STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** C#: NJ# 505, NJ 714 Based on interviews, and record review, as well as review of pertinent facility documents on 2/27/20, 2/28/20, 3/2/20, 3/3/20, and 3/4/20 it was determined that the facility failed to administer medications and wound treatments according to physician's orders [REDACTED].#1 and #4) reviewed for medication administration and wound treatment. This deficient practice is evidenced by the following: 1. According to the Admission Record (AR) form, Resident #4 was admitted to the facility with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), an assessment tool, dated 10/26/19, Resident #4 had moderate cognitive impairment and required extensive assistance from staff with Activities of Daily Living (ADLs). The Care Plan (CP) initiated on 10/25/19 showed that the Resident had a [DIAGNOSES REDACTED]. The physician's orders [REDACTED].#4 had the following orders but not limited to: [MEDICATION NAME] (Atrovent) 0.02% nebulizer solution, take one (1) vial (0.5 milligrams) by nebulizer four (4) times a day (9:00 am, 1:00 pm, 5:00pm and 9:00 pm); Umeclidinium [MEDICATION NAME] (Incruse Ellipta) 62.5 micrograms (mcg)/ inhaler inhale 1 puff once a day (9:00 am); [MEDICATION NAME]-[MEDICATION NAME] (Duo-Neb) 0.5-2.5 milligrams (mg)/3 milliliters (ml), take 1 vial (3 ml total) by nebulization 4 times a day (9:00 am, 1:00 pm, 5:00 pm and 9:00 pm); [MEDICATION NAME] ([MEDICATION NAME]) 1.25 milligram (mg)/0.5 ml nebulizer solution take 0.5 ml (1.25 mg total) by nebulization 4 times a day (9:00 am, 1:00 pm, 5:00pm and 9:00 pm); [MED] [MEDICATION NAME] ([MED]) 100 units/ml subcutaneous, finger sticks, blood sugars with meals and in the evening for Diabetes Mellitus; [MEDICATION NAME] tablet 100 mcg by mouth daily at 6:00 am for [MEDICAL CONDITION]; [MEDICATION NAME] ([MEDICATION NAME]) 10 mg by mouth twice a day for [MEDICAL CONDITION] Reflux Disease. The Routine Medications (RM) form for 10/2019 showed the aforementioned orders. The RM further showed that on 10/25/19 at 5:00 pm and 9:00 pm, the nursing staff failed to document to indicate that the Atrovent, Duo-neb and [MEDICATION NAME] were administered; on 10/25/19 at 9:00 am the nursing staff failed to document to indicate that the Incruse Ellipta inhaler was administered; on 10/25/19 at 6:30 am nursing staff failed to document the administration of finger sticks blood sugars; on 10/25/10 at 6:00 am the nursing staff failed to document to indicate for the administration of [MEDICATION NAME] tablet; on10/25/19 at 6:00 am and 5:00 pm the nursing staff failed to document the administration of [MEDICATION NAME] tablet. Resident #4's Nurse's Notes (NN) for 10/19 showed that there was no documentation to indicate that the Resident was administered the aforementioned medications at the aforementioned dates and times. The NN dated 10/25/19 showed that the Resident was inquiring about his/her medications on 10/26/19, was experiencing shortness of breath and was sent to an Acute Care Hospital (ACH) for evaluation on 10/26/19. The ACH INTER-FACILITY TRANSFER AFTER VISIT SUMMARY (IFTAVS) showed that Resident #4 was admitted to the ACH on 10/26/19. The DETAILS OF HOSPITAL STAY showed that the Resident was admitted to the ACH due to the medication not being administered at the facility. The form Order Status (OS) showed that the above medications were dispensed and delivered to the facility on [DATE] at 12:00 midnight. The surveyor conducted an interview with Licensed Practical Nurse (LPN #3, primary LPN for Resident #4 from 10/24/19 at 11:00 pm to 10/25/19 at 7:00 am) on 3/4/20 at 9:40 am. The LPN revealed that she always signed the RM right after administering medication. She further revealed that if she did not sign on the RM, it meant that she did not administer the medications. The surveyor conducted an interview with LPN #4 (primary LPN for Resident #4 on 10/25/19 during 3:00 pm to 11:00 pm shift and on 10/25/19 from 11:00 pm to 10/26/19 to 7:00 am) on 3/4/20 at 11:55 am. The LPN revealed that she wrote the NN dated 10/25/19 and that the correct date should have been 10/26/19. She further revealed that if she did not sign the RM, it meant that she did not administer the medication. She stated that she did not document on the RM on 10/25/19 during 3:00 pm to 11:00 pm shift for Resident #4's medications because the aforementioned medications were not available. The surveyor conducted an interview with Assistant Director of Nursing (ADON) on 3/4/20 at 12:19 pm. The ADON revealed that when the there was no signature on RM indicating that a medication was administered, it meant that the medication was not administered. The surveyor conducted an interview with Director of Nursing (DON) on 3/4/20 at 9:27 am. The DON revealed that when there was no signature on the RM it meant that the medication was not administered. 