STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avant Rehabilitation and Care Center	1314 Brunswick Avenue Trenton, NJ 08638

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 Based on observation, interview, record review, and review of pertinent facility documentation, the facility failed to implement their abuse policy to investigate a.) an allegation of sexual abuse between two residents, b.) thoroughly and timely investigate allegation of verbal abuse, c.) thoroughly and timely investigate injuries of unknown origin identified for 4 of 6 residents reviewed for abuse (Resident #10, #56, #63, #65), and 1of 1 resident's (Resident #193) reviewed for hospitalization and was evidenced by the following: Refer to F600 and F684 On 08/10/22, multiple staff members observed on the locked nursing unit, Resident #63, a registered sex offender, exit Resident #10's room. Resident #10 had intellectual disabilities and was dependent completely on staff for Activities of Daily Living (ADLs). Resident #63 was reported to be happy, bobbing their head side to side while smiling with feces on both of their hands. Certified Nursing Aide (CNA #1) reported this observation was alarming and reported it to a Licensed Practical Nurse (LPN #1). CNA #1, LPN #1, and Behavioral Aide (BA #1) entered Resident #10's room and observed the bed curtain was open, the resident was lying in bed with the blanket pulled down, their hospital type gown was pulled up, and their incontinence brief was twisted and opened to one side with feces coming outside of the brief. Resident #10 was reported to be shaking and appeared nervous while saying, mommy, rape, and doctor. LPN #1 reported the incident to the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) who both failed to investigate and report the situation. Resident #10 remained on the locked nursing unit for two weeks with Resident #63 until Resident #10's room was changed on 8/25/22 by the DON since the resident reportedly did not need to be on a locked unit. Resident #63 remained on the locked unit with no additional monitoring and was free to roam around the unit and into other resident rooms. An interview with the LNHA revealed that the facility observed Resident #63 exit Resident #10's room on video surveillance footage, footage that was unable to be provided to the survey team. The LNHA stated that Resident #63 was only in Resident #10's room for six to seven minutes, and upon interview, Resident #63 stated he/she was in Resident #10's bathroom by mistake, the LNHA stated that was determined as plausible since LPN #1 was at some point inside Resident #10's room while administering medication and did not observe Resident #63. The LNHA concluded that no abuse had occurred, therefore, no investigation was required. On 09/27/22 at 11:02 AM, the surveyor reviewed the five investigations provided by the DON. None of which included the incident alleged by staff that occurred between Resident #10 and Resident #63. (continued on next page)

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/27/22 at 11:09 AM, the LNHA stated and confirmed that the surveyor had all of the facility investigations. The LNHA, upon inquiry, stated that he did not keep any soft files, but then stated there may be one or two reportables (mandatory facility reporting) and he would check. 27193 b. On 09/23/22 at 7:20 AM, while in the hallway, the surveyor (#2) overheard a loud verbal exchange that was occurring near the nursing station. While approaching the nursing station, the surveyor observed a resident [Resident #56] standing in the hallway facing the nursing station and was talking loudly. Then a female staff exited the nursing station and was yelling, screaming and pointing the finger as she walked toward Resident #56 and in the resident's face. The surveyor stood by the nursing station and observed the night nurse was directly facing the hallway, with an unobstructed view and where the verbal argument was taking place. A Certified Nursing Assistant (CNA#3) was sitting at the desk, a laundry staff was in the hallway, the medication nurse, a Registered Nurse (RN #1), all witnessed the incident, and none of the staff intervened. The resident was later identified by staff as Resident #56. Resident #56 approached surveyor #2 and stated, Can you help me, all I want is a diaper. The one that I had on would be wet in 2 hours. The surveyor informed TNA #4 of the resident's requested needs. TNA #4 then continued to argue with Resident #56 and remained in the hallway near the linen cart. TNA#4 did not provide the disposable incontinence brief to the resident. On 09/23/22 at 7:30 AM, surveyor #2 interviewed TNA #4 who was involved in the above incident. TNA #4 informed the surveyor that she had been working at the facility for the last 4 months. The surveyor inquired about any in-service education received on Dementia care, she acknowledged receipt of in-service education. The surveyor asked her to comment on the observed behavior witnessed in the hallway. TNA #4 stated that Resident #56 pointed fingers at her first because she did not allow Resident #56 to obtain a disposable incontinence brief from the linen cart that was parked in the hallway. In return TNA #4 stated she pointed the fingers back at him/her. TNA #4 stated there were no disposable briefs on the floor. On the morning prior to the above incident, Surveyor #2 entered the nursing station of the 300's Unit and observed a pack of disposable brief on the counter of the low side of the unit. Although TNA #4 stated there was no disposable incontinence brief on the floor, the pack of disposable incontinence briefs were still on the counter following the witnessed verbal altercation with TNA #4 and Resident #56. CNA #3 who was sitting at the nursing desk on the locked unit, stood up and provided a disposable incontinence brief to Resident #56. Resident #56 thanked CNA #3 and returned to his/her room. On 09/26/22 at 12:06 PM, Surveyor #2 met with the LNHA and the DON and requested the investigation for the incident of 09/23/22. Both indicated that they were not aware of the incident. 