STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. Building B. Wing	08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Healthcare Center	1417 Brace Road Cherry Hill, NJ 08034

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43765 Complaint Intake NJ144427 Based on observations, interviews, and facility procedure review, it was determined that the facility failed to clean debris from resident room floors for 3 (room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) of 3 rooms observed on Court Two Hallway A. Findings included: 1. During a tour of Court Two Hallway A on 08/06/2021 at 1:20 PM, open doors to room [ROOM NUMBER] revealed an observation of debris on the floor which included bits of paper, a tissue, and dirt. An open door to room [ROOM NUMBER] revealed an opened clear plastic wrapper on the floor under a raised bed and general debris of bits of paper and dirt. An open door to room [ROOM NUMBER] revealed many black rectangular pieces of debris over half the open floor space and other bits of paper debris. On 08/06/2021 at 1:32 PM, an interview was conducted with Housekeeper #1 on Court Two Hallway B. The housekeeper stated she had been assigned to clean Hallway B for the last couple of months. The housekeeper stated she did not clean Hallway A, and the housekeeper who cleaned Hallway A did not come to work today. Housekeeper #1 stated she did not know who would clean Hallway A. On 08/07/2021 at 9:44 AM, an interview was conducted with Housekeeper #3, who was observed on Court Two Hallway B. The housekeeper stated she was not the housekeeper of Court Two and was supposed to be working in the laundry. The housekeeper stated she had been told to come to the floor to be a presence in the hallway since someone was in the building. The housekeeper indicated she was not really here to clean all these rooms. On 08/07/2021 at 1:27 PM, an observation from Hallway A into open doors of resident rooms revealed room [ROOM NUMBER] still had bits of paper and general debris on the floor, room [ROOM NUMBER] still had a clear plastic opened wrapper on the floor along with bits of paper and debris, and room [ROOM NUMBER] still had a large amount of rectangular black debris and bits of paper on the floor. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/2021 at 1:33 PM, an observation was made of the debris visible in room [ROOM NUMBER] with Licensed Practical Nurse (LPN) #3 and Unit Manager (UM) #3. The LPN and UM stated they did not know the schedule of housekeepers and had not seen a housekeeper on the unit this day. The LPN and UM did not know what the substance was on the floor of room [ROOM NUMBER] but stated they would have a housekeeper come up to clean it. On 08/08/2021 at 8:17 AM, an interview was conducted with the Administrator. The Administrator stated that each housekeeper had about 15 rooms to clean, and the rooms were cleaned daily. The housekeeper director was not in the building this weekend. The facility was still in the process of actively looking to hire more housekeepers. On 08/09/2021 at 10:33 AM, an interview was conducted with Housekeeper #5. The housekeeper stated she was scheduled to clean Court Two Hallway A for the past two months. The housekeeper stated she was off this past weekend, and the rooms did not appear as if they had been cleaned, and the floors were very dirty. On 08/09/2021 at 11:44 AM, an interview was conducted with the Housekeeping Director (HD). The HD stated this weekend he had housekeeping staff call out and one staff resigned. The HD stated Housekeeper #3 was assigned as a floater to clean Court Two halls when the regular staff were off. The HD stated he expected the resident rooms to be cleaned daily. A review of the facility procedure, titled, Cleaning Methods-Housekeeping, updated on 05/17/2021, included under Standard: Cleaning of residents' rooms will be performed daily. New Jersey Administrative Code S 8:39-31.4(a)

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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** 43017 Complaint Intake NJ145778 Based on observations, record reviews, interviews, and facility policy review, it was determined the facility failed to provide a safe environment to prevent resident-to-resident abuse for 5 (Residents #3, #14, #15, #16, and #17) of 5 sampled residents for resident-to-resident abuse. Resident #13 had a diagnosis of schizophrenia and was known to be aggressive. Residents #3, #14, #15, #16, and #17 were assaulted by Resident #13. Some of the assaults resulted in minor injuries, including bruising, abrasions and laceration that required sutures. It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, S483.12 (Freedom from Abuse, Neglect and Exploitation) at a scope and severity of J. The IJ began on 07/29/2021 when the resident's physician indicated the resident was no longer appropriate for skilled nursing facility placement due to aggression, with multiple altercations with other residents. The resident needed long-term psychiatric placement for stabilization, but the resident remained in the facility. The resident assaulted another resident