2. According to the AR form Resident #1 was admitted to the facility with [DIAGNOSES REDACTED]. According to the MDS dated [DATE], showed that Resident #1's cognition was intact and required extensive assistance from staff with ADLs. The Care Plan initiated on 9/25/19 and revised on 10/12/19 showed that the Resident had wounds on the following that included but were not limited to: Stage 3 on the Right Posterior Knee, Deep Tissue Injury (DTI) on the Right Distal Lateral Foot, Right Proximal Lateral Foot/Right Ankle. Interventions was included but not limited to: administer treatments as ordered. The PO showed the following orders: Right Lateral Foot: On 1/20/20 at 1:30 pm apply [MEDICATION NAME] dressing (is a wafer type of dressing that contains gel-forming agents in an adhesive compound laminated onto a flexible, water-resistant outer layer. Some formulations contain an alginate to increase absorption capabilities) on the Right Lateral Foot cover with [MEDICATION NAME] dressing change 3 times per week. On 2/15/20 at 10:30 am the aforementioned order was discontinued, the new order was to cleanse the Right Lateral Foot with Normal Saline (NSS) apply [MEDICATION NAME] dressing every other day. On 2/22/20 the aforementioned order was discontinued, the new order was to apply Xeroform dressing (is a sterile wound dressing that is non-adherent, which means it won't stick to the wound so dressing changes are less painful and trauma to the wound is minimized) on Right Lateral foot change every other day. The ROUTINE TREATMENTS (RT) for the month of 2/2020 showed the aforementioned orders. However, there was no documentation to indicate that the wound treatments were administered for the following dates and time: On 2/5/20, 2/7/20, 2/10/20, 2/12/20, and 2/23/20 on the 7:00 to 3:00 shift. Right Lateral Ankle: On 2/15/20 at 10:30 am cleanse Right Lateral Ankle with NSS apply Xeroform dressing then gauze then 4 layers of [MEDICATION NAME] dressing change 3 time a week and as needed The RT for the month of 2/2020 showed the aforementioned orders. However, there was no documentation to indicate that the wound treatments were administered for the following dates and time: On 2/5/20, 2/10/20, and 2/23/20 on the 7:00 to 3:00 shift. Right Dorsal Foot: On 2/10/20 apply Xeroform dressing to blister on the Right Dorsal Foot change every other day and as needed. The RT for the month of 2/2020 showed the aforementioned orders. However, there was no documentation to indicate that the wound treatments were administered for the following dates and time: On 2/10/20 and 2/23/20 on the 7:00 to 3:00 shift. Right Posterior Knee: On 2/22/20 apply Xeroform dressing on the Right Posterior Knee cover with gauze and [MEDICATION NAME] (Kling dressing) change every other day. The RT for the month of 2/2020 showed the aforementioned orders. However, there was no documentation to indicate that the wound treatment was administered for the following date and time: On 2/23/20 on the 7:00 to 3:00 shift. The Progress Notes (PN) for the month of 2/2020 showed that there was no documentation that the wound treatment was administered on the aforementioned date and shift. The surveyor conducted an interview with the Assistant Director of Nursing (ADON) on 3/4/20 at 12:15 pm. The ADON stated that it was the nurse's responsibility to document on the resident's nurse's notes and the RT that the treatment was administered. She further stated that if the treatment was not documented it meant it was not done. The facility's policy titled Medication Administration Errors Policy and Procedure revised 1/20 showed that: .POLICY .Types of errors include: a. Omission . The facility's policy entitled Medication Administration Policy and Procedure revised 6/19 showed that: .Policy Interpretation and Implementation .3. Medications

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.

