STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

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 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # NJ 5 Based on observation, interview, and record review, it was determined that the facility failed to provide a visually impaired resident with the care and assistance needed to meet the resident's needs. This deficient practice was identified for Resident #3, 1 of 14 residents reviewed and was evidenced by the following: According to the Admission Record (AR), Resident #3 was admitted to the facility with the [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) an assessment tool dated 6/22/2020 reflected that Resident #3 had moderately impaired vision and was not able to see newspaper headlines but could identify objects. The MDS also indicated that the resident was cognitively intact and required extensive to total assistance with activities of daily living (ADL's). According to Progress Note dated 6/26/2020 at 16:11 hours, the Nurse Practitioner (NP) documented that Resident #3 was legally blind. According to the Social Service assessment dated [DATE] at 09:18 am, the Social Worker (SW) documented that Resident #3 had visual limitation that were affecting the resident's ability to function. The Occupation Therapy (OT) Evaluation and Plan of Treatment dated 6/17/2020-7/15/2020 reflected that Resident #3 presented with new onset of impaired vision. The OT Discharge Summary dated 6/17/2020-8/2020 indicated that skilled treatment interventions included instructing and training the resident in compensatory strategies 2/2 for low vision in order to facilitate independence with ADL's and functional mobility. The OT note dated 7/24/2020 indicated that Resident #3 required sit to stand from bed with rolling walker with contact guard assistance and tactile cues for hand placement secondary to visual deficits. According to an Optometry report dated 07/29/2020, the resident was examined, and it was determined that Resident #3 had decreased vision and that vision was moderately impaired. On 9/1/2020 at 11:35 AM, the surveyor interviewed a Certified Nursing Assistant (CNA) who stated that Resident #3 was alert and oriented and required total assistance with care. She indicated that the resident required assistance with eating, assistance with using his/her personal cell phone because the resident was blind. The CNA stated that the resident had certain preferences that some days he/she needed assistance with his/her meals during the day due to [MEDICAL CONDITION]. On 9/1/2020 at 12:05 PM, the surveyor interviewed the Cook Supervisor (CS) who indicated that there was a select menu that residents were able to choose meals from daily and that there was also an always available menu that is offered daily to residents so that they can choose food to eat anytime of the day. The CS stated that she assisted residents with meal selection daily. On 9/1/2020 at 12:30 PM the surveyor interviewed Resident #3 who stated that he/she required assistance with reading because he/she was blind. He/she stated that he/she required assistance with dialing the phone because he/she could not see the numbers and that he/she also required assistance with reading the menu and using the remote control for the TV. I don't get help with reading the menu and dialing my phone. I can't see because and blind. During the interview with Resident #3, the surveyor observed a CNA enter the resident's room to pick up a un-touched lunch tray that was sitting on the windowsill. The resident told the CNA that he/she did not want the meal that was served at lunch. The CNA asked the resident what he would like to eat, and the resident stated, What do you have? The CNA did not offer the resident or assist the resident with the Always Available menu (food that is available all day). The resident then stated, Do you see what I mean, how do I know what's on the menu if nobody tells me. The surveyor asked the CNA to get the Always Available menu and go over it with the resident. The surveyor reviewed Resident #3's Care Plan (CP) and there was no individualized resident Care Plan developed to address the resident's preferences regarding visual his/her impairment. The surveyor interviewed the acting Registered Nurse Unit Manager (RN UM) who stated that Resident #3 was legally blind and the he/she required assistance with reading, meals, dialing the phone and using the remote control. She added that she did not know that Care Plan was not developed to address the resident's preferences due to visual limitations. On 9/1/2020 at 1:30 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that Resident #3 had impaired vision, but the vision was now worse. She added that he used to be able to read the food menu but is now having difficulty and needs more assistance. On 9/2/2020 at 9:10 AM, the surveyor interviewed