STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315200	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARISTACARE AT DELAIRE	400 W STIMPSON AVE LINDEN, NJ 07036

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 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ 889 Based on observation, interview and record review, it was determined that the facility failed to follow wound protocol to initiate incident report and treatment when there is a new wound identified, in accordance with nursing standards of clinical practice and the facility's pressure ulcer policy. This deficient practice was identified for Resident #1, 1 of 1 resident reviewed for pressure ulcer and 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 stated, The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical 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 stated, 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 9:20 AM, the surveyor observed the 3rd-floor unit and residents' rooms, noted to be clean and with no identified odor. On [DATE] at 9:11 AM, the Licensed Practical Nurse #1 (LPN#1) informed the surveyor that according to the facility's policy, all residents with incontinence and required assistance with activities of daily living (ADLs) are provided with turning and repositioning (T and P), preventative cream barrier and incontinence care every two hours or as needed. She further stated that the nurse would assess any resident who develops a new pressure ulcer, initiate an investigation report, report to the physician to obtain a treatment order, and notify the responsible party. LPN#1 informed the surveyor that all the facility residents were on weekly skin monitoring in the Treatment Administration Record (TAR). At that time, LPN#1 indicated that she was the nurse of Resident #1 in the unit. LPN#1 stated that Resident #1 was cognitively impaired, required total assistance with ADLs, and had facility acquired pressure ulcers of the upper back and the sacrum. She further stated that she could not remember if she was the one who first identified the wounds and if an investigation was initiated when the new wounds were identified. Furthermore, LPN#1 informed the surveyor that the sacrum and upper back pressure ulcers were unstageable, did not deteriorate, the treatment was Santyl, and was followed up by the wound doctor weekly until the resident expired. LPN#1 was unable to remember if there were previous treatment medications before the Santyl order. A review of the resident's Face Sheet (an admission summary), disclosed that the resident had [DIAGNOSES REDACTED]. A review of the [DATE] Comprehensive Minimum Data Set (CMDS) and [DATE] Quarterly MDS, an assessment tool used to facilitate the management of care, indicated the resident Brief Interview for Mental Status (BIMS) was not attempted because the resident was comatose (persistent vegetative state/no discernible consciousness). The CMDS and Quarterly MDS both revealed that the resident had no pressure ulcers. A review of the Incident Report (IR), provided by the Medical Record Staff (MRS), showed that the resident was noted with a stage two pressure ulcer at the mid-back on [DATE] by LPN#2. The [DATE] IR summary showed that the physician and the family were notified of the new wound. A review of the Nurses Note showed that on [DATE] at 15:06 (3:06 PM), LPN #1 informed Resident #1's responsible party about the pressure ulcer to the sacrum. A review of the IR provided by the MRS showed no investigation was initiated for the [DATE] identification of the pressure ulcer to the sacrum. The surveyor reviewed the New Order Review of the physician for [DATE], which revealed that Resident #1 had a physician's order, dated [DATE], Santyl ([MEDICATION NAME] medicine) ointment applied to the sacrum and upper back topically one time a day for wound treatment cover with border gauze. Further review of the New Order Review of the physician for [DATE] showed an order for [REDACTED]. During a phone conversation on [DATE] at 11:50 AM, LPN#2 declined to talk to the surveyor. On [DATE] at 1:24 PM, the Director of Nursing (DON) informed the surveyor that it was expected for the nurses who identified a new pressure ulcer to initiate an investigation, notify the physician to obtain a treatment order, notify the responsible party and document according to the facility protocol and policy with regards to wounds and pressure ulcer. She further stated that preventative treatments were in place and that the wounds were unavoidable due to the resident's comorbidities. On that same date at 2:48 PM, the DON informed the survey team that LPN#1 and LPN#2 were disciplined due to failure to follow wound protocol by not initiating an incident report and treatment orders to the identified pressure ulcers of Resident #1 on [DATE] and [DATE]. The DON provided a copy of the Disciplinary Action Report dated [DATE] addressed to LPN#1 and LPN#2. A review of the undated Pressure Ulcers/Skin Breakdown-Clinical Protocol Policy that was provided by the Licensed Nursing Home Administrator (LNHA) reflected, The physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. A review of the undated Pressure Ulcer Risk Assessment Policy provided by the LNHA revealed that Risk Assessment-a pressure ulcer risk assessment will be completed .Monitoring: nurses are to be notified to inspect the skin if skin changes are identified .report other information in accordance with facility policy and professional standards of practice. NJAC 8:,[DATE].2 (b)

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

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.