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) must be administered in accordance with the orders, including any required time frame .13. The individual administering the medication must initial the resident's MAR (Medication Administration Record) on the appropriate line after giving each medication and before administering the next ones .16. If drug is withheld, refused, or given at the time other than the scheduled time, the individual administering the medication shall initial and circle the MAR indicated [REDACTED]. If a medication is unavailable the pharmacy will be contacted for the medication to be received on the next scheduled delivery. The primary MD (Medical Doctor) will be notified of the unavailable medication and orders obtained as needed . NJAC 8:39-29.2 (d)
F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** C #: NJ: 6, 4, 4, 3, 8 Based on observation, interviews, and record review, as well as review of pertinent facility documents on 2/27/20, 2/28/20, 3/2/20, 3/3/20 and 3/4/20, it was determined that the facility failed to ensure foot care was received for 1 of 3 residents (Resident #8) observed for resident's care. This deficient practice is evidenced by the following: 1. According to the Admission Record (AR) form Resident #8 was admitted to the facility with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), an assessment tool, dated 2/2/20, Resident #8 was cognitively intact and required supervision to limited assistance from staff with Activity in Daily Living (ADL). The Care Plan (CP) for Resident #8, initiated on [DATE] showed that the Resident had Diabetes Mellitus. Interventions included but were not limited to: refer to Podiatrist for foot care, nurse to monitor, document foot care needs and to cut long nails. The CP for Resident #8, initiated on [DATE] showed that the Resident had an Activity of Daily Living (ADL) self care performance deficit related to Activity Intolerance. Interventions included but were not limited to: during bathing check nail length, trim and clean on bath days and as necessary. On 2/27/20 at 9:30 am, the surveyor observed Resident #8 was sitting in the recliner chair. Resident #8 stated he/she was having difficulty putting on his/her socks because his/her toenails were too long. The surveyor observed Resident #8's toenails on both feet were untrimmed, long, thick and curled downward. Resident #8 stated that the staff knew about his/her long toenails since admission to the facility. However, no staff or Podiatrist cut/trimmed his/her toenails. The physician's orders [REDACTED]. However, Resident #8 was not on the list since his/her admission on 10/28/19. Furthermore, the list dated 1/14/20 to [DATE] showed that Resident #8 was not added to the list until 2/17/20 for the Podiatry consult. However, up to the time of survey on 2/27/20 to 3/4/20, Resident #8 had not seen the Podiatrist to cut his/her toenails. In addition, Resident #8's medical record showed no documentation to indicate that the Resident was seen by the Podiatrist since admission (10/28/19) or the staff trimmed the Resident's toenails. During a follow-up interview with Resident #8 on 2/28/20 at 11:00 am, the Resident stated that he/she requested to see the Podiatrist since the day of the admission (10/28/19). The staff would tell him/her that they would add Resident #8 on the list to be seen by the Podiatrist (foot doctor). However, no Podiatrist came to see the Resident. The Resident stated he/she could not trim his/her toenails alone because of the Diabetes Mellitus, he could injure his/her toes. The surveyor conducted an interview with the Certified Nurse Assistant (CNA #1, asssigned CNA for Resident #8) on 2/28/20 at 12:19 pm. The CNA stated that he knew that Resident #8 had long, thick, curled, untrimmed toenails, and he reported it to the Unit Manager (UM #1). He stated that Resident #8's toenails had not been trimmed or cut since the Resident's admission to the facility. The surveyor conducted an interview with the Unit Manager (UM #1) on 3/3/20 at 10:29 am. UM #1 stated that CNAs and nurses were not allowed to cut residents' toenails. Residents who needed their toenails trimmed would be put on the list located at the Receptionist desk. The nurse would call the Receptionist, to add the resident's name on the list for the Podiatrist consult. The UM revealed that the facility had a new