the OT who stated that Resident #3 had a [MEDICAL CONDITIONS] (Stroke) in June which affected his/her vision. She indicated that the resident had no formal eye examination, but it was determined by observation and what the resident tells the staff what he/she can see and not see. I always tell the staff to assume that he/she was blind and to make sure he/she was set up properly for example food tray, call bell and assistance with phone. On 9/2/2020 at 1:20 PM, the Assistant Director of Nursing (ADON) stated that a individualized Care Plan should have been developed for Resident #3 to address the [DIAGNOSES REDACTED]. On 9/3/2020 at 3:00 PM. The surveyor interviewed the Director of Nursing (DON) who confirmed that a Care Plan should have been developed to address the needs that Resident #3 had due to visual impairment. According to the facility policy dated September 2013 and titled Care Planning indicated that the facility's Care Planning/Interdisciplinary team was responsible for development of an individualized comprehensive care plan for each resident. The policy also indicated that the resident, the resident's family and or the resident's legal representative and guardian or surrogate at encouraged to participate in the development of and revisions to the resident's care plan. NJAC 8:39- 4.1 (a) 11 and 12.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ 538 and #NJ 215 Based on interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to perform a complete and thorough investigation for a fall, document in the medical record, and notify the physician and responsible party of a fall with injury in accordance with the facility policy related to a resident falls for 2 of 3 residents reviewed for falls, (Resident #6 and Resident #2, closed record). This deficient practice was evidenced by the following: The surveyor reviewed the Admission Record of Resident #6 which indicated that the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) (an assessment tool) revealed that Resident #6 had a Brief Intermittent Mental Status (BIMS) score of 01 which indicated that the resident was severely cognitively impaired. Further review of the document identified that the resident required extensive assistance of one person for both transfers and ambulation. The surveyor reviewed a Health Status Note (HSN) contained within the Progress Notes (PN) that was written by Licensed Practical Nurse (LPN) #1 on 02/01/20 at 11:05 PM in which LPN #1 documented that Resident #6 had a fall at 7:00 PM in the dining room. LPN #1 described the resident as being awake, alert and oriented to self, but unable to answer any questions. LPN #1 noted that she notified the Supervisor, Medical Doctor and the resident's family. Further review the HSN (s) revealed an Interdisciplinary Team (IDT) noted that was written by Registered Nurse #1 on 02/02/20 at 8:08 PM, which detailed that Resident #6's fall was witnessed by another (unnamed) resident in the dining room. That resident reported to staff that Resident #6 pushed his/her chair back, stood and fell on the floor. Resident #6 stated that he/she wanted to get up when asked. The surveyor reviewed the QA Report of Incident dated 02/01/20 at 7:00 PM, which contained an investigative statement from Nursing which detailed that a resident (Resident #11) who was in the dining room reported Resident #6's fell and was on the floor. The nurse responded and found Resident #6 lying on the floor on their left side. The Supervisor was notified immediately and assessed the resident who was found to have no injuries. Nursing detailed that the fall was witnessed by another resident (Resident #11)

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) who was in the dining room at the time of the fall. Resident #11 reported that Resident #6 pushed back the regular chair that he/she was sitting in and got up independently and fell . The nurse documented that no staff witnessed the incident. Review of the Conclusion portion of the report revealed that Resident #6's fall was witnessed by another (unnamed) resident in the dining room. The Conclusion also specified that Resident #6 's Care Plan was updated for staff not to leave him/her unattended. On 09/02/20 at 11:10 AM, the surveyor requested to view the witness statements that accompanied the QA report. T he Assistant Director of Nursing (ADON) provided the surveyor with Employee Statements that were completed by both LPN #1 and Certified Nursing Assistant (CNA) #1 on 02/01/20. The ADON also provided an Incident Report Statement completed by Resident #11 that was not signed or dated by the employee who obtained the statement. The ADON stated that Resident #11 witnessed the fall, had a BIMS Score of 15 reflecting fully intact cognition and still resided at the facility. The surveyor reviewed the Incident Report Statement which noted the date of incident as 02/02/20 