41858 c. Review of an additional Nursing Progress note documented by LPN #5, dated 07/04/22 at 3:08 PM, revealed; X-ray of right leg/foot complete awaiting results. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A Nursing Progress note (unidentified nurse), dated 07/04/22 at 8:38 PM, revealed x-ray of the right ankle was done, result was relayed to the nurse on call, that the pt. (patient) has an acute appearing malleolar fracture recommend; Ankle Series, dr (doctor) made aware of the fracture and the recommendation with new order to apply ace bandage, and an orthopedic and podiatry consult ASAP (as soon as possible), ace wrap bandage applied pt in bed, no actual swelling or warmness noted, no facial grimaces noted at this time, awaiting for the hard copy of the x-ray. A Radiology Report of the Foot-Right (3 Views) dated 07/04/22, revealed, Impression: Acute appearing medial malleolar fracture. The Physician's Orders revealed an order dated 07/04/22 at 8:19 PM, Treatment: apply ace wrap to right ankle daily only remove for care and an order dated 7/4/22 at 8:22 PM, for Consultation: pt to have an orthopedic appt for the fracture of right ankle ASAP. Nursing Progress note (unidentified nurse), dated 07/08/22 at 4:05 PM, revealed; Appointment made for Wednesday July 20 2022 at 930 am .Family has been made aware of appointment .Transportation needs to be made. Family may be able to accompany patient. Review of Nursing Progress (unidentified nurse) note, dated 7/11/22 at 10:41 am, revealed; Resident Transportation has been scheduled for apt (appointment) on 07/20/22. On 09/27/22 at 10:04 AM, Surveyor #3 interviewed CNA #4, who stated that Resident # 65 required total care from staff, and that you have to make sure the resident's hearing aides were in to communicate. She stated Resident #65 required two-person assistance with the use of a mechanical lift (mobility device used to help people with mobility challenges to get out of bed). When surveyor asked CNA #4 about the resident's right malleolar fracture, she stated the resident has never fallen but the resident had a cast recently from arthritis. CNA #4 stated that if there was a bruise or an injury of unknown origin, she would tell the nurse right away and would have to give a statement as to what was found and where it was. On 09/27/22 at 10:15 AM, Surveyor #3 interviewed LPN #6, who stated that an injury of unknown origin wound would have to be assessed by the nurse, the physician would be called, and the family notified. There would be an incident report completed, a three day look back for nurses aids and she would obtain statements from the nurse aides that had taken care of the resident. She stated that the findings would be listed on the 24-hour report. LPN #6 stated that Resident #65 required use of a mechanical lift with two persons to get out of bed. She stated she did not know how the right malleolar fracture had occurred but she knew the cast was taken off a few weeks ago. She stated there should have been an investigation started by the nurse caring for the resident when the injury was found. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/29/22 at 10:19 AM, Surveyor #3 interviewed LPN# 7, who stated that if there was an injury of unknown origin, there, should be an investigation which included going back 72 hours and getting statements from all staff that had come into contact with the resident. If possible, try to get information from the resident. Notify the supervisor, the family and the physician. There should be an incident report, a progress note and an investigation. The nurse should complete a full body check to make sure there were no other injuries underneath the clothing. LPN #7, who was assigned to Resident # 65 at the time of the interview, stated she did not know about the resident's recent right malleolar fracture. She further stated that Resident #65 was total dependence with ADLs and that there, absolutely should be an incident report and investigation from all staff that had contact with that resident for past 72 hours. Surveyor #3 asked LPN #7 the process for when a resident went to a physician visit. She stated the report of consultation form was sent with the patient, the nurse filled out the reason why the facility was sending the resident and the consulting physician should fill out findings and recommendations and send the form back with the resident. She further stated that the form should be in paper chart. At this time, Surveyor #3 requested LPN #7 to show the surveyor the consult from the orthopedic physician for 07/20/22. She was unable to locate the consult form or the physician's consult in the chart. She stated she would have to check to see if the chart was thinned. On 09/29/22 at 10:30 AM, Surveyor #3 interviewed CNA #4 in regards to Resident #65, she stated she was assigned to the resident at the time of the interview. She stated she knew the resident well. She stated the resident had a recent ankle fracture, but she didn't know how it happened. CNA#4 took the surveyor to Resident #65's room and showed the surveyor Resident #65's right ankle which was propped up on a pillow. A review of the orthopedic consults provided by the facility on 09/29/22, revealed a consult dated 07/20/22, Treatment: Non-displaced fracture of lateral malleolus of right fibula, initial closed fracture; Procedure: Orthotics, Cast BK NWB (below the knee, non-weight bearing) right. On 09/30/22 at 10:15 AM, Surveyor #3 interviewed Registered Nurse/Unit Manager (RN/UM) #1, who stated that if there was an injury of an unknown origin it would be initially investigated, an incident report would be done, interview who identified the injury, inspect the surroundings, written statements would be taken from all staff shifts going back 72 hours, the family and the physician would be notified. The incident would be discussed in morning meeting and depending on what the interdisciplinary team found, it would be reported to the New Jersey Department of Health (NJDOH). The family and the physician would be notified of the investigation results. 