STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. Building B. Wing	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cranford Park Care	600 Lincoln Park East Cranford, NJ 07016

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19106 Based on observation, interview, and record review it was determined that the facility failed to preserve the dignity of 2 of 14 residents, Resident #35 and #41. The deficient practice is evidenced as follows: 1. On 6/6/22 at 11:27 AM, the surveyor observed Resident #35 awake in bed. A urinary drainage bag was visible hanging from the bed facing the open doorway to the hall. The drainage bag was not stored in a privacy bag. On 6/07/22 at 12:00 PM, the resident was seated in a recliner chair at the bedside. The resident's urinary drainage bag was visible from the hallway. The drainage bag was stored in a clear plastic bag and hung from the chair. The resident stated to the surveyor that he/she was unaware of the placement of the collection bag. On 6/07/22 at 2:00 PM, the surveyor interviewed the Certified Nursing Assistant. She stated the urinary collection bag should be placed in a clear plastic bag. On 6/07/22 at 2:06 PM, the surveyor interviewed the unit Registered Nurse/Infection Preventionist (RN). The RN stated the urinary drainage bag should be placed in a privacy bag for dignity purposes. She stated the facility had many of them in stock and she would retrieve one from central supply. She further stated the urinary drainage bag should not be stored in a clear plastic bag. The surveyor reviewed the hybrid medical record which revealed the following information. The 4/18/22 quarterly Minimum Data Set assessment tool indicated the resident had no cognitive impairment (Section C). The resident utilized an indwelling urinary catheter (Section H). Sections I and J included diagnoses of myasthenia gravis (a chronic, progressive disease resulting in muscle weakness), benign prostatic hyperplasia, and obstructive uropathy. The indwelling urinary catheter care plan, revised 5/4/22, did not address placement of the collection bag in a privacy bag. On 6/9/22 at 1:30 PM, the surveyor discussed dignity concerns with the Administrator and his administrative team. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed policies for Catheter Care, dated 5/8/18 and Privacy During the Delivery of Care dated 5/12/22 and neither policy addressed the use of a privacy bag. 26420 2. On 6/9/22 at 9:21 AM, the surveyor observed a Licensed Practical Nurse (LPN) complete a wound treatment on the buttock of Resident # 41. After the LPN was done with the treament she used alcohol based hand gel, took a marker out of her pocket, and initialed and dated the border dressing that she had applied to the resident's buttock. On 6/9/22 at 10:15 AM, the surveyor reviewed the resident's medical record which revealed the following: A current Physician's Order Sheet (POS) with an order with a start date of 6/3/22 that read Cleanse right buttock with saline. Apply Xeroform, cover with foam dressing daily. Reposition side to side and monitor for changes. one time a day for pressure ulcer. The POS had diagnoses which included Sepsis, Unspecified Organism, and Type 2 Diabetes. A quarterly Minimum Data Set assessment dated [DATE] indicated that the resident scored a 7 when the Brief Interview for Mental Status was done. This indicated that the resident had severe cognitive impairment. On 6/13/22 at 1:34 PM, the surveyor spoke with the Director of Nursing, the Administrator, and the Corporate Nurse about the wound treatment observation, they agreed that the nurse should not have written on the dressing when it was on the resident. The surveyor reviewed the facility's policy and procedure titled Wound Ulcer Treatment dated 1/28/22, which revealed that it is the policy of this facility to maintain the resident's privacy and dignity during wound treatment and staff is to remove gloves and place them in disposable bag, wash hands with soap and water, apply tape to secure the dressing in place and to apply the date to the tape before applying the dressing. NJAC 8:39-4.1 (a) 12

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31656 Based on observation, interview, and record review it was determined that the facility failed to develop and implement a comprehensive, person-centered care plan for residents at the facility. This deficient practice was identified for 10 of 21 residents reviewed for comprehensive care plans (Resident #55, #42, #28, #32, #51, #43, #47, #62, #4, and #53), and was evidenced by the following: On 6/7/22 at 10:25 AM, the surveyor observed Resident #55 sleeping in bed in their room. The surveyor could not interview Resident #55. On 6/8/22 at 9:35 AM, the surveyor interviewed the Licensed Practical Nurse # 1 (LPN), who was assigned to care for Resident #55. The LPN # 1 informed the surveyor that Resident #55 goes to hemodialysis on Tuesday, Thursday, and Saturday at approximately 2:00 PM. The LPN # 1 explained that Resident #55 had recently returned from the hospital, where he/she underwent a surgical procedure to create an arteriovenous (AV) graft site (access used for dialysis) on the right arm for dialysis access. Review of the medical records revealed that Resident #55's AV graft was not correctly being monitored, checking bruit and thrill (Feel for a vibration, also called a pulse or thrill. With a stethoscope, listen for a swishing sound, or bruit). On 6/8/22 at 10:30 AM, the surveyor interviewed the LPN # 1. The LPN # 1 stated that the facility should be monitoring the AV graft for bruit and thrill sounds. The LPN # 1 verified that this was not occurring nor was there any documentation ordering the monitoring. On 6/9/22 at 9:30 AM, the LPN # 1 advised the surveyor that the AV graft was not usable. Resident #55 was still receiving hemodialysis through their permcath (special IV line into the blood vessel in your neck or upper chest just under the collarbone used for hemodialysis access). The surveyor reviewed Resident #55's hybrid medical records that revealed the following: According to the Admission Record, Resident #55 was admitted with diagnoses that included End Stage Renal Disease (ESRD) with dependence on renal dialysis. The Admission Minimum Data Set (MDS) an assessment tool dated 4/29/22, revealed that the facility performed a Brief Interview for Mental Status (BIMS) which indicated that the resident had a score of 12 out of 15. The resident was assessed to be moderately impaired. The June 2022 Order Summary Report revealed a physician's order for hemodialysis every Tuesday, Thursday, and Saturday at 2:00 PM. Review of the Nurse's Progress Notes on admitted d 4/22/22 specifies, Perma cath noted to right upper chest, dressing clean, dry, resident on hemodialysis at [Dialysis Center] on Tuesdays, Thursdays, and Saturdays at 4 PM. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Nurse's Progress Notes following hospitalization dated 6/1/22 revealed, Resident was brought back from [hospital name] after having a right upper external AV graft placement on 5/27. Review of the Nurse's Progress Notes dated 6/9/22 establishing, Check AVF Site for Bruit and Thrill. None Noted. Access not functioning. Permcath used for Hemodialysis. Review of the most recent care plan (CP), section titled, [Resident #55] needs dialysis hemodialysis related to End Stage Renal Disease. The CP identified, Do not draw blood or take B/P in right arm with graft. There was no documentation referring to Resident #55's graft not functioning. Resident #55 only has use of a permcath for dialysis access, which is not mentioned in the CP. The CP was never updated with an accurate dialysis access port (Permcath), that should be monitored. 39399 2. On 6/7/22 at 9:55 AM, the surveyor observed Resident #28 seated in bed in the resident's room. On 6/9/22 at 11:04 AM, the surveyor reviewed Resident # 28's medical record. Resident #28 was admitted to the facility on [DATE] with diagnoses that included but not limited to Traumatic Subarachnoid Hemorrhage, Hypertension, Psychosis and Anemia. Further review of the resident records revealed that Resident #28 was admitted under Hospice care as of 12/20/21 for Senile Degeneration of Brain. The resident's most recent quarterly MDS, an assessment record used to facilitate the management of care, dated 3/19/22 revealed a BIMS score of 03 which indicated that Resident #28 had severely impaired cognition. The surveyor reviewed the Interdisciplinary CP for Resident #28, which had no coordination of care between Hospice and the facility. On 6/9/22 , the surveyor interviewed the LPN # 2 assigned to the resident who stated that another nurse was responsible for updating the care plans if there was any changes. On 6/13/22 at 1:00 PM, the surveyor discussed hospice care plan concerns with the Administrator and his administrative staff who agreed that there was no care plans initiated for the resident upon admission to hospice. No further information was provided. 3. On 6/7/22 at 10:30 AM, the surveyor observed Resident #62 in bed with eyes closed. On 6/13/22 at 12:21 PM, the surveyor reviewed Resident #62 's medical record. Resident #62 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to Protein-Calorie Malnutirtion; History of COVID-19; Hypertension and Dementia. Further review of the resident records revealed that Resident #62 was admitted under Hospice care as of 7/28/21 for Senile Degeneration of Brain. The resident's most recent quarterly MDS, an assessment record used to facilitate the management of care, dated 5/7/22 revealed that Resident #62 had severely impaired cognition. The surveyor reviewed the CP for Resident #62 which had no coordination of care between Hospice and the facility. On 6/9/22, the surveyor interviewed the LPN # 2 assigned to the resident who stated that another nurse was responsible for updating the care plans if there were any changes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/13/22 at 1:00 PM the surveyor discussed hospice care plan concerns with the Administrator and his administrative staff who agreed that there were no care plans initiated for the resident upon admission to hospice. No further information was provided. 19106 4. On 6/06/22 at 12:09 PM, the surveyor observed Resident #4 awake and alert in bed watching television. The unit Registered Nurse/Infection Preventionist (IPRN) stated the resident was receiving hospice services. A review of the hybrid medical record revealed the following information. The June 2022 Order Summary Report included a 3/2/22 physician's order for hospice services. The MDS assessment tools dated 2/11/22 and 5/14/22 indicated the resident was receiving hospice services. The resident's current comprehensive care plan did not include a care plan for hospice care and services. On 6/10/22 at 10:28 AM, the surveyor interviewed the unit IPRN. She stated there should be a hospice care plan for Resident #4. She stated when a resident is admitted or readmitted to the facility, the admitting nurse initiates or revises the care plan. She further explained the previous Director of Nursing (DON) was writing the care plans up until May, at which time they left employment. She stated the new DON will be reviewing all residents for comprehensive care planning going forward. On 6/13/22 at 1:00 PM, the surveyor discussed the hospice care plan concern with the Administrator and his administrative staff. 44605 5. On 6/07/22 at 10:08 AM, the surveyor observed Resident # 53 in bed with Oxygen nasal canula in place and the concentrator was running at 3 liters per minute. Resident stated, they were having occasional pain in knee when they were doing therapy and was receiving pain patch on pain their left knee but is no longer receiving the patch. The surveyor reviewed Resident #53's medical record. The admission record reflected that Resident #53 was admitted to the facility on [DATE] with diagnoses that included but not limited to Covid-19, Dysphagia Oropharyngeal Phase, Muscle Weakness, Respiratory Failure, and Anxiety Disorder. The surveyor reviewed the June 2022 Physician's Order form, which showed that Resident #53 had a Physician 's order from the administration of O2 (Oxygen) at 2L/min via NC (Nasal Cannula) continuously every day and night shift, Lidocaine Patch 4 % apply to left knee topically one time a day for pain management and remove per schedule, and Seroquel Tablet 25 MG (Quetiapine Fumarate) give 1 tablet via PEG-Tube every 12 hours for Psychosis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:15 AM, the surveyor interviewed LPN # 3 in resident's room. LPN #3 stated the resident has an order for oxygen at 2 liters per minute but observed and confirmed the oxygen was running at 3 liters per minute. LPN #3 stated the resident is currently receiving Tylenol for pain, but they were receiving a Lidocaine patch for left knee pain, but that was discontinued yesterday, also receiving Seroquel twice a day for anxiety, which normally is helpful for the resident. At 1:00 PM, the surveyor reviewed Resident #53's CP, which showed that the facility did not develop a care plan that included the use of Oxygen, Pain Medication, and/or Anxiety/Psychotropic medications. On 6/09/22 at 09:57 AM, the surveyor re-interviewed LPN #3. LPN #3 stated the DON should review the medical record and initiate the resident's care plans. LPN #3 unable to produce care plans from pain, respiratory for continuous oxygen use, and anti-psychotic medication. LPN #3 stated, it's very possible the pain care plans were not made for those issues. On 6/10/22 at 10:31 AM, the surveyor team interviewed the IPRN. IPRN stated, when a patient is admitted , the nurse initiates the baseline care plan, but the DON was previously completing the comprehensive care plan. The new DON will be reviewing all residents for care plan. IPRN further stated, they would have expected there to be care plans for those areas. The surveyor reviewed the policy and procedure for Oxygen Administration with a review date of 10/21/21, which revealed that it is the policy of this facility to provide comfort to residents by administering oxygen when insufficient oxygen is being carried by the blood to the tissues, and staff should check the physician's order for the liter flow and method of administration and licensed staff will check the oxygen flow rate on all residents on oxygen therapy during rounds and compare it against the physician's order at the start and end of each shift. The surveyor reviewed the policy and procedure for Pain Assessment and Management revised on 3/28/21, which revealed comfort and sensitivity in a caring environment shall be offered to all residents, verbal and nonverbal expressions of pain and discomfort will be addressed property, and an order to set forth guidelines in determining the presence and severity of pain and to develop an individualized resident pain management program. 