and the statement illustrated that Resident #11 and another unnamed resident were in the dining room and observed a Resident #6 fall on the floor and they alerted the nurse. Resident #11 signed the undated entry. On 09/02/20 at 11:24 AM, the surveyor interviewed Resident #11 who stated that the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 obtained a written statement from the resident today. The resident stated that at the time of Resident #6's fall he/she did not recall there being any facility staff in the dining room and she alerted LPN #1. Resident #11 further stated that he/she was never asked to provide a statement of the event until today. On 09/02/20 at 11:39 M, the surveyor interviewed the LPN/UM #1 who stated that she verbally asked Resident #11 if she recalled Resident #6's fall today but did not obtain a written statement from the resident. On 09/02/20 at 12:15 PM, in a later interview with the LPN/UM #1, she clarified that ADON and Director of Nursing (DON) asked her to obtain a statement from Resident #11 today as LPN #1 documented that the fall was observed by a resident but didn't document the resident's name. She stated that Resident #11 was interviewed today but the other resident had memory issues and couldn't recall the event when interviewed so she didn't bother to obtain a statement from him/her. She stated that the former ADON was responsible to review the Incident Report for accuracy. She stated that she probably shouldn't have gotten the statement today but LPN #1 didn't think of doing it. She further stated that the former ADON probably didn't think of it either. On 09/02/20 at 1:04 PM, the surveyor conducted a phone interview with LPN #1 who stated that on 02/01/20 as she passed out her medications the residents were in the dining room. She stated that Resident #11 and another resident informed her that Resident #6 fell . She further stated that she told the Supervisor that the fall was witnessed by another resident. The second resident who witnessed the fall had difficulty communicating due to [MEDICAL CONDITION]. On 09/02/20 at 1:19 PM, the ADON informed the surveyor that she called LPN #1 who remembered the resident's names who witnessed Resident #6's fall on 02/02/20 and both residents were oriented x 4 so LPN #1 should have had the residents provide a written statement that day. The ADON stated that the LPN/UM #1 had Resident #11 provide a written statement today and she should have signed it and dated it at that time. The ADON stated that the statement instead should have been obtained at the time of the event on 02/02/20. The ADON stated that Resident #6 should have been in the line of sight as safety is our priority here. On 09/04/20 at 9:15 AM, the surveyor interviewed the DON and the Administrator who stated that she educated LPN #1 that when someone fell and the fall was witnessed she needed to obtain a statement. She stated that LPN #1 didn't think to obtain a statement since the witness was another resident. She further stated that the investigation was a team effort. The Administrator stated that statements were required to be obtained on the day of the event before responsible staff left so that the details are fresh in their minds and they don't forget anything. She further stated that witnesses should also be interviewed right away. The Administrator stated that LPN #1 didn't feel that it was appropriate to obtain a statement from a resident. She stated that LPN #1 didn't know, but the Supervisor should have known to do so. The DON clarified that that the second resident that witnessed the Resident #6's fall couldn't remember the events when the LPN/UM #1 attempted to conduct an interview and thus a statement was not obtained. The surveyor interviewed the facility policy, Accidents and Incidents-Investigating and Reporting (Revise March 2018) which revealed the following: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. The name(s) of witnesses and their accounts of the accident or incident; Complaint #NJ 215 According to the Admission Record (AR), Resident #2 was admitted to the facility with the [DIAGNOSES REDACTED]. The annual Minimum Data Set (MSD) an assessment tool dated 10/13/19, indicated that Resident #2 had severe cognitive impairment, required extensive assistance with ADL's and was at risk for falls. The surveyor reviewed a facility document titled, Confidential Resident Incident Report (CRIR) dated 11/13/2019. Based on this report, Resident #2 had a fall on 11/9/19 at 4:15 PM. The report was not initiated until 11/13/2019 and according to Certified Nursing Assistant (CNA) statement and Licensed Practical Nurse (LPN) statement attached to the CRIR the fall occurred on 5/9/2019 at 4:15 PM. The report reflected that the resident was found on the floor by the bed. The fall was caused by the resident transferring from the chair to bed. The report also