31654 d. Resident #193 sustained four falls including two falls that occurred on 08/20/21, and two falls that resulted in transfer to the emergency roiagnom on [DATE] and 09/24/21, which resulted in an acute, traumatic right subdural hematoma, which required an emergent craniotomy and neuro intensive care. There were no facility investigations. On 10/04/22 at 11:16 AM, the surveyor reviewed the entirety of the closed medical record for Resident #193 which was provided by the facility on 09/26/22 at 3:00 PM, and revealed the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dated 08/20 and timed at 4A[4:00AM], Fall #1, Resident found by aide on floor, on [his/he] back lying on R[right] side of bed, no visible injuries, denies pain, 2 assist transferred resident back to bed and push bed towards wall, monitored through the night and signed by a Licensed Practical Nurse (LPN #1). There was no documented evidence that a documented physical assessment was completed. Dated 8/20 and timed at 7A, 7:10A [7:00 AM, 7:10 AM], Fall #2 , after talking to daughter heard resident yelling out help me nurse, help me. Found [him/her] before has [sic.] bed sitting up on floor. Transfer back to bed and in w/c [wheelchair] out to nurses station No apparent injuries. Denies hitting [his/her] head and signed by LPN #1. There was no documented physical assessment for resident #193. A subsequent un-timed and un-dated NN revealed, MD [physician] to be informed later of falls and also [daughter] for fall #2 signed by LPN #1. A subsequent NN un-timed and dated 08/20/21 revealed resident received in the hallway sitting in [his/her] wheelchair, neuro checks (an evaluation to determine if the nervous system was impaired) initiated, no abnormal behavior, resident was compliant with adl [activities of daily living] care and meds [medications], vitals wnl [within normal limits], will continue to monitor signed by LPN #2. There was no documented evidence that the physician, or daughter were notified of the two falls that occurred on 08/20/21. Dated 09/01/21 and timed at 10:00 AM [Fall #3], Resident received awake and lying in bed. Around 8:30 A. M. was found by CNA [certified nurse aide] on the floor lying face down. The CNA noted writer and resident was observed lying face down. No visible injury or bruising. Resident remained in stable condition. Signed by LPN #2. A NN dated 09/01/21 and timed at 3:30 PM, Resident didn't return on the 7-3 shift and signed by LPN #2. Dated 09/24/21 [Fall #4] and then continued on another page titled Interdisciplinary Progress Notes (IPN) revealed, Date and Time: TC 7-3 (No specific time documented) which revealed this morning when one of the aide went into the residents room and found [him/her] laying on [his/her]back with [his/her] head slightly elevated, with vomit on [his/her] face, on the side of the bed and on [his/her] pillow. I called his/her [Doctor] and was told to send [him/her] to the E.R. [emergency room] [he/she] was transported to the E.R. at about 8 AM. [He/she] was sent with [his/her] face sheet and personal belongings and was signed by LPN. On 10/04/22 at 3:22 PM, the surveyor conducted and interview with the Director of Nursing (DON) and inquired if there were any incidents or investigations for Resident #123 and she stated she will inquire. On 10/04/22 at 4:18 PM, the surveyor, in the presence of another surveyor, inquired to the Licensed Nursing Home Administrator (LNHA) and Regional Licensed Nursing Home Administrator (RLNHA) if there were any investigations for Resident #193. The RLNHA stated no there were no investigations that the facility was aware of. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/05/22 at 9:56 AM, the surveyor interviewed the DON regarding what the process was if a resident sustained an injury of unknown origin. The DON stated it should be investigated and reported to the State. The surveyor inquired as to the documentation on 09/24/21 regarding Resident # 193. The DON stated, we should have done a skin check before they went out to the hospital. The DON stated she would want to know why the resident vomited. The DON stated, there should absolutely be specifics on the transfer sheet regarding the vomiting and how the resident was found, and the DON stated, it is imperative. The DON also stated she would get a statement from the CNA. The DON stated the hospital needed to know that information and she stated, I would expect to see any additional information related to the resident, it doesn't end [the resident] going out. The DON stated, I would want to know what happened and they have to notify the responsible party and the doctor. On 10/05/22 at 10:49 AM, the surveyor interviewed the LNHA, regarding what the process was for injuries of unknown origin. The LNHA stated there should be an investigation for injuries of unknown origin. On 10/05/22 at 3:57 PM, the RegionalAdministrator (RLNHA), in the presence of the Regional Nurse and DON, informed the surveyor that there were no investigations for Resident #193. The RLNHA stated she had checked with the DON to look through her office and there was also nothing from the LNHA. The RLNHA stated 100% there should be an investigation completed for all falls or unusual occurrences. On 10/05/22 at 4:05 PM, the surveyor inquired to the DON regarding any incidents, investigations or reportable events for Resident #193. The DON stated, I have nothing