44834 6. On 6/6/22 at 10:41 AM, two surveyors toured the unit with the LPN # 4. The LPN # 4 told the surveyors that Resident #42 was COVID-19 positive and was on transmission-based precautions (TBP) which are special measures that are put in place to prevent the spread of infection. On 6/6/22 at 11:24 AM, the surveyor observed a sign on Resident #42's door which read, Please see nurse before entering room. On 6/6/22 at 11:25 AM, the surveyor observed Resident #42 in bed wearing a nasal cannula (a medical device to provide supplemental oxygen therapy) attached to an oxygen concentrator. The surveyor observed that the oxygen concentrator was set to 3 LPM. (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 Resident #42's hybrid medical record. The Admission Record revealed that the resident was admitted to the facility with diagnoses that included but were not limited to Fracture of Right Femur (a partial or complete break in the bone of the thigh) and Hypertension (high blood pressure). The resident's most recent quarterly MDS an admission record used to facilitate the management of care revealed a BIMS score of 99 which reflected that Resident #42 was unable to complete the interview. The MDS indicated that the resident appeared to have an OK short-term and long-term memory. The MDS also indicated that Resident #42 used oxygen while as a resident. A review of a 6/1/22 Progress Note written by the Nurse Practitioner indicated that Resident #42 had lung cancer and was dependent on oxygen. A Laboratory Result dated 5/31/22 revealed that Resident #42 tested positive for COVID-19 via a reverse transcription PCR (a laboratory method used to make many copies of a specific genetic sequence for analysis) test for COVID-19. The Clinical Physician Orders indicated that Resident #42 had a 6/3/22 active order for Quarantine precaution x 14 days monitor for sob (shortness of breath), cough, and temp for covid positive results. A further review of the Clinical Physician Orders indicated that Resident #42 had a 5/17/22 active order for Supplemental oxygen at 2LPM continuous via nasal cannula. The care plan initiated on 1/13/22 failed to address Resident #42's respiratory function or oxygen use. The care plan also failed to address the specific goal and intervention for Resident #42 while they were using supplemental oxygen. A further review of the care plan also failed to address that the resident was positive for COVID-19 or that they were placed on TBP. The care plan also failed to address the specific goal and intervention for Resident #42 while they were COVID-19 positive and on TBP. On 6/8/22 at 9:41 AM, the surveyor interviewed the Registered Nurse (RN). The surveyor stated that Resident #42 had COVID-19 and that they used supplemental oxygen. The surveyor asked if there should be care plans in place because the resident was COVID-19 positive, was on TBP, and used supplemental oxygen. The RN stated, definitely. The surveyor asked the RN how soon after a positive COVID-19 test should a care plan be initiated. The RN stated, right away. On 6/13/22 at 1:18 PM, the surveyor expressed her concern to the Administrator and his administrative staff The surveyor asked if administration would expect to see care plans initiated and implemented. The DON stated, yes. 7. On 6/6/22 at 11:14 AM, the surveyor observed Resident #32 in bed. The resident was awake, alert, and oriented but appeared thin. (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 observed Resident #32's medical record. The Admission Record revealed that the resident was admitted to the facility with diagnoses that included but were not limited to Encounter for Palliative Care (care focused on providing relief from the symptoms and stress of serious illness), and Dementia. The resident's most recent significant change in status MDS, revealed a BIMS score of 8 out of 15, reflecting moderately impaired cognition. The MDS also indicated that Resident #32 was receiving hospice care while as a resident. The Order Recap Report indicated a 4/1/22 active physician order for, Hospice evaluate and treat. The care plan initiated on 4/1/2019 failed to address that Resident #32 was admitted to hospice or was receiving palliative care. The care plan also failed to address the specific goal and intervention for Resident #32 while they were admitted to hospice or were receiving palliative care. On 6/8/22 at 9:41 AM, the surveyor interviewed the RN # 2. The surveyor asked if the RN # 2 would expect to see that a resident on hospice had a care plan in place to address that they were receiving hospice or palliative care services. The RN # 2 stated that she would expect for one to be in place. On 6/13/22 at 1:18 PM, the surveyor expressed her concern to the Administrator and his administrative staff. The surveyor asked if administration would expect to see a care plan initiated and implemented. The DON stated, yes. 45759 8. On 6/7/22 at 11:36 AM, the surveyor observed Resident #51 in the resident's room sitting in a wheelchair. Resident #51 informed the surveyor that he/she was recently hospitalized . A review of the resident's hybrid medical record revealed the following information: The Admission Record revealed that Resident #51 was admitted to the facility on [DATE] with diagnoses that included but not limited to Iron Deficiency Secondary to Blood Loss (Chronic) and Renovascular Hypertension. A review of Resident #51's paper chart titled New Jersey Universal Transfer Form dated 4/15/22 revealed that the resident was transferred to the hospital due to Resident vomiting large amount of coffee ground emesis, complaining of abdominal pain. A review of Nurse's Progress Notes dated 4/17/22 revealed that the resident was readmitted to the facility with a diagnosis of GI Bleed. The Annual MDS dated [DATE] revealed a BIMS score of 11 out of 15, which indicated that the resident had moderate cognitive deficit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The June 2022 Order Summary Report included a 5/29/21 physician's order for Aspirin Tablet Chewable 81 mg 1 tablet by mouth one time a day and a 3/16/21 physician's order for Clopidogrel Bisulfate Tablet 75 mg 1 tablet by mouth one time a day which placed the resident at a higher risk for bleeding. The surveyor reviewed the resident's CP. There was no care plan developed regarding the resident's use of the medications. On 6/13/22 at 1:18 PM, the surveyor discussed the concerns with the administrator and his administrative staff and acknowledged that there was no care plan initiated for the resident upon readmission to the facility. No further information was provided. On 6/14/22 at 9:22 AM, the surveyor interviewed the LPN # 5 assigned to the resident and acknowledged that there should have been a care plan initiated for the resident who had a history of GI Bleed and is taking medications that placed the resident at a higher risk for bleeding. 46049 6. The surveyor reviewed Resident # 43's hybrid medical record of which revealed the following: The resident's Admission Record listed diagnoses that included anxiety disorder and depression. The Admission MDS assessment, dated 4/6/22, indicated the facility assessed the resident's cognitive status using a BIMS. The resident scored a 15 out of 15 which indicated that the resident was cognitively intact. The MDS assessment also indicated the resident had active diagnoses of anxiety disorder and depression and was receiving antidepressants and antianxiety medications. A psychiatry progress note, dated 6/7/22, indicated Resident #43 was receiving Paxil for depression and Clonazepam for anxiety. It also indicated the resident reported intermittent anxiety. A review of the physician's orders and the medication administration record of Resident #43 revealed the resident was receiving Paxil 40 mg (PARoxetine HCl) Give 1 tablet by mouth one time a day, order date of 3/31/22 and ClonazePAM Tablet 0.5 MG Give 1 tablet by mouth two times a day, order date of 6/4/22. On 6/10/22 at 10:29 am, the surveyor interviewed LPN # 6, about the care planning process. LPN # 6 stated to her knowledge from she started working at facility the RN would initiate care plans, and then the LPNs would update and add to them. LPN # 6 further stated care plans would be updated when there were significant changes with residents. The surveyor asked LPN # 6 for Resident # 43 who was receiving medication for depression and anxiety, if it would be expected for the resident to have a care plan. LPN acknowledged that the resident should have care plans related to psychoactive medications (a medication that affects the mind) and related diagnoses. On 6/10/22 at 10:40 AM, the surveyor interviewed unit IPRN, about the care planning process for residents. She stated when a resident is admitted or readmitted to the facility, the admitting nurse initiates or revises the care plan. She further explained the previous DON was writing the care plans up until May, at which time they left employment. She stated the new DON will be reviewing all residents for comprehensive care planning going forward. The IPRN stated it would be expected for the resident to have a psychoactive care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/13/12 at 1:12 PM, the surveyor met with Administrator, the DON, and IPRN discuss care plan concerns for Resident #43. 7. The surveyor reviewed Resident # 47's hybrid medical record which revealed the following: The resident's Admission Record listed diagnoses that included generalized muscle weakness, Type 2 Diabetes Mellitus, and depression. The Admission MDS assessment, dated 4/7/22, which indicated the facility assessed the resident's cognitive status using a BIMS. The resident scored a 11 out of 15 which indicated that the resident had moderate cognitive impairment. The MDS assessment also indicated that the resident was at risk of developing pressure ulcers/injuries, the resident was receiving antidepressants and insulin injections. A review of the physician's orders revealed: A physician's order, dated 6/3/22, which read: TX to Left buttock : NSS wash , santyl , foam dressing daily. A physician's order, dated 6/3/22, which read: TX to Right buttock : NSS wash , Santyl , foam dressing daily. A physician's order, dated 5/5/22, which read: Lexapro Tablet 10 MG (Escitalopram Oxalate) Give 1 tablet by mouth one time a day. A physician's order, dated 5/16/22, NovoLOG Solution 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale subcutaneously before meals and at bedtime. The wound consultant notes, dated 6/1/22, indicated Resident #47 had pressure ulcers to buttocks. A review of the resident's CP revealed: There was no CP related to pressure ulcers or risks of skin breakdown for the resident. There was no care plan related to Resident #47 diagnosis of Type 2 Diabetes Mellitus or resident receiving insulin medication. There was a care plan with a focus that read [Resident #47] is at nutritional risk secondary to fluctuating appetite likely related to depression. There was no other care plan related to Resident #47 receiving antidepressant medication or diagnosis of depression. On 6/8/22 at 11:26 AM, the surveyor interviewed LPN # 7 about the care planning process and who was responsible for care plans. LPN # 7 stated the previous DON used to be responsible for developing care plans, and the nurses would update care plans based on changes in the resident's status. LPN # 7 further stated now the nurses develop care plans and update the care plans if needed. LPN # 7 stated any changes with residents or anything new to add will be updated right away. The surveyor asked LPN # 7 about the resident' s wounds. LPN # 7 reviewed the EMR and stated the wound was first documented on 5/6/22 as moisture dermatitis. (continued on next page)

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Cranford Park Care	600 Lincoln Park East Cranford, NJ 07016

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/9/22 at 12:45 PM, the surveyor interviewed LPN # 7 about care plans for residents with wounds or at risk for skin breakdown. LPN # 7 stated residents at risk for skin breakdown should have a care plan. LPN # 7 further acknowledged residents with an actual or new wound should have a care plan. The surveyor asked LPN # 7 if the Resident #47 had a care plan in place. LPN # 7 reviewed the EMR and confirmed there was no care plan related to pressure ulcer or skin integrity for the resident. LPN # acknowledged Resident #47 should have had a care plan related to skin breakdown and actual wounds. LPN # 7 stated she would follow up with the unit RN about creating a care plan for the resident. On 6/10/22 at 10:29 AM, the surveyor interviewed LPN # 7, about the care planning process. LPN # 7 stated to her knowledge from she started working at facility the RN would initiate care plans, and then the LPNs could update and add to them. LPN # 7 further stated care plans would be updated when there were significant changes with residents. The surveyor asked LPN # 7 for Resident # 47 who was receiving medication for depression, if it would be expected for resident to have a care plan. LPN # 7 acknowledged that the resident should have care plans related to psychoactive medications (a medication that affects the mind) and related diagnoses. On 6/10/22 at 10:40 AM, the surveyor interviewed IPRN, about the care planning process for residents. She stated when a resident is admitted or readmitted to the facility, the admitting nurse initiates or revises the care plan. She further explained the previous DON was writing the care plans up until May, at which time they left employment. She stated the new DON will be reviewing all residents for comprehensive care planning going forward. The IPRN stated it would be expected for the resident to have a psychoactive care plan. On 6/15/22 at 12:55 PM, the surveyor informed the Administrator and his administrative staff discuss concerns of care plans for the resident. The facility policy for baseline care plans and comprehensive care plans, last reviewed 10/20/21, indicated each resident is to receive a baseline care plan within 48 hours to address all immediate care needs. Additionally, a comprehensive care plan is to be implemented for each resident's physical, psychosocial, and functional needs. The surveyor reviewed the facility's policy and procedure titled, Wound Care Protocol with a revised dated of 1/28/22, which read Care planning must be formulated for all residents with actual or potential wound(s). NJAC 8:39-11.2(e)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 19106 Based on observation, interview, and record review it was determined the facility failed to consistently follow standards of clinical practice with regard to a.) safely securing medications, b.) accurately documenting medication administration, c.) correctly following physician's orders. The deficient practice is evidenced by the following. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; 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. 