indicated that the resident obtained a skin tear on the left leg and chest area. There was no documentation on the CRIR that the family was notified and there was no date or time that the physician was notified. The CRIR form was not initiated until 4 days after the fall occurred. The surveyor reviewed a written statement from the Certified Nursing Assistant (CNA) untimed and dated 11/9/2019, that indicated the CNA initiated a stand-and-pivot transfer when the residents legs became crossed and the resident fell to the ground. The CNA reported the fall to the nurse (Licensed Practical Nurse) that was on duty. The surveyor reviewed a statement dated 11/13/2019 (4 days after the fall) written by the Licensed Practical Nurse (LPN) that was on duty 5/9/2019 3 pm-11 pm who was notified of the fall. According to the statement the CNA on duty reported the fall to the LPN who documented in the statement that he notified the Registered Nurse Supervisor (RNS) who was in charge on the 3 pm-11 pm shift. The LPN's statement reflected that the resident was observed to be on the floor by the bed. Resident #2 was observed as having a skin tear on the left leg and the chest area and that treatments were initiated to the skin tears. The statement did not indicate if the family or physician was notified. There was no documentation in the electronic medical record of the nursing progress notes on 5/9/2019 3 pm-11 pm shift that Resident #2 had fallen and obtained an injury. The LPN did not document the fall in the medical record nor initiate the CRIR. The RNS on duty did not document that the resident had a fall in the medical record nor did she initiate an investigation into the fall. There was no evidence that a fall assessment or a pain assessment was done at the time of the residents fall. There was also no documentation that the physician was notified or that the family was notified of the fall until 11/12/2019 at 6:43 PM, by the nurse practitioner. The LPN that was notified of Resident #2's fall on 5/9/2019 at 4:15 PM was not able to be interviewed and was not an employee of the facility at this time. On 9/4/2020 at 9:15 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the LPN should have initiated the CRIR. She also stated that the Supervisor on duty should have documented the fall in the medical record that Resident #2 was assessed. The DON stated that the expectation of the facility response to an incident or accident was to gather data, document date and time, cause, initiate investigation immediately, gather statements and document information in the resident's medical record. The DON also confimed that this did place for Resident #2's fall of 5/9/2019 at 4:15 PM. On 9/4/2020 at 9:35 AM, the surveyor interviewed the former Registered Nurse Supervisor (RN NS)that was on duty on 5/9/2020 3 pm-11 pm shift, when Resident #2 fell . The RN NS stated that she was informed by the the nurse on 11/6/2019 that Resident #2 fell and had a skin tear. She admitted that she should have documented the fall in the medical record, but did not know why she didn't. She also stated that she should have started the investigation but is not sure why she didn't because it was too long ago. The DON provided the surveyor with a timeline of events and according to the timeline the DON documented and confirmed that an incident report was not generated nor was the investigation initiated as per facility policy on 5/9/2019 at 4:15 PM, when the fall occurred. On 9/4/2020 at 10:00 AM, the DON and Administrator both agreed and confirmed that the LPN and RN NS should have initiated an incident and accident reports immediately when discovered. Also, that the LPN and RN NS on duty should have documented in the medical record when the fall occurred and should have notified the physician and the family. The DON also admitted that all employee statements were not obtained during the initial investigation and provided the surveyor with 5 additional written statements by nursing staff dated 9/2/2020 that were not completed at the time of the investigation. The surveyor reviewed facility Staff In-Service and Education document dated 10/12/19 with staff signatures that indicated that the LPN and RN Supervisor that identified the fall for Resident #2 on 11/9/2019 were educated on Incidents and Accidents. The education content dated 10/16/19 included the incident and accident process, incident/accident reports, statements and understanding of the process. The education contained a Incident/Fall Packet that revealed the following responsibilities of the nursing staff which included: -Please complete the following packet for any resident incident; fall or change in level of plan; skin impairment/bruise. -Complete incident report in risk watch. Please call the appropriate supervisor to assist in getting you in to complete the incident report. Immediately collect statements from the

