all contributing factors have been conducted; all staff in-serviced on the Abuse and Neglect Policy. Refer to F658 Based on interviews, record review, and review of other facility documentation, it was determined that the facility failed to ensure nursing staff appropriately removed an indwelling urinary catheter (soft plastic or rubber tube that is inserted into the bladder to drain urine) in accordance with professional standards of nursing practice which necessitated a transfer to the hospital for treatment, and a urinary tract infection. This deficient practice was identified for 1 of 3 Residents reviewed for indwelling urinary catheter care (Resident #179) and 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 or 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 well-being, and executing medical regimes 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 facility's failure to have a system in place to ensure that nursing staff appropriately removed an indwelling catheter posed a serious and immediate threat to the health and welfare of all residents who required catheter care. An adverse outcome was likely to occur as the identified non-compliance resulted in an immediate Jeopardy (IJ) situation that began on [DATE] at 2:50 PM when the Registered Nurse (RN) improperly removed the indwelling catheter. The RN used scissors to cut through Resident #179's indwelling catheter, which then caused the remaining catheter to retract into the bladder. The Immediate Jeopardy (IJ) situation was identified during an onsite survey conducted on [DATE], and the facility was notified of the IJ, on the same day, at 3:20 PM. The facility submitted an acceptable removal plan on [DATE] at 2:55 PM. The team verified the removal plan during an onsite visit conducted on [DATE]. Findings included: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 10:30 AM, the surveyor toured the 200 Unit of the facility and observed that Resident #179's door was closed. On the door, the surveyor observed signage posted which identified the required PPE (Personal Protective Equipment) to enter the room. The surveyor observed staff donning (putting on) and doffing (removing) with the required PPE before entering and exiting the room. An interview with the Registered Nurse/Unit Manager (RN/UM) revealed that Resident #179 was in isolation for Extended Spectrum Beta Lactamase (ESBL, antibiotic-resistant bacteria) and Methicillin Resistant Staphylococcus Aureus (MRSA, antibiotic-resistant bacteria) in the urine. On [DATE] at 11:29 AM, the surveyor donned the appropriate PPE, knocked at the door, waited for Resident #179 to answer, and entered the room. The surveyor observed Resident #179 in bed, awake with eyes open, and the surveyor observed a splint to the left arm. The surveyor explained the purpose of the visit, and Resident #179 agreed to be interviewed. Resident #179 was alert and stated that he could not move their left arm. Resident #179 answered all questions appropriately. The surveyor observed an indwelling urinary catheter covered with a catheter drainage bag hung on the bed frame. On [DATE] at 09:30 AM, the surveyor returned to the 200 Unit, the door was open, and Resident #179 was not inside the room. Upon inquiry, the RN/UM informed the surveyor that Resident #179 had tested + for COVID-19 in the evening during routine testing and was transferred to the 700 Unit. On [DATE] at 08:30 AM, the surveyor observed Resident #179 in the 700 Unit. The door was closed. Signage with the required PPE was posted on the door. The surveyor reviewed the medical record for Resident #179 on [DATE]. According to the Admission Face Sheet (an admission summary), Resident #179 was readmitted to the facility on [DATE] following hospitalization for urinary retention. Resident #179 had diagnoses that included but were not limited to, hypertension, diabetes mellitus, depression, hyperlipidemia, and End Stage Renal Disease. A review of Resident #179's Plan of Care, updated on [DATE] and [DATE], revealed that Resident #179 had decreased range of motion (ROM) and muscle strength related to co-existing chronic medical conditions. Resident #179 also was at risk for infection due to urinary retention. The care plan goal was for Resident #179 to not have a urinary tract infection and to receive the care needed to maintain their current functional status. The Annual Minimum Data Set Assessment (MDS), an assessment tool used by the facility to prioritize care, dated [DATE], revealed that Resident #179 scored ,d+[DATE] on the Brief Interview for Mental Status (BIMS), which indicated intact cognition. Section H of the MDS, which addressed Bladder and Bowel, Resident #179 received a score of 9 for H 0300. The score was indicative of the presence of an indwelling catheter in the bladder. The Interdisciplinary Progress Notes (IDPN) revealed that on [DATE] at 3:00 PM, a Registered Nurse documented in the IDPN, Per assigned desk nurse statement, in the process of removing the resident catheter. She cut it and put a towel under it to prevent the urine from draining into the resident's pants. Before she could pull the catheter out, part of the catheter retracted. It was reported to the writer. Director of Nursing (DON) and Assistant Director of Nursing (ADON) were made aware. NP (Nurse Practitioner) made aware and gave the order to transfer Resident #179 to the Emergency Department (ED) for retracted [indwelling urinary] catheter . Resident #179 was picked up at 2:55 PM by 911 crew. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A late IDPN entry dated [DATE], timed 3:30 PM, read, Dc' d [indwelling urinary] catheter retracted in the process of removing it. Resident transferred to ED. On [DATE] at 11:52 AM, the surveyor interviewed the RN/UM regarding the IDPN dated [DATE]. The RN/UM stated that the Registered Nurse (RN #1), who oversaw the unit on [DATE], cut the indwelling urinary catheter in the process of removing the indwelling urinary catheter. She stated that there was an order to remove the indwelling urinary catheter on [DATE]. RN #1 proceeded to execute the order to remove the urinary catheter. The RN/UM stated that RN #1 reportedly had never removed a urinary catheter before. She cut the urinary catheter with a pair of scissors instead of using a syringe to remove the water to deflate the balloon. The remaining urinary catheter then retracted into the bladder. Resident #179 was transferred to the ED for evaluation and treatment on the same day. The hospital discharge summary was requested and was not available for review by the surveyor. The RN/UM stated she would inform the DON of the request for the hospital discharge summary. On [DATE] at 12:30 PM, the surveyor interviewed the Director of Nursing (DON). The DON confirmed that she was aware of the above incident and informed the surveyor that RN #1 was suspended pending disciplinary action. The surveyor requested the investigation and the employee file for review. The surveyor also requested RN #1's telephone contact to conduct an interview. On [DATE] at 9:23 AM, the surveyor interviewed a random Registered Nurse (RN) assigned to the 200 unit regarding nursing resource materials available to the staff. The RN directed the surveyor to the binder outside the nursing station that contained all the policies and procedures. The surveyor located in the binder policy # 4:035 B titled, Indwelling Catheter Replacement, dated [DATE], which outlined the following: Indwelling Catheter replacement must have a physician order indicating size and schedule. Indwelling catheter replacement must be done by a registered nurse whose clinical skill has been checked by the instructor of nursing. If the physician and/or registered nurse, who has demonstrated clinical competence for this procedure, is not available, send the resident to the emergency room for an indwelling Catheter. The policy did not include a procedure to remove an indwelling urinary catheter. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Wound care / Dressing Change Suctioning skill/ Trach care Glucometer Medication Pass Indwelling catheter replacement CPR The facility's Indwelling Catheter Replacement policy did not cover Foley Catheter Removal. On [DATE] at 10:37 AM, the surveyor interviewed with the NP responsible for Resident #179's care. The NP stated that she wrote an order to remove the indwelling urinary catheter and initiate a voiding trial. She received a call from the nurse, who stated that something had happened. The nurse stated she cut the indwelling urinary catheter to remove it, and the catheter retracted. The NP stated, I came on the unit, examined the resident, and the resident was not in pain. I gave an order to transfer Resident #179 to the ED for evaluation and treatment. The NP stated, I had never heard of such a procedure. The NP further stated that she was not informed of any follow-up or recommendations from the ED. The NP stated that she reviewed the After Visit Summary the next day and could not identify what treatment was provided. She said she called the hospital and spoke to the staff, but the hospital staff could not comment on what treatment was provided. The NP stated she asked for the Urology report and was informed that the Urologist was not called in to see Resident #179. The NP then explained to the ED, what had happened, and that the issue needed to be addressed immediately. The NP stated the Urologist was then made aware that Resident #179 had the retracted catheter in the bladder. On [DATE] at 12:03 PM, the surveyor interviewed the NE in charge of orientation and staff competencies. The surveyor inquired about specific competencies and skill sets necessary to care for resident needs. The NE provided the surveyor with the orientation package. A review of the orientation package confirmed that indwelling urinary catheter removal was not included in the competencies. RN #1 did not receive in-service training for indwelling urinary catheter removal. The NE stated that Licensed Staff had to go to general orientation classes for two days and then work with a mentor on the floor for 14 days (for full-time) employees. Mandatory training was scheduled yearly, and skill sets for competencies were completed every two years. Based on the orientation package provided, the facility staff did not receive competency training for indwelling urinary catheter removal. The NE stated that he was aware of the adverse outcome with the Foley catheter on the [DATE] incident. He was informed that Resident #179 was transferred to ED for treatment because the indwelling urinary catheter was improperly removed. The surveyor requested in-service education training provided after the incident, but none had been provided. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	When asked how nursing staff competency education was being tracked, the NE added that the DON would inform him of any needed in-service training. The Orientation package provided by the facility was reviewed with the NE on [DATE] and did not include Foley Catheter Removal. The current policy revealed how to insert an indwelling urinary catheter only. The facility was unable to provide the rationale for nursing staff not being trained or assessed for competency on how to remove an indwelling urinary catheter. On [DATE] at 4:40 PM, the surveyor conducted a second interview with RN #1. She stated that she had performed the skill to remove an indwelling urinary catheter before deflating the balloon. She stated that cutting the indwelling urinary catheter was a simple procedure that she had not used prior. She stated that she overheard nurses saying that you could cut the indwelling urinary catheter to remove it, and that was why she cut the indwelling urinary catheter. She stated that after the incident, she went to the internet, watched a video, and realized that she did not follow the proper technique. RN #1 stated that she cut the catheter 4 to 5 inches below the insertion site, not by the port, to evacuate the water. The surveyor then asked RN #1 to elaborate on the indwelling urinary catheter removal procedure. She stated: 1. Verify the order, identify the patient, explain the procedure, provide privacy, use a syringe to deflate the balloon by aspirating the water, and gently pull the indwelling urinary catheter. She stated she was very concerned regarding the resident's well-being. She kept calling every day to inquire regarding Resident #179's status. RN #1 elaborated on the process of properly removing an indwelling urinary catheter. She could not provide the rationale for cutting the indwelling urinary catheter, which caused Resident #179 to be transferred to the ED for treatment. On [DATE] at 09:30 AM, The DON provided the Investigation Report for review. The surveyor reviewed the final report, which revealed the following: Physical Evidence On [DATE], the charge nurse reported that in the process of removing Resident #179's indwelling urinary catheter, she cut the catheter and part of it retracted into the bladder. Resident #179 was immediately discharged to the hospital for intervention. CT urogram (used to examine the kidneys and bladder) without contrast was performed in the hospital with the impression there is significant bladder wall thickening with peri cystic inflammation suggesting cystitis (inflammation of the urinary bladder), no hydronephrosis or renal calculi identified, a note is made of small bilateral pleural effusion (abnormal fluid collection between thin layers of tissue lining the lung and the wall of the chest cavity), and urinary bladder is partially collapsed around Foley catheter. No further intervention was taken at the hospital. Recommendations: [DATE] Urology consult by ___, with recommendation for bladder ultrasound. [DATE] Bladder ultrasound taken on with conclusion of bladder not visualized, to consider ST scan not ordered. On [DATE] resident was seen by the Cardiology group and cleared for cystoscopy. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE], a cystoscopy was performed for removal, and a new Foley catheter was placed. The resident was referred for a follow-up with a Urologist. Resident's care plan revision: Bladders scan every shift Monitor for signs and symptoms of infection<[TRUNCATED]

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 31654 Based on interview and document review it was determined facility failed to: a.) ensure that the facility Quality Assurance Improvement Program (QAP), identified, developed and implemented Quality Assurance Improvement Plans (QAPI) to address areas related to infection prevention and control related to an ongoing COVID-19 outbreak that began on 11/23/21, b.) ensure all infections and antibiotic usage was monitored by the QAP, and c.) ensure the QAP monitored all 13 clinical areas per facility policy. The deficient practice impacted 5 of 5 currently occupied resident units and was evidenced by the following: Refer to 886L, 880L, 881F On 08/16 22 at 10:24 AM, during the entrance conference held with the facility administration, the administration informed the survey team that the facility was presently in an outbreak of COVID-19 which began on 11/23/21. On 08/31/22 at 12:53 PM, the surveyor interviewed the facility Licensed Nursing Home Administrator (LNHA) regarding the facility Quality Assurance and Improvement (QAI) process. The LNHA stated the Assistant Nursing Home Administrator (ANHA) was in charge of the QAI program, and stated as the LNHA she was present at the monthly meetings. On 09/02/22 from 9:04 AM to 9:42 AM, the surveyor interviewed the ANHA, with a QAI Nurse present. The ANHA stated she has been responsible for the facility quality assurance process on and off since 2008, and then resumed the responsibility back in 2021. The ANHA stated her role for the QAI was to work with the department heads, work with the quality indicators, and assist with the department heads to ensure what was supposed to be submitted for each department's individual QAPI plans. The surveyor asked the ANHA to list the current QAPI plans for all facility departments. The ANHA stated, in addition to monitoring falls and elopements, the current active QAPI plans for each department were as follows per the January 2022 QAPI report: Activity Department (related to low attendance at resident activities), Business Department (related to vendors and visitor incidents), Nutrition (related to resident weight loss), Food Service (related to the food, including temperature and taste), Housekeeping (related to the cleanliness of resident rooms and cleaning of wheelchairs), Infection Control (related to increasing the COVID-19 boosters and vaccination status percentage for employees), Maintenance (related to perimeter door identification), Medical Records (related to closed and discontinued charts, medical errors, medication pass compliance, restorative program audit, as needed psychotropic medication, pain with wound treatments, and reportable event monitoring. The ANHA then reviewed the July 2022 QAPI report and report and stated additional QAPI plans included from Rehabilitation (related to wound modalities), Nursing (related to medical storage), Social Services (related to ombudsman release of papers, funeral homes and grievances, Staff Development (related to mandatory educational topics). (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor inquired to the ANHA regarding how new topics for QAPI plans were developed and initiated. The ANHA stated when we conduct the QAPI meeting the departments would usually come up with new topics, and if the department needed to form a QAPI team then we would determine who would be on the team. The ANHA stated that the QAP process would include identifying root causes analysis regarding the problem. The ANHA stated once a root cause analysis was completed for a QAPI, it would be reviewed to identify if a system issue or a staff issue was the problem and then addressed by the group that was assigned the problem. The QAP would also review the policies, develop new policies as needed, and finalize the new policies. The ANHA stated that the LNHA has joined us in the policy revision meetings and the surveyor inquired as what role that the facility Medical Director (MD) had with the QAPI. The ANHA stated that he would be updated on the QAPI's, and right now it is on a limited basis. The surveyor asked the ANHA what the purpose of the QAP was. The ANHA stated to ensure that we have effective and efficient quality care for the residents and we want to make sure we are giving the proper care to the residents. The surveyor inquired to the ANHA regarding how the QAP would determine what QAPI plans were initiated regarding infection control. The ANHA stated that based on the past meetings that the facility Infection Preventionist RN (IP/RN) was monitoring COVID-19 boosters, and stated the IP/RN just brought up the COVID-19 boosters for a QAPI. The ANHA stated that any issues from previous surveys would be enacted into a QAPI plan also. The surveyor inquired to the ANHA regarding any infection control related concerns that were current QAPI plans, or anything related to the ongoing COVID-19 outbreak that began November 23, 2021. The ANHA stated it's not part of any QAPI's that have been brought up in the QAP meetings. The ANHA stated there was a separately held infection control (IC) meeting. The surveyor inquired to the ANHA if she attended the IC meeting and she responded no. The surveyor asked if infection control issues should be part of the QAPI program an she stated not really. The surveyor asked the ANHA to confirm if there were any additional QAPI plans related to infection control. The ANHA showed the surveyor the document that confirmed the only infection control parameter that was currently monitored by the QAP was for the COVID-19 boosters. The surveyor asked the ANHA if the QAP had been aware of the concerns regarding the lack of contact tracing, and COVID-19 testing that was identified during the current survey, and the ANHA stated no. The surveyor inquired to the ANHA if antibiotic use was tracked and reported at the QAPI meetings. The ANHA stated that antibiotic stewardship was not part of the QAPI meeting, and stated that the IC/RN was focusing on urinary tract infections only regarding the antibiotic stewardship, however, the IC/RN should be tracking all infections. The surveyor inquired if any part of the infection control meetings were carried through to the QAPI program, and she stated no they were not integrated, and the infection control meeting minutes were not part of the QAP. On 09/02/22 at 10:03 AM, the surveyor interviewed the IC/RN in the presence of the survey team. The surveyor inquired to the IC/RN regarding what current infection control QAPI plans were in place. The IC/RN stated the COVID-19 boosters were the current infection control QAPI. The surveyor asked the IC/RN what was the purpose of the infection control meeting. The IC/RN stated the purpose of the infection control meeting was to discuss infection control issues. The surveyor asked the IC/RN if information discussed at the IC meeting transferred to the QAP. The IC/RN stated she would present numbers of infections, however there was no benchmarks or QAPI plans created. The surveyor asked the IC/RN if QAPI plans were developed regarding any infection control concerns. The IC/RN stated infection control issues would not develop into a QAPI plan. The IC/RN stated I just present any issues, and stated no when asked if after numbers of infections were discussed, would then specific and measurable goals be developed. The IC/RN stated that QAPI was focused on specific issues and how we could improve things in a specific format and stated I am so backed up with work, that is something I could just present. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/02/22 at 10:21 AM, the surveyor interviewed the LNHA in the presence of the survey team regarding the QAPI program. The LNHA stated the ANHA was responsible for implementing the QAPI program and stated that we also have an infection control meeting. The surveyor inquired to the LNHA if the infection control meeting was integrated into the QAPI program and she stated yes, it was part of the QAPI. The surveyor inquired if the QAPI plans should be specific and measurable and the LNHA stated yes, it is not running the way I would like it to run. The LNHA stated that minimally there should be a status update for the clinical care areas, and stated she was aware that the clinical care areas were not being monitored. The LNHA stated I am ultimately responsible for everything that happens in the building, to ensure appropriate management for each of the departments and to monitor goals and outcome of the other assistant administrators. The surveyor asked the LNHA what the purpose of the QAP was. The LNHA stated to identify areas needed for improvement, measure progress and set goals. A review of the facility Quality Assurance Improvement Plan, Approved 05/02/2022 by the LNHA. Revealed the following: Purpose: .strive to consistently provide the highest quality resident-centered long term care, through efforts to continuously improve services, care and treatment through professional collaboration, innovation and dedication in a setting that promotes dignity and independence. The QAPI program will systematically monitor all services provided by the facility and implement appropriate interventions to promote continual improvement in quality of care, quality of life, resident choice, person-centered care and services provided; Components of the QAPI Plan: The QAPI program will incorporate the following components in the implementation of the QA plan, Maintain a Quality Assurance Committee which is responsible for the implementation of the QAPI plan. The QA committee will identify, define, and measure performance improvement concerns and establish goals in order to provide optimal care and services, Identify and prioritize problems and opportunities for improvement, Incorporates the following Five Elements essential base for the Performance Improvement program which includes: 1. Design and Scope: the QAPI program will be ongoing and comprehensive to include all departments and services provided, 2. Leadership: administration supports and develops a culture of striving for continual improvement in order to provide excellence in all areas of service and care. Encourages input from residents, families and caregivers to identify problems. Will ensure provision necessary resources to address areas of concern, 3. Feedback, Data Systems and Monitoring: draws data from multiple sources. Monitors and tracks care, services and project outcomes, 4. Performance Improvement Projects (PIPS): implements and monitors specific projects to address identified concerns, 5. Systematic Analysis and Action: utilizes Root Cause Analysis to thoroughly examine the cause or exacerbation of an identified problem; QAPI Leadership: Administrator will be responsible for oversight of the QAPI program ., .will ensure regular reports of the QAPI program and activities; Quality Assurance Coordinator (QA) is responsible for implementation of the QAPI program. The QA Coordinator will work with administration and staff to ensue collection and analysis of data from all identified sources. QA Committee meetings, led by the QA Coordinator, will meet at least quarterly to review collected data, identify problems and prioritize areas of concern for potential intervention projects; The QA Leadership Committee will be responsible to review and analyze collected data, investigate root causes of problems identified, and assist with decisions on actions to implement that will address the underlying cause of the problem. Quality Improvement Program Areas of Assessment and Monitoring: The Quality Assurance Improvement program will monitor the following clinical care areas: Clinical Care: 1. Pressure ulcers and skin breakdown, 2. Psychoactive drug use, 3. hospitalization s and re-hospitalization s, 4. Medication errors, 5. Catheter rates and care, 6. Weight loss, 7. Infections, Antibiotic use, 9. Restraint use, 10. Bowel Impactions, 11. Falls/fall resulting in injury, 12. Incidents of potential abuse, neglect or misappropriation, 13. Other identified care areas. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	NJAC 8:39-33.1(a)(b); 8:39-33.2 (a)(b)(c)7

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Part A Based on interview and review of pertinent documents, it was determined that the facility, who has been in an active COVID-19 outbreak status since 11/23/21, failed to conduct immediate and thorough contact tracing to further prevent the spread of COVID-19 (a deadly virus) by failing to ensure: a.) a process was in place to conduct comprehensive contact tracing upon the identification of a single new case of COVID-19 in a staff or resident. b.) a facility contact tracing policy was completed and implemented, c.) appropriate staff were trained on the contact tracing policy, d.) the facility followed all Centers for Disease Control (CDC), local health department, state health department, and all current guidance related to infection control. The deficient practice was identified during a review of eight sampled COVID-19 positive residents (Residents #444, #446, #3, #445, #447, #46, #76, and #179), dates ranging from 12/28/21 through 08/16/22 and a review of six sampled COVID-19 positive staff members dates ranging from 08/1/22 through 08/16/22 and was identified by the following: The facility's system wide failure to conduct and retain complete COVID-19 close contact tracing upon the identification of a single new case of COVID-19 posed a serious and immediate risk to the health and well-being of all staff and residents who resided at the facility and who were placed at risk for contracting a contagious infectious and potentially deadly virus. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 09/06/22 at 4:16 PM. The survey team verified the removal plan during an on-site visit conducted on 09/08/22 at 12:47 PM. Reference: Contact Tracing for COVID-19 CDC https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/contact-tracing.html Reference F 886L On 08/16/22 at 10:24 AM, during the entrance conference, the Administrative team informed the survey team that the facility was currently experiencing an outbreak of COVID-19, which began on 11/23/21. The survey team was provided with the facility's ongoing line listing (a document that is transmitted to the department of health and lists all COVID-19 cases during an outbreak) and a blank copy of the Contact Tracing Form undated that the team was told was currently being used for tracking close exposures. The surveyor asked to review the facility Contact Tracing. The facility provided and the surveyor reviewed the Resident & Staff COVID-19 Incident Reports updated 4/21, which included but were not limited to please be as detailed as possible and type all responses 9. Explain contact tracing that has been completed in detail. The surveyor reviewed the facility and provided Incident Reports for the following COVID-19 positive residents: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	#444 who was fully vaccinated and resided in the Old [NAME] unit, presented symptomatic with a cough and sneezing and tested positive on 12/28/21. The contact tracing section failed to list any staff or residents who may have been a close contact (persons who may have been exposed to an infectious contagious disease and may require quarantine measures to help prevent further spread of the disease). #446, who was fully vaccinated and resided in the Eagle unit, presented symptomatic with a cough and tested positive on 01/4/22. The contact tracing section failed to list any staff or residents who may have been a close contact. #445, who was fully vaccinated and resided in the Freedom unit, presented symptomatic with fever and shortness of breath and tested positive on 01/30/22. The contact tracing section failed to list any staff or residents who may have been a close contact. #447, who was fully vaccinated and resided in the Freedom unit, presented symptomatic with a fever and shortness of breath and tested COVID-19 positive on 02/03/22. The form identified Resident #447 as leaving the facility three times per week to attend hemodialysis treatment (treatment to remove impurities from the blood). The contact tracing section failed to list any facility staff, hemodialysis staff, transport staff, visitors, or residents who may have been identified as a close contact. #3, who was fully vaccinated and resided in the Freedom unit, presented asymptomatic (having no symptoms) and tested COVID-19 positive on 08/03/22. The contact tracing section failed to list any staff or residents who may have been identified as a close contact. #46, who was fully vaccinated and resided in the Freedom unit, presented symptomatic with a cough and tested positive on 08/7/22. The contact tracing section failed to list any staff or residents who may have been a close contact. #76, fully vaccinated and resided in the Freedom unit, was asymptomatic and tested positive on 08/11/22. The contact tracing section failed to list any staff or residents who may have been a close contact. #179, who was fully vaccinated and resided in the Freedom unit, was asymptomatic and tested positive on 08/16/22. The contact tracing section failed to list any staff or residents who may have been a close contact. A review of the facility provided COVID-19 Resident & Staff Incident Reports for the positive staff members revealed the following: Licensed Practical Nurse (LPN) #2 was asymptomatic and tested positive on 08/1/22. The contact tracing section failed to list any staff or residents who may have been a close contact. Noted LTC facility 07/30/22, 7 (am) - 3 (pm). passed medication, did not have close contact with any staff residents. An Administrative staff member presented symptomatic with nasal congestion and an itchy throat and tested positive on 08/6/22. The contact tracing section failed to list any staff or residents who may have been a close contact. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	LPN #1 presented symptomatic with a runny nose and tested positive on 08/7/22. The contact tracing section failed to list any staff or residents who may have been a close contact. LPN was noted to have worked on 08/06/22. On 08/29/22 at 8:39 AM, during an interview with the surveyor, in the presence of the survey team, the facility Infection Preventionist Registered Nurse (IP RN) was asked to provide contact tracing for the residents and staff members who had tested COVID-19 positive. The IP/RN stated that when someone was exposed to COVID-19, she was responsible for completing the contact tracing to identify any close contacts. However, she stated she would not list or include any staff or residents in her contact tracing. She then stated she could not provide any additional documentation related to any staff or residents who may have been exposed to COVID-19 because she kept that information in a personal notebook. The IP/RN stated that she was alone, no secretary, no help, and that she did not document any potential exposers to COVID-19 that may have occurred to others. The surveyor then requested a list of the exposed close contacts. The IP/RN stated she would not be able to provide a list. The IP/RN also stated that there was no facility policy or procedure on contact tracing, and she was unaware that she was responsible for completing and retaining any contact tracing documents. On 08/29/22 at 9:32 AM, during an interview with the surveyor, a Licensed Practical Nurse Unit Manager (LPN/UM) in the Liberty Unit stated that if a resident tested COVID-19 positive, the IP/RN would isolate the resident and do the investigation. She further stated that if a staff member tested COVID-19 positive, they would be sent home, and the IP/RN would do all the paperwork. On 08/29/22 at 9:40 AM, during an interview with the surveyor, the RN Employee Health Nurse stated that she was responsible for the routine COVID-19 testing for the staff and residents and when a resident would return to the facility. She stated that the IP/RN would complete all contact tracing and that she would not be provided any of the contact tracing information. The RN Employee Health Nurse further stated that contact tracing was important to warn others who were exposed to COVID-19 so that they would be tested . On 08/29/22 at 11:27 AM, the IP/RN provided six incomplete facility Contact Tracing Forms for the requested COVID-19 positive staff. The IP/RN again stated to the surveyor that there was no policy for contact tracing, so she would use the Center for Disease Control and Prevention (CDC) guidance. On 08/30/22 at 10:58 AM, during an interview with the surveyor, the IP/RN stated that the facility had enough testing supplies to perform facility-wide COVID-19 testing. When asked again about documented COVID-19 positive close contacts and the actions taken, the IP/RN stated she would talk to the staff but not write things down. She again stated that she would keep the information in a personal notebook and would throw out that information when the case was resolved. The IP/RN stated she was unaware of any formal documentation or form to use, so she would not be able to inform the surveyor of the exposed staff or residents or their COVID-19 testing in response. The IP/RN stated that contact tracing would be used to prevent the spread of infection in the facility. On 08/31/22 at 9:37 AM, the IP/RN provided incomplete contact tracing for the requested COVID-19 positive residents. The contact tracing forms revealed the following missing or incomplete information for the residents: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	# 444: no name of interviewer, no date of interview, no demographic and locating information, no history of prior positive COVID-19 tests, no date of COVID-19 specimen collection, no breaks/meals rooms & areas, no actions taken listed for follow up testing, and there was nothing documented under reviewed by facility infection control nurse. The only potential contacts listed were one Certified Nursing Assistant (CNA) on each shift for the day of the COVID-19 positive test and previous 48 hour lookback. # 446: no name of interviewer, no date of interview, no demographic and locating information, no history of prior positive COVID-19 tests, no date of COVID-19 specimen collection. The only potential contacts listed were one CNA on each shift for the day of the COVID-19 positive test and the previous 48 hour look back. No actions were taken for follow-up testing, and the facility infection control nurse noted