Podiatrist since 1/2020. The UM stated that the last time she recalled the new Podiatrist came to the facility was 2/4/20. The UM was unable to explain why Resident #8 was not on the list to be seen by the Podiatrist since his/her admission. The UM went on to state that she could not recall if she made a request to add Resident #8 on the list for the Podiatry consult. The UM was aware that Resident #8 needed the Podiatry consult because the Resident's toenails were long and thick. The surveyor conducted an interview with the Director of Nursing (DON) on 3/3/20 at 12:06 pm. The surveyor mentioned Resident #8's toenails (as described above). The DON stated that Resident #8 needed to be on the list for the Podiatry consult. However, she could not explain why the Resident was not on the list since the Resident's admission to ensure that the Resident received proper treatment and foot care. Receptionist #1 and #2 were not available for an interview with the surveyor on [DATE] at 1:00 pm and 1:10 pm. The facility's policy titled Foot Care Policy and Procedure dated 1/2020 showed PURPOSE: To ensure the facility has a program to maintain optimal foot hygiene for the residents .PROCEDURE/GUIDELINES: .6. Any abnormalities are to be reported to the physician for immediate treatment. 7. Residents will be referred to podiatry for any abnormalities and routine care as per state guidelines. NJAC 8:39-27.1(a) NJAC 8:39-27.2(g)
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** C#: NJ: 6, 4, 4, 3, 8 Based on observations, interviews, and record review, as well as review of pertinent facility documents on 2/27/20, 2/28/20, 3/2/20, 3/3/20, and 3/4/20 it was determined that the facility failed to ensure there was adequate staffing to provide for the needs of residents for 3 of 6 Residents (Resident #5, #6, and #14) observed for nursing care. This deficient practice is evidenced by the following: 1. According to the ADMISSION RECORD (AR) form, Resident #14 was admitted to the facility with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), an assessment tool, dated 1/25/20, Resident #14 was severely cognitively impaired and required total assistance from staff with Activities of Daily Living (ADLs). The Care Plan (CP) initiated on 7/22/19 showed that the Resident had an alteration in ADL self-care performance. Intervention included but was not limited to: Provide 1 staff assist with transfers, bathing, hygiene and dressing. During the tour with the Assistant Director of Nursing (ADON) on 2/28/20 at 10:20 am. The ADON stated that Residents census on the Subacute Unit (SU, unit that Resident #5, Resident #6 and Resident # 14 resided on) on 2/28/20 was 27. The NURSING Daily Attendance Report dated 2/28/20 showed that there was only one (1) Certified Nursing Assistant (CNA #1) scheduled to work on the 7:00-3:00 pm shift. The surveyor conducted an incontinence observation with the ADON and Licensed Practical Nurse (LPN #4, the primary LPN on the SU on 2/28/20 during the day shift) on 2/28/20 at 10:30 am. The surveyor observed Resident #14 was still in bed. The surveyor, the ADON, and LPN #4 observed Resident #14 was wearing 2 incontinent briefs, and the first incontinent brief was soiled with moderate amount of urine. LPN #4 stated that she smelled a strong urine odor as soon as she opened Resident #14's incontinent briefs. Then the ADON and LPN #4 performed incontinence care and repositioned Resident #14 in bed for comfort. The surveyor attempted to interview Resident #14 on 2/28/20 at 10:46 am. However, Resident #14 was unable to respond to the surveyor. CNA #3 (CNA assigned to Resident #14 on 2/27/20 during the night shift) was not available for an interview on [DATE] at 11:08 am with the surveyor. 