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) appropriate parties to be included in this packet. -Neuro checks are only to be done if the resident was witnessed hitting his/her head or for any unwitnessed fall. -Please complete a Fall Assessment and Pain Assessment in P.C.C (Electronic medical record) for any falls -Please update the Care Plan for actual fall, applying an immediate intervention. -Do Not Forget to notify the family and the MD. -Put an order in PCC for documentation every shift for 3 days. -DON and Administrator must be notified of injury of unknown origin immediately. The facility policy date and revised July 2017 and titled, Accidents and Incidents-Investigating and Reporting indicated that all accidents and incidents involving residents, employees, visitors, vendors, ect., occurring on our premises shall be investigated and reported to the Administrator. The Policy Interpretation and Implementation revealed: 1.) The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2.)The following data, as applicable, shall be included: -The date and time of the accident or incident took place. -The nature of the injury/illness (e.g., fall, nausea, ect.) -The circumstances surrounding the accident or incident. -Where the accident or incident took place. -The names of witnesses and their accounts of the accident or incident. -The injured persons account of the accident or incident. -The time the injured person's attending physician was notified as well as the time the physician responded and his or her instructions. -The date and the time the family was notified and by whom. -The condition of the injured person, including his/her vital signs. -The disposition of the injured person. -Any corrective action taken. -Follow-up information. -Other pertinent data as necessary or required. -The signature and the title of the person completing the report. NJAC 8:39-27.1 (a)
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 5 Based on interview, review of medical records and other pertinent facility documentation it was determined that the facility failed to follow professional standards of clinical practice and facility policy with respect to the following: 1. Obtaining physician's order for the treatment of [REDACTED].#2 closed record) reviewed for incidents and accidents. 2. The facility also failed to administer medication in accordance with the manufacturer specifications during the medication pass observation. This deficient practice was identified for 1 of 2 nurses administering medications to 2 of 4 residents (Resident #12 and Resident #13). 3. The facility failed to conduct a reweigh to confirm a significant weight loss according to their policy for Resident #4. These deficient practices were 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 and 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 within the framework of casefinding; 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. According to the Admission Record (AR), Resident #2 was admitted to the facility with the [DIAGNOSES REDACTED]. The annual Minimum Data Set (MSD) an assessment tool dated 10/13/19 indicated that Resident #2 had severe cognitive impairment, required extensive assistance with ADL's and was at risk for falls. The surveyor reviewed a facility form titled Confidential Resident Incident Report which documented that Resident #2 had a fall on 11/9/19 at 4:15 PM. The report reflected that the resident sustained [REDACTED]. There was no documentation in the resident's Progress Notes (PN) on 11/9/2019 or 11/10/2019 that a treatment was applied to Resident #2's chest or left leg skin tear. There were no treatment orders for Resident #2's left lower leg skin tear or chest skin tear in the Treatment Administration Record (TAR) on 11/9/2019, 11/10/2019, 11/11/2019 or 11/12/2019. According to the TAR dated 11/1/2019-11/30/2019, Resident #2 did not have a treatment ordered to the left lower leg and chest wound until 11/13/2019. According to the physician Order Recap Report dated 11/10/19 to 11/20/19 a treatment order was not obtained for the left lower leg wound and chest wound until 11/13/2019. The physician order dated 11/13/2019, reflected an order to cleanse left shin with NSS apply [MEDICATION NAME] cream and cover with [MEDICATION NAME] (no [MEDICATION NAME]) cover with ABD pad and wrap with cling. The physician order dated 11/13/2019 indicated that the chest wound was to be covered with gauze and adhered with paper tape. The nurse who had identified the skin tears on the left lower leg and chest was no longer employed by the facility and was not able to be interviewed. On 9/3/2020 at 10:35 AM, the surveyor telephoned interviewed the Licensed Practical Nurse (LPN #1) who cared for Resident #2 on 11/12/2019 3 pm-11 pm. The nurse indicated that when she went into Resident #2's room to do wound care she observed