on 08/08/2021. On 08/08/2021 at 12:00 PM, an IJ was identified. At 5:16 PM, the facility Administrator and Assistant Director of Nurses (ADON) were provided with the completed IJ template and notified of the existence of an IJ for abuse. The Administrator signed the template and returned the original to the survey team. On 08/11/2021 at 1:41 PM, a Removal Plan was accepted by the New Jersey Department of Health (NJDOH). The IJ continued until 08/09/2021 at 10:00 PM, when the facility alleged the elements of the Removal Plan had been implemented. On 08/13/2021 at 9:30 AM, a surveyor conducted an onsite revisit to verify the Removal Plan had been implemented. Resident #13 had been removed from the facility on 08/08/2021. The facility implemented the Removal Plan, which included education for certified nursing assistants (CNAs), nursing assistants (NAs), and licensed nursing staff for the Atrium, Court Two, and Pavilion and Vent Units on how to properly monitor residents who were on one-to-one behavior monitoring. CNAs, NAs, and licensed staff were being educated on staying within arm's reach of a resident, never leaving a resident alone, ensuring that the one-to-one was covered by another staff member when going to break, and documenting whereabouts and behaviors. The facility had an updated seating chart of the Pavilion Unit to include any resident on one-to-one will have a seating plan during meals and recreational activities to lessen the chance of another resident being harmed by impulsive behaviors. The facility will continue with the current psychiatry group for continuity of care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The noncompliance remained on 08/13/2021 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy based on the following: The facility had not implemented all areas of the Removal Plan that included the at-risk weekly meeting to discuss behaviors, care plans, and possibly new interventions, and the monthly psychotropic meetings with psychiatrists, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers (UMs) to discuss any actual and potential issues which may include medication changes or additional interventions. Findings included: A review of a Facility Reported Event (FRE) sent to the New Jersey Department of Health (NJDOH) on 05/31/2021 revealed the following: Resident #3 was the victim of an unproved assault by Resident #13. The attack resulted in Resident #3 being transferred to a local hospital for suture repair of a laceration above the left eyebrow. Resident #13 had diagnoses which included schizophrenia, schizoaffective disorder, tracheostomy, and anxiety disorder. The admission Minimum Data Set (MDS), dated [DATE], indicated Resident #13 had a BIMS (Brief Interview for Mental Status) score of 10 out of 15, which indicated the resident was moderately impaired in cognition. The resident was independent with bed mobility, transfers, walking in room, and toileting. The resident required supervision with walking on the corridor, locomotion off the unit, and personal hygiene. The MDS revealed the resident had no range of motion impairments and used a walker. On 08/06/2021 it was observed Resident #13 resided on a locked dementia unit, not a locked behavioral unit. 1. A facility incident report dated 04/22/2021, reported by an eyewitness (another resident), indicated Resident #13 had slapped a female resident (Resident #15) across the face, while waiting for dinner in the activity room. Resident #15's statement revealed Resident #13 smacked Resident #15 in the face. Resident #15 had diagnoses which included dementia and the resident required supervision with transfers and ambulation. The report indicated Resident #13 denied the allegation at first then changed the story. The resident stated Resident #15 had touched Resident #13's food so Resident #13 smacked Resident #15. There were no staff witnesses. The report did not state whether Resident #15 received injuries. The resident's care plan dated 04/22/2021 indicated the resident could become aggressive toward staff and other residents. The interventions put in place were: 1. Anticipate when this resident and Resident #15 were not getting along, separate them, and redirect both parties to keep from having a resident-to-resident altercation. 2. Allow the resident to have quiet time alone in their room if they request to be alone. 3. Allow the resident to vent feelings in a private place. 4. Redirect attention when the resident starts to get upset. (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's care plan also indicated Resident #13 initiated acts of physical aggression on 04/22/2021. A physician's progress note dated 04/23/2021 issued two new orders: 1. Resident #13 was to be placed on 1-on-1 for behaviors, and 2. Discontinue 1-on-1 and place on Q 1-hour checks. No one-on-one monitoring documentation was provided by the facility after inquiries. 