1. On 6/06/22 at 10:50 AM the surveyor observed Resident #35 awake in bed with a medicine cup containing 10 pills on the over bed table. The resident told the surveyor that earlier that morning the resident stated to the unit Registered Nurse/Infection Preventionist (RN) that the resident was not ready to take the medication. The resident instructed the RN to leave the medication at the bedside and they would take them when ready. The resident stated the RN normally waits until the resident takes the medication. On 6/06/22 at 10:55 AM the surveyor brought the RN into the resident's room. The RN confirmed she left the medications at the resident's bedside. She stated she was very busy and didn't want to be late passing medications to other residents. The RN stated the resident promised her they would take the medications and the RN left the room before the resident took them. The RN stated she documented in the Electronic Medication Administration Record (EMAR) that the medications were given when the resident had not yet taken the medicine. She stated the facility policy is to wait to observe that the resident takes the medication before leaving the room and before documenting in the EMAR. The RN told the surveyor there was one confused ambulatory resident on the unit whose room was at the far end of the unit from Resident #35. Neither the surveyor or the RN observed any residents in the hallway outside of Resident #35's room. Resident #35 stated no residents were in the vacinity while the medications were unsecured on the over bed table. On 6/7/22 at 1:30 PM the surveyor discussed with the Administrator and his administrative team the concerns of leaving medications unattended at the resident's bedside and documenting the medications as given when they were not yet taken by the resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	31656 2. On 6/6/22 at 10:30 AM, the surveyor inspected the Unit A medication cart and found a bottle of Fluticasone Propionate 50 mcg Nasal Spray received from the pharmacy on 3/1/22 and opened on 3/14/22. An unopened bottle contains 120 doses. The bottle found appeared full and belonged to Resident #30. The surveyor also found a new unopened bottle of Fluticasone Propionate 50 mcg Nasal Spray in the medication cart received on 5/12/22 from the pharmacy. The surveyor in the presence of the RN, compared the two bottles of Fluticasone (opened and new bottle). The RN agreed that the bottle opened on 3/14/22 appeared almost full. The RN stated that if there is a problem with administration of medication, nursing should document missed dose or refused. The surveyor reviewed the EMAR for March, April, May and June 2022. The Physician's order read, Fluticasone Propionate Suspension 50 mcg 1 spray in each nostril every morning and at bedtime for stuffy nose. The bottle of medication was a 60 day supply and should have been completed on May 14, 2022 if the medication was administered daily. Nursing had documented daily on all 4 months that the medication was administered. 3. On 6/7/22 at 10:25 AM, the surveyor observed Resident #55 sleeping in bed in their room. The surveyor could not interview Resident #55. The surveyor interviewed LPN#2, who was assigned to care for Resident #55. LPN#2 informed the surveyor that Resident #55 goes to hemodialysis on Tuesday, Thursday, and Saturday at approximately 2:00 PM. The surveyor reviewed Resident #55's hybrid medical records that revealed the following: According to the Admission Record, Resident #55 was admitted with diagnoses that included End Stage Renal Disease (ESRD) with dependence on renal dialysis, Type 2 Diabetes Mellitus and Hypertension (HTN). The Admission Minimum Data Set (MDS) an assessment tool dated 4/29/22, revealed that the facility performed a Brief Interview for Mental Status (BIMS) which indicated that the resident had a score of 12 out of 15. The resident was assessed to be moderately impaired. The surveyor reviewed the April, May and June 2022 EMAR that included Physician's orders for: a. Isosorbide Mononitrate ER 60 mg 1 tablet via percutaneous endoscopic gastrostomy (PEG)-tube daily for HTN. Hold for Systolic Blood Pressure (SBP) less than 110. Review of the documentation on the EMAR demonstrated that the Isosorbide Mononitrate ER 60 mg was administered once in April 2022 when the medication should have been held due to low SBP. The Mononitrate ER 60 mg was documented as held 5 times in May 2022 without documenting any of the SBP needed to determine if the medication should be administered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Carvedilol 25 mg 1 tablet via PEG-tube twice daily for HTN. Hold for SBP less than 110 and Heart Rate (HR) less than 60. Review of the documentation on the EMAR demonstrated that the Carvedilol 25 mg was administered once in April 2022, 3 times in May when the medication should have been held, due to low SBP. The Carvedilol 25 mg was documented as held 5 times in May 2022 without documenting any of the SBP needed to determine if the medication should be administered. The Carvedilol was documented as administered 8 times in June 2022 without the documentation of SBP or HR on the EMAR to determine if the medication should be administered. c. Amlodipine Besylate 10 mg 1 tablet via PEG-tube daily for HTN. Hold for SBP less than 110. Review of the documentation on the EMAR demonstrated that the Amlodipine 10 mg was documented as held 6 times in May 2022 without documenting any of the SBP needed to determine if the medication should be administered. d. Hydralazine HCl 100 mg 1 tablet via PEG-Tube three times a day for HTN. Hold for SBP less than 110 and on dialysis days on Tues., Thurs., and Sat days. Review of the documentation on the EMAR demonstrated that the Hydralazine HCl 10MG was administered on 9 dialysis days when the medication should have been held in May 2022. On 6/8/22 at 2:00 PM, the surveyor discussed this issue with the RN. The RN could not explain why these medications were administered or how the nursing staff was able to bypass the EMAR, which had prompts requiring documentation of SBP and HR. The RN stated that all parameters should be documented at the time of medication administration. On 6/15/22 at 1:35 PM the surveyor met with the Director of Nursing (DON), Administrator and RN. No further information was provided. NJAC 8:39-29.2(a); 8:39-29.2(c)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26420 Based on observation, interview, and record review, it was determined that the facility failed to provide care and services during the treatment of a pressure ulcer in a manner to facilitate healing by following infection control protocols and failed to follow the physician's treatment order. This was found with 1 of 3 residents reviewed for pressure ulcer treatment, Resident # 41. The deficient practice was evidenced by the following: On 6/9/22 at 9:21 AM the surveyor observed a wound treatment to the right buttock of Resident # 41. The Licensed Practical Nurse (LPN) prepared supplies on the treatment cart in the doorway of the resident's room. The LPN removed border gauze from the treatment cart and stated the recommendation from the wound team was to use foam dressing but we don't have foam dressing. Central supply knows that the order is for foam dressing. The wound team does not know that we don't have foam dressing but we can make them aware and they can change the order if they want to. The nurse then stated, The treatment is usually done on the night shift so After gathering the supplies the LPN cleaned the over bed table with a disinfectant wipe and set up a clean field, she then washed her hands for 40 seconds then rinsed her hands. When rinsing, her hands went in the water that was pooling in the bottom of the sink. When done rinsing she dried her hands with a paper towel. There was an open toothbrush on the sink. The surveyor asked the LPN whose toothbrush that was. The LPN stated she did not know who it belonged to. The bathroom that the LPN used to wash her hands was the bathroom that was shared between two rooms, the resident receiving the wound treatment and the room next door to the resident. After washing her hands the LPN went to the resident's bedside where the clean field was set up. The LPN opened a bottle of saline and poured it on the gauze over the garbage while she held the gauze. The LPN proceeded to clean the wound with the saline soaked gauze, she wiped the wound four times, first inner one swipe then outer one swipe, then the last two times, the nurse wiped inside the wound, then outside the wound, then inside the wound then outside the wound, with the same gauze. After cleaning the wound the LPN dried the wound with dry sterile gauze, she patted the wound, inner, outer, inner, outer multiple times. She then applied the xeroform (a sterile, non-adhering dressing consisting of absorbant fine mesh gauze) and covered it with a border gauze, not the foam dressing in accordance with the physician's order. After completing the wound treatment the LPN washed her hands for 40 seconds then when rinsing, her hands went into the water that was pooling in the bottom of the sink. When done rinsing she dried her hands with a paper towel. On 6/9/22 at 9:57 AM when the wound treatment was done the surveyor asked the LPN if she was a full time nurse at the facility. The LPN said yes, she worked 12 hour shifts but not always on the same unit. The surveyor asked the LPN if she ever did wound treatments on her shift. The LPN said yes she did. On 6/9/22 at 10:15 AM, the surveyor reviewed the resident's medical record which revealed the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current Physician's Order Sheet (POS) with an order with a start date of 6/3/22 that read Cleanse right buttock with saline. Apply Xeroform, cover with foam dressing daily. Reposition side to side and monitor for changes. one time a day for pressure ulcer. The POS had diagnoses which included Sepsis, Unspecified Organism, and Type 2 Diabetes. A quarterly Minimum Data Set assessment dated [DATE] indicated that the resident scored a 7 when the Brief Interview for Mental Status was done. This indicated that the resident had severe cognitive impairment. On 6/13/22 at 1:34 PM the surveyor spoke with the Director of Nursing, the Administrator, and the Corporate Nurse about the wound treatment observation. The Corporate Nurse stated The nurse should have called the physician if the foam dressing was not available, she should have called the physician and received a new order for an appropriate dressing to be used that was in stock. The Corporate Nurse also confirmed that the nurse should have used a one swipe technique when cleaning the wound and should not have put her hands in the pooling water at the bottom of the sink. On 6/14/22 at 11:00 AM the surveyor reviewed the facility's policy and procedure titled Wound Ulcer Treatment with a revision date of 1/28/22. Under Procedure #2 read Gather all supplies-check Physician's Order for the wound treatment #11 read Moisten sterile/clean dressings or swabs and cleanse the wound, if ordered, moving from top to bottom or from center of the wound outward. Use a new swab or gauze pad for each cleansing motion. Clean the area around the wound as well. # 12 read Use a gauze pad to dry the wound with the same motion as in step 11 . NJAC 8:39-19.4 (a); 27.1 (a)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 34421 Based on observation, interview, record review, and review of other pertinent facility documents on 6/7/2022, it was determined that the facility failed to maintain water temperatures at a safe level to prevent potential burns or injury. This deficient practice was identified in 3 of 3 units (A unit (includes A floor, Upper Annex and Lower Annex), B unit and C unit) reviewed for water temperatures. The facility's failure to monitor and follow up on water temperatures after adjusting the boiler setting, placed Resident # 23, as well as all other residents, at risk for unsafe water temperatures to prevent potential burns or injury, which resulted in an Immediate Jeopardy (IJ) situation that began on 6/5/22. The IJ ran from 6/5/22 to 6/8/22, including the first date that the Maintenance Director (MD) increased the water temperature without monitoring or following up on the temperatures. The facility's Licensed Nursing Home Administrator (LNHA) was notified of the IJ on 6/7/22 at 5:00 PM. An acceptable written Removal Plan was received on 6/8/22 at 5:07 PM. The Removal Plan was verified by the survey team onsite on 6/8/22 at 10:59 AM, lifting the immediacy, and the survey team continued verification of the Removal Plan onsite throughout the survey while onsite for the dates of 6/6/22, 6/7/22, 6/8/22, 6/9/22, 6/10/22, 6/13/22, 6/14/22, 6/15/22 and 6/16/22. The evidence was as follows: Reference: State Operations Manual, Effective November 28,2017 Sub-Reference: [NAME], A.R. Herriques, F.C. Jr. Studies of thermal injuries: II The relative importance of time and surface temperature in the causation of cutaneous burn. Am J Pathol 1957; 23;695-720; Understanding Potential Water Heater Scald Hazards. A [NAME] Paper Developed by the American Society of Sanitary Engineering Scald Awareness Task Group,Published: March 2012(R) A burn is damage to the skin and underlying tissue caused by heat, chemicals or electricity. Burns damage or destroy the skin cells. Scalds result from the destruction of one or more layers of the skin due to contact with hot liquids or steam. The temperature to which the skin is exposed and the length of time the skin is exposed to the burning substance determine the depth of injury. Table 1. Time and Temperature Relationship to Serious Burns Water Temp Time Required for a 3rd Degree Burn to Occur 155 F 68 C 1 sec 148 F 64 C 2 sec 140 F 60 C 5 sec (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	133 F 56 C 15 sec 127 F 52 C 1 min 124 F 52 C 3 min 120 F 48 C 5 min 100 F 37 C Safe Temperatures for Bathing (see Note) NOTE: Burns can occur even at water temperatures below those identified in- the table, depending on an individual ' s condition and the length of exposure. On 6/7/22, during a Recertification Standard Survey, the survey team noted that the water temperature in bathroom sink located in the lobby was hot to the touch. The surveyor calibrated the thermometer at 11:45 AM. At 12:28 PM, the surveyor went into the two rooms that are located on the first-floor lobby area. In Unit C room [ROOM NUMBER] the sink hot water temperature was 124.5 degrees Fahrenheit (degrees F) and the sink hot water temperature in Unit C room [ROOM NUMBER] was 146.5 degrees F. At 12:32 PM, the surveyor interviewed Resident # 23, who stated that a Certified Nursing Assistant (CNA) gave the resident a shower this morning and the water was too hot. The resident stated that he/she asked the CNA to adjust the temperature as it was too hot, and the CNA stated that she could not feel the water temperature since she was wearing gloves. The resident stated that the CNA removed her gloves, felt the water and adjusted the