that there were more skin tear areas then expected. She stated there were no treatment orders for a skin tear on the resident's left lower leg or the chest area, but there were intact dressings. On 9/3/2019 at 10:45 AM, the surveyor conducted a telephone interview with LPN #2 who worked 11/10/19 on the 7 am-3 pm shift who stated that the she was not informed by the previous nurse that Resident #2 had any skin tears and that the Certified Nursing Assistant (CNA) that was assigned to Resident #2 did not report that the resident had any skin tears. She stated that she did not know the resident had skin tears because there were no treatment orders for skin tears to the left lower leg and the chest area. On 9/3/2020 at 10:50 AM, the surveyor conducted a telephone interview with LPN #3 who worked on 11/11/19 the 3 pm-11 pm shift. LPN #3 stated that the resident had intact dressings to the chest and lower left leg, but did not see treatment orders in the medical record or TAR. LPN #3 also added that she could not remember if there were ordered treatments to Resident #2's left lower leg or chest wound. On 9/4/2020 at 9:15 AM, the surveyor interviewed the Director of Nursing (DON) who confirmed that there were no physician treatment orders obtained for Resident #2's left lower leg wound and chest until 11/13/2019 and that the treatment orders should have been obtained on 11/9/2019 when the resident developed the skin tears. According to the facility policy dated October 2010 and titled, Wound Care indicated that the purpose of this procedure is to provide guidelines for the care of wounds to promote healing and that staff should verify that there is a physician's order for this procedure. Documentation that should be recorded in the resident's medical record: -The type of wound care given. -The date and time the wound care was given. -The position in which the resident was placed. -The name and the title of the individual performing the wound care. -Any changes in the resident's condition. -All assessment data (i.e., wound bed color, size, drainage, ect) obtained when inspecting the wound. -How the resident tolerated the procedure. -Any problems or complaints made by the resident related to the procedure. -If the resident refused the treatment and the reason why. -The signature and title of the person recording the data. 2. Complaint #NJ 6 At 8:37 AM, the surveyor met with the Licensed Practical Nurse (LPN #4) outside of Resident #12's room to observe the medication pass. Resident #12 was observed lying in bed awake. LPN #4 stated that the resident was a brittle diabetic and that she first needed to check the resident's blood sugar prior to medication administration. She further stated that since breakfast had not yet been served to the resident that she normally gave the resident something to eat while the medications were administered. At 8:46 AM, the surveyor observed LPN #4 who prepared six medications which included [MEDICATION NAME] (Glimepiride)) (oral blood sugar lowering drug used to treat type 2 diabetes) 1 mg (milligram) and [MEDICATION NAME] (Glimepiride) 4 mg for a total of 5 mg, for Resident #12. The surveyor with LPN #4, reviewed the labels for Glimeride ([MEDICATION NAME]) 1 mg and Glimeride ([MEDICATION NAME]) 4 mg for Resident #12. The label listed a pharmacy cautionary statement which specified, Take with a meal. LPN #4 reviewed the order aloud but did not acknowledge the cautionary statement affixed to the medication packaging. The surveyor accompanied LPN #4 into Resident #12's room. The surveyor did not observe a breakfast tray or any food items in the resident's room. LPN #4 administered the prepared oral medications to Resident #12 without offering food or asking the resident if he/she had eaten. At 9:15 AM, the surveyor observed a staff member set Resident #12 up with their breakfast tray after it arrived at the resident's room. At 8:55 AM, the surveyor observed Resident #13 seated in a chair at the bedside eating breakfast. The resident had eaten 100% of the meal that was on the plate and continued to eat cereal. LPN #4 entered the resident's room and spoke with the resident in the presence of the surveyor who observed from the doorway. At 9:05 AM, LPN #4 obtained Resident #13's blood sugar prior to medication administration. She stated that the resident's blood sugar was 157 and the resident did not require any insulin according to the physician's parameter orders. At 9:06 AM, the physician approached LPN #4 and discussed Resident #13 before he entered the resident's room. At 9:15 AM, LPN #4 prepared 15 oral medications in the presence of the surveyor. The LPN read the order aloud for Repaglinide (oral blood sugar lowering drug) 2 mg give 2 tablets for a total of 4 mg, take before meals. The medication was scheduled to be administered at 7:30 AM according to the Medication Administration Record.