2. A facility incident report dated 04/28/2021 at 4:30 PM revealed both residents were in the dining room when Resident #13 hit Resident #16 in the face. Resident #16 retaliated and started hitting Resident #13 in the face. Resident #16 had a diagnosis of dementia and was independent with transfers and ambulation. It was noted Resident #13 had abrasions to the forehead and right side of the face. The residents were separated, but later in the same mealtime, Resident #13 tried to hit Resident #16 again. Resident #16 started throwing punches at Resident #13. Both residents were placed on 1-on-1, and 911 was called to transfer Resident #13 to a local crisis center. The incident report indicated the resident was held at the crisis center but returned to the facility later in the night (no time given). The resident's care plan updated on 04/28/2021 revealed additional interventions: 1. The resident was educated not to physically hit another resident but to seek assistance from a staff member if the resident has any issues. 2. Always keep the resident away from Resident #16. 3. Place the resident on Q (every) 15-minute checks until the resident can be evaluated by a psychiatrist. 4. Render first aid for injuries. The resident's care plan also indicated Resident #13 initiated acts of physical aggression on 04/28/2021. The only new intervention was to place the resident on Q 15-minute checks. The report did not report a time frame for Q 15-minute checks to be conducted. The other interventions had already been recommended. The incident report for Resident #16 revealed Resident #13 would be placed on one-on-one when returned to the facility. No one-on-one monitoring documentation was provided by the facility after inquiries. Per the care plan, one-on-one was not a new intervention, and no time frame was provided related to how long one-on-one would be provided. The incident report did not indicate if Resident #13 was still on Q one-hour checks per a physician order dated 04/23/2021. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A physician's order dated 04/30/2021 indicated Resident #13 was to be placed on Q 15-minute checks for behaviors. 3. A facility incident report dated 05/31/2021 at 2:42 PM indicated around 10:00 AM, a nurse went to the activity room to retrieve Resident #13 to escort the resident to the resident's room for wound treatment. The nurse left Resident #13 behind as she left to move the treatment cart to the resident's room. Resident #13 was walking unattended as Resident #3 walked by Resident #13 in the hallway. The nurse heard a sound, turned around and saw that Resident #13 had hit Resident #3 in the face. The attack was unprovoked. The incident report indicated the residents were separated and Resident #3 was transported to a local emergency room for evaluation of an injury above the left eyebrow. Resident #3 was returned to the facility around 2:00 PM. Resident #13 refused to be transported to the crisis center. One-on-one observation was initiated, per physician order, until evaluated by psychiatric consult. No psychiatric consult note was provided by the facility after inquiries. No one-on-one monitoring documentation was provided by the facility after inquiries. A nurse's note dated 05/31/2021 at 8:28 PM indicated Resident #3 returned to the facility with stitches above the left eyebrow to repair a laceration. Resident #13's care plan revealed the intervention was to place Resident #13 on one-on-one until evaluated by a psychiatrist. This intervention was not new. A physician's progress note dated 05/31/2021 indicated Resident #13 was to be placed on one-on-one until cleared by psychiatric consultant related to aggression. The care plan contained no new interventions. A nurse's note written by the Director of Nurses (DON) on 07/07/2021 at 3:00 PM indicated Resident #13 was to be placed on Q 15-minute checks for 72 hours for behavior monitoring and safety surveillance. Unsafe or belligerent behaviors were to be documented every shift. 4. A facility incident report dated 07/13/2021 at 4:30 PM reported Resident #13 was walking past Resident #14 when Resident #13 started hitting Resident #14. The staff separated the residents, but Resident #13 continued to threaten the other resident. Both residents were sent out to a local crisis center. Neither resident had injuries and they were both placed on one-on-one when they returned to the facility. The report indicated Resident #14 had redness to the right side of the forehead and tenderness to the right shoulder. No one-on-one monitoring documentation was provided by the facility after inquiries. Resident #14 had a diagnosis of anxiety disorder and was independent with transfers and ambulation. Resident #13's care plan contained no new interventions. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A physician's order dated 07/15/2021 (no time) indicated Resident #13 was a danger to others and to send the resident to a crisis center. No reports were in the medical record that indicated the resident had been sent to the crisis center. A physician's order dated 07/29/2021 indicated Resident #13 was to be kept on one-on-one due to aggression with multiple altercations with other residents. The resident needed long-term psychiatric placement for stabilization. The resident was not suitable for placement at this skilled nursing facility (SNF). A social worker should work with the family for placement. The above handwritten physician's order had a large circle drawn around the order, with a large star and a big check mark drawn beside it. On 08/07/2021 at 9:45 AM, Resident #13 was observed by the surveyor to be seated without one-on-one in the dining/activities room. There were other residents seated in the dining/activities room with the resident. On 08/07/2021 at 12:11 PM, Resident #13 was observed by the surveyor walking in the hallway near the dining/activities room without supervision. It was observed there was no staff member providing one-on-one. On 08/08/2021 at 10:00 AM, the Administrator was asked why Resident #13 was not immediately transferred to another facility when the physician wrote an order (on 07/29/2021) to find a long-term psychiatric facility for the resident because the unit the resident was in was not suitable for the resident. He stated the physician spoke with him on 07/29/2021 and did not express to him the resident needed to be transferred out immediately. The Administrator stated he contacted a sister facility the following day (07/30/2021) and arranged for the resident to be transferred to [named facility]. On Thursday of the following week (08/05/2021), the family refused to allow the resident to be transferred. He stated the resident had a tracheostomy, which made it more difficult to find placement for the resident. The Administrator stated he had not made any additional arrangements to transfer the resident out of the unit. The Administrator was asked why the resident was not transferred to the facility's behavior unit. He stated he had tried but the physician in charge of the unit would not accept the resident. He added he thought the physician had said the resident needed two diagnoses, and he would not accept him. The Administrator stated he did not remember when he spoke with the physician at the behavior unit. He said when the resident was sent out to the crisis center, the center only kept the resident a few hours. Then they send the resident back to the facility, and the facility is required to take the resident back. The Administrator was asked to provide documentation of attempts to provide placement for the resident. He stated everything was verbal. There was no documentation of anything. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A facility incident report dated 08/08/2021 at 11:10 AM revealed Resident #13 repeatedly hit Resident #17 on the right side of the face. This episode occurred in the activities/dining room. Resident #13 was observed to stand up, approach Resident #17 and start punching Resident #17 in the face. Resident #13 was transferred to a local crisis center at a local hospital. Resident #17 was transferred to a local hospital for evaluation and treatment. The incident report revealed Certified Nurse Aide (CNA) #6 (who was assigned to provide one-on-one) provided a written statement which indicated she was not with Resident #13 when Resident #13 started hitting Resident #17 in the face. Resident #17 was cognitively impaired in cognition and required the use a wheelchair. On 08/08/2021 at 11:30 AM, Unit Manager #3 stated CNA #6 had been assigned to provide one-on-one for Resident #13. During the survey, multiple attempts were made to reach CNA #6. On 08/20/2021 at 1:00 PM, two more attempts were made to contact CNA #6. Multiple attempts had been made to contact the CNA. It sounded as though the call was hung up on. On 08/08/2021 at 4:15 PM, Resident #17 had returned from the hospital and was observed sitting in the dining/activity room. The left side of the face was swollen, with redness and bruising above the left eye and on the right corner of the mouth. On 08/09/2021 at 10:00 AM, three CNAs (CNAs #1, #7, and #8) who provided direct care for Resident #13 stated the resident was unpredictable. There was no way to predict what would set the resident off. If another resident got too close, the resident would jump up and hit the other resident. If a resident walked by, the resident would strike out and hit the other resident. Resident #13 did not like for other residents to be near. Sometimes Resident #13 just did not like the way another resident looked at the resident. Resident #13 was very fast. On 08/09/2021 at 11:20 AM, Resident #13's physician was contacted by phone. He stated he was on vacation, he didn't have the medical record with him, and he didn't remember anything. On 08/09/2021 at 2:00 PM, the Administrator and the DON (Director of Nurses) both verbalized the physician's order did not indicate the transfer needed to be immediate. They added the physician had spoken with each of them, and he did not tell them to transfer the resident immediately. They were asked if there was documentation of constant supervision for Resident #13, such as one-on-one. They stated they did not have a form that recorded one-on-one, but the resident was always on one-on-one. They were asked if interventions had been reviewed, and if new interventions had been put in place after every altercation. They stated the resident was always on one-on-one. On 08/20/2021 at 2:15 PM, the resident's physician stated he had recommended Resident #13 be transferred to a psychiatric unit because the resident was a danger to the other residents. The physician added the resident had been to a crisis center multiple times and that was not effective. The facility had been unable to prevent assaults on other residents by placing the resident on one on one. The physician stated he had discussed medication changes with the resident and a family member, and they had refused, because they felt the resident did not need medications. The physician stated since everything had failed the resident needed to be transferred out as quickly as possible, immediately if possible. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility currently has one resident on one to one observation because he is a fall risk and has poor safety awareness. Residents at risk for safety compromising behavior will be audited and their care plans will be updated if appropriate on 8/09/21 by 10:00PM. The facility started education for CNAs, NAs, and licensed nursing staff for the Atrium, Court two , Pavilion and vent unit on how to properly monitor residents who are on one to one behavior monitoring. CNAs, NAs, and license staff are being educated on staying within arm's reach of the resident, never leaving a resident alone, ensuring that the one to one is covered by another staff member when going to break, and document whereabouts and behaviors. This education was initiated on 8/8/21 and will be completed by 8/9/2021 by 10:00 PM. Behaviors will be discussed, care planned, and new interventions initiated weekly during at risk meetings. The attendees of these meeting are the Medical Director, social workers, DON, IP, ADON, Dietician, and Unit Managers. Clinical Interdisciplinary team (IDT) attending the at risk meetings will relay the outcome through kardex via point click care when care plans are updated with new or revised interventions to the floor nurses, NAs, and CNAs. Communication will also take place verbally and may even be written as orders or in-services when appropriate. Monthly psychotropic meetings with psychiatrists, DON, ADON, and Unit Managers to discuss any actual and potential issues which may include medication changes or additional interventions. Any resident displaying aggressive or other behaviors that may be detrimental to others will have an arranged seating plan during meals and recreational activities. Any resident on one to one will also have a seating plan during meals and recreational activities to lessen the chance of another resident being harmed by impulsive behaviors. We will continue with the current psychiatry group for continuity of care. Admissions will communicate with Administrator, DON, ADON and Unit Managers to determine whether the facility can properly care for residents with behaviors. Residents with history of aggression who are deemed a danger to other residents and staff, who are no longer appropriate for SNF placement will be sent to crisis for further evaluation immediately. If the psychiatrist still feels that the resident is a danger to others, then the facility will not be accepting the resident back. On 08/13/2021 at 9:30 AM, a surveyor conducted an onsite revisit to verify the Removal Plan had been implemented. Resident #13 had been removed from the facility on 08/08/2021. The facility implemented the Removal Plan, which included education for certified nursing assistants (CNAs), nursing assistants (NAs), and licensed nursing staff for the Atrium, Court Two, and Pavilion and Vent Units on how to properly monitor residents who were on one-to-one behavior monitoring. CNAs, NAs, and licensed staff were being educated on staying within arm's reach of a resident, never leaving a resident alone, ensuring that the one-to-one was covered by another staff member when going to break, and documenting whereabouts and behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility had an updated seating chart of the Pavilion Unit to include any resident on one-to-one will have a seating plan during meals and recreational activities to lessen the chance of another resident being harmed by impulsive behaviors. The facility will continue with the current psychiatry group for continuity of care. The noncompliance remained on 08/13/2021 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy based on the following: The facility had not implemented all areas of the Removal Plan that included the at-risk weekly meeting to discuss behaviors, care plans, and possibly new interventions, and the monthly psychotropic meetings with psychiatrists, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers (UMs) to discuss any actual and potential issues which may include medication changes or additional interventions. New Jersey Administrative Code S 4.1 (a)(5)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43017 Complaint Intake: NJ145778Based on observations, record review, and interviews, it was determined the facility failed to provide supervision to prevent resident-to-resident