on Resident #193 and the DON stated that she and the LNHA could not locate any incidents or reportable event. The DON stated that Resident #193 vomited, and none of the information was found out, nothing was on the transfer note. The RLNHA stated she was not aware that Resident #193 had any falls and was unsure why the resident's belongings were sent to the hospital. At that time, the surveyor requested a timeline of events for Resident #193 from the RLNHA. On 10/06/22 at 10:00 AM, the RLNHA provided the timeline for Resident #193. The CLNHA stated that Resident #193 was transferred to the hospital on 07/30/21 due to a change in mental status and readmitted to the facility on [DATE]. The CLNHA confirmed the first falls occurred on 07/20/21 and there were no investigations completed, and no incident reports were completed regarding the 09/01/21 fall either. The RLNHA confirmed there was no documented nursing physical assessment for the two falls that occurred on 08/20/21 and the fall on 09/01/21. 10/06/22 at 10:31 AM, the RLNHA stated to the surveyor that with any injury of unknown origin, an incident report with statements and a full head to toe investigation should have been completed. The following facility provided policies were reviewed: Accidents-Occurrence Investigation revealed All accidents will be investigated, documented and reported to the New Jersey Department of Health as appropriate. Definitions: Accident: refers to any unexpected or unintentional incident, which may result in injury or illness to a resident . Fall: refers to unintentionally coming to rest on the ground, floor or other lower levels, but not as a result of an overwhelming external force (i.e. resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without an injury is still a fall unless there is evidence suggesting otherwise when a resident is found on the floor, a fall is considered to have occurred . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procedure: Responsibility Person responsible for area in which the accident occurred (Initiator). Action: Initiated the accident report and enters required information. Notifies RN/Clinical Care Manager; RN/Clinical Care Manager: Action: Investigates the situation and assesses the resident/patient, completes the nurse section of the Accident Report, Determines/implements immediate corrective action. Licensed Nurse RN/LPN: Notifies M.D. & Clinical Care Manager, Identifies relevant environmental risk factors, Notifies Plant Operations and/or housekeeping as appropriate, Documents the accident event and notification of family in the progress notes, Place resident/patient on 24 hour report x 72 hours, Documents resident/patient status in the progress notes X 72 hours, RN/CCM: Initiates/updates CCP with a new intervention, Clinical Care Manager: Reviews the accident report and other pertinent information with the interdisciplinary Team at morning report the following business day, RN/Clinical Care Manager: Initiates Incident report, Obtains statements from all staff, residents, visitors, volunteers present at the time of the accident, by the end of the shift, Obtains statements until a determination can be made as to the time of the accident, Clinical Care Manager: Reviews accident report, statements occurrence report, clinical record and surveillance data as indicated. Completes Summary of Findings and Determination regarding Abuse, Neglect, and Mistreatment, Initiates Corrective Action Plan, Notifies family/significant others of the findings of the Occurrence Investigation, Submits all documents to the A.D.N./D.N.S., D.N.S./A.D.N.: Reviews each case, relevant documents and the clinical record to validate findings and determine results, Forwards original accident reports to the Education Dept., DNS/ADN: Reviews significant injuries and injuries of unknown origin with the Administrative Team (Administrator/Associate Administrator/ Medical Director/Associate Medical Director), Administrative Team: Conducts root cause analysis, as needed, DON/Designee: Notifies DOH and other regulatory agencies as per regulations if: reasonable cause to suspect abuse, neglect and mistreatment has been determined, failure to follow the CCP, which resulted in resident injury, injuries of unknown origin. A review of facility policy, Abuse Prevention & Reporting revised 5/20/22, Policy: 1. Residents of Atrium Center for Rehabilitation and Nursing will be protected from abuse, neglect, mistreatment, or misappropriation of property in accordance with State and Federal Regulations. 2. All alleged or suspected incidents of abuse, neglect, mistreatment, or misappropriation of residents' property will be thoroughly investigated, and findings documented in report format. 3. Any case in which abuse, neglect, mistreatment, or misappropriation of resident's property has been identified via the investigation, or a conclusion cannot be drawn will be reported promptly to the State Department of Health. 4. Allegations of abuse will be investigated in accordance with abuse and reporting guidelines. Identification: 2. The facility will investigate all unusual incidents and all injuries of unknown origin. Clues to help Identify Abuse: A. Physical Abuse Clues: Resident denies physical abuse however physical exam reveals .fractures. Responsibility: All non-licensed employees, Actions: 1. reports complaints and/or evidence of suspicion of abuse neglect injury of unknow origin or mistreatment to their supervisor immediately, 2. will complete written statements to aid in investigation. All licensed employees, Actions: 1. Notifies their supervisor immediately, 2. Notifies Administration of same. 3. Will complete written statement to aid in investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nursing Supervisor/Social worker, Actions: 1. Obtains a statement from the resident in question, 2. Takes immediate