temperature and the water temperature was better for the rest of the shower. The resident stated that the water felt hot on his/her right arm and showed the surveyor. There was no visible burn, discoloration or marks on the resident's arm where resident said the hot water touched. There was no assessment documented by the staff for Resident # 23's hot water complaint. No other residents reported burns, injury or hot water temperatures. At 12:34 PM, the surveyor asked the Licensed Practical Nurse (LPN), who cared for the Resident # 23, for the name of which CNA provided a shower for Resident # 23. The LPN stated that a hospice CNA gave the resident a shower this morning. The surveyor requested the hospice CNA's contact information as the LPN stated that the hospice CNA was not in the facility today. Further water temperature testing done by the surveyors revealed hot water temperatures in the following units and rooms: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In Unit C room [ROOM NUMBER]; the sink hot water temperature was 121 degrees F, in the Upper Annex main bath; the shower hot water temperature was 134.9 degrees F, in the Lower Annex room [ROOM NUMBER]; the sink hot water temperature was 139.4 degrees F, in the Lower Annex room [ROOM NUMBER]; the sink hot water temperature was 138.8 degrees F, in Unit A room [ROOM NUMBER]; the sink hot water temperature was 112.4 degrees F, in Unit A rooms [ROOM NUMBERS]; the shared bathroom sink hot water temperature was 123.4 degrees F, in Unit A rooms [ROOM NUMBERS]; the shared bathroom sink hot water temperature was 127.4 degrees F, Unit B room [ROOM NUMBER]; the sink hot water temperature was 122.2 degrees F, and Unit B room [ROOM NUMBER]; the sink hot water was 120.8 degrees F. According to the above referenced Time and Temperature Relationship to Serious Burns, these temperatures are well above the safe temperatures for resident use. The water temperatures were confirmed with the LNHA as follows: At 2:15 PM, the LNHA calibrated his thermometer in the presence of the surveyor. At 2:18 PM, the surveyor and the LNHA checked Unit C room [ROOM NUMBER] sink hot water temperature, and the surveyor's thermometer read 143.3 degrees F and the LNHA's thermometer read 143.6 degrees F. At 2:25 PM, the surveyor and the LNHA checked the shower hot water temperature in Unit C's main bath, and the surveyor's thermometer read 134.1 degrees F and the LNHA's thermometer read 134.1 degrees F. At 2:33 PM, the surveyor and the LNHA checked the sink hot water temperature in Unit B room [ROOM NUMBER], and the surveyor's thermometer read 123.2 degrees F and the LNHA's thermometer read 123.8 degrees F. At 2:36 PM, the surveyor and the LNHA checked the sink hot water temperature in Unit A room [ROOM NUMBER] and 115, and the surveyor's thermometer read 123 degrees F and the LNHA's thermometer read 123.1 degrees F. At 2:40 PM, the surveyor and the LNHA checked the sink hot water temperature in Unit A room [ROOM NUMBER], and the surveyor's thermometer read 120.4 degrees F and the LNHA's thermometer read 120.6 degrees F. At 2:42 PM, the surveyor and the LNHA checked the sink hot water temperature in Lower Annex room [ROOM NUMBER], and the surveyor's thermometer read 140 degrees F and the LNHA's thermometer read 140.5 degrees F. At 2:47 PM, the surveyor and the LNHA checked the sink hot water temperature in Lower Annex room [ROOM NUMBER], and the surveyor's thermometer read 139.7 degrees F and the LNHA's thermometer read 138.7 degrees F. At 2:50 PM, the LNHA stated that he was verbally informed by the MD that the MD adjusted water temperatures over the past weekend as residents complained that the water temperature was cold. The LNHA stated that the MD said that he adjusted it to the highest setting. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	At 2:53 PM, the surveyor and LNHA went to observe the boiler and the boiler was set to the highest setting of very hot. The LNHA adjusted the setting from very hot to a setting of low. The LNHA stated that it should take 2 hours until the temperature adjusts back to normal at a range of no higher than 110 degrees F. At 3:02 PM, the surveyor interviewed the House Keeping Director (HKD) who was covering for the MD today. The HKD stated that no one complained about water temperatures today and that there was no documentation of complaints of water temperature this weekend and why the temperature was adjusted. The HKD stated that the MD filled out the monthly water temperature logs dated May 4, 2022, May 11, 2022, May 18, 2022 and June 1, 2022, which was provided to the surveyor and revealed 110 degrees F for each of the 53 rooms checked for water temperature for those four weeks. The HKD stated that the facility will not use hot water until this is resolved. At 3:40 PM, the HKD stated that there were no maintenance books on all units with documentation of concerns because at this time the process is that if there are any issues, it is communicated verbally. At 4:15 PM, the surveyor interviewed the Hospice CNA, who cared for Resident # 23. The Hospice CNA stated that as she got the resident ready for the shower today, the water seemed hot as she touched it with her arm, she turned on the cold water and made the temperature more comfortable. The Hospice CNA stated that the resident did not complain of hot water and only asked for the water to be a little warm. The Hospice CNA stated that she did not report the hot water temperature to anyone because she was able to adjust the temperature with use of the cold water. The surveyor reviewed the Safe Water policy and procedure, dated 1/1/22, which revealed that the water temperatures will be set to a temperature of no more than 110 degrees F, and that the maintenance staff will check water heater temperature controls and the temperatures of tap water in all hot water circuits weekly and as needed. On 6/7/22 at 10:35 AM, the surveyor interviewed the MD who stated that on Sunday 6/5/22, a nurse called him and said that the water temperature was cold, and the pilot light was out. The MD stated that he came into the facility and re-set the pilot and it turned on. The MD stated that he set the boiler to just under the hot setting and stated that he left the facility without documenting anything or following up on the water temperature. The MD stated that Monday, 6/6/22 at 5AM, he came back to check the boiler, the pilot light was on, and the setting was set to just under hot setting. He stated that the temperature of the water read 110 degrees F and he checked Unit B and Unit C, but did not document this anywhere. The MD stated that on Tuesday 6/7/22, the nurse called to tell the LNHA and stated that the water was cold again, this was also not documented anywhere and the LNHA did not state this. The MD stated that a plumber came on Tuesday 6/7/22, and the MD stated that the plumber must have set the boiler to very hot. The surveyor requested documentation of the plumber visit and there was no documentation provided to the surveyor. The facility's failure to monitor and follow up on water temperatures after adjusting the boiler setting, placed Resident # 23, as well as all other residents, at risk for unsafe water temperatures, which resulted in an Immediate Jeopardy situation. (continued on next page)

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	315390	A. Building B. Wing	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cranford Park Care	600 Lincoln Park East Cranford, NJ 07016

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 6/7/22 at 5:00 PM, the surveyors met with the LNHA, Director of Nursing, and Clinical Liaison to inform them of the IJ. An IJ template was emailed to the LNHA at 5:07 PM. On 6/8/22 at 10:59 AM, the LNHA submitted the removal plan and the surveyor verified the plan that the facility which revealed that the facility lowered the water heater dial, water temperatures were checked on all sinks and bathroom/shower stalls in the whole building every 30 minutes and will be documented in the water temperature log for 30 days, all staff was in-serviced regarding water temperature safety, MD/designee was educated regarding checking water temperatures when a water temperature setting is adjusted to ensure that it is within a safe temperature level, maintenance communication policy revision for a communication book to be on each unit, separate work order form will be utilized for any immediate issue, monthly audits on all the water temperatures taken daily and monthly QAPI on water temperatures x 3 months and quarterly thereafter. The non-compliance for F689 remained on 6/16/22 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy. NJAC 8:39-31.7 (h)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605 Based on observation, interview, and review of facility documentation, it was determined the facility failed to ensure two residents were receiving supplemental oxygen as prescribed by the physician. This was found for 2 of 2 residents reviewed for oxygen, Resident #53 and Resident #42, and was evidenced by the following: On 6/07/22 at 10:08 AM, the surveyor observed Resident # 53 in bed receiving Oxygen via a nasal canula (a medical device to provide supplemental oxygen therapy) attached to an oxygen concentrator, which was on and set at 3 liters per minute (LPM). The oxygen tubing was dated 6/7/22. The surveyor reviewed Resident #53's medical record which revealed the following: The admission record which reflected that Resident #53 was admitted to the facility on [DATE] with diagnoses that included Covid-19, Dysphagia Oropharyngeal Phase, Muscle Weakness, Respiratory Failure, and Anxiety Disorder. The June 2022 Physician's Order form, which showed that Resident #53 had a Physician's order for the administration of oxygen (O2) at 2 LPM via NC (Nasal Cannula) continuously every day and night shift. On 6/7/22 at 10:15 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 in the resident's room. LPN #1 stated the resident had an order for oxygen at 2 LPM. LPN #1 confirmed the oxygen was running at 3 LPM. LPN #1 further stated, the respiratory therapist told her to increase the oxygen concentration to keep their O2 at least 97%, but the order was not updated to reflect that. On 6/9/22 at 9:45 AM, the surveyor conducted a phone interview with the Respiratory Therapist (RT) #1. RT #1 stated they saw all the residents weekly and recalled that Resident # 53's oxygen order was for two LPM. The surveyor informed RT #1, that they observed the oxygen concentrator set at 3 LPM on June 7th, 8th, and 9th. RT #1 stated, he was not made aware of any changes and should have been informed if there was a respiratory issue with the resident. On 6/9/22 at 10:15 AM, the surveyor reviewed Resident #53's medical record. The resident's Medical Administration Record (MAR) and Treatment Administration Record (TAR) were signed by the LPN, for O2 set at 2 LPM on the days where the surveyor observed the oxygen set at 3 LPM. On 6/13/22 at 11:00 AM, the surveyor interviewed the Director of Nursing (DON) who stated they would expect to the O2 concentration to match the physician's orders. 44834 On 6/6/22 at 11:25 AM, the surveyor observed Resident #42 in bed wearing a nasal cannula (a medical device to provide supplemental oxygen therapy) attached to an oxygen concentrator. The surveyor observed that the oxygen concentrator was set to 3 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/7/22 at 11:55 AM, the surveyor observed Resident #42 in bed wearing a nasal cannula attached to an oxygen concentrator. The surveyor observed that the oxygen concentrator was set to 3 LPM. On 6/8/22 at 9:32 AM, the surveyor interviewed the Registered Nurse (RN). The surveyor asked why Resident #42 wore oxygen. The RN stated that Resident #42 wore oxygen because they felt anxious and became short of breath. On 6/8/22 at 9:41 AM, the surveyor requested that the RN accompany her into Resident #42's room. The surveyor asked how many liters of oxygen the resident was receiving per minute. The RN stated, 3 liters. The surveyor asked if this was appropriate. The RN stated that it was appropriate. On 6/8/22 at 9:45 AM, the surveyor asked the RN to look at Resident #42's Clinical Physician Orders with her. The surveyor asked the RN what the physician's order was for oxygen. The RN stated, 2 liters. The RN stated that she would change the setting on the oxygen concentrator back to 2 LPM. The surveyor reviewed Resident #42's hybrid medical record which revealed the following: The Admission Record which included that the resident was admitted to the facility with diagnoses that included but were not limited to Fracture of Right Femur (a partial or complete break in the bone of the thigh) and Hypertension (high blood pressure). The resident's most recent quarterly Minimum Data Set (MDS), an admission record used to facilitate the management of care indicated that a Brief Interview for Mental Status (BIMS) score of 99 which indicated that Resident #42 was unable to complete the interview. The MDS indicated that the resident appeared to have an OK short-term and long-term memory. The MDS also indicated that Resident #42 used oxygen while a resident. A review of a 6/1/22 Progress Note written by the Nurse Practitioner indicated that Resident #42 had lung cancer and was dependent on oxygen. A further review of the Clinical Physician Orders indicated that Resident #42 had a 5/17/22 active order for Supplemental oxygen at 2LPM continuous via nasal cannula. On 6/13/22 at 1:18 PM, the surveyor expressed her concerns to the Licensed Nursing Home Administrator (LNHA) and DON. No additional information was provided. A review of the facility policy, Oxygen Administration with a review date of 10/12/21 indicated that licensed staff should check the physician's order for liter flow and method of administration and should check the oxygen flow rate on all residents on oxygen therapy during rounds and compare it against the physician's order at the start and at the end of each shift. NJAC 8:39-29.2(d)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31451 Based on observation, interview, and record review, it was determined that the facility failed to 1.) consistently ensure the Hemodialysis Reports were completed by both the facility and dialysis center; 2.) failed to assess residents returning from the dialysis center for any complications; 3.) follow physician's orders regarding management of medications. The deficient practice was observed for 2 of 2 residents (Resident #25 and #55) reviewed for dialysis care. The deficient practice was evidenced by the following: 1. On 6/6/22 at 12:40 PM, the surveyor observed Resident #25 seated at the dining room table waiting for the noon meal. The resident was pleasant when interviewed. The resident informed the surveyor that he/she goes to hemodialysis (a process of purifying the blood of a person whose kidneys are not working normally) every Tuesday, Thursday, and Saturday. The resident further stated that the pickup time was after lunch and returns to the facility between 5 PM and 6 PM. The surveyor reviewed Resident #25's hybrid medical records (paper and electronic, EMR) that revealed the following: According to the Admission Record, Resident #25 was admitted with diagnoses that included End Stage Renal Disease (ESRD). The Annual Minimum Data Set (MDS) an assessment tool dated 3/23/22, revealed that the facility performed a Brief Interview for Mental Status (BIMS) which indicated that the resident had a score of 14 out of 15. The resident was assessed to be cognitively intact. The June 2022 Order Summary Report revealed a physician's order for hemodialysis every Tuesday, Thursday, and Saturday. Chair time was scheduled for 2 PM and the resident was to be picked up at 1 PM. Resident #25 received hemodialysis by way of an access site called a permcath (a special intravenous line that is inserted into the blood vessel in the neck or upper chest). The Hemodialysis Report forms that the facility used to communicate with the dialysis center have two sections to be filled out when the resident goes to dialysis. The top portion revealed the resident's pre-dialysis vital signs (blood pressure, pulse, and respirations) and the remaining part of the form was designated for the dialysis center to document weights pre and post dialysis and any additional information. There were three dates on the Hemodialysis Report, 5/19/22, 5/26/22 and 6/2/22 that were not completed by the dialysis center. The Progress Notes located in the EMR were reviewed from 3/1/22 to 6/9/22 that revealed the nurses do not document when the resident leaves the facility for the dialysis center, do not consistently document the resident's return from dialysis, and do not document the assessment of the resident's access site (permcath) and obtain vital signs to ensure there was no complications. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was observed that during the months of March 2022; April 2022; all of May 2022 except for 5/26/22 where the nurse documented the resident returned from dialysis, however no assessment documentation; and from June 1-9, 2022, there was one entry on 6/2/22 that the resident was status post dialysis, no assessment of the access site included, nor vital signs were obtained. The care plan titled [the resident] Hemodialysis Dialysis r/t renal failure included an intervention to monitor intake and output. According to the Order Summary sheet, Electronic Medication Administration Record (EMAR) and Electronic Treatment Record (ETAR), there was no physician's order for monitoring intake and output and no documentation that intake and output was being monitored. The care plan does not include an intervention to monitor the resident's blood pressure and access site post dialysis. On 6/8/22 at 11:38 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that the Hemodialysis Reports are to be completed by the dialysis center before the resident returns to the facility. She stated that when the forms are not filled out, the center would be notified, and asked to fax over a copy of the report. LPN #1 stated they don't always send the copy to the facility. LPN #1 further stated that there was no process to do a post dialysis assessment when the resident returns from the dialysis center. She stated that we look at the resident and they look fine. LPN #1 confirmed that the resident returned from the dialysis center between 6:30 PM - 6:45 PM. On 6/13/22 at 1:00 PM the surveyor spoke with LPN #1 and asked her where the intake and output was documented for Resident # 25. LPN #1 said there was no physician's order for intake and output and it should not have been on the care plan to document the intake and output. She said it was an error. 31656 2. On 6/7/22 at 10:25 AM, the surveyor observed Resident #55 sleeping in bed in their room. The surveyor could not interview Resident #55. The surveyor interviewed LPN#2, who was assigned to care for Resident #55. LPN#2 informed the surveyor that Resident #55 goes to hemodialysis on Tuesday, Thursday, and Saturday at approximately 2:00 PM. LPN#2 explained that Resident #55 had recently returned from the hospital, where he/she underwent a surgical procedure to create an arteriovenous (AV) graft site (preferred access used for dialysis) on the right arm for dialysis access. Since the AV graft was not yet usable, Resident #55 was still receiving hemodialysis through their permcath. The surveyor reviewed Resident #55's hybrid medical records that revealed the following: According to the Admission Record, Resident #55 was admitted with diagnoses that included ESRD with dependence on renal dialysis. The Admission MDS dated [DATE], revealed that the facility performed a BIMS which indicated that the resident had a score of 12 out of 15. The resident was assessed to be moderately impaired. The June 2022 Order Summary Report revealed a physician's order for hemodialysis every Tuesday, Thursday, and Saturday at 2:00 PM. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/7/22 at 11:20 AM, the facility presented three Hemodialysis Report forms that the facility used to receive communication from the dialysis center for Resident #55. The dates included on the Hemodialysis Reports were 5/26/22, 6/2/22, and 6/4/22 completed by the dialysis center. The forms lacked any information post dialysis once the resident returned to the facility. On 6/7/22 at 11:30 AM, when the surveyor inquired about any previous Hemodialysis Reports, the Registered Nurse (RN) on the unit, explained that all previous forms were lost. The RN revealed that when Resident #55 was transferred to the hospital on 5/26/22, the dialysis book (which included all the previous forms) was lost. The RN added that when a resident returns to the facility vitals and Permcath port check should be evaluated as well as documented on the Hemodialysis Report form. The Progress Notes (PN) referring to Resident #55 located in the EMR were reviewed from 4/22/22 to 6/7/22. The PN revealed that the nurses did not document the assessment of the resident's vital signs when the resident returns from dialysis, to ensure there were no complications. It was demonstrated that during the months of April 2022 except 4/23/22 and 4/30/22; May 2022 except for 5/21/22 and 5/27/22 there were no documented assessments of vitals when Resident #55 returned from dialysis. It was indicated that from June 1-7, 2022, there were no documented assessments of vitals when Resident #55 returned from dialysis. The care plan area titled Hemodialysis r/t ESRD reviewed, specified Monitor VITAL SIGNS prior and upon returning from dialysis. Notify MD (Medical Doctor) of significant abnormalities. Review of the Dialysis Management Policy with a revision date of 1/1/2022 stated The [facility name] has designed and implemented processes which strive to ensure the comfort, safety, and appropriate management of hemodialysis residents. Included in the body of the Dialysis Management Policy were these Procedures: 5. Assure facility completed dialysis communication form accompanies resident to dialysis on treatment days, to communicate resident information and coordinate between dialysis center and facility. 6. Dialysis center personnel to complete dialysis communication form and return to facility. 7. Upon return from dialysis center, review information provided on dialysis communication form. Communicate and address as appropriate. Complete post-dialysis information and place in resident's medical record. 8. Post-dialysis, assess access site. Document bleeding, pain, redness, and swelling. 10. Obtain resident's dry weight from dialysis center, post treatment. 11. Maintain fluid restrictions, as ordered. Record intake if fluid restriction is ordered. On 6/9/22 at 1:45 PM the surveyors discussed the above concerns with the Administrator and Director of Nursing who could provide any further information or explain why the required information and documentation was missing. NJAC 8:39 - 27.1(a)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 19106 Based on interview and record review, it was determined that the facility failed to ensure that the residents' primary physician signed and dated monthly physician orders to ensure that the residents' current medical regimen was appropriate. This deficient practice was observed for 13 of 17 residents (Residents 4, 35, 28, 62, 55, 43, 47, 53, 61, 51, 41, 42, 32) reviewed and occurred over several months. This deficient practice was evidenced by the following: The surveyors reviewed the hybrid medical records (paper and electronic) for the residents listed above that revealed the residents' primary physician had not hand signed the Order Summary Reports (monthly physician's orders) located in the residents' chart. In addition, there were no electronic signatures under the physician's orders for the following residents. 1. The hybrid medical records of Resident #4 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for April 2022 and May 2022. 2. The hybrid medical records of Resident #35 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for March 2022, April 2022, and May 2022. On 6/8/22 at 11:26 AM, the surveyor interviewed the unit Registered Nurse/Infection Preventionist (RN) regarding the location of physician signatures for monthly physician's orders. The RN stated the physician signs the monthly orders on the paper record. 39399 3. The hybrid medical records of Resident #28 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for March 2022, April 2022 and May 2022. 4. The hybrid medical records of Resident #62 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for March 2022, April 2022, and May 2022. 31656 5. Resident #55's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for April 2022, May 2022, and June 2022. 46049 6. The hybrid medical records of Resident #47 revealed the resident's physician had not hand signed or electronically signed the physician's orders for March 2022, April 2022, and May 2022. 7. The hybrid medical records of Resident #43 revealed the resident's physician had not hand signed or electronically signed the physician's orders for March 2022, April 2022, and May 2022. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	44605 13. The hybrid medical records of Resident #53 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for February 2022, March 2022, April 2022 and May 2022. 45759 8. Resident #51's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for March 2022, April 2022, and May 2022. 9. Resident # 61's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for March 2022, April 2022, and May 2022. 26420 10. Resident #41's medical record revealed the resident's physician had not hand sign or electronically sign the monthly physician's orders for March 2022, or April 2022. There was no Physician's Order Sheet (POS) in the medical record for May 2022. 44834 11. Resident #32's hybrid medical records revealed the resident's physician had not hand sign or electronically sign the monthly physician's orders for March 2022, April 2022, and May 2022. 12. Resident #42's hybrid medical records revealed the resident's physician had not hand sign or electronically sign the monthly physician's orders for March 2022, April 2022 and May 2022. On 6/8/22 at 11:26 AM, the surveyor interviewed Licensed Practice Nurse (LPN #1) assigned to Floor C about where the physicians sign the orders for residents. LPN #1 stated the physicians usually sign in the resident's electronic chart. On 6/8/22 at 1:59 PM the surveyor interviewed LPN #2 assigned to Floor A, and asked when the physician came in to sign the physician's orders and how they signed the orders. LPN #2 said when the physician came in he signed the paper chart but he hadn't been in for a while. The surveyor showed LPN #2 the POSs for March and April (May wasn't in the chart) and that they were not signed. LPN #2 said she knew the Director of Nursing (DON) asked the doctor to come in and sign his orders recently. On 6/15/22 at 10:07 AM, the surveyor interviewed the Director of Nursing (DON) regarding the signing and location of physician signatures for monthly physician's orders. The DON stated the physician signs the monthly orders on the paper record. A review of the facility's policy titled Physician's Order dated 6/12/22 under Procedure #3 reads; The physician's order will be reviewed and signed by the physician monthly. All physicians' providers are given access in the EHR for electronic signature. If the physicians choose to do paper monthly review the 11-7 nurse will print the monthly POS at the end of the month and will be placed in the doctor's folder for signature monthly. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	NJAC 8:39-23.2

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 46049 Based on observation and interview of facility staff it was determined that the facility failed to ensure that the daily posting of licensed nurses and certified nursing assistant staffing, and the resident census, was posted daily at the beginning of the shift. This deficient practice was observed on 2 days of the survey and was evidenced by the following: On 6/6/22 and 6/7/22, the surveyor did not observe the Nursing Home Resident Care Staffing Report posted in the facility. On 6/8/22 at 1 p.m., the surveyor asked the Director of Nursing (DON) where the staffing report was posted. The DON stated he would find out and then directed the surveyor to the Staffing Coordinator about the staffing report. On 06/08/22 at 1:07 PM., the surveyor interviewed the Staffing Coordinator about where the staffing report was posted. The Staffing Coordinator brought the surveyor to the location where the staffing report would have been posted. The area was only accessible to staff and the Nursing Home Resident Care Staffing Report was not observed posted. The Staffing Coordinator stated they were unable to print out the staffing report and had tried calling the State for assistance. The Staffing Coordinator stated when the issue started, she informed the Administrator who directed her to contact the State. The Staffing Coordinator stated the State helped her with her access to the system, but she was still not able to print the staffing report. The Staffing Coordinator stated that prior to not being able to print the staffing report, she would post the staffing report in the location shown to the surveyor. On 6/8/22 at 2:02 PM, the staffing coordinator could not provide any email correspondence with the State. The staffing coordinator further stated that a Human Resources staff member helped with the issue of printing and that she was now able to print the staffing report. The staffing coordinator stated the issue of not being able to print report began two to three weeks ago. The staffing coordinator acknowledged the staffing report should be in a visible area of the facility for everyone to see and stated the staffing report would now be posted at the reception desk in the main lobby. On 6/16/22 at 11:30 a.m., the surveyor informed the Administrator and DON regarding concerns with the posting of the Nursing Home Resident Care Staffing Report. There was no additional information provided. NJAC 8:39-41.2