altercations for 5 (#3, #14, 15, 16, 17, and #19) of 5 residents whose records were reviewed for resident-to-resident abuse. This had the potential to affect all residents who resided in the facility. Findings included: A review of a Facility Reported Event (FRE) sent to the New Jersey Department of Health (NJDOH) on 05/31/2021 revealed the following: Resident #3 was the victim of an unproved assault by Resident #13. The attack resulted in Resident #3 being transferred to a local hospital for suture repair of a laceration above the left eyebrow. Resident #13 had diagnoses which included schizophrenia, schizoaffective disorder, tracheostomy, and anxiety disorder. The admission Minimum Data Set (MDS), dated [DATE], indicated Resident #13 had a BIMS (Brief Interview for Mental Status) score of 10 out of 15, which indicated the resident was moderately impaired in cognition. The resident was independent with bed mobility, transfers, walking in room, and toileting. The resident required supervision with walking on the corridor, locomotion off the unit, and personal hygiene. The MDS revealed the resident had no range of motion impairments and used a walker. On 08/06/2021 it was observed Resident #13 resided on a locked dementia unit, not a locked behavioral unit. 1. A facility incident report dated 04/22/2021, reported by an eyewitness (another resident), indicated Resident #13 had slapped a female resident (Resident #15) across the face, while waiting for dinner in the activity room. Resident #15's statement revealed Resident #13 smacked Resident #15 in the face. Resident #15 had diagnoses which included dementia and the resident required supervision with transfers and ambulation. The report indicated Resident #13 denied the allegation at first then changed the story. The resident stated Resident #15 had touched Resident #13's food so Resident #13 smacked Resident #15. There were no staff witnesses. The report did not state whether Resident #15 received injuries. The resident's care plan dated 04/22/2021 indicated the resident could become aggressive toward staff and other residents. The interventions put in place were: 1. Anticipate when this resident and Resident #15 were not getting along, separate them, and redirect both parties to keep from having a resident-to-resident altercation. 2. Allow the resident to have quiet time alone in their room if they request to be alone. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	3. Allow the resident to vent feelings in a private place. 4. Redirect attention when the resident starts to get upset. The resident's care plan also indicated Resident #13 initiated acts of physical aggression on 04/22/2021. A physician's progress note dated 04/23/2021 issued two new orders: 1. Resident #13 was to be placed on 1-on-1 for behaviors, and 2. Discontinue 1-on-1 and place on Q 1-hour checks. 2. A facility incident report dated 04/28/2021 at 4:30 PM revealed both residents were in the dining room when Resident #13 hit Resident #16 in the face. Resident #16 retaliated and started hitting Resident #13 in the face. Resident #16 had a diagnosis of dementia and was independent with transfers and ambulation. It was noted Resident #13 had abrasions to the forehead and right side of the face. The residents were separated, but later in the same mealtime, Resident #13 tried to hit Resident #16 again. Resident #16 started throwing punches at Resident #13. Both residents were placed on 1-on-1, and 911 was called to transfer Resident #13 to a local crisis center. The incident report indicated the resident was held at the crisis center but returned to the facility later in the night (no time given). The resident's care plan updated on 04/28/2021 revealed additional interventions: 1. The resident was educated not to physically hit another resident but to seek assistance from a staff member if the resident has any issues. 2. Always keep the resident away from Resident #16. 3. Place the resident on Q (every) 15-minute checks until the resident can be evaluated by a psychiatrist. 4. Render first aid for injuries. The resident's care plan also indicated Resident #13 initiated acts of physical aggression on 04/28/2021. The only new intervention was to place the resident on Q 15-minute checks. The report did not report a time frame for Q 15-minute checks to be conducted. The other interventions had already been recommended. The incident report for Resident #16 revealed Resident #13 would be placed on one-on-one when returned to the facility. One-on-one was not a new intervention, and no time frame was provided related to how long one-on-one would be provided. The incident report did not indicate if Resident #13 was still on Q one-hour checks per a physician order dated 04/23/2021. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	A physician's order dated 04/30/2021 indicated Resident #13 was to be placed on Q 15-minute checks for behaviors. 