STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STERLING MANOR	**794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052**

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ 484 Based on interview, medical record review and review of other facility documentation, it was determined that the facility failed to notify a resident's emergency contact representative regarding transfer to the hospital. This deficient practice was identified for Resident #5, 1 of 3 residents reviewed for hospital transfers and was evidenced by the following: According to the face sheet, Resident #5 was admitted to the facility with [DIAGNOSES REDACTED]. Review of the most recent Minimum Data Set (MDS), an assessment tool, dated 08/11/2020, revealed that Resident #5 scored 6 out of 15 on the Brief Interview for Mental Status, which indicated a severe cognitive deficiency. The MDS included a [DIAGNOSES REDACTED]. Review of the Nurse's Notes revealed that Resident #5 was sent to the hospital on [DATE] after falling and fracturing a knee. A copy of the face sheet from that date indicated that the person responsible for the resident's account was Self. The section listing Next of Kin to Notify in Case of Emergency was blank. The Nurse's Note, dated 03/23/2020, included the following information: After investigation able to locate granddaughter .and she was agreeable to be next of kin on face sheet. The resident's current face sheet from the medical record indicated that it was updated on 03/23/2020 and it included the name of the resident's granddaughter as the next of kin. Further review of the Nurse's Notes revealed that Resident #5 was again hospitalized from [DATE] - 05/26/2020. The resident was also sent to the hospital on [DATE] and returned to the facility that day. Neither of these nursing progress notes, dated 05/21/2020 or 07/13/2020, included documentation that the resident's emergency contact was notified of the transfer. In addition, the Universal Transfer Forms (UTF) for these hospitalization s did not include any Contact Person or telephone number to reach a family representative. On 08/21/2020 at 2:11 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who had written the progress notes on 05/21/2020 and 07/13/2020 as well as the corresponding UTFs. LPN #1 stated that when a resident was sent to the hospital, the nurses should contact the family as soon as possible to let them know so that the hospital unit staff doesn't call and surprise them. When the surveyor inquired about documentation of the notification, LPN #1 replied, When we write a Nurse's Note, we write that the doctor was notified and which relative was notified. After surveyor inquiry, LPN #1 stated that she thought the resident's granddaughter's name had just been added to the face sheet and that was the reason she was not contacted. On 08/21/2020 at 3:05 PM, the surveyor interviewed the Director of Nursing (DON) who stated that when a resident was transferred to the hospital, the nurse would have to get an order from the physician and get the resident ready for transport. She stated that after the resident left the building, the staff would call the family listed on the face sheet. She added that the staff were supposed to try and contact all of the family names listed on the face sheet. If they were unable to contact a representative, they should put it in the 24 hour report. The next shift should follow-up and let the family know that the resident was hospitalized . The DON added that the nurses at the facility do everything, but the documentation is very poor. When they send them out you have to write the notes. The facility staff could not provide any documentation that the resident's representative was notified that Resident #5 was sent to the hospital on [DATE] or 07/13/2020. On 08/21/2020 at 4:07 PM, the Administrator provided the facility's policy regarding Change in a Resident's Condition or Status. This policy, which was Reviewed on 5/2020, included the following statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). NJAC 8:39-13.1 (c)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #NJ 366 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to ensure an indwelling urinary catheter drainage bag (drainage bag) was stored in an appropriate manner to prevent the spread of infection. This deficient practice was identified for Resident #1, 1 of 1 sampled resident reviewed for urinary catheter care and was evidenced by the following: During a tour of the West Unit, on 08/21/2020 at 9:18 AM, the surveyor observed Resident #1 lying in bed. The surveyor observed Resident #1's drainage bag and tubing on the side of the bed that faced the door. The drainage bag was not in a privacy bag and was not attached to the bed. The drainage bag and tubing were lying directly on the floor. When interviewed at that time, Resident #1 stated that the drainage bag was not supposed be on the floor and that it had a hook to attach it to the bed frame. The surveyor observed an intact hook to the resident's drainage bag. Review of the Quarterly Minimum Data Set (MDS), an assessment tool, dated 05/29/2020, revealed Resident #1 was readmitted with [DIAGNOSES REDACTED]. The MDS revealed the resident was identified as cognitively intact and totally staff dependent for activities of daily living. On 08/21/2020 at 10:17 AM, the surveyor entered Resident #1's room with the Certified Nurse Assistant (CNA #1) and observed the resident's drainage bag and tubing stored directly on the floor. When interviewed at that time, CNA #1 stated the resident's drainage bag should not have been stored directly on the floor. CNA #1 further stated the drainage bag should have been hooked to the bed and kept off of the floor. During an interview with the Licensed Practical Nurse (LPN #1) on 08/21/2020 at 10:48 AM, LPN #1 stated that drainage bags were changed biweekly and as needed. LPN #1 further stated that the resident's drainage bag was supposed to be inside of a privacy bag and attached to the bed or wheelchair. LPN #1 stated the drainage bag should not be stored on the floor for infection control. During an interview with the Director of Nursing (DON) on 08/21/2020 at 3:12 PM, the DON stated that a resident's drainage bag should be inside a privacy bag. The DON further stated that drainage bags should not drag or be stored on the floor for infection control. The surveyor reviewed the facility's Catheter Care, Urinary policy with the revision date of 09/2014. The policy reflected, under the Infection Control section, to use standard precautions when handling the drainage system. The policy further reflected to be sure the catheter tubing and drainage bag are kept off the floor. NJAC 8:39 - 19.4(a)(5)

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