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cranford Park Care	600 Lincoln Park East Cranford, NJ 07016

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 31656 Based on observation, interview, and record review, it was determined that the facility failed to ensure required monthly visits by the Consultant Pharmacist (CP) in May 2022. This irregularity was identified for 14 of 15 residents reviewed by the survey team, Resident #4, #13, #28, #32, #35, #41, #42, #43, #45, #47, #51, #53, #61, and #62. The deficient practice was evidenced by the following: On 6/13/22 at 10:02 AM, the surveyor requested CP monthly reports for March, April, and May 2022 from the Director of Nursing (DON). The DON informed the surveyor that there were no CP reports for the month of May 2022. The DON submitted CP reports dated 3/30/22 and 4/30/22 to the surveyor. On 6/13/22 at 10:15 AM, the surveyor interviewed the facility Administrator (LNHA) who stated that the CP did not perform a Medication Regimen Review or Unit Inspection in May 2022. The LNHA could not explain why the CP had not visited the facility in May 2022. On 6/15/22 at 11:15 AM, the surveyor interviewed the Regional CP who explained that there were some financial issues which caused the absence of the May 2022 Medication Regimen Review (MRR) and Unit Inspection of the facility. The Regional CP stated that these issues were discussed with the LNHA in May 2022 but were not resolved until June 2022, causing the omission of May 2022 CP review of the facility. The surveyor interviewed the Regional CP in reference to the entries noted on the CP Evaluation sheet indicating 5/2022 no recommendations. The Regional CP explained that these were late entries, documented on 6/7/22 when the CP performed the MRR for June 2022. The Regional CP explained that the CP performing the MRR for the facility should have indicated that it was a late entry for May 2022 and performed in June 2022. 1. The surveyor reviewed Resident #4's Face Sheet (FS) (A one-page summary of important information about a patient) that listed the resident's diagnosis which included but was not limited to Hypertension, Anxiety, Depression and Cerebral Infarction. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. 2. The surveyor reviewed Resident #13's FS that documented the resident's diagnosis which included but was not limited to Hypertension, Heart Failure, Chronic Atrial Fibrillation and Diabetes Mellitus. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. The surveyor reviewed Resident #28's FS that documented the resident's diagnosis which included but was not limited to Dementia, Hypertension, Psychosis and Acute Emboli's / Thrombosis. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. 4. The surveyor reviewed Resident #32's FS that documented the resident's diagnosis which included but was not limited to Acute Respiratory Failure, Depression, Dementia, and Osteoporosis. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. 5. The surveyor reviewed Resident #35's FS that documented the resident's diagnosis which included but was not limited to Hypertension, Diabetes Mellitus, and Emboli's / Thrombosis. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. 6. The surveyor reviewed Resident #41's FS that documented the resident's diagnosis which included but was not limited to Hypertension, Dementia, Hyperlipidemia and Acute Respiratory Failure. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. 7. The surveyor reviewed Resident #42's FS that documented the resident's diagnosis which included but was not limited to Hypertension, Fracture of right femur and muscle weakness. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. 8. The surveyor reviewed Resident #43's FS that documented the resident's diagnosis which included but was not limited to Fracture of right femur, Depression, Anxiety, and Hypotension. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. 9. The surveyor reviewed Resident #45's FS that documented the resident's diagnosis which included but was not limited to Cerebral Infarction, Depression, Hypertension, and Diabetes Mellitus. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. 10. The surveyor reviewed Resident #47's FS that documented the resident's diagnosis which included but was not limited to Congestive Heart Failure, Depression, Hypertension, Chronic Kidney Disease and Diabetes Mellitus. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11. The surveyor reviewed Resident #51's FS that documented the resident's diagnosis which included but was not limited to Dementia, Depression, Hypertension, and Diabetes Mellitus. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. 12. The surveyor reviewed Resident #53's FS that documented the resident's diagnosis which included but was not limited to Respiratory Failure, Anxiety, Hypotension, and Gastrostomy. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. 13. The surveyor reviewed Resident #61's FS that documented the resident's diagnosis which included but was not limited to Alzheimer's Disease, Depression, Hypertension, and Diabetes Mellitus. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. 14. The surveyor reviewed Resident #62's FS that documented the resident's diagnosis which included but was not limited to Gastrostomy, Epilepsy, Hypertension, and Dementia. Review of the CP Evaluation sheet revealed documentation by the CP monthly from 12/22/21 to 4/30/22. An entry was made for 5/2022 no recommendations, which was not an indication of a May 2022 MRR by the CP, but rather a late entry from the CP MRR performed on 6/7/22. NJAC 8:39 - 29.3 (a 1, 6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 31656 Based on observation, interview, and record review it was determined that the facility failed to properly remove expired medications and medications with shortened expiration dates (expired). This deficient practice was observed in 1 of 2 medication carts inspected and in the back up storage area, as evidenced by the following: On 6/6/22 at 10:10 AM, the surveyor inspected Unit C, medication cart and the findings were as follows: 1. The surveyor noted insulin Levemir 100 units/milliliter (u/ml) which was delivered to the facility for Resident #36 on 4/10/22 from the provider pharmacy. The documented opening date for the Levemir 100 u/ml 10 ml bottle was 4/19/22. Levemir 100 u/ml insulin has a 28 day expiration date once opened. This would have deemed this medication to have been expired after May 16, 2022. 2. The surveyor noted insulin Levemir 100 units/milliliter (u/ml) which was delivered to the facility for Resident #41 on 4/8/22 from the provider pharmacy. The documented opening date for the Levemir 100 u/ml 10 ml bottle was 4/13/22. Levemir 100 u/ml insulin has a 28 day expiration date once opened. This would have deemed this medication to have been expired after May 10, 2022. 3. The surveyor noted a Fluticasone Propionate and Salmeterol Inhalation 100 mcg/50 mcg dated opened on 11/14/21 for Resident #12. Review of the April, May and June 2022 Physician's Orders revealed that there were no current orders for this medication for Resident #12. On 6/6/22 at 12:12 PM the surveyor informed the Director of Nursing (DON) of the findings. The DON stated that insulin has a 28 day expiration. The insulin should have been removed from the medication cart and replaced with new insulin. When the surveyor informed the DON of the Fluticasone Propionate and Salmeterol Inhalation 100 mcg/50 mcg, the DON stated that this medication was discontinued a long time ago and should have been removed from the medication cart and discarded. On 6/9/22 at 11:08 AM, the surveyor accompanied the Housekeeping Director to the back up storage area and several medications were found to be expired: 1. 2 x 42 Omeprazole 20 mg expired 9/2021 2. 1 x 100 Vitamin B6 50 mg expired 4/22 3. 3 x 100 Vitamin D3-50 50,000 International Unit (IU) expired 4/21 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/8/22 at 1:15 PM, the issue was presented to the Administrator and DON. There was no further information supplied by the facility in response to the abnormalities presented. On 6/15/22 at 11:15 AM, the surveyor interviewed the Regional CP who explained that there were some financial issues which caused the absence of a May 2022 Unit Inspection of the facility. The Regional CP explained that the Consultant Pharmacist performed unit inspections at the facility on 4/28/2022 and then again on 6/6/2022. On 6/16/22 at 8:40 AM, the surveyor received the policy and procedure for Expired Non-Narcotic Medications and OTC (P&P). The policy part of the P&P states, To ensure that expired non-narcotic medications and over the counter medications (OTC) are appropriately destructed. The procedure part of the P&P states, 1. 11-7 shift nurses will check med carts and med rooms to any expired non-narcotic medications and OTC medications that are expired. 3. The expired meds will be destructed by two nurses using the drug buster. On 6/15/22 at 1:15 PM, the issues were once again presented to the Administrator and DON. There was no further information supplied by the facility in response to any of the abnormalities presented. NJAC 8:39- 29.4(b)2

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34421 Based on observation, interview, record review and policy review, it was determined that the facility failed to store potentially hazardous foods in a manner to prevent food borne illness. This deficient practice was evidenced by the following: On 6/6/22 at 10:50 AM, in the presence of the Food Service Director (FSD) the surveyor observed the following: 1. In the dry storage area, the surveyor observed a random sampling of dented cans which were in rotation for use. The surveyor observed the following: - Six #10 sized cans of mixed fruit with 1-inch sized dents on the upper lip, - Two #10 sized can of mixed fruit with 2-inch sized dents on the body of the cans, -One #10 sized can of mandarin oranges with a 1-inch sized dent on the upper lip of the can, -One #10 sized can of mandarin oranges with a 2-inch sized dent on the upper lip of the can, -One #10 sized can of sliced beets with 4-inch sized dents on the body of the can, 2. In the walk-in refrigerator, the surveyor observed 24 raw shell eggs in an egg carton which was on a shelf located directly above a container of cooked, hard-boiled eggs. The FSD stated that the raw eggs should not have been stored above any cooked food items. 3. On another shelf in the walk-in refrigerator, the surveyor observed a 1/2 full bottle of Texas sauce with an open dated of 3/28/22 and a 1/2 full bottle of Barbeque sauce with an open date of 5/25/22. The FSD stated that these items should not be on shelf and should have been discard after 14 days of them being opened. 4. The surveyor opened the ice machine lid and inspected the inside. The surveyor observed a brown and black colored substance on the plastic barrier flat inside the ice machine, which was touching the ice inside the machine. The FSD stated that the plastic barrier flat should have been clean. The FSD stated that she usually inspects the ice machine each day and forgot to check it today. On 6/9/22 at 2:00 PM, the surveyor discussed the above concerns with the Administrator and the Director of Nursing. The surveyor reviewed the facility's updated policy and procedure titled Food Storage. The policy indicated to store cooked foods above raw foods to prevent contamination and all foods should be covered, labeled and dated and will be consumed by their safe use by dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the facility's updated policy and procedure titled Production, Storage and Dispensing of Ice. The policy indicated that ice will be produced, stored and dispensed in a manner to avoid contamination. The procedure indicated that the ice dispenser will be cleaned inside and outside at least monthly and/or as needed. NJAC 8:39-17.2(g)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45759 Based on observation, interview, and record review, the facility failed to maintain a complete and accurate record related to code status and allergies for 2 of 21 residents reviewed for medical records (Residents #61, and #45), as evidenced by the following: 1. On 6/8/22 at 9:45 AM, the surveyor observed Resident #61 seated in a chair and watching television in the resident's room. A review of the resident's hybrid medical record revealed the following information: The Admission Record revealed that Resident #51 was admitted to the facility on [DATE] with diagnoses that included but not limited to Type 2 Diabetes Mellitus Without Complications (High Blood Sugar) and Alzheimer's Disease (A brain disorder that causes problems with thinking, memory, and behavior). The Quarterly Minimum Data Set (QMDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 6 out of 15, which indicated that the resident had severe cognitive deficit. On 6/14/22 at 1:00 PM, upon reviewing Resident #61's code status in the physician's orders and dashboard in the resident's Electronic Medical Record (EMR), a DNR/DNI (Do Not Resuscitate/Do Not Intubate) order dated 3/15/22 and a Full Code (If a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive) order dated 2/2/22 were both in place. A review of A New Jersey Practitioner Order for Life-Sustaining Treatment (NJ POLST) DNR/DNI form dated 3/28/22 was in the resident's physical chart. On 6/14/22 at 1:37 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) and asked her where she would check for a resident's code status. The LPN stated, I would look in [the electronic record] first. It usually has the most up-to-date code status information. The LPN further stated that if she is unable to locate a resident's code status in the EMR, she checks the resident's physical chart. When the surveyor showed the LPN the active Full Code and DNR/DNI orders in Resident #61's EMR, the LPN acknowledged that there were two conflicting active code statuses in the resident's EMR. The LPN stated, It looks like [the resident] came in with a full code, and a month after there's an order for DNR/DNI and they didn't discontinue the Full Code order. The LPN acknowledged that there should not have been two different active code statuses in the resident's EMR. No other information was provided. 