2. According to the AR form, Resident #6 was admitted to the facility with [DIAGNOSES REDACTED]. The RESIDENT-DATA COLLECTION (RDC) dated 2/25/20 showed that the Resident required one staff assist with transfers and ambulation. The RDC further showed that the Resident was alert, cooperative, quick to comprehend and oriented. The Care Plan (CP) initiated on 2/25/20 showed that the Resident had an alteration in ADL self-care performance. Intervention included but was not limited to: Provide 1 staff assist with transfers, bathing, hygiene and dressing. The CP initiated on 2/25/20 showed that the Resident had a potential for skin impairment due to immobility. Interventions included but were not limited to: follow facility policy/protocol for the prevention/treatment of [REDACTED]. During the tour on 2/28/20 at 11:59 am the surveyor observed Resident #6 still in bed and the Resident's incontinent brief was moderately soiled with urine. The surveyor conducted an interview with Resident #6 on 3/2/20 at 10:22 am. The Resident stated that on 2/28/20 during the day shift there was only 1 CNA on the unit assigned to assist the Residents. Resident #6 further stated that he/she was cleaned up for the first time at 12:39 pm, even though he/she had been asking for assistance throughout the shift numerous times. 3. According to the AR form, Resident #5 was admitted to the facility with [DIAGNOSES REDACTED]. According to the MDS, an assessment tool, dated 2/15/20, Resident #5 had no cognitive impairment and required extensive assistance from staff with ADL. The Care Plan (CP) initiated on 5/13/19 showed that the Resident had an alteration in ADL self-care performance. Intervention included but was not limited to: Provide two (2) staff assist with transfers and one (1) staff assist with bathing, hygiene and dressing. The CP initiated on 5/13/19 showed that the Resident had a potential for skin impairment due to immobility. Interventions included but were not limited to: follow facility protocol for the prevention of skin breakdown and incontinence care. During the tour on 2/28/20 at 1:35 pm, the surveyor observed Resident

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) #5 was still in bed and the Resident's diaper was moderately soiled with urine. The surveyor conducted an interview with Resident #5 on 3/2/20 at 10:14 am. The Resident stated that on 2/28/20 during the day shift there was only one (1) CNA on the Subacute Unit (SU) assigned to assist/provide the residents. The Resident further stated that he/she was cleaned up for the first time at 1:50 pm on 2/28/20. The Resident revealed that he/she had been asking for help with changing the incontinent brief numerous times throughout the shift. The surveyor conducted an interview with the Certified Nursing Assistant (CNA #2, the primary CNA on the SU on 2/28/20 during the day shift) on 2/28/20 at 1:03 pm. The CNA revealed that she was the only scheduled CNA to work on the SU on 2/28/20 during the day shift and that she was expected to take care of 27 Residents. She further revealed that she was responsible for morning care and incontinence rounds for all 27 Residents as well as assisting with feeding for Residents who required it. She revealed that she was unable to complete the incontinence rounds every two hours in accordance with nursing standards of care and protocol. She further revealed that she could only do the rounds one time since 7:00 am. She stated that at this time (1:03 pm) some Residents were still in bed and not washed as she was unable to get to the residents as expected. The surveyor conducted an interview with Staffing Coordinator (SC) on 2/28/20 at 1:30 pm. She revealed that on 2/28/20 there was only one CNA scheduled to work on the SU during the day shift. She further revealed that there should be 2 to 3 CNAs working on that unit during the day shift. She stated that the SU was short staffed on 2/28/20. The surveyor conducted an interview with Licensed Practical Nurse (LPN #2, the primary LPN on the SU on 2/28/20 during the day shift) on 3/2/20 at 11:44 am. The LPN revealed that SU was short staffed on 2/28/20. She further revealed that there was only one CNA scheduled to work during the day shift and was expected to take care of 27 Residents. She stated that because of short staffing, the CNA was very limited with the amount of care she was able to provide to Residents, even with the LPN and other facility staff help. She revealed that Resident were not toileted as often as needed and were not turned and repositioned as often as needed which was at least every 2 hours. She further revealed that that skin breakdown could occur if Residents were not toileted and turned and repositioned every 2 hours. The undated facility's job description titled Nursing Department Staffing Coordinator Job Description showed General Purpose: The primary purpose of your job position is to ensure adequate and appropriate staffing of the facility nursing department to meet the needs of the residents . NJAC 8:39-27.1(a)