nothing under review. # 3: no name of interviewer, no date of interview, no demographic and locating information, no history of prior positive COVID-19 tests, no date of COVID-19 specimen collection, no known exposures to residents, the only potential contacts listed were one CNA on each shift for the day of the COVID-19 positive test and previous 48 hour lookback, no actions taken listed for follow up testing, and nothing noted under reviewed by facility infection control nurse. # 445: no name of interviewer, contact tracing does not include the date 01/30/22 which the resident tested positive or 01/29/22, which was 24 hours prior, no date of interview, no demographic and locating information, no history of prior positive COVID-19 tests, no date of COVID-19 specimen collection, the only potential contacts listed were one CNA on each shift for the day of the COVID-19 positive test and previous 48 hour lookback, no breaks/meals rooms & areas, no action taken by the facility for follow up testing, and nothing noted under reviewed by facility infection control nurse. # 447: no name of interviewer, no date of interview, no demographic and locating information, no history of prior positive COVID-19 tests, no breaks/meals rooms & areas, the only potential contacts listed were one CNA on each shift for the day of the COVID-19 positive test and previous 48 hour lookback, no actions taken by the facility for follow up testing, and nothing noted under reviewed by facility infection control nurse. # 46: no name of interviewer, no date of interview, no demographic and locating information, no history of prior positive COVID-19 tests, no date of COVID-19 specimen collection. The only potential contacts listed were one CNA on each shift for the day of the COVID-19 positive test and previous 48 hour lookback, no action taken by the facility for follow up testing, and nothing noted under review by facility infection control nurse. # 76: no name of interviewer, no date of interview, no demographic and locating information, no history of prior positive COVID-19 tests, no date of COVID-19 specimen collection. The only potential contacts listed were one CNA on each shift for the day of the COVID-19 positive test and previous 48 hour lookback, no known exposures to residents, no breaks/meals rooms & areas, and no action taken by the facility for follow up testing, and nothing noted under reviewed by facility infection control nurse. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	# 179: no name of interviewer, no date of interview, no demographic and locating information, no history of prior positive COVID-19 tests, no date of COVID-19 specimen collection. The only potential contacts listed were one CNA on each shift for the day of the COVID-19 positive test and previous 48 hour lookback, no breaks/meals rooms & areas, no action taken by the facility for follow up testing, and nothing noted under reviewed by facility infection control nurse. A review of the contact tracing forms for the COVID-19 positive staff revealed the following missing or incomplete information: LPN #2: No known exposures to residents were listed, and it was noted on the form that the LPN worked normally during the 3:00 PM - 11:00 PM shift, and no actions had been taken by the facility. The contact tracing form noted, LTC facility 7/30/22, 7 (am) to 3 (pm) passed medication and did not have close contact with any staff or residents. LPN #3: the form was not completed until 08/31/22 after the surveyor inquiry. The surveyor inquired where the IP RN retrieved the information since she had indicated she had discarded all of her documents related to contact tracing. The IP/ RN stated to the surveyor that she had completed from memory. Administrative staff: The form was not completed until 08/31/22 after the surveyor inquiry. The IP RN stated she had completed the document from memory. LPN #1: There was a known exposure and had listed the initials of one resident, the area was left blank, and there was no documentation of the identified resident who was exposed to COVID-19 as having a follow up COVID-19 test. A section under review by the facility infection control nurse was blank. Food Service Worker #2: form not completed until 08/31/22 after surveyor request. IP RN stated she had completed it from memory. Food Service Worker #1: form not completed until 08/31/22 after surveyor request. IP RN stated she had completed from memory. Nothing was noted under reviewed by the facility infection control nurse. On 08/31/22 at 11:21 AM, during an interview with the surveyor, in the presence of the survey team, the IP/RN stated the contact tracing forms she had provided were all filled out yesterday (08/30/22) based on memory. When asked about additional staff who may have had close contact, such as the nurses caring for the residents who tested COVID-19 positive, the IP/RN stated the nurses were not with the residents long enough. The IP/RN stated that exposure would be traced back 48 hours prior for someone who had been within six feet for 15 minutes or more. She further stated, I know from memory that none of the nurses were. Although, she was unable to provide any documented evidence of interviews, reviews of assignment sheets, or any process related to contact tracing to determine a possible COVID-19 exposure. The IP/RN stated that the facility implemented routine broad based COVID-19 testing. She stated the facility tested the staff thrice a week in December 2021 and the residents once or twice a week. The IP/RN stated she was not sure why that stopped. The IP/RN stated that the close contacts were not all tested when exposed. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 08/31/22 at 1:12 PM, during an interview with the surveyor, in the presence of the survey team, the facility Licensed Nursing Home Administrator (LNHA) stated the facility was familiar with the process for contact tracing. At 1:14 PM, the IP/RN joined the interview and told the surveyor that it was the facility process for her to keep her notes. The IP/RN further stated that she remembered from December 2021 onward that none of the nurses who cared for the COVID-19 positive residents spent over 15 minutes with the residents and that no treatments were done either. The LNHA stated that what the IP/RN stated was incorrect, and the facility required formal tracking (contact tracing). The LNHA further stated that the IP/RN should have conducted the contact tracing at the time of the exposure and not from her memory. The LNHA stated that the IP/RN's statement that the nurses did not spend more than 15 minutes was not fully accurate. On 09/01/22 at 9:22 AM, during an interview with surveyors in the conference room, the IP RN stated that she consulted with the local health department (LHD) mostly about deaths, not contact tracing. The IP RN stated, the nurses (facility) I spoke to were in and out (of the resident rooms); I should have kept my contact tracing and personal notes, and the IP/RN stated, we didn't have a policy for contact tracing. The IP/RN confirmed to the surveyor that there was no facility contact tracing policy and stated, unfortunately, no. The surveyor inquired to the IP/RN if she was able to confirm if the nurses who tested COVID-19 positive did not spend 15 minutes or more with residents, and the IP/RN stated she cannot say 100% if the nurses did not stay 15 minutes or more. The IP/RN again stated that contact tracing was important to not spread the virus in the facility. The surveyor requested communication information from the LHD. A review of the communication with the LHD provided by the IP/RN on 09/02/22 at 9:30 AM, revealed emails sent to the LHD as follows: 01/04/22, the IP/RN asked for a meeting, and the LHD asked for her concerns; 01/25/22 the IP RN asking for clarification if she needed to test the roommate of a COVID-19 positive resident and would she need to test again in 48 hours; 04/22/22 the IP/RN asking about quarantining residents not up to date with COVID-19 vaccinations in response to COVID-19 positive residents on the same unit; and 07/18/22 regarding staff going on vacation and coming back COVID-19 positive if they would need to be reported. The IP/RN could not provide any communication to her from the LHD regarding guidance on contact tracing. On 09/02/22 at 9:47 AM, the IP/RN stated that if someone tested COVID-19 positive on a Saturday, she was told she could wait until Monday but could not state who gave her that directive. She stated, the nurses on the weekend would verbally tell her, but there was no documentation regarding the conversation. The IP/ RN acknowledged that close contacts should have included visitors, and physicians, therapy staff but that she did not have documentation that they were ever included on the contact tracing forms. On 09/02/22 at 11:34 AM, during a telephone interview with the survey team, the Medical Director (MD) stated he started at the facility in July 2022. He stated that he had not had any discussions about contact tracing yet, but he was aware of the facility statistics. The MD further stated that he had finished reviewing the Infection Control manual, which was not complete regarding close contacts, and that it would be on the agenda to discuss with the IP RN during their next meeting. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/02/22 at 12:04 PM, during an interview with two surveyors, the Assistant Nursing Home Administrator (ANHA) stated she was responsible for the oversight of the IP/RN. She stated her responsibilities were to ensure that the IP/RN completed her job functions and was supported. The ANHA stated a form should be used regarding contact tracing and that the IP/RN had no choice but to follow the facility directives and complete the form. The ANHA stated that the contact tracing form should be done that day (the day of the exposure). The ANHA further stated that if it was not documented, how do we know. She stated that the contact tracing forms were completed to prevent the spread of infection and that exposed close contact should not have been working until they have been tested for COVID-19. On 09/06/22 at 11:31 AM, the surveyor attempted to reach either of the two representatives from the LHD that the IP/RN stated she was in contact with. Two phone messages and email communication was sent. There was no response from either LHD Representative assigned to the facility. On 09/06/22 at 12:03 PM, during a follow-up interview with the survey team, the IP/ RN was asked again if she had received any guidance from the LHD, given the facility had been active COVID-19 outbreak since 11/23/21. The IP/RN stated that she would have to check her emails but believed the LHD may have sent her links to reference. At 12:13 PM, the IP/RN presented the surveyor with additional guidance from the LHD dated 01/19/22, which had not been provided previously. The IP/RN and the surveyor reviewed a guidance in part which included but was not limited to: if the facility can perform contact tracing and can identify close contacts, testing should be done as follows: staff .with exposure with COVID-19 positive individual, residents . who had close contact with a COVID-19 positive individual. If the facility is unable to perform contact tracing and is unable to identify close contacts, testing should be done as follows: staff .test all staff facility wide or at a group level if staff are assigned to a specific location where the new case occurred. Residents .test all residents facility wide or at a group level if staff are assigned to a specific location where the new case occurred. The IP/RN again stated she had stopped doing things this way because the facility was short staffed, so if someone tested positive over the weekend, they (facility staff) were short staffed, so nobody was immediately tested . The IP/RN stated we were told to just do routine testing by the administration. The IP/RN stated when she found out that was incorrect, she followed what the administration had told her to do but could not provide a name or a directive. On 09/06/22 at 12:28 PM, during an interview with two surveyors, the LHNA stated they were never made aware that the IP/RN had stopped following the LHD guidance. The LHNA further stated that the guidance should have always been followed. At 1:04 PM, the LHNA further stated that upon questioning other administrative staff, there was no administrative staff who instructed the IP/RN to stop following the LHD guidance. On 09/07/22 at 10:54 AM, during an interview with the survey team, the MD stated that contact tracing should include all who were exposed, such as food service workers, nurses, residents, visitors, and everyone. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the facility provided, Outbreak Response Plan revised 2/22, included but was not limited to the following: Purpose - to protect our residents, families, and staff from harm resulting from an outbreak of an infectious disease organism; the IP would be responsible for conducting routine audits of Infection Control in the facility, establish and implement policies and procedures for screening for exposure, will collaborate with facility medical director, public health authorities, regarding interventions to implement responses; Contact Tracing Form - to include name of interview/contact tracer, date of interview, name of resident, history prior positive COVID, date of a + (positive) COVID, date of symptoms/asymptomatic subtract 2 days prior to test result date or symptoms listed (this is the contact tracing date), known exposures, staff in close contact, activities/locations/shift times visited, breaks/meals contacts, outside employment, actions taken by the facility, and reviewed by the Infection Control nurse. The facility's Outbreak Response Plan had not been followed. A review of the facility provided, Facility Assessment, dated 02/17/22, included but was not limited to Interventions for Controlling Infectious/Communicable Diseases for all Individuals with Residents and Facility Contact - daily surveillance by Infection Control to monitor for any new infections or spread of infections; during the COVID-19 pandemic, the home (facility) identified the need to improve upon the Infectious Disease Outbreak Response Plan. A review of the facility provided CDC guidance the IP RN stated she was referencing, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 (COVID-19) Spread in Nursing Homes updated 02/02/22, included but was not limited to: older adults living in congregate settings are at high risk of being affected by respiratory and other pathogens such as SARS-CoV-2; a strong infection prevention and control program (IPC) is critical to protect residents and healthcare personnel (HCP); even as nursing homes resume normal practices, they must remain vigilant for SARS-CoV-2 infection in order to prevent spread and protect residents and HCP; New Infection in HCP or Residents - because of the risk of unrecognized infection among residents, a single new case of SARS-CoV-2 in any HCP or resident should be evaluated as a potential outbreak; perform contact tracing to identify any HCP who have had a higher-risk exposure or resident who may have had close contact with individual SARS-CoV-2 infection regardless of vaccination status. The CDC guidance had not been followed by the facility for contact tracing. A review of the facility provided, [redacted] Testing of Residents and Healthcare Personnel for COVID-19 dated August 2021, included but was not limited to: Purpose - will comply with all local and/or state health departments for guidance; all residents shall be tested if there is a new confirmed case (resident or staff) in the facility. A review of the facility provided IP responsibilities, undated, included but was not limited to: The IP is accountable for decreasing the incidence and transmission of infectious diseases between patients, staff, visitors, and the community; establishing a routine, ongoing, and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections, infection risks, communicable disease outbreaks and to maintain or improve resident health status. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the facility provided, Job Specification Infection Control Nurse dated 06/05/21, included but was not limited to: Conducting surveillance rounds to eliminate risks of infection to residents, patients, and personnel; evaluating and maintains records of infections among residents, patients, and staff; acts as the infection control liaison between all hospital departments and medical services, the infection control committee, and hospital administration; prepares clear, technically sound, accurate, and informative reports on epidemiologic and infection matters containing findings, conclusions, and recommendations; and establishes and maintains records, reports, and files. Reference: Centers for Medicare & Medicaid Services (CMS), QSO-20-38-NH, Revised 03/10/22, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements. A review of the Centers for Medicare and Medicaid Services (CMS) directive QSO-20-38-NH, dated revised 03/10/22, included but was not limited to the definition of Close contact, which refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over 24 hour period. Guidance - To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set forth by the HHS Secretary. The testing summary included that for newly identified COVID-19 positive staff or residents in a facility that can identify close contacts, the facility should, regardless of vaccination status, test all staff that had a higher-risk exposure with a COVID-19 positive individual and test all residents who had close contact with a COVID-19 positive individual. Testing during an outbreak revealed -that upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g., facility-wide) testing. Documentation of testing - upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested , the dates that staff and residents who tested negative are retested , and the results of all tests. NJAC 8:39-19.2(a); 19.4(a); 19.4(d)(f)(g) Refer to F 886 37175 Part B. F 880 remains a deficiency at a scope and severity of a D based on the following: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to maintain proper infection control practices identified during 1 of 2 wound treatment observations (Resident #81). This deficient practice was evidenced by the following: On 08/17/22 at 01:20 PM, during the initial tour of the facility, the surveyor observed Resident #81 seated in a motorized wheelchair in the main recreation area, participating in activities. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the Face Sheet (an admission summary) reflected that Resident #81 was admitted to the facility in November of 2014 with diagnoses that included cardiac dysrhythmia (irregular heartbeat), hypertension (high blood pressure), and chronic ischemic heart disease (inadequate supply of blood to the heart). A review of the annual Minimum Data Set (MDS), an assessment tool dated 03/08/2022, indicated a Brief Interview for Mental Status (BIMS) score at 00 out of 15, which indicated the resident had severe cognitive impairment. A review of the quarterly MDS dated [DATE] revealed that the resident had a stage 2 pressure ulcer (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin). A review of the 8/17/22 physician's telephone order revealed an order to clean the left buttock wound with normal saline, apply alginate and cover with bordered foam gauze, and apply zinc oxide to the peri-wound twice a day and when needed for 7 days. The same physician's order was also noted on the August 2022 Treatment Administration Record (TAR). On 08/25/22 at 9:00 AM, the surveyor observed the Licensed Practical Nurse (LPN) perform a wound treatment for Resident # 81's facility acquired Stage 2 pressure ulcer to the left buttock. The surveyor observed the LPN wash her hands for 45 seconds. She donned (put on) gloves and cleaned the overbed table with disinfectant sanitizing wipes. The surveyor observed the LPN place a barrier on the table and taped a plastic bag on the side of the table. The LPN then placed an open pack of 4 x 4 gauze, two (2) border gauze, one (1) bottle of normal sterile saline (NSS), and a pair of metal scissors on the barrier. The LPN doffed (removed) her gloves and performed hand washing for 30 seconds, then donned a new pair of gloves and assisted the resident onto their left side. The Certified Nursing Assistant (CNA) was also present and assisted the resident during wound care. The wound was exposed, and no dressing was present because the CNA reportedly had performed care prior to the observation. The surveyor observed the LPN pour the NSS onto a piece of gauze, cleansed the left buttock wound from inner to outer motion, and threw the gauze into the plastic bag. The LPN reached into her pocket with her gloved hand, removed a pen, dated the border gauze, and then p [TRUNCATED]

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Based on interview and document review, it was determined that the facility failed to ensure: 1.) full implementation of the Antibiotic Stewardship (AS) program, including ongoing monitoring, and 2.) consistent use of a nationally recognized surveillance criteria prior to consulting with the prescriber as per facility policy. The deficient practice occurred for 3 of 3 months reviewed (May 2022, June 2022, and July 2022) for AS and was evidenced by the following: Refer to F865 F 1.) On 08/30/22 at 10:27 AM, the surveyor interviewed the Infection Preventionist Registered Nurse (IP/RN) regarding the AS program. The IP/RN stated that the AS program was started in either 2018 or 2019 and was being re-launched. The IP/RN informed the surveyor that the Situation Background Assessment-Recommendation (SBAR), a nationally recognized tool with criteria used to evaluate clinical status prior to communication with prescriber to determine the appropriateness of antibiotic use for an infection, was only used to track urinary tract infections (UTI). The IP/RN stated that the AS policy was not being followed. She stated that the nurses were not consistently documenting symptoms in the resident charts, and staff were not consistently utilizing the SBAR form for UTIs. The IP/RN stated when the SBAR had not been utilized, that she then asked the nurses for documentation of symptoms after an antibiotic had already been prescribed for a UTI. The IP/RN confirmed that the specific SBAR for UTI criteria should have been completed prior to any resident receiving a prescribed antibiotic. On 08/31/22 at 10:23 AM, the surveyor interviewed the IP/RN regarding the process for determining when a new antibiotic would be ordered for a resident. The process included: reviewing the supervisor report book every morning to determine new antibiotic orders, and then she walked from unit to unit and checked the 24-hour report book for new antibiotics that had been ordered. The IP/RN stated if a new antibiotic was ordered, she would check the resident's medical record for documentation that may have included any symptoms or associated labs to justify antibiotic use. The IP/RN stated then she would make hand-written notes on the Orders for Antibiotic pharmacy report as a system of record keeping. The IP/RN stated that if an antibiotic was not reported on either of the books she reviewed, then she printed another pharmacy report (Orders for Antibiotics) on the Monday of the following week. The IP/RN stated, if a symptom was not documented, I do not count it as facility acquired infection. She stated there were no SBARs currently being utilized for any other infections other than UTIs A review of the Order for Antibiotics provided by the IP/RN, which included the IP/RN's handwritten documentation for antibiotics active between 07/01/22 through 08/01/22, revealed residents with pneumonia, upper respiratory infections, skin infections, eye infections, and UTI's. The infections did not have corresponding SBARs completed prior to contacting the prescriber, or additional documentation. Further review of the last three months of antibiotics tracking reflected the following: A review of the May 2022 Active Antibiotic spreadsheet reflected that 27 antibiotics were started in the month. The facility was unable to provide SBARs for all the antibiotics started. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the June 2022 Active Antibiotic spreadsheet reflected that 25 antibiotics were started in the month. The facility was unable to provide SBARs for all the antibiotics started. A review of the July 2022 Active Antibiotic spreadsheet reflected that 24 antibiotics were started in the month. The facility was unable to provide SBARs for all the antibiotics started. On 08/31/22 at 1:26 PM, during a follow-up interview with the survey team, the IP/RN stated the facility was currently in phase two (2) of four (4) phases of the AS Program. The IP/RN reviewed the facility policy for AS in the presence of the survey team and informed the surveyors that a target date for completion of all phases was not available in her facility guidance. The IP/RN stated that there were parts of the phase 3 program being implemented. However, she did not offer details. The IP/RN stated that she was the only person conducting the AS Program for the entire facility. The IP/RN confirmed that she had been informed to only focus on UTIs for completion of the SBAR form. The IP/RN acknowledged there were other types of infections in the facility, including respiratory. However, she reiterated the facility was using the SBAR for UTIs only. The IP/RN stated the purpose of AS was to decrease antibiotic usage and resistance. The IP/RN reviewed the AS policy, approved with the Infection Prevention Manual on 03/21/2022 by the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and IP/RN. The Nursing Staff section of the policy revealed, in the event of a suspected/actual infection, clinical nursing staff are responsible for utilizing the SBAR assessment prior to consulting with the prescriber. The IP/RN stated she was not required to use the standardized assessment tool (SBAR) before contacting a prescriber. She stated that the Infection Control Team had been aware that the facility had been in phase 2 of the implementation of the AS program, and the program was not fully implemented. On 09/01/22 at 1:46 PM, during an interview with the survey team, the Quality Assurance Coordinator stated the Antibiotic Stewardship program rolled out in 2017 and started with education. She informed the surveyors that all 4 phases of the program were implemented, and the facility was tracking all antibiotic usage. On 9/02/22 at 9:33 AM, during an interview with two surveyors, the DON stated her function in the program was collaborative, and the IP/RN educated her. The DON was unable to inform the surveyors as to which phase of the antibiotic stewardship program the facility had implemented. She confirmed the SBAR was inconsistently used for UTIs and was not used for any other infections. The DON confirmed the SBAR should have been utilized for all infections. The DON further stated that the nurses on the floors caring for the residents should utilize the SBAR, not the IP/RN. The DON could not speak to the effectiveness of the facility antibiotic surveillance with the inconsistent use of the SBAR for UTIs and no usage for all other infections. On 9/02/22 at 12:17 PM, during an interview with two surveyors, the Assistant Nursing Home Administrator (ANHA #2) stated they were in Phase 3 and did not have a fully implemented AS program. ANHA #2 acknowledged that the surveillance program would not be accurate without utilizing an SBAR consistently for all infections. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Infection Control Committee Meeting minutes with 14 facility staff members, dated July 20, 2022, included but was not limited to: a meeting was held (date unknown) with the Infection Control nurse and [redacted] infection control consultant. The AS policy was being revised; 12 facility acquired infections in June 2022, and it was noted that several UTIs were noted without any symptoms noted. SBARs were not completed for any of the urinary tract infections. The meeting failed to document all the infections which required antibiotics. During a review of the facility policy titled Infection Control Program Policy Statement, under Procedure, indicated: The Infection Control Committee of the facility shall include representatives of at least administration, nursing, medical, dietary, housekeeping services and pharmacy who, under the direction of a qualified infection Control Nurse shall develop and implement an Infection Control program . A review of the facility provided, Infection Prevention Manual dated 3/21/22, included but was not limited to Nursing Staff in the event of a suspected/actual infection utilize the SBAR prior to consulting with the prescriber, Infection Prevention, and Control Coordinator coordinates the AS under the oversight of the Medical Director .ongoing monitoring and tracking, monitors adherence to prescribing practices and evidence-based best practices, communicates with DON to ensure nursing staff is utilizing the SBAR and [redacted] criteria assessment tools to assess residents for possible infection; and Focused monitoring - as part of the AS, the Infection Control Coordinator will provide ongoing monitoring of UTIs and multi-drug resistant organism infections (MDRO). The monitoring was to include the type of MDRO, diagnosis date, resident location, resident history of antibiotic therapy for the past six months, and outcome. During a review of the IP/RN job description under Program Management reflected that the IP/RN is to Utilize nationally recognized surveillance criteria such as but not limited to CDC's National Healthcare Safety Network (NHSN) or Revised Mc Geer [Mc [NAME]] criteria to track trends and identify opportunities for improvement based on data analysis. During a review of the facility policy manual, Antibiotic Stewardship Program with an approved date of 3/21/22, under Focused Monitoring: As a part of the antibiotic stewardship program, the Infection Control Coordinator will provide ongoing monitoring of the following infections: Urinary Tract Infections (UTIs), The Infection Control Coordinator will track the presence of UTI's Monitoring shall include: New diagnosis of UTI in residents with an indwelling catheter (Review [SBAR] criteria), (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on interviews and review of pertinent documents, it was determined that the facility failed to ensure: a.) a process was followed to initiate immediate action, and conduct COVID-19 testing upon the identification of a single COVID-19 positive result, b.) that staff who were exposed were COVID-19 tested prior to working at the facility, c.) Federal, State and infection control guidelines were followed, and d.) the facility Infectious Disease Outbreak Response Plan was followed to prevent exposure and mitigate the spread of COVID-19, a deadly highly transmissible infectious disease. The facility's system wide failure to immediately conduct COVID-19 testing upon the identification of a single new case of a COVID-19, posed a serious and immediate risk to the health and well-being of all staff and residents who resided at the facility and who were placed at risk for contracting a contagious infectious and potentially deadly virus. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 09/01/22 at 2:37 PM. The removal plan was verified as implemented by the survey team during an onsite visit conducted on 09/06/22 at 4:31 PM. The evidence was as follows: Refer to 880L On 08/16/22 at 10:24 AM, during the entrance conference held with the Administrative team. The survey team was informed that the facility was currently experiencing an outbreak of COVID-19 which began on 11/23/21. The surveyor requested the contact tracing (process to identify people who have come in contact with someone diagnosed with an infectious disease) for seven residents and four staff members. The surveyor reviewed what the facility Infection Preventionist Registered Nurse (IP/RN) provided, Resident & Staff COVID-19 Incident Reports updated 04/21, which included but was not limited to please be as detailed as possible and type all responses, 9. Explain contact tracing that has been completed in detail, and 10. Describe action(s) taken. The review was as follows: #444 who was fully vaccinated and resided on Old [NAME] unit, presented symptomatic with a cough, and sneezing and tested positive on 12/28/21. The contact tracing section failed to list any staff or residents who may have been a close contact. #446 who was fully vaccinated and resided on Eagle unit, presented symptomatic with a cough, and tested positive on 01/4/22. The contact tracing section failed to list any staff or residents who may have been a close contact. #445 who was fully vaccinated and resided on Freedom unit, presented symptomatic with fever and shortness of breath, and tested positive on 01/30/22. The contact tracing section failed to list any staff or residents who may have been a close contact. (continued on next page)

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New Jersey Veterans Memorial Home Menlo	132 Evergreen Rd Edison, NJ 08818

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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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	#447 who was fully vaccinated and resided on Freedom unit, presented symptomatic with a fever and shortness of breath, and tested positive on 02/3/22. Resident #447 was noted to be transported to hemodialysis three days a week. The contact tracing section failed to list any facility staff, hemodialysis staff, transport staff, visitors, or residents who may have been a close contact. #46 who was fully vaccinated and resided on Freedom unit, presented symptomatic with a cough, and tested positive on 08/7/22. The contact tracing section failed to list any staff or residents who may have been a close contact. #76 who was fully vaccinated and resided on Freedom unit, was asymptomatic and tested positive on 08/11/22. The contact tracing section failed to list any staff or residents who may have been a close contact. #179 who was fully vaccinated and resided on Freedom unit, was asymptomatic and tested positive on 08/16/22. The contact tracing section failed to list any staff or residents who may have been a close contact. Licensed Practical Nurse (LPN) #2 was asymptomatic and tested positive on 08/1/22. The contact tracing section failed to list any staff or residents who may have been a close contact. LPN #3 presented symptomatic with cough, body aches and congestion and tested positive 08/1/22 and the last day worked at the facility was 07/28/22. An Administrative staff member presented symptomatic with nasal congestion and an itchy throat and tested positive 08/6/22. The contact tracing section failed to list any staff or residents who may have been a close contact. LPN #1 presented symptomatic with a runny nose and tested positive on 08/7/22. The contact tracing section failed to list any staff or residents who may have been a close contact. On 08/29/22 at 8:39 AM during an interview with the surveyor, the facility IP/RN was asked to provide contact tracing for eight residents reviewed between 12/28/21 through 08/16/22 and for six staff members reviewed from 08/01/22 through 08/16/22, all were noted on the facility line-list as have been tested COVID-19 positive. The IP/RN stated that when someone was exposed, she would do the contact tracing but would not list the staff or residents. She stated she would not be able to provide any documentation of staff or residents who may have been exposed because she kept that information in a personal notebook. She further stated that she was alone, no secretary, no help and that she did not document the exposed people. The IP/RN stated that she also followed the facility's Outbreak Response Plan. On 08/29/22 at 9:32 AM, during an interview with the surveyor, a Licensed Practical Nurse Unit Manager (LPN/UM) on Liberty Unit stated that if a resident tested COVID-19 positive, the IP/RN would isolate the resident and do the investigation. She further stated that if a staff member tested COVID-19 positive, they would be sent home and the IP/RN would do all the paperwork. The LPN/UM further stated that she was not sure if testing was done when someone was exposed, but she knew the facility had a team to do routine testing of the residents and staff. (continued on next page)

