STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALLAIRE REHAB & NURSING	115 DUTCH LANE ROAD FREEHOLD, NJ 07728

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** complaint #NJ 433 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) notify the New Jersey Department of Health of an injury incident of an unknown origin that resulted in a fracture, and b.) report the results of the investigation to the New Jersey Department of Health within five working days of the incident. This deficient practice was identified for 1 of 3 residents reviewed with facility reportable events (Resident #5). The evidence was as follows: On 8/18/20 at 10:30 AM after the entrance conference with the Licensed Nursing Home Administrator (LNHA), the surveyor requested a list of facility reportable events since 1/1/2020. The surveyor reviewed the list provided by the LNHA at 11:20 AM, which reflected that Resident #5 had a facility reportable event that occurred on 4/19/20. The surveyor reviewed the medical record for Resident #5. A review of the Admission Record face sheet (an admission summary) reflected that Resident #5 was admitted to the facility with [DIAGNOSES REDACTED]. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 2/29/20 reflected that Resident #5 had a brief interview for mental status (BIMS) score of 3 out of 15, indicating a severely impaired cognition. A review of the electronic Progress Notes (ePN) dated 4/19/20 at 10:57 PM reflected that the resident was noted to be in bed with a large bruise color/purple noted on right leg. Facial grimacing noted when given care. The note reflected that the resident was treated for [REDACTED]. The results of X-ray revealed right lower leg and knee fx(fracture). The physician ordered for the resident to be transported to the emergency department for further evaluation and the family representative was made aware. A review of the facility's X-ray report dated 4/19/20 reflected a right knee and lower right leg fracture. The report specified, There is a vertically-oriented intra-articular fracture involving the right lateral tibia plateau with mild displacement .diffuse osseous demineralization (reduced bone mineral substances) is noted On 8/18/20 at 2:27 PM, the LNHA provided the surveyor a copy of the Reportable Event Record/Report dated 4/20/20. There was no record that the reporting documents of the incident that occurred on 4/19/20 were submitted to the New Jersey Department of Health (NJDOH). The LNHA stated he had no proof of the transmittal of reporting. On 8/19/20 at 12:34 PM, the surveyor observed Resident #5 in his/her private room reclining in a geri-chair. The surveyor attempted to interview the resident but the resident just stared at the surveyor. On 8/19/20 at 3:00 PM, the Director of Nursing (DON) acknowledged to the survey team she was responsible for the investigations and reporting to the NJDOH. She stated that she faxes reportable events to the NJDOH and that she did not routinely keep a record receipt that a fax was sent to the NJDOH. She confirmed she was unable to find confirmation that it was sent to the NJDOH, but stated that she had spoken to the NJDOH on 7/20/20 according to her notes. She was unable to provide documented evidence that the reportable event was sent to the NJDOH that the results of the investigation were sent after five working days of the incident. A review of the facility's Abuse Investigation and Reporting policy revised 12/2019 included, All alleged violations .including injuries of an unknown source will be reported by the the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility . and All alleged violation .including injuries of an unknown source .will be reported immediately, but not later than: Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or Twenty-Four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone. NJAC 8:39-9.4(f); Appx. B
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #NJ 433 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to develop an individualized care plan in a timely manner for a resident who transferred from surface to surface using a mechanical lift. This deficient practice was identified for 1 of 3 residents reviewed dependent on a mechanical lift (Resident #5). The evidence was as follows: On 8/18/20 at 10:30 AM after the entrance conference with the Licensed Nursing Home Administrator (LNHA), the surveyor requested a list of facility reportable events since 1/1/2020. The surveyor reviewed the list provided by the LNHA at 11:20 AM, which reflected that Resident #5 had a facility reportable event that occurred on 4/19/20. The surveyor reviewed the medical record for Resident #5. A review of the Admission Record face sheet (an admission summary) reflected that Resident #5 was admitted to the facility with [DIAGNOSES REDACTED]. A review of a Physical Therapy Evaluation and Plan of Treatment dated 11/18/2018 included a functional assessment that the resident was totally dependent on transfers without attempts to initiate. The evaluation indicated, (Hoyer (mechanical lift)transfer). A review of the resident's individualized care plan created 5/28/18 and revised 7/20/18 included that the resident required, transfers by 2 staffs for out of bed activities. It did not address the need for a mechanical lift for transfers in accordance with the Physical Therapy Evaluation and Plan of Treatment until 7/27/20. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 2/29/20 reflected that Resident #5 had a brief interview for mental status (BIMS) score of 3 out of 15, indicating a severely impaired cognition. It further included that the resident was dependent with surface to surface transfers and required a two person physical assist. On 8/19/20 at 10:50 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that Resident #5 was transferred via a mechanical lift using two staff members. The CNA could not speak to a time in which the resident was not transferred using a mechanical lift because she had only worked at the facility since May 2020. At 11:26 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who had revised the resident's care plan on 7/20/18 for a two-person transfer. The LPN stated that the staff had been using a two-person mechanical lift transfers for Resident #5 for a while. She further stated that she believed at one point Family did not want (Resident #5) to have a hoyer lift. She could not speak any further to the resident's care plan or why the mechanical lift transfer was not in the resident's care plan in a timely manner based on the Physical Therapy Evaluation and Treatment Plan dated 11/18/2018. The LPN acknowledged that the resident's representative preferences regarding not wanting Resident #5 to use a mechanical lift was also not documented within the resident's individualized care plan. At 11:30 AM, the surveyor interviewed CNA #2 who stated that she worked full time during the day shift. CNA #2 stated that Resident #5 had required a two person mechanical lift but the family didn't want Resident #5 to use a mechanical lift for transfers at one point, but they never said why. She couldn't speak to when the family had made the request to not use a mechanical lift. At 11:50 AM, the surveyor interviewed the Occupational Therapist (OT)/Assistant

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

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Director of Rehab who stated that he did not work directly with Resident #5 but had familiarity that the resident's representative did not want the resident to use the mechanical lift at one point. He could not speak to when or why. At 12:04 PM, the surveyor interviewed the Physical Therapist (PT) who reviewed the PT Evaluation dated 11/18/2018. The PT acknowledged that the resident was dependent on a mechanical lift for transfers, and that it was possible that he/she had progressed to not needing a mechanical lift for transfers. The PT acknowledged it should be recorded in the resident's plan of care. At 12:34 PM, the surveyor observed Resident #5 in his/her private room reclining in a geri-chair. The surveyor attempted to interview the resident but the resident just stared at the surveyor. At 3:00 PM, the Director of Nursing (DON) acknowledged to the survey team that nurses were responsible for updating the care plan in a timely manner. She could not speak to why the use of mechanical lift transfers was not updated until 7/27/20. At 5:15 PM, the LNHA acknowledged to the survey team that the care plan did not reflect the use of the mechanical lift for Resident #5 until 7/27/20. He stated that staff were following the resident's plan of care but it just wasn't documented in the care plan in a timely manner. He was unable to provide documented evidence within the medical record to indicate why the care plan had still reflected a two person assistance for transfers, when the resident required a two-person assist using a mechanical lift for transfers. A review of the facility's Managing Falls and Fall Risk policy revised 12/2019 included, The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan . A review of the facility's Using a Mechanical Lift Machine policy revised 12/2019 included to document the type of lift used in the medical record. NJAC 8:39-11.2 (e), (f), (h)
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 Based on observation, interview and record review it was determined that the facility failed to: a.) document in the electronic Treatment Administration Record for the accountability of a wound treatment, and b.) ensure a dressing was dated and timed in accordance with professional standards of nursing practice. This deficient practice was identified for 1 of 3 residents reviewed for wounds (Resident #2). 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 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 with in the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The evidence was as follows: On 8/18/20 at 9:27 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) informed the surveyor that Resident #2 had non-healing pressure ulcers. At 9:40 AM, the surveyor observed Resident #2 in bed on an air mattress. The resident stated to the surveyor that he/she had non-healing pressure ulcer wounds to the left and right buttock area. Resident #2 informed the surveyor that he/she would often not allow certain nurses perform a wound treatment for [REDACTED]. The resident independently turned to his/her left side to show the surveyor the wound, and the surveyor observed a large dressing on the left and right buttocks. There was no date or time written on the dressing indicating when it had been placed on the resident. The surveyor reviewed the medical record for Resident #2. A review of the Admission Record face sheet (an admission summary) reflected that the resident had [DIAGNOSES