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) At 9:20 AM, the surveyor interviewed LPN #4 who stated that she should have given Resident #12 graham crackers with his/her medications as the medication was supposed to be given with a meal and breakfast was not served to the resident until 9:15 AM. She further stated that she normally would have called the doctor or nurse practitioner before she administered Repaglinide because the resident was still eating, and the medication was ordered before meals but there was too much going on. At 10:10 AM, the surveyor interviewed the LPN/Unit Manager who stated that LPN #4 should have provided Resident #12 with milk and crackers when the [MEDICATION NAME] (Glimepiride) was administered. She further stated that LPN #4 could have reviewed the resident's orders before she began the medication pass to ensure that she was aware of diabetic medication requirements for both residents. The surveyor reviewed the facility policy, Administering Medications (Revised 2012/Adopted April 2016), which revealed the following: Medications must be administered in accordance with orders, including any required time frame. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 3. Complaint #NJ 6 The surveyor reviewed the Admission Record of Resident #4 which revealed that the resident was admitted to the facility in Januaryof 2020 with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set ((MDS) dated [DATE], revealed that the resident had a Brief Intermittent Mental Status score of 15 which indicated that the resident was cognitively intact and required extensive assistance of two persons for transfers. The surveyor reviewed Resident #4's weight report which revealed that the resident's admission weight that was obtained on 01/24/20 via Hoyer Lift (an assistive device to lift one from a bed to chair) was 255 pounds (lbs). On 04/06/20 the Registered Dietician (RD) documented that the resident's weight was 213.9 lbs, a 41.1 pound weight loss was identified and a re-weight to confirm accuracy was not documented. The surveyor reviewed a Dietary Note dated 05/01/20 which revealed that Resident #4's admission weight was 255 lbs and on 04/06/20 the resident weighed 213.9 lbs. The RD documented a significant weight loss for a 3 month time frame and noted that March weight was not available for comparison, and she was unable to determine validity of the weight change. The RD documented that the resident had documented bilateral lower extremity swelling and chronic [MEDICAL CONDITION] with weight fluctuations expected. The resident had a documented good appetite and intake of greater than 75% of meals on average. The RD noted that resident's needs were met with current intake of meals andsupplement. She noted that she would monitor the resident's weights. Further review of the Weight Report revealed that on 05/11/20, the RD documented that Resident #4 weighed 198 lbs. There was no documented re-weight to validate the accuracy of the resident's weight. The surveyor reviewed a Nutrition Note dated 05/11/20 which revealed that the resident experienced a weight loss of 15.9 lbs or 8% which she described as clinically significant in 1 month. The RD documented an unplanned but favorable weight loss and noted that the resident had a good appetite and continued with current diet and supplement. The surveyor noted that on 06/12/20 Resident #4's weight was obtained via Hoyer Lift and the resident weighed 203 lbs and experience a five pound weight gain. The had a documented refused to be weighed in July of 2020. On 08/10/20 the resident was weighed by the RD and she documented that the resident weighed 200.1 lbs. On 09/04/20 at 10:38 AM, the surveyor interviewed the RD who stated that Resident #4 was admitted to the facility in January 2020 and the former RD documented on 01/30/20 that the resident had a usual body weight of 208 lbs. The RD stated that the resident had refused to be weighed four times. She further stated that the resident had an identified 16% weight loss on 04/06/20 that was expected due to the resident's [MEDICAL CONDITION] and bilateral lower extremity swelling. The RD stated that the Resident #4 was overweight and was closer to his/her usual body weight. She noted that the resident was ordered Prostate (protein supplement) for wound healing of venous ulcers. She stated that as of 08/10/20 the resident was within acceptable body weight range. The RD stated that we could argue the accuracy of the 01/24/20 weight and we probably should have gotten a re-weight within 24 hours because if the weight was obtained by a Certified Nurse Aide a Nurse was required to be present to validate the weight. She further stated that the resident refused to be weighed on 01/27/20. The RD stated that when she recorded the resident's weight on 04/06/20 of 213.9 lbs she was required to re-weigh the resident per policy due to a 3% change in the weight a re-weight was required. The RD stated she was unsure why a reweigh was not done as she delegated the reweigh to the Unit Manager (UM). The RD further stated that she did not document that she verbally requested the UM to weigh the resident. The RD stated that she was new to the facility and was learning the process and didn't know that she was required to document the delegation for the UM to reweigh Resident #4. She stated that with the resident being overweight she thought that it was a favorable weight loss for the resident. Further review of the Weight Report revealed that on 05/11/20 the RD documented that Resident #4 weighed 198 lbs. She stated that she believed that she requested a reweigh, but without documentation of the request she could not be certain. She stated that a reweigh was required at that time in accordance with the facility policy. The RD stated that today she would be more conscientious to ensure that a reweigh was obtained and the request and any refusals were well documented. She stated that she felt that Resident #4 had adequate nutrition versus malnutrition and the weight loss was related to the [MEDICAL CONDITION] and [MEDICAL CONDITION] which she stated had improved through the use of a diuretic ([MEDICATION NAME]) which the resident continued to take. The surveyor reviewed the facility policy, Weight Assessment and Intervention (Adopted March 2