41679 2. On 06/07/22 at 11:36 AM, the surveyor observed Resident #45 seated in a chair well-groomed and watching television in the resident's room. A review of the resident's hybrid medical record revealed the following information: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Record revealed that Resident #45 was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction due to unspecified occlusion or stenosis of unspecified Cerebral Artery, SL Major Depressive Disorder, Recurrent, Moderate, Essential Primary Hypertension, Type 2 Diabetes Mellitus Without Complications (High Blood Sugar), Hyperlipidemia (Unspecified), and Unspecified Glaucoma. The QMDS dated [DATE] revealed a BIMS score of 9 out of 15, which indicated that the resident had severe cognitive deficit. The hybrid medical record did not contain a POLST when checked on 06/07/22 at 11:36 AM. The current comprehensive care plans included a care plan for a POLST with instructions for full code status and the provision of artificial fluids if necessary. The EMR dashboard identified the resident was listed as a FULL CODE not a DNR. The EMR dashboard identified the resident as having No Known Allergies. The physical (paper) medical record was reviewed. The medical binder had 2 stickers attached - a red and black sticker identifying the resident as DNR and a sticker identifying the resident as Allergic to Sulfa Antibiotic. The surveyor interviewed the Administrator on 06/08/22 at 1:35 PM regarding the POLST who confirmed that the POLST should have been in the hybrid medical record. On 6/10/22, the POLST was completed by the Certified Social Worker and placed in the hybrid medical record. On 6/14/22 at 10:50 AM, the surveyor interviewed the RN assigned to the resident and asked where she would check for a resident's code status and any known allergies. The RN stated that she would always look in the EMR first. The RN checked EMR and confirmed that Resident #45 was FULL CODE and No Known Allergies. The surveyor asked what the process would be if the computer was down. The RN stated she would check the resident's physical chart. When the surveyor showed the RN the DNR sticker and the Allergy sticker for Sulfa Antibiotic in Resident #45's physical chart, the LPN acknowledged that there were two conflicting code statuses in the resident's EMR and the physical chart. The RN stated the stickers on the physical chart should have been removed when recycled for the new resident. The RN acknowledged that there should not have been two different code statuses between the resident's EMR and physical chart. The RN stated medical records is responsible for building the new charts. On 06/14/22 at 11:16 AM the Admissions Director (AD) was interviewed and asked about the chart process, AD stated the chart is made up by her but with basic information about the resident. The surveyor advised the AD of the DNR and Allergy stickers on a physical chart for Resident #45 and that the EMR had FULL CODE and No Known Allergies. The AD stated the receptionist takes off the stickers and there was an issue with the last receptionist not following the process and was let go because of it. On 6/14/22 at 3:19 P.M., the Administrator and the Director of Nursing provided the surveyor with paperwork that the chart had been changed from DNR/Sulfa Allergy to a FULL CODE/No Known Allergies. The DNR and Sulfa stickers were removed from the chart. The surveyor observed the resident's chart with the corrected code status 6/15/22 at 11:00 AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/14/22 at 2:41 PM, the surveyors discussed the concerns on the conflicting physician orders of the code status and allergies in the resident's EMR with the administrator and his administrative staff. The Director of Nursing/Registered Nurse (DON/RN) acknowledged that there should not have been two different active code statuses in the resident's EMR and that the Full Code order should have been discontinued when the DNR/DNI order was in place for the resident. He additionally stated the resident's allergies should be consistently documented throughout the electronic and paper charts. On 6/15/22 at 8:57 AM, the surveyor reviewed the facility policy, Code Status Documentation Policy with a revised date of 6/12/22 and revealed under Policy: To resident's code status will be accurately documented to ensure that information is accessible to health care provider during emergency to avoid delay of treatment. Procedure: 1. Code status will be documented in the EHR and physical chart. 3. The nurse will ensure that a physician's order is obtain for the code status. 4. The social worker must audit the code status monthly to ensure that the information is accurate and will update when necessary. Updated information for any changes will be communicated to the nurse to ensure that physician's order will reflect the changes. NJAC 8:39-23.2 (a)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cranford Park Care	600 Lincoln Park East Cranford, NJ 07016

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34421 Based on observation, interview, and record review, it was determined that the facility failed to follow appropriate measures to prevent and control the spread of infection for: a.) improper use personal protective equipment (PPE), b.) improper hand hygiene during kitchen tour, c.) improper hand hygiene during a pressure ulcer treatment, and c.) improper storage of a urinary drainage bag. The deficient practices were evidenced by the following: 1. On 6/6/22 at 9:05 AM, upon entering the facility, the surveyor observed a Receptionist wearing a cloth face mask, the surveyor asked what kind of mask should be worn and the Receptionist stated she is not sure and will ask her Supervisor. At 10:50 AM, the surveyor inspected kitchen with the Food Service Director (FSD). In the food preparation area, the surveyor observed Food Service Worker (FSW) # 1 and FSW # 2 with surgical face masks worn under their chins and not covering their mouth and nose. The surveyor observed FSW # 1 pull her surgical mask up over her mouth and nose and with gloved hands, she grabbed a sheet pan of food and placed it inside an oven. The surveyor interviewed FSW#1 and FSW # 2 regarding face mask no worn over their mouth and nose and they both stated that they should have worn the mask correctly over their mouth and nose. FSW # 2 stated that she should have removed her gloves and washed her hands after touching her surgical mask. At 11:05 AM, the surveyor observed the FSD put soap on her hands and lathered her hands for 3 seconds, then she rinsed off her hands under running water. The surveyor asked the FSD how her hands should have been washed and she stated that she should have lathered her hands for 20 seconds. The FSD rewashed her hands and this time she only lathered the soap on her hands for 10 seconds then rinsed her hands under the water. The surveyor asked her why she only lathered for 10 seconds and the FSD stated that she must have counted to 20 too fast. On 6/9/22 at 2:00 PM, the surveyor discussed the above concerns with the Administrator and the Director of Nursing (DON). The surveyor reviewed the facility's Outbreak Management Checklist for COVID-19, dated 12-17-21, which revealed that cloth face coverings are not personal protective equipment and are not appropriate substitutes for a surgical mask or respirator. 19106 2. On 6/06/22 at 12:09 PM the surveyor observed Resident #4 awake and alert in bed watching television. On 6/07/22 at 9:45 AM the surveyor interviewed the unit RN/Infection Preventionist (RN). The RN stated the resident had multiple pressure and vascular ulcers. On 6/10/22 at 6:43 AM the surveyor observed the unit Licensed Practical Nurse #6 (LPN #6) perform a pressure ulcer treatment for Resident #4. The LPN and surveyor reviewed the physician's order for the treatment. LPN #6 handwashed according to the facility policy. The clean field was set up on the resident's over bed table with no concerns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the course of the treatment the LPN donned and doffed gloves 3 times without performing hand hygiene after doffing gloves, as follows: The LPN removed the soiled pressure ulcer dressing with gloved hands, removed the gloves and donned clean gloves without performing hand hygiene. LPN #6 then cleansed the wound without having washed her hands prior to donning gloves. The LPN removed her gloves and donned new gloves without performing hand hygiene. The LPN applied medicated gauze to the pressure ulcer without having performed hand hygiene before donning the new gloves. Wearing the same gloves, LPN #6 removed a pen from her uniform pocket, wrote the date on the topper dressing, placed the pen back into her pocket, and applied the topper dressing to the wound. LPN #6 doffed and donned new gloves without performing hand hygiene. Upon completion of the pressure ulcer treatment, LPN #6 performed hand washing according to the facility policy. The surveyor discussed with LPN #6 the concerns regarding changing gloves without performing hand hygiene and storing a pen used during the treatment in her pocket. She verbalized understanding of the infection control breaches. A review of the hybrid medical record revealed the following information. The June 2022 Order Summary Report included a 4/9/22 treatment order for a sacral wound. The order read cleanse the wound with saline, apply a single layer of Xeroform and apply a dry dressing every night shift. The 2/11/22 quarterly Minimum Data Set (MDS) assessment tool indicated the resident had 1 pressure ulcer and 2 venous or arterial wounds. The 5/4/22 wound care plan addressed multiple pressure and vascular wounds present on admission. On 6/14/22 at 1:45 PM the surveyor discussed with the Administrator and his administrative staff the infection control breaches related to hand hygiene and the storage of pens used during treatments. On 6/14/22 the surveyor reviewed the facility policy Wound Ulcer Treatment, revised 1/28/22. The policy indicated staff must perform hand hygiene after removing gloves. The policy did not address storing pens used for treatments in staff pockets. 3. On 6/06/22 at 11:26 AM the surveyor observed Resident #35 alert and awake in bed. At that time the surveyor observed an uncapped urinary drainage collection bag placed on a paper towel on the bathroom sink in the resident's bathroom. On 6/07/22 at 12:57 PM the surveyor observed an uncapped collection bag placed on the resident's bathroom sink. On 6/07/22 at 2:07 PM The surveyor accompanied the CNA #10 into the residents bathroom and confirmed the placement of the uncapped collection bag. CNA #10 stated she didn't leave it like that. She stated she was in the bathroom earlier and didn't notice it. She said it should be placed in a plastic bag or privacy bag when not in use. She did not state that the collection bag must be capped. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	06/07/22 at 2:10 PM the surveyor interviewed the RN. She stated stored urine collection bags must always be capped. The RN stated she will re-educate all of the CNAs . A review of the hybrid medical record revealed the following information. The June 2022 Order Summary Report included a 10/29/21 physician's order for the placement of a suprapubic indwelling urinary catheter. The 4/18/22 quarterly MDS assessment tool indicated the resident had 2 urinary-related diagnoses, neurogenic bladder and obstructive uropathy (Section I). The resident was noted to utilize an indwelling urinary catheter (Section H). The 5/4/22 urinary catheter care plan did not include interventions regarding the storage of urinary catheter drainage collection bags. On 6/14/22 at 1:45 PM the surveyor discussed with the Administrator and his administrative staff the infection control breaches regarding the storage of uncapped urinary catheter drainage collection bags. On 6/16/22 the surveyor reviewed the facility policy Catheter Care: Changing and/or Emptying Collection Bag, revised 5/8/18. Steps 10 and 11 of the policy specified the stored collection bag must be capped. 46049 4. On 6/7/22 at 11:45 AM, the surveyor arrived on the Floor A unit. The surveyor observed rooms with isolation bins by door with PPE supplies and signage that read stop please see nurse before entering. The surveyor interviewed LPN #3 about the residents on isolation on the unit. LPN #3 stated the residents on isolation precautions were new admissions or re-admissions and upon admission residents were placed on COVID-19 quarantine precautions for 14 days. The surveyor asked LPN#3 about the type of precautions taken for these residents. LPN#3 stated the residents were on contact and droplet precautions, and the staff were expected to wear gowns, gloves, N95 mask and face shield. On 6/7/22 at 11:50 AM, the surveyor observed CNA #3 exiting an isolation room wearing only a surgical mask. The surveyor interviewed CNA #3 about the isolation precautions for the resident in the room she just exited. CNA #3 stated the residents who come in as admissions were placed on precautions but could not say what type of isolation precautions the resident was on. The surveyor asked CNA #3 what PPE would be worn in the resident's room. The LPN stated gloves, gown, and mask should be worn. The surveyor asked CNA #3 what type of mask would be worn. CNA #3 stated she had been advised that a surgical mask was acceptable. She could not remember what staff person told her this. On 6/7/22 at 11:54 AM, the surveyor observed CNA #4 exiting an isolation room wearing a KN95 mask only. The surveyor interviewed CNA #4 about the isolation precautions for the resident in the room she just exited. The CNA stated the resident was on isolation. The surveyor asked about the PPE to be worn in the room. The CNA stated that before going into the room a gown, gloves, N95 mask, face shield, and foot covers were to be worn. CNA#3 further stated, I wanted to answer the call light for the resident .No, I didn't wear gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/7/22 at 12:05 PM, the surveyor interviewed LPN #3 regarding observations of the CNAs using inappropriate PPE for isolation rooms. The surveyor and LPN#3 observed CNA #5 exiting an isolation room only wearing a surgical mask. LPN #3 went to speak with CNA #5 about not using appropriate PPE. On 6/7/22 at 12:21 PM, the surveyor interviewed CNA #5 regarding an observation of exiting an isolation room. CNA #5 stated that the resident returned from the hospital and was on isolation. CNA #5 stated staff were expected to wear an N95 mask, gown, gloves, face shield and foot covers. The surveyor asked CNA #5 if she wore PPE besides surgical mask when she entered the resident's room and the CNA #5 replied, no. CNA #5 acknowledged she should have worn appropriate PPE, including an N95 mask, gown, gloves, and face shield when entering the isolation room. On 6/14/22 at 1:48 PM, the surveyor informed the Administrator, the DON, and the IP of the observed concerns. On 6/15/22 at 9:58 AM, the surveyor interviewed the IP about observed concerns of staff not using appropriate PPE entering rooms of residents on isolation. The IP stated isolation rooms have bins with PPE supplies by the door and signage on the door. The IP acknowledged staff entering rooms of residents on isolation should have donned full PPE, which includes a gown, N95 mask with surgical mask over it, face shield, gloves, and shoe covers if preferred, prior to entering the