REDACTED]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/19/20 included that the resident had a brief interview for mental status score of 15 out of 15, indicating a fully intact cognition. IT further included that the resident had two stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcers that were present upon admission to the facility. A review of the resident's individualized care plan dated 8/20/18 included that Resident #2 had two stage IV pressure ulcers to the sacrum/ischium (tail bone), and that the resident refused weekly wound measures and skin assessments. The care plan revised on 7/24/20 further included that that the resident refused to have a wound clinic and wound physician follow the management of the wounds. Interventions included to Administer treatment as ordered by physician and monitor for deterioration and improvement and Monitor behavior episodes and attempt to determine underlying cause .Document behavior and potential causes. A review of the Physician order [REDACTED]. Cover with gauze or sponge every day shift. A review of the electronic Treatment Administration Record (eTAR) for July 2020 reflected the corresponding PO dated 5/14/20 for the treatments to the left and right buttock wounds. The treatments were plotted to be administered during the day shift (7 AM-3 PM). The eTAR reflected blanks for the administration of the treatment on both the left and right buttock wounds on 7/16/20, 7/25/20, 7/29/20, and 7/31/20. A review of the corresponding electronic Progress Notes (ePN) dated 7/16/20 at 11:41 AM and 3:24 PM reflected that the resident refused to have the wound treatments performed despite multiple attempts. Further review of the ePN dated 7/25/20, 7/29/20, and 7/31/20 did not reflect documented evidence that the wound treatment was performed or that Resident #2 had refused the treatment to the left and right buttock. On 8/19/20 at 8:20 AM, the surveyor interviewed the LPN/UM who stated that the resident was independent with care but required assistance with wound dressing changes to the left and right buttocks. The LPN/UM stated that the resident had a history of [REDACTED]. She stated that nurses attempt to perform the dressing changes multiple times during the days, but sometimes the resident refuses to get back into bed and will stay out of bed until midnight sometimes. She stated that if the resident refused a wound dressing change, it should be documented in the eTAR. At 8:55 AM, the surveyor interviewed the medication LPN. The LPN stated that the resident had a history of [REDACTED]. She stated that the resident would often require repeated attempts to perform the treatment and sometimes would not allow a nurse to do a treatment. She confirmed that if the resident refused it should be documented in the eTAR or progress notes. The surveyor showed the LPN the eTAR for July 2020 with the blanks on 7/16/20, 7/25/20, 7/29/20 and 7/31/20. The LPN stated that it may have been left blank because the resident refused the treatment and it was left open for the next shift to try. She confirmed there should then be a progress note for the day shift that he/she refused the treatment. At 9:15 AM, the surveyor interviewed Resident #2 a second time. The resident informed the surveyor that the day shift always performed the wound treatment during their shift, and was unable to provide a name of a nurse that did not perform a wound treatment as ordered by the physician. The resident confirmed he/she refused a wound treatment dressings at times as well. At 9:24 AM, the surveyor observed the Registered Nurse (RN) perform a wound treatment dressing change to the left and right buttock for Resident #2. The surveyor observed that the old dressing was not signed with a date and time. The surveyor interviewed the Registered Nurse who confirmed that there was no date or time written on the old dressing. She stated that she had performed a dressing change the day before and put a date and time on it so that it must have been the night shift that had changed the dressing and didn't put the date and time on it. The RN confirmed the date and time should always be written on the dressings during application in accordance with professional standards of nursing practice. The RN also informed the surveyor that the resident had a history of [REDACTED]. She stated that if the resident refused a treatment it wouldn't be documented anywhere else. On 8/19/20 at 5:10 PM, the surveyor interviewed the Licensed Nursing Home Administrator in the presence of the survey team. The LNHA stated that the resident had a history of [REDACTED]. He stated that the resident had a care plan for his/her noncompliance. The LNHA stated that the refused the wound treatment on 7/25/20, 7/29/20 and 7/31/20, but that it just wasn't documented in the eTAR or the ePN's. He acknowledged that there should have been documentation in the resident's medical record that he/she refused the treatment on those dates. The LNHA acknowledged that the date and time should be documented on the wound dressing in accordance with professional standards of nursing practice. A review of the facility's policy Prevention of Pressure Ulcers/Injuries revised 12/2019 included, that staff were to Evaluate, report, and document . in the resident's medical record. The policy did not address recording the date or time on the wound dressing upon the dressing change. NJAC 8:39-11.2(a), 27.1(b), 29.2(b)