necessary precautions/management pending complete investigation, 3. Interim case conference is held to develop interventions to ensure resident physical harm, pan, and/or anguish is minimized. Administrator/DNA/Designee, Actions: 1. Will ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknow source . are reported immediately to the administrator and/or representative and to other officials in accordance with State law through established procedures (including to the State survey and certification agency), 2. Will ensure that the results of all investigations are reported to the administrator .within 24 hours of the incident. Allegation of Abuse, neglect, exploitation or mistreatment and injuries of unknow source, Action: 1. All alleged violations of abuse are to be reported immediately but no later that 2 hours if the alleged violation involve abuse or results in serious bodily injuries. NJAC 8:39 4.1 (a)(5), 27.1(a)(b)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Complaint # NJ152936 Based on interview, closed record review and review of pertinent documents, it was determined that the facility failed to ensure the facility policies for Accidents, Occurrence Investigation and Prevention of Falls were followed to ensure: a.) a resident identified at risk for falls on [DATE], and at high risk for falls on [DATE], had a care plan initiated for the prevention of falls, b.) an assessment of any physical injuries was completed and documented post fall, c.) an accident report was completed and verified incident post fall, d.) post-fall, the Interdisciplinary Team re-evaluated the resident and revised interventions to prevent a recurrence, e.) a root cause analysis would be conducted post occurrence and immediate measures to protect the resident was implemented, and f.) any interventions are consistently documented per professional standards of practice. This deficient practice occurred for 1 of 1 closed records reviewed for hospitalization (Resident #193), who sustained four falls, including two falls that occurred on [DATE], and two falls that resulted in an emergent transfer to the hospital on [DATE] and [DATE]. The [DATE] fall resulted in Resident #193 sustaining an acute, traumatic right subdural hematoma, which required an emergent craniotomy and and required neuro intensive care. The deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On [DATE] at 11:16 AM, the surveyor reviewed the entirety of the closed medical record for Resident #193 which was provided by the facility on [DATE] at 3:00 PM, and revealed the following: A hospital record dated [DATE] completed for Resident #193, prior to admission to the facility, revealed a Computerized Tomography scan of the Head or Brain without contrast (a scan utilizing computers and X-rays) was completed on [DATE]. The scan revealed There are no acute findings. The hospital Plan of Care dated [DATE] revealed Resident #193 had a Problem: At Risk for Falls, Patient is high risk for falls, has experienced falls, or falls have resulted in injury. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	After admission to the facility a Fall Risk Evaluation dated [DATE], revealed the resident scored an 8 on the Falls Risk Evaluation. On a subsequent Fall Risk Evaluation dated [DATE], revealed If the total score is 10 or greater, the resident should be considered at High Risk for potential falls. A prevention protocol should be initiated immediately and documented on the care plan. Resident #193 scored 11 on the evaluation which is considered high risk. A review of a Physical Therapy (PT) Evaluation and Plan of Treatment, dated [DATE], revealed Resident #193 was a fall risk. A review of the Interdisciplinary Care Plan for Resident #193 revealed four Care Plans which included: Anticoagulant Therapy, Wounds/Impaired Skin Integrity, ADL Dysfunction and Risk for Falls/Injuries. The Risk for falls/Injuries Care Plan revealed Problem: Pt [patient] is at risk for falls as r/t [result to] impaired mobility. Goal: will have minimal falls through review date. The interventions dated [DATE], with a target date [DATE], included the following: Keep call bell and frequently used items within reach, Keep room clutter free and well lit, keep bed in lowest position, encourage resident to wear appropriate no skid footwear, Assist with transfers X 1, PT/OT screen as needed, Check all that apply was D/C (discontinued) with a line through it on [DATE], and bed alarm, chair alarm, and floor mat was unchecked. The Care Plan for Resident #193 did not reflect any documented interventions to prevent falls despite being identified at risk for falls on [DATE], a Care Plan for falls was not initiated until twenty-one days later. The August and [DATE] Treatment Administration Record (TAR) and Medication Administration Record (MAR) were reviewed and did not reveal documented evidence of fall interventions that were identified in the Care Plan that were initiated on [DATE]. Fall #1: A Nurses Note (NN) dated ,d+[DATE] and timed at 4A[4:00AM], Fall #1, Resident found by aide on floor, on [his/he] back lying on R[right] side of bed, no visible injuries, denies pain, 2 assist transferred resident back to bed and push bed towards wall, monitored through the night, VS [vital signs] , d+[DATE]-[DATE].8. DTR [daughter] called and notify of incident and signed by a Licensed Practical Nurse (LPN #1). There was no documented evidence that the physician was notified of the fall, and no evidence that a documented physical assessment was completed. This fall was not documented on the Care Plan and Interventions were not revised to prevent further falls. Fall #2: A NN dated ,d+[DATE] and timed at 7A, 7:10A [7:00 AM, 7:10 AM], Fall #2 , after talking to daughter heard resident yelling out help me nurse, help me. Found [him/her] before has [sic.] bed sitting up on floor. Transfer back to bed and in w/c [wheelchair] out to nurses station and, VS , d+[DATE]-[DATE].5. No apparent injuries. Denies hitting [his/her] head and signed by LPN #1. There was no documented physical assessment for resident #193. A subsequent un-timed and un-dated NN revealed, MD [physician] to be informed later of falls and also [daughter] for fall #2 signed by LPN #1. This fall was not documented on the Care Plan and Interventions were not revised to prevent further falls. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	A subsequent NN un-timed and dated [DATE], revealed resident received in the hallway sitting in [his/her] wheelchair, neuro checks (an evaluation to determine if the nervous system was impaired) initiated, no abnormal behavior, resident was compliant with adl [activities of daily living] care and meds [medications], vitals wnl [within normal limits], will continue to monitor signed by LPN #2. There was no documented evidence that the physician, or daughter was notified of the two falls that occurred on [DATE]. A NN dated [DATE], and timed at 1PM neuro checks in progress, s/p [status post] fall. All neuro checks WNL [within normal limits], no neuro [neurological] changes at this time. will cont. [continue] to monitor, signed by Registered Nurse (RN #1). There were no additional NN documented regarding any completed neuro checks or monitoring. There was no documented evidence of neuro checks having been completed in the medical record, or in the MAR or TAR for [DATE]. Fall #3: A NN dated [DATE], and timed at 10:00 AM, Resident received awake and lying in bed. Around 8:30 A.M. was found by CNA [certified nurse aide] on the floor lying face down. The CNA noted writer and resident was observed lying face down. No visible injury or bruising. Resident remained in stable condition. B/P ,d+[DATE], P68, R16, SP02 98, T97.6. Neuro checks in place. Resident c/o (complaint of) [headache] rated ,d+[DATE] [pain scale]. PRN [as needed] Tylenol (pain reviewed) 650 MG (milligrams) administered. MD (physician) made aware and daughter. The daughter requested for her [family member's] name to be removed due to being deceased , signed by LPN #2. A NN dated [DATE], and timed at 3:30 PM, Resident didn't return on the ,d+[DATE] shift and signed by LPN #2. Incident #4: A NN dated [DATE], and then continued on another page titled Interdisciplinary Progress Notes (IPN) revealed, Date and Time: TC ,d+[DATE] (No specific time documented) which revealed this morning when one of the aide went into the residents room and found [him/her] laying on [his/her]back with [his/her] head slightly elevated, with vomit on [his/her] face, on the side of the bed and on [his/her] pillow. I assessment [sic.] [Resident #193] had a 210 B/S [blood sugar] B/P [blood pressure] ,d+[DATE] (numerical portion was circled), HR [heart rate]-92, O2 [oxygen saturation] 97.2, temp [temperature] 96.8, when I called to to [Resident #193] [he/she] barely opened [his/her eyes] was breathing, BR [breath rate] -24, but was very [sic.] lethargic. I called his/her [Doctor] and was told to send [him/her] to the E.R. [emergency room] [he/she] was transported to the E.R. at about 8 AM. [He/she] was sent with [his/her] face sheet and personal belongings and was signed by LPN #1. There was no documented nursing notes, or notes from other disciplines documented in the medical record on either an IPN or NN. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	A New Jersey Universal Transfer Form (UTF) had a Date of Transfer: [DATE], Time of Transfer:[blank] revealed Resident #193 was transferred to the hospital on [DATE] at an unknown time. The Reasons for Transfer:(Must include brief medical history and recent changed in physical function or cognition) Lethargy, V/S: BP,d+[DATE], P 100, R 14, T 97.2, Pain: [Blank], Primary Diagnosis: CVA, The following areas were left blank; Code Status, DNR, DNH, DNI, Out of Hospital DNR Attached, Secondary Diagnosis, Mental Health Diagnosis (if applicable), At Risk Alerts: None, Falls, Pressure Ulcer, Aspiration, Wanders, Elopement, Seizure, Harm to: N/A, Self, Others, Weight Bearing Status: None, Left Leg:, Limited, Full, Right Leg: Limited, Full, Mental Status: Disoriented and Dementia, Function: Walk [Not Able], Transfer [Not Able], Toilet [Not Able], Attached Documents:(must attach current medication information) Labs was checked off and Face Sheet[an admission summary], MAR[medication administration record], Medication Reconciliation, TAR [Treatment Administration Record], POS [Physician Order Sheet], Diagnostic Studies, Operative Report, Respiratory Care, Advanced Directive, Code Status, Discharge Summary, PT[physical therapy] note, OT [occupational therapy] Note, HX/PE [history and physical exam] and Other was blank, Labs was checked off. The Sending Facility Contact: Title, Unit and Phone section was blank, the Form Completed by and Title section was blank. There was no information on the UTF that correlated with the [DATE] LPN #1 NN that indicated the recent changes in physical function. The Admission Record revealed Resident #193 had Admitting Diagnosis that included, but was not limited to, Dysarthria (a speech disorder from neurological injury), CVA, Malignant Hypertension (sudden spike in blood pressure), and Type 2 Diabetes Mellitus. On [DATE] at 2:41 PM, the surveyor conducted a telephone interview with LPN #1 regarding the documentation on [DATE], regarding Resident #193. LPN #1 asked the surveyor if she was in trouble and stated she did not recall the resident, or remember her documentation, or any incident on [DATE], and she was unable to speak to it. On [DATE] at 3:22 PM, the surveyor conducted and interview with the Director of Nursing (DON) and showed the DON the UTF for Resident #123 dated [DATE]. The surveyor inquired if there were any incidents or investigations for Resident #123 and she stated she will inquire. At