rooms. The surveyor reviewed the facility's policy titled Admission/Re Admission, dated 4/1/22, which read under Procedure, All new admissions/re admissions are placed in a single room and will be quarantined depending on the COVID test result and 3. Any resident that has been exposed in the hospital whether negative or positive will be quarantine for 14 days from date of admission. The policy did not specify the precautions for residents on quarantine. The surveyor reviewed the facility's policy titled, Infection Control Policy, dated 5/20/21, indicated that for residents on droplet precautions that a gown, gloves, N95 facemask, and goggles or face shield should be worn. 39399 5.) On 6/6/22 at 10:00 AM, prior to the initial tour at the nursing units. The facility's DON stated COVID-19 positive residents resided in Unit B. He stated that Unit B staff must wear a face shield or goggles and an N95 respirator mask when in the hallway. He further stated if there was a need to go inside a COVID-19 positive resident's room, staff must wear face shield or goggles, N95 respirator mask with surgical mask over, disposable gown and disposable gloves. On 6/6/22 at 10:42 AM, the surveyor toured Unit B with LPN #5 who stated that there were several residents on the unit that are positive for COVID-19. The surveyor observed that LPN #5 was only wearing a KN95 mask (similar to a N95 respirator mask but has ear loops and is made to meet Chinese standards of medical masks) while walking in the unit B hallway. The surveyor also observed CNA #8 in the hallway wearing only a surgical mask. The surveyor interviewed CNA #8 who stated she only needed to wear a surgical mask when in the hallway. CNA #8 further stated that when she enters a COVID-19 resident's room, she would need to don a KN95 mask. The surveyor interviewed CNA #8, asking if she was fit tested for an N95 mask. She stated she could not recall if she was ever fit tested for an N95 mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 11:14 AM, the surveyor observed a staff person inside the COVID-19 positive room while interacting with the resident. The staff person was wearing a disposable gown, gloves and a KN95 mask. At 11:40 AM, the surveyor observed the staff person come out of the resident's room with a used gown, proceed to remove the gown outside of the resident's door, and then went back inside the COVID-19 room to discard the used gown in the designated garbage bin. The surveyor interviewed the staff person who stated that he was one of the facility's Occupational Therapists (OT). The OT agreed that he was not wearing any face shield or goggles while inside the COVID-19 positive room while performing the therapy. 44834 6. On 6/6/22 at 10:41 AM, two surveyors toured the B Unit with the LPN # 5. The LPN # 5 stated to the surveyors that there were several residents who were COVID-19 positive on the resident care unit. The surveyors observed that LPN # 5 was wearing a KN95 mask. The surveyor asked what personal protective equipment (PPE) the LPN wore inside the rooms of residents who were COVID-19 positive. The LPN # 5 stated that COVID-19 positive residents were on transmission-based precautions (TBP) which are special measures that are put in place to prevent the spread of infection. The LPN # 5 stated that she wore PPE including a KN95 mask inside the COVID-19 positive rooms. The surveyor asked if the LPN # 5 was fit tested (a series of steps used to determine the suitability of a respirator mask for a specific user) for a N95 mask. The LPN # 5 stated that she was fit tested by the facility but that the facility does not have the mask for which she was fit tested . On 6/6/22 at 11:34 AM, the surveyor observed a sign on the door to resident room [ROOM NUMBER] which stated, Please see nurse before entering room. The surveyor observed CNA # 7 emerge from the resident's room wearing a 3M 9502+ N95 mask. The surveyor asked CNA # 7 if the resident whose room she came out of had COVID-19. CNA #1 stated that the resident did have COVID-19. The surveyor asked if she was fit tested for the N95 mask that she was observed wearing. CNA # 7 stated that she was fit tested by the facility but for a different N95 mask, and that this mask is more, breathable. The surveyor asked if one N95 mask could be substituted for another. CNA # 7 stated that, you should wear the mask you're fitted for. On 6/8/22 at 9:50 AM, the surveyor observed KN95 masks in a PPE caddy outside of room [ROOM NUMBER], a room with a COVID-19 positive resident. On 6/8/22 at 9:26 AM, the surveyor observed a sign on the door to resident room [ROOM NUMBER] which stated, Please see nurse before entering room. The surveyor observed CNA # 8 inside the resident room wearing a gown, gloves, and a surgical mask over a respirator mask. The surveyor did not observe that CNA # 8 was wearing eye protection while inside the resident room. On 6/8/22 at 10:00 AM, the surveyor interviewed CNA # 8 in the hallway. The surveyor observed that the respirator mask on CNA # 8 was a KN95 mask. The surveyor asked what CNA # 8 was wearing in the COVID-19 positive room. CNA # 8 stated that she was wearing a KN95 mask in addition to her other PPE. The surveyor asked if this mask was appropriate to wear in a COVID-19 positive room CNA # 8 stated that it was. The surveyor asked why CNA # 8 was not wearing eye protection. CNA # 8 stated that she did not see a face shield in the PPE caddy outside of the room, so she did not put one on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/8/22 at 10:58 AM, the surveyor interviewed the Infection Preventionist Nurse (IPN). The surveyor asked why there were KN95 masks inside of PPE caddies outside of the rooms of COVID-19 positive residents. The IPN stated that KN95 masks should be worn inside of COVID-19 positive rooms. The surveyor asked if staff were fit tested for these masks. The IPN stated that staff were not. The surveyor asked if staff should be wearing a mask that they are fit tested for inside the rooms of COVID-19 positive residents. The IPN stated, yes. On 6/9/22 at 10:07 AM, the Housekeeping Director (HD) accompanied three surveyors to the supply rooms for PPE. The surveyors observed numerous boxes of 3M 8511 N95 masks and numerous boxes of KN95 masks in the storage areas. The surveyor observed 7 boxes of 20 [NAME] L-188 N95 masks in the supply rooms. At this time the surveyors interviewed the HD. The surveyor asked the HD who was responsible to stock PPE on resident units. The HD stated that he was. The surveyor asked how he decided which masks were brought up to nursing units. The HD stated that until recently he did not know the difference between KN95 masks and the different types of N95 masks and that it was a mistake to bring KN95 masks up to the resident unit and to stock them inside PPE caddies outside of COVID-19 positive resident rooms. The surveyor asked if there were any more [NAME] L-188 N95 masks in storage in the facility aside from the 7 boxes of 20 masks observed by the surveyor. The HD stated that there were not. On 6/9/22 at 10:49 AM, the surveyor reviewed the facility's Qualitative Fit Test Record which indicated which employees were fit tested for which respirator mask. The record revealed that all employees including the LPN # 5, CNA # 7, and CNA #8 were fit tested for the [NAME] L-188 N95 mask. The record failed to reveal that any employees were fit tested for any other N95 mask including the ones that were stocked in the facility. On 6/9/22 at 10:52 AM, three surveyors interviewed the Licensed Nursing Home Administrator (LNHA). The LNHA stated that the manufacturer ran out of [NAME] L-188 N95 masks so they sent the 3M 8511 N95 masks instead. The LNHA stated that this switch happened a few weeks ago. The LNHA stated that the facility completed fit testing for the 3M 8511 N95 masks this week. On 6/9/22 at 11:50 AM, the surveyor viewed the facility's PPE Burn Rate Spreadsheet for 5/22/22- 6/4/22. The spreadsheet indicated that on 5/22/22 the facility had 45 boxes of KN95 masks and on 6/4/22 that the facility had 38 boxes of KN95 masks. The spreadsheet indicated in a row titled, other that 3M 1860 N95 masks were also counted by the facility. The spreadsheet failed to indicate that any N95 masks were used by the facility during this time. The consumption of KN95 masks by the facility in this time was on average 0. 54 cases per day. The consumption of 3M 1860 N95 masks was indicated by the spreadsheet as, no data. On 6/9/22 at 1:57 PM, the surveyor expressed her concerns regarding staff not wearing respirator masks that they were fit tested for, regarding staff observed not wearing proper PPE in COVID-19 isolation rooms, and regarding staff not being fit tested for the N95 masks that the facility stocked. On 6/14/22 at 12:55 PM, the surveyor observed CNA # 9 standing outside of a resident room [ROOM NUMBER] with a sign on it that read, Please see nurse before entering room. The surveyor observed that CNA # 9 was wearing a N95 mask with the straps of the mask tucked into the mask, not secured around his head or neck. The surveyor observed that CNA # 9 was wearing a surgical mask on top of his N95 mask, and that this mask was holding the N95 mask to his face. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At this time the surveyor observed CNA # 9 knock on the door to the resident's room. The resident came to the door and handed CNA # 9 their lunch tray. The resident stood in the doorway to their room and spoke with CNA # 9 for two minutes. CNA # 9 was within 6 feet of the resident during this time. On 6/14/22 at 1:42 PM, the surveyor interviewed CNA # 9. The surveyor asked if the resident was positive for COVID-19. CNA # 9 stated that the resident was. The surveyor asked if the resident should be out of their room and in the doorway. CNA # 9 stated that they should not have been. The surveyor described the way that she observed CNA # 9's mask while he was in the hallway speaking with the COVID-19 positive resident and asked him why it was worn like that. CNA # 9 stated that the mask broke while he was in another resident's room and that he did not yet have a chance to change it. The surveyor asked if the mask should have been worn like that. CNA # 9 stated that this was not the correct way to wear a mask and that he should have changed into a new one. On 6/14/22 at 1:58 PM, the surveyor expressed her concern about CNA # 9 to the LNHA and DON. The facility's Infection Control Policy with a revised date of 5/20/21 indicated that for residents on droplet precautions (the type of TBP used for COVID-19 positive residents) that a gown, gloves, N95 facemask, and goggles or face shield should be worn. N.J.A.C. 8:39-19.4(a)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure staff are vaccinated for COVID-19 34421 Based on observation, interview, and record review, it was determined that the facility failed to ensure that the Mandatory COVID-19 Vaccination Policy and Procedure was implemented to track and document the vaccination status for all facility staff. The deficient practice was evidenced by the following: On 6/9/22 at 9:30 AM, the surveyor reviewed the COVID-19 Vaccination Matrix (VM) that the facility provided. The VM revealed that there were 89 total staff employed. The VM revealed that 89 staff received the primary vaccination series for the COVID-19 immunization. Of the 89 staff, 86 staff were due for the booster dose, 3 staff were not due for the booster dose and only 35 staff received the booster dose. The VM revealed that 38 staff of the 89 were up to date with the vaccination requirement. The facility is at 42.7% compliance with the vaccination requirement. On 6/9/22 at 1:34 PM, the surveyor reviewed the National Healthcare Safety Network (NHSN) data regarding the facility reported percentage of fully vaccinated staff for the week ending 5/29/22. The facility reported the percentage of staff fully vaccinated was 100% and the percentage of boosted staff was 48.9%. On 6/9/22 at 12:55 PM, the surveyor interviewed a Licensed Practical Nurse (LPN), who was wearing an N95 mask. The LPN stated that she did not get her booster dose when she was due for it and did not explain why. The surveyor reviewed the facility policy and procedure titled Employee Covid Vaccination policy dated 4/16/22 which revealed that all staff members were mandated to have a Covid-19 booster to be up to date with the required vaccination by April 11, 2022, and staff who were not up-to-date with Covid 19 vaccination with no medical or religious exemption would be removed from the schedule until Covid vaccination mandate requirement was complete. On 6/9/22 at 2:00 PM, the surveyor interviewed the Administrator who stated that he was aware that there were staff who were not up to date with vaccination as their policy and regulations mandate. He stated that he could not take those staff members off of the schedule because he needed the staff since the facility was short-staffed. The Administrator stated that the facility had a plan to address this concern. NJAC 8:39-19.1(b); 19.4(a)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41679 Based on observation and interview, it was determined that the facility failed to provide 80 square feet per resident of living space in multi-bedded resident rooms. This was a repeat deficiency from the Recertification survey of 2019 as evidenced by the following: On 6/7/22 2:30 PM, the surveyor observed rooms #103, 109, 110, 111, and 203 were two bedded rooms. Rooms #103, 110, 111, and 203 were measured at 140 square feet instead of 180 square feet and room [ROOM NUMBER] was measured at 150 square feet instead of 160 square feet. The rooms were occupied by one resident with two beds in each room. The surveyor observed in rooms #104, 112, 204, 205, 209, 210, 211, and 212 were two bedded rooms. Rooms #104, 204, and 209 were measured at 150 square feet instead of 160 square feet. Also, rooms #112, 205, 210, 211, and 212 were measured at 140 square feet instead of 180 square feet. The rooms were occupied by two residents in each room. On 6/7/22 at 3:15 PM, the surveyor discussed the above concern with the Administrator and the Director of Nursing. The Administrator stated the rooms were only being used for single occupancy and when the new beds were delivered they were placed in the resident rooms mentioned above for storage. He further stated that the new beds were going to be moved into rooms when the old beds were removed. The Administrator had no response when the surveyor identified the rooms with two residents. On 6/14/22 at 11:28 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) assigned to room [ROOM NUMBER], who told the surveyor that the room was too small and it was too difficult to use the hoyer lift with two CNAs and two residents in the room at the same time. The facility indicated in their 2019 Plan of Correction the following the rooms are only to be occupied by one resident and no other residents would be admitted to the rooms. NJAC 8:39-31.1(d)