3. A facility incident report dated 05/31/2021 at 2:42 PM indicated around 10:00 AM, a nurse went to the activity room to retrieve Resident #13 to escort the resident to the resident's room for wound treatment. The nurse left Resident #13 behind as she left to move the treatment cart to the resident's room. Resident #13 was walking unattended as Resident #3 walked by Resident #13 in the hallway. The nurse heard a sound, turned around and saw that Resident #13 had hit Resident #3 in the face. The attack was unprovoked. The incident report indicated the residents were separated and Resident #3 was transported to a local emergency room for evaluation of an injury above the left eyebrow. Resident #3 was returned to the facility around 2:00 PM. Resident #13 refused to be transported to the crisis center. One-on-one observation was initiated, per physician order, until evaluated by psychiatric consult. A nurse's note dated 05/31/2021 at 8:28 PM indicated Resident #3 returned to the facility with stitches above the left eyebrow to repair a laceration. Resident #13's care plan revealed the intervention was to place Resident #13 on one-on-one until evaluated by a psychiatrist. This intervention was not new. A physician's progress note dated 05/31/2021 indicated Resident #13 was to be placed on one-on-one until cleared by psychiatric consultant related to aggression. The care plan contained no new interventions. A nurse's note written by the Director of Nurses (DON) on 07/07/2021 at 3:00 PM indicated Resident #13 was to be placed on Q 15-minute checks for 72 hours for behavior monitoring and safety surveillance. Unsafe or belligerent behaviors were to be documented every shift. 4. A facility incident report dated 07/13/2021 at 4:30 PM reported Resident #13 was walking past Resident #14 when Resident #13 started hitting Resident #14. The staff separated the residents, but Resident #13 continued to threaten the other resident. Both residents were sent out to a local crisis center. Neither resident had injuries and they were both placed on one-on-one when they returned to the facility. The report indicated Resident #14 had redness to the right side of the forehead and tenderness to the right shoulder. Resident #14 had a diagnosis of anxiety disorder and was independent with transfers and ambulation. Resident #13's care plan contained no new interventions. A physician's order dated 07/15/2021 (no time) indicated Resident #13 was a danger to others and to send the resident to a crisis center. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	A physician's order dated 07/29/2021 indicated Resident #13 was to be kept on one-on-one due to aggression with multiple altercations with other residents. The resident needed long-term psychiatric placement for stabilization. The resident was not suitable for placement at this skilled nursing facility (SNF). A social worker should work with the family for placement. The above handwritten physician's order had a large circle drawn around the order, with a large star and a big check mark drawn beside it. On 08/07/2021 at 9:45 AM, Resident #13 was observed to be seated without one-on-one in the dining/activities room. There were other residents seated in the dining/activities room with the resident. On 08/07/2021 at 12:11 PM, Resident #13 was observed walking in the hallway near the dining/activities room without supervision. It was observed there was no staff member providing one-on-one. On 08/08/2021 at 10:00 AM, the Administrator was asked why Resident #13 was not immediately transferred to another facility when the physician wrote an order (on 07/29/2021) to find a long-term psychiatric facility for the resident because the unit the resident was in was not suitable for the resident. He stated the physician spoke with him on 07/29/2021 and did not express to him the resident needed to be transferred out immediately. The Administrator stated he contacted a sister facility the following day (07/30/2021) and arranged for the resident to be transferred to [named facility]. On Thursday of the following week (08/05/2021), the family refused to allow the resident to be transferred. He stated the resident had a tracheostomy, which made it more difficult to find placement for the resident. The Administrator stated he had not made any additional arrangements to transfer the resident out of the unit. The Administrator was asked why the resident was not transferred to the facility's behavior unit. He stated he had tried but the physician in charge of the unit would not accept the resident. He added he thought the physician had said the resident needed two diagnoses, and he would not accept him. The Administrator stated he did not remember when he spoke with the physician at the behavior unit. He said when the resident was sent out to the crisis center, the center only kept the resident a few hours. Then they send the resident back to the facility, and the facility is required to take the resident back. The Administrator was asked to provide documentation of attempts to provide placement for the resident. He stated everything was verbal. There was no documentation of anything. A facility incident report dated 08/08/2021 at 11:10 AM revealed Resident #13 repeatedly hit Resident #17 on the right side of the face. This episode occurred in the