that time the surveyor reviewed the UTF with the DON. The DON stated the UTF was incomplete. On [DATE] at 4:18 PM, the surveyor, in the presence of another surveyor, inquired to the Licensed Nursing Home Administrator (LNHA) and Regional Licensed Nursing Home Administrator (RLNHA) if there were any investigations for Resident #193. The LNHA stated no there were no investigations that the facility was aware of. On [DATE] at 4:30 PM the surveyor, in the presence of another surveyor, requested any information from the Interim Infection Preventionist Licence Practical Nurse (IIPLPN) related to the reason #193 was sent to the hospital on [DATE]. On [DATE] at 8:27 AM, the IIPLPN provided the surveyor a Daily Report dated [DATE], and showed the surveyor that Resident #193 was transferred to the emergency roiagnom on [DATE], for a change in mental status and had no other information related to [DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	On [DATE] at 9:56 AM, the surveyor interviewed the DON regarding what the process was if a resident sustained an injury of unknown origin. The DON stated it should be investigated and reported to the State. The surveyor inquired as to the documentation on [DATE] regarding Resident # 193. The DON stated we should have done a skin check before they went out to the hospital. The DON stated she wanted to know why the personal belongings were documented as sent with Resident #193 to the hospital, and what was the reason the resident vomited. The DON stated there should absolutely be specifics on the transfer sheet regarding the vomiting and how the resident was found, and the DON stated it is imperative. The DON also stated she would get a statement from the CNA and confirmed the UTF had to be accurate, filled out and include the contact information on the UTF. The DON stated the hospital needed to know that information and she stated, I would expect to see any additional information related to the resident, it doesn't end [the resident] going out. The DON stated I would want to know what happened and they have to notify the responsible party and the doctor. The surveyor requested the policy for the UTR, emergent transfer policy. The surveyor inquired to the DON if the resident had expired at the hospital, would the facility know. The DON stated she was unaware if Resident #193 expired, but the facility should know that information. The surveyor requested the assignment sheet for Resident #193 on [DATE]. On [DATE] at 2:30, the Unit Manger provided the assignment sheet for [DATE] at 2:30 PM. Upon review and discussion with the Human Resource Staff, the surveyor was unable to contact any additional staff that worked on [DATE]. On [DATE] at 12:54 PM, the RLNHA stated there was no faciliy policy for completion of the UTF and no facility discharge policy. On [DATE] at 10:49 AM, the surveyor interviewed the LNHA, regarding what the process was for injuries of unknown origin. The LNHA stated there should be an investigation for injuries of unknown origin. On [DATE] at 3:57 PM, the RLNHA, in the presence of the Regional Nurse and DON, informed the surveyor that there were no investigations for Resident #193. The RLNHA stated she had checked with the DON and she confirmed that the LNHA also had no investigations. The RLNHA stated 100% there should be an investigation completed for all falls or unusual occurrences. On [DATE] at 4:05 PM, the surveyor inquired to the DON regarding any incidents, investigations or reportable events for Resident #193. The DON stated I have nothing on Resident #193 and the DON stated that she and the LNHA could not locate any incidents or reportable event records for Resident #193. The DON stated that Resident #193 vomited, and none of the information was found out about what happened, nothing was on the transfer note. The RLNHA stated she was not aware that Resident #193 had any falls, and was unsure why the resident's belongings were sent to the hospital. At that time, the surveyor requested a time line of events for Resident #193 from the RLNHA. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	On [DATE] at 10:00 AM, the RLNHA provided the time-line for Resident #193. The RLNHA stated the that Resident #193 was identified as a fall risk on [DATE], with a fall risk assessment score of 8, then transferred to the hospital on [DATE] due to a change in mental status, readmitted to the facility on [DATE], and scored an 11 on the fall risk assessment. The RLNHA stated on [DATE], is when the Care Plan for falls was first initiated and reviewed the interventions. The surveyor inquired if the interventions were documented as being implemented and the RLNHA stated that from time to time and they were just in the nursing notes which the RLNHA confirmed were sporadic. The RLNHA confirmed the first falls occurred on [DATE], and there were no investigations completed, and no incident reports were completed regarding the [DATE], fall either. The RLNHA stated she spoke to LPN #1 regarding the incident that she documented with Resident #193 on [DATE]. The RLNHA stated that LPN #1 informed her that she does remember the incident and LPN #1 confirmed that Resident #193 sustained a fall, and stated to the RLNHA that she had remembered the fall. The RLNHA confirmed that there was no documented nursing physical assessment completed for Resident #193 and confirmed there was no documented nursing physical assessment for the two falls that occurred on [DATE], and on [DATE]. The RLNHA stated that LPN #1 confirmed that she did not document that Resident #193 had a fall on the UTF, and the RLNHA stated it doesn't even appear that the person fell per what was documented on the UTF and the RLNHA confirmed there were no neuro checks documented. [DATE] at 10:31 AM, the RLNHA stated to the surveyor that with any injury of unknown origin, an incident report with statements