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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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 08/29/22 at 9:40 AM during an interview with the surveyor, the RN Employee Health Nurse stated that she was only responsible to test the staff and residents routinely and upon return to the facility if the resident had gone out. The RN Employee Health Nurse further stated that contact tracing was important to warn others who were exposed so they may be tested as there was a 2 to 14 day incubation period for COVID-19. On 08/29/22 at 11:27 AM, the IP/RN provided incomplete facility, Contact Tracing Forms for the six requested COVID-19 positive staff. The IP/RN stated there was no policy for contact tracing so she would use the Center for Disease Control and Prevention (CDC) guidance and stated she would provide that information. On 08/30/22 at 10:58 AM during an interview with the surveyor, the IP/RN stated that the facility had enough testing supplies to perform facility wide COVID-19 testing. The IP/RN had provided the CDC guidance, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, dated 02/02/22. The surveyor reviewed the guidance with the IP/RN and asked about the directive that asymptomatic residents with close contact to someone COVID + (positive), regardless of vaccination status, should have two viral tests. Testing is recommended immediately and if negative, in 5-7 days after the exposure. The surveyor asked the IP/RN to provide documentation of the tests and follow up tests. The IP/RN stated she would talk to the staff but did not write things down. She again stated that she had kept the information in a personal notebook and would throw out that information when the case was resolved. The IP/RN stated she was unaware of any formal documentation or form to use and retain so she would not be able to inform the surveyor of the exposed staff or residents or their COVID-19 testing in response. The IP/RN stated that contact tracing would be used to prevent the spread of infection in the facility. A review of the facility provided, Outbreak Response Plan revised 02/22, included but was not limited to the following: Purpose - to protect our residents, families, and staff from harm resulting from an outbreak of an infectious disease organism; the IP would be responsible for conducting routine audits of Infection Control in the facility, establish and implement policies and procedures for screening for exposure, will collaborate with facility medical director, public health authorities, regarding interventions to implement responses; Contact Tracing Form - to include name of interview/contact tracer, date of interview, name of resident, history prior positive COVID, date of a + (positive) COVID, date of symptoms/asymptomatic subtract 2 days prior to test result date or symptoms listed (this is the contact tracing date), known exposures, staff in close contact, activities/locations/shift times visited, breaks/meals contacts, outside employment, actions taken by the facility, and reviewed by the Infection Control nurse; Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposed individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC; and will test any resident symptomatic for the Infectious organism and will conduct additional testing of residents and staff in accordance with applicable DOH (Department of Health), CDC and CMS (Centers for Medicare & Medicaid Services) guidance. On 08/31/22 at 9:37 AM, the IP/RN provided incomplete contact tracing forms for the eight requested COVID-19 positive residents reviewed and the six COVID-19 positive staff who were reviewed. The incomplete contact tracing forms revealed the following: (continued on next page)

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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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident (R) #444 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, known exposure to residents, and areas for breaks/meals, and reviewed by facility Infection Control Nurse. R #446 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, no exposure to residents, date of symptoms, and areas for breaks/meals, and reviewed by facility Infection Control Nurse. R #3 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, known exposures to residents, and reviewed by facility Infection Control Nurse. R #445 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, areas for breaks/meals, known exposure to residents, and areas for breaks/meals, and reviewed by facility Infection Control Nurse. R #447 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, known exposures to residents, and reviewed by facility Infection Control Nurse. R #46 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, date of start of symptoms, known exposures to residents, and reviewed by facility Infection Control Nurse. R #76 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, known exposures to residents, area for breaks/meals, and reviewed by facility Infection Control Nurse. R #179 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, date of positive COVID-19 test result, known exposures to residents, and reviewed by facility Infection Control Nurse. LPN #2 no: area left blank, known exposures to residents or staff noted. LPN #3 noted to be symptomatic with cough, body aches, and congestion on 08/01/22. Possible exposures were not identified from the date of symptoms back 48 hours. Administrative staff member: area left blank of names of those who were in close contact with since contact tracing date of 08/04/22. LPN #1 no: name of residents (only one set of initials noted), reviewed by facility Infection Control nurse. Food Service Worker #2: area left blank action taken by facility, contact tracing notes asymptomatic and corresponding Incident Report noted symptomatic with cough, headache, runny nose, and vomiting. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Food Service Worker #1: area left blank, actions taken by facility. On 08/31/22 at 11:21 AM during an interview with the surveyor, the IP/RN stated the contact tracing forms she had provided were all filled out yesterday (08/30/22) based on memory. When asked about additional staff who may have been a close contact such as the nurses caring for the residents who tested COVID-19 positive, the IP/RN stated the nurses were not with the residents long enough to be considered a close contact. The IP/RN stated that an exposure would be traced 48 hours prior for someone within six feet for 15 minutes or more. She further stated, I know from memory that none of the nurses were (with the residents for 15 minutes or more consecutively in a 24 hour period). The IP/RN stated that the facility implemented routine broad based COVID-19 testing back in December 2021 where the staff were tested three times a week and the residents were tested on ce or twice a week. The IP/ RN stated that close contacts were not all tested when identified as exposed. The IP/ RN further stated that testing of close contacts would depend on what time a person tested positive. She stated sometimes staff would have gone home and so testing would be, as soon as possible. The IP/RN acknowledged that the forms should have been complete. On 08/31/22 at 1:12 PM during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) stated they were familiar with the process of contact tracing. At 1:14 PM, the IP/RN joined the interview and stated that it was facility process for her to keep her own notes and that the facility would test everyone weekly. The IP/RN further stated that she remembers from December 2021 on that none of the nurses who cared for the COVID-19 positive residents spent over 15 minutes with the residents and that there were no treatments done either. The LNHA stated that was incorrect and the facility did require formal tracking (contact tracing). The LNHA further stated that the IP/RN should have conducted the contact tracing at the time of the exposure and not from memory. The LNHA stated that the IP RN's statement that the nurses did not spend more than 15 minutes with the residents was not fully accurate. Based on interviews and a review of pertinent documents, it was determined that the facility failed to ensure: a.) a process was followed to initiate immediate action and conduct COVID-19 testing upon the identification of a single COVID-19 positive result, b.) that staff who were exposed were COVID-19 tested prior to working at the facility, c.) Federal, State and infection control guidelines were followed, and d.) the facility Infectious Disease Outbreak Response Plan was followed to prevent exposure and mitigate the spread of COVID-19, a deadly, highly transmissible infectious disease. The facility's system wide failure to immediately conduct COVID-19 testing upon the identification of a single new case of COVID-19, posed a serious and immediate risk to the health and well-being of all staff and residents who resided at the facility and who were placed at risk for contracting a contagious infectious and potentially deadly virus. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 09/01/22 at 2:37 PM. The survey team verified the removal plan during an on-site visit conducted on 09/06/22 at 4:31 PM. The evidence was as follows: Refer to 880L (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 08/16/22 at 10:24 AM, during the entrance conference held with the Administrative team. The survey team was informed that the facility was currently experiencing an outbreak of COVID-19, which began on 11/23/21. The surveyor requested contact tracing (a process to identify people who have come in contact with someone diagnosed with an infectious disease) for seven residents and four staff members. The surveyor reviewed what the facility Infection Preventionist Registered Nurse (IP/RN) provided, Resident & Staff COVID-19 Incident Reports, updated 04/21, which included but was not limited to please be as detailed as possible and type all responses, 9. Explain contact tracing that has been completed in detail, and 10. Describe action(s) taken. The review was as follows: #444 who was fully vaccinated and resided in the Old [NAME] unit, presented symptomatic with a cough and sneezing and tested positive on 12/28/21. The contact tracing section failed to list any staff or residents who may have been a close contact. #446, who was fully vaccinated and resided in the Eagle unit, presented symptomatic with a cough and tested positive on 01/4/22. The contact tracing section failed to list any staff or residents who may have been a close contact. #445, who was fully vaccinated and resided in the Freedom unit, presented symptomatic with fever and shortness of breath and tested positive on 01/30/22. The contact tracing section failed to list any staff or residents who may have been a close contact. #447, who was fully vaccinated and resided in the Freedom unit, presented symptomatic with a fever and shortness of breath and tested positive on 02/3/22. Resident #447 was noted to be transported to hemodialysis three days a week. The contact tracing section failed to list any facility staff, hemodialysis staff, transport staff, visitors, or residents who may have been a close contact. #46 was fully vaccinated and resided in the Freedom unit, presented symptomatic with a cough, and tested positive on 08/7/22. The contact tracing section failed to list any staff or residents who may have been a close contact. #76, who was fully vaccinated and resided in the Freedom unit, was asymptomatic and tested positive on 08/11/22. The contact tracing section failed to list any staff or residents who may have been a close contact. #179, who was fully vaccinated and resided in the Freedom unit, was asymptomatic and tested positive on 08/16/22. The contact tracing section failed to list any staff or residents who may have been a close contact. Licensed Practical Nurse (LPN) #2 was asymptomatic and tested positive on 08/1/22. The contact tracing section failed to list any staff or residents who may have been a close contact. LPN #3 presented symptomatic with cough, body aches, and congestion and tested positive on 08/1/22 and the last day worked at the facility was 07/28/22. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An Administrative staff member presented symptomatic with nasal congestion and an itchy throat and tested positive on 08/6/22. The contact tracing section failed to list any staff or residents who may have been a close contact. LPN #1 presented symptomatic with a runny nose and tested positive on 08/7/22. The contact tracing section failed to list any staff or residents who may have been a close contact. On 08/29/22 at 8:39 AM, during an interview with the surveyor, the facility IP/RN was asked to provide contact tracing for eight residents reviewed between 12/28/21 through 08/16/22 and for six staff members reviewed from 08/01/22 through 08/16/22, all were noted on the facility line-list as have been tested COVID-19 positive. The IP/RN stated that when someone was exposed, she would do the contact tracing but would not list the staff or residents. She stated she could not provide any documentation of staff or residents who may have been exposed because she kept that information in a personal notebook. She further stated that she was alone, no secretary, no help and that she did not document the exposed people. The IP/RN stated that she also followed the facility's Outbreak Response Plan. On 08/29/22 at 9:32 AM, during an interview with the surveyor, a Licensed Practical Nurse Unit Manager (LPN/UM) in Liberty Unit stated that if a resident tested COVID-19 positive, the IP/RN would isolate the resident and do the investigation. She further stated that if a staff member tested COVID-19 positive, they would be sent home, and the IP/RN would do all the paperwork. The LPN/UM further stated that she was unsure if testing was done when someone was exposed, but she knew the facility had a team to do routine testing of the residents and staff. On 08/29/22 at 9:40 AM, during an interview with the surveyor, the RN Employee Health Nurse stated that she was only responsible for routinely testing the staff and residents and, upon return to the facility, if the resident had gone out. The RN Employee Health Nurse further stated that contact tracing was important to warn others who were exposed so they may be tested as there was a 2 to 14 day incubation period for COVID-19. On 08/29/22 at 11:27 AM, the IP/RN provided the incomplete facility, Contact Tracing Forms, for the six requested COVID-19 positive staff. The IP/RN stated there was no policy for contact tracing so she would use the Center for Disease Control and Prevention (CDC) guidance and stated she would provide that information. On 08/30/22 at 10:58 AM, during an interview with the surveyor, the IP/RN stated that the facility had enough testing supplies to perform facility wide COVID-19 testing. The IP/RN had provided the CDC guidance, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, dated 02/02/22. The surveyor reviewed the guidance with the IP/RN and asked about the directive that asymptomatic residents with close contact to someone COVID + (positive), regardless of vaccination status, should have two viral tests. Testing is recommended immediately and if negative, in 5-7 days after the exposure. The surveyor asked the IP/RN to provide documentation of the tests and follow up tests. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The IP/RN stated she would talk to the staff but did not write things down. She again stated that she had kept the information in a personal notebook and would throw out that information when the case was resolved. The IP/RN stated she was unaware of any formal documentation or form to use and retain, so she would not be able to inform the surveyor of the exposed staff or residents or their COVID-19 testing in response. The IP/RN stated that contact tracing would be used to prevent the spread of infection in the facility. A review of the facility provided, Outbreak Response Plan revised 02/22, included but was not limited to the following: Purpose - to protect our residents, families, and staff from harm resulting from an outbreak of an infectious disease organism; the IP would be responsible for conducting routine audits of Infection Control in the facility, establish and implement policies and procedures for screening for exposure, will collaborate with facility medical director, public health authorities, regarding interventions to implement responses; Contact Tracing Form - to include name of interview/contact tracer, date of interview, name of resident, history prior positive COVID, date of a + (positive) COVID, date of symptoms/asymptomatic subtract 2 days prior to test result date or symptoms listed (this is the contact tracing date), known exposures, staff in close contact, activities/locations/shift times visited, breaks/meals contacts, outside employment, actions taken by the facility, and reviewed by the Infection Control nurse; Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposed individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC; and will test any resident symptomatic for the Infectious organism and will conduct additional testing of residents and staff in accordance with applicable DOH (Department of Health), CDC and CMS (Centers for Medicare & Medicaid Services) guidance. On 08/31/22 at 9:37 AM, the IP/RN provided incomplete contact tracing forms for the eight requested COVID-19 positive residents reviewed and the six COVID-19 positive staff who were reviewed. The incomplete contact tracing forms revealed the following: Resident (R) #444 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, known exposure to residents, and areas for breaks/meals, and reviewed by facility Infection Control Nurse. R #446 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, no exposure to residents, date of symptoms, and areas for breaks/meals, and reviewed by facility Infection Control Nurse. R #3 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, known exposures to residents, and reviewed by facility Infection Control Nurse. R #445 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, areas for breaks/meals, known exposure to residents, and areas for breaks/meals, and reviewed by facility Infection Control Nurse. R #447 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, known exposures to residents, and reviewed by facility Infection Control Nurse. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R #46 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, date of start of symptoms, known exposures to residents, and reviewed by facility Infection Control Nurse. R #76 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, known exposures to residents, area for breaks/meals, and reviewed by facility Infection Control Nurse. R #179 no: name of interviewer, no date of interview, demographic or locating information, history of prior positive COVID-19 tests results, date of collection specimen, date of positive COVID-19 test result, known exposures to residents, and reviewed by facility Infection Control Nurse. LPN #2 no: area left blank, known exposures to residents or staff noted. LPN #3 was noted to be symptomatic with cough, body aches, and congestion on 08/01/22. Possible exposures were not identified from the date of symptoms back to 48 hours. Administrative staff member: area left blank of names of those who were in close contact with since contact tracing date of 08/04/22. LPN #1 no: name of residents (only one set of initials noted), reviewed by facility Infection Control nurse. Food Service Worker #2: area left blank action taken by facility, contact tracing notes asymptomatic and corresponding Incident Report noted symptomatic with cough, headache, runny nose, and vomiting. Food Service Worker #1: area left blank, actions taken by the facility. On 08/31/22 at 11:21 AM, during an interview with the surveyor, the IP/RN stated the contact tracing forms she had provided were all filled out yesterday (08/30/22) based on memory. When asked about additional staff who may have been a close contact, such as the nurses caring for the residents who tested COVID-19 positive, the IP/RN stated the nurses were not with the residents long enough to be considered a close contact. The IP/RN stated that an exposure would be traced 48 hours prior for someone within six feet for 15 minutes or more. She further stated, I know from memory that none of the nurses were (with the residents for 15 minutes or more consecutively in a 24 hour period). The IP/RN stated that the facility implemented routine broad-based COVID-19 testing back in December 2021, where the staff were tested three times a week, and the residents were tested on ce or twice a week. The IP/ RN stated that close contacts were not all tested when identified as exposed. The IP/ RN further stated that testing of close contacts would depend on what time a person tested positive. She stated sometimes staff would have gone home and so testing would be as soon as possible. The IP/RN acknowledged that the forms should have been complete. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 08/31/22 at 1:12 PM, during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) stated they were familiar with the process of contact tracing. At 1:14 PM, the IP/RN joined the interview and stated that it was a facility process for her to keep her own notes and that the facility would test everyone weekly. The IP/RN further stated that she remembers from December 2021 that none of the nurses who cared for the COVID-19 positive residents spent over 15 minutes with the residents and that no treatments were done either. The LNHA stated that was incorrect, and the facility did require formal tracking (contact tracing). The LNHA further stated that the IP/RN should have conducted the contact tracing at the time of the exposure and not from memory. The LNHA stated that the IP RN's statement that the nurses did not spend more than 15 minutes with the residents was not fully accurate. On 09/01/22 at 9:22 AM, during an interview with surveyors in the conference room, the IP/RN stated that she consulted with the local health department (LHD) but did not get any guidance on testing close contacts versus broad-based testing. The IP/RN stated, the nurses (facility) I spoke to were in and out (of resident rooms); I should have kept my contact tracing personal notes; I cannot say 100% if the nurses did not stay 15 minutes or more. The surveyor requested communication information from the LHD. A review of the communication with the LHD provided by the IP/RN on 09/02/22 at 9:30 AM, revealed emails sent to the LHD as follows: 01/04/22, the IP/RN asked for a meeting, and the LHD asked for her concerns; 01/25/22 the IP/RN asking for clarification if she needed to test the roommate of a COVID-19 positive resident and would she be required to retest in 48 hours and the IP/RN added according to an attached policy (not provided), she would say no; 04/22/22 the IP RN asking about quarantining residents not up to date with COVID-19 vaccinations in response to COVID-19 positive residents on the same unit, and 07/18/22 regarding staff going on vacation and coming back COVID-19 positive if they would need to be reported. On 09/01/22 at 9:34 AM, during an interview with the surveyors, the IP/RN stated that not all the staff were tested at the facility. She stated some would go elsewhere to get tested , but they would have to let her know. The IP/RN again stated she did not keep the contact tracing or testing documentation. She stated that the documents should have been kept, but most of the contact tracing was done by her, and in December, she was getting like 10 positives (COVID-19) a day. The IP/RN could not provide any documented evidence of COVID-19 testing performed outside of the facility. On 09/02/22 at 9:47 AM, the IP/RN stated that if someone tested COVID-19 positive on a Saturday, she would wait until Monday. She stated, the nurses on the weekend would verbally tell her (who was exposed), but there was no documentation regarding the conversation. The IP/RN acknowledged that close contacts should have included visitors, physicians, and therapy staff but that she did not have documentation that they were ever included on the contact tracing forms to be tested . On 09/02/22 at 11:34 AM, during a telephone interview with the survey team, the Medical Director (MD) stated he started working at the facility