activities/dining room. Resident #13 was observed to stand up, approach Resident #17 and start punching Resident #17 in the face. Resident #13 was transferred to a local crisis center at a local hospital. Resident #17 was transferred to a local hospital for evaluation and treatment. The incident report revealed Certified Nurse Aide (CNA) #6 (who was assigned to provide one-on-one) provided a written statement which indicated she was not with Resident #13 when Resident #13 started hitting Resident #17 in the face. Resident #17 was cognitively impaired in cognition and required the use a wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	A facility incident report dated 08/08/2021 at 11:10 AM reported CNA #6 provided a written statement which indicated she was not with Resident #13 when Resident #13 started hitting Resident #17 in the face. On 08/08/2021 at 11:30 AM, Unit Manager #3 stated CNA #6 had been assigned to provide one-on-one for Resident #13. On 08/08/2021 at 4:15 PM, Resident #17 had returned from the hospital and was observed sitting in the dining/activity room. The left side of the face was swollen, with redness and bruising above the left eye and on the right corner of the mouth. On 08/09/2021 at 10:00 AM, three CNAs (CNAs #1, #7, and #8) who provided direct care for Resident #13 stated the resident was unpredictable. There was no way to predict what would set the resident off. If another resident got too close, the resident would jump up and hit the other resident. If a resident walked by, the resident would strike out and hit the other resident. Resident #13 did not like for other residents to be near. Sometimes Resident #13 just did not like the way another resident looked at the resident. Resident #13 was very fast. On 08/09/2021 at 11:20 AM, Resident #13's physician was contacted by phone. He stated he was on vacation, he didn't have the medical record with him, and he didn't remember anything. On 08/09/2021 at 2:00 PM, the Administrator and the DON (Director of Nurses) both verbalized the physician's order did not indicate the transfer needed to be immediate. They added the physician had spoken with each of them, and he did not tell them to transfer the resident immediately. They were asked if there was documentation of constant supervision for Resident #13, such as one-on-one. They stated they did not have a form that recorded one-on-one, but the resident was always on one-on-one. They were asked if interventions had been reviewed, and if new interventions had been put in place after every altercation. They stated the resident was always on one-on-one. New Jersey Administrative Code S 8:39-5.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43017 Complaint Intake: NJ145778 Based on observation, record review, and interviews, it was determined the facility failed to follow up on pharmacy recommendations for 1 (Resident #20) of 3 sampled residents whose medication passes were observed. This had the potential to affect all residents who resided in the facility. Findings included: 1. Resident #20 had diagnoses which included chronic obstructive pulmonary disease, deep vein thrombosis, and coronary artery disease. The resident's Minimum Data Set, dated dated dated [DATE] recorded the resident was severely impaired in cognition and required supervision with activities of daily living. A physician's order dated 05/26/2021 recorded the resident was to be administered Periactin (an antihistamine) for allergies two times a day. On 08/07/2021 at 9:30 AM, Licensed Practical Nurse (LPN) #6 was observed preparing the resident's morning mediations for Resident #20. It was observed Periactin was not on the medication cart. The LPN stated the medication was ordered yesterday but was not on the cart. She stated she would have the pharmacy deliver it immediately. She left the cart to notify the pharmacy. On 08/07/2021 at 9:45 AM, the Assistant Director of Nurses (ADON) was asked if he could find the form that indicated when the medication had been ordered. On 08/07/2021 at 10:30 AM, the ADON provided a pharmacy review form dated 07/24/2021 which indicated the pharmacist had recommended Periactin be discontinued, and cyproheptadine 4 (MG) milligram tablet be substituted, due to the resident's insurance did not cover Periactin. On 08/07/2021 at 11:00 AM, the ADON provided a physician's order which indicated the resident was to be administered cyproheptadine 4 mg daily. The order stated to restart once the medication was in the facility. The ADON stated the unit manager had only been here a few days and was unaware of the recommendation. He added the former unit manager had not acted on the recommendation and had not informed anyone. The ADON was asked for the facility policy/procedure for making sure staff was aware of new pharmacy recommendations. He stated he wasn't sure there was a policy, but he would look. On 08/07/2021 at 2:30 PM, the ADON stated he had been unable to locate a policy for how to ensure pharmacy recommendations were readably available for the unit manager to review and act upon.| New Jersey Administrative Code S 8:39-29.3(a)(1)