and a full head to toe investigation should have been completed. The RLNHA stated that the falls, possibly the first three, but definitely the last fall, if there were injuries it should have been reported to the Department of Health. On [DATE], the surveyor reviewed the hospital records provided by the receiving hospital for Resident #193's emergent transfer on [DATE], which revealed the following: The Hospital Patient Information sheet revealed Resident #193 was admitted to the Emergency Department from the nursing facility on [DATE] at 8:32 AM. A Physician Progress Note, dated [DATE], and Electronically Signed by the Physician (MD) at 11:03 AM. (Resident #193) was admitted after being found with altered mental status in nursing home and vomit in beard. CAT scan of head was performed in the emergency department and revealed a large right subdural hematoma (a serious condition where blood collects between the skull and the surface of the brain and is usually caused by a head injury) with a right intraparenchymal hemorrhage (blood pooling in tissues of the brain) status post a decompressive hemicraniotomy. A Internal Medicine Progress Note, dated [DATE], and Electronically Signed by the MD at 1:34 PM. The Patient (Resident #193) came to the hospital after experiencing a fall. Patient was diagnosed with an acute, traumatic, right subdural hematoma and was admitted to neuro intensive care after having an emergent craniotomy (emergency surgery to remove part of the bone from the skull to expose the brain). The following facility provided policies were reviewed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Accidents-Occurrence Investigation Policy Originated:,d+[DATE], revealed All accidents will be investigated, documented and reported to the New Jersey Department of Health as appropriate. Definitions: Accident: refers to any unexpected or unintentional incident, which may result in injury or illness to a resident . Fall: refers to unintentionally coming to rest on the ground, floor or other lower levels, but not as a result of an overwhelming external force (i.e. resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without an injury is still a fall unless there is evidence suggesting otherwise when a resident is found on the floor, a fall is considered to have occurred . Procedure: Responsibility Person responsible for area in which the accident occurred (Initiator). Action: Initiated the accident report and enters required information. Notifies RN/Clinical Care Manager; RN/Clinical Care Manager: Action: Investigates the situation and assesses the resident/patient, completes the nurse section of the Accident Report, Determines/implements immediate corrective action. Licensed Nurse RN/LPN: Notifies M.D. & Clinical Care Manager, Identifies relevant environmental risk factors, Notifies Plant Operations and/or housekeeping as appropriate, Documents the accident event and notification of family in the progress notes, Place resident/patient on 24 hour report X 72 hours, Documents resident/patient status in the progress notes X 72 hours, RN/CCM: Initiates/updates CCP with a new intervention, Clinical Care Manager: Reviews the accident report and other pertinent information with the interdisciplinary Team at morning report the following business day, RN/Clinical Care Manager: Initiates Incident report, Obtains statements from all staff, residents, visitors, volunteers present at the time of the accident, by the end of the shift, Obtains statements until a determination can be made as to the time of the accident, Clinical Care Manager: Reviews accident report, statements occurrence report, clinical record and surveillance data as indicated. Completes Summary of Findings and Determination regarding Abuse, Neglect, and Mistreatment, Initiates Corrective Action Plan, Notifies family/significant others of the findings of the Occurrence Investigation, Submits all documents to the A.D.N./D.N.S., D.N.S./A.D.N.: Reviews each case, relevant documents and the clinical record to validate findings and determine results, Forwards original accident reports to the Education Dept., DNS/ADN: Reviews significant injuries and injuries of unknown origin with the Administrative Team (Administrator/Associate Administrator/ Medical Director/Associate Medical Director), Administrative Team: Conducts root cause analysis, as needed, DON/Designee: Notifies DOH and other regulatory agencies as per regulations if: reasonable cause to suspect abuse, neglect and mistreatment has been determined, failure to follow the CCP, which resulted in resident injury, injuries of unknown origin. Policy and Procedure for the Prevention of Fall, undated; Communication of Risk, Residents at risk for falls will be communicated to the interdisciplinary team via the care plan, Evaluation of Fall Incidents, Assess residents for any obvious injuries, notify the medical provider and document a progress note reflecting the resident's appearance, evidence of injury and location, Monitor resident post incident to observe for latent injury, After a fall has occurred, the interdisciplinary team will re-evaluate the resident and revise intervention to prevent recurrence, PT/OT to screen residents and recommend interventions, if indicated, Quality Assurance, Complete an occurrence and conduct post occurrence and conduct post occurrence review to attempt to ascertain root cause analysis of the incident and implement immediate measures to protect the resident, Occurrence will be discussed in the morning report; current and alternative interventions/preventative measures will be explored and implemented upon agreement by the IDC team, Nursing department will track the number of falls per month by collecting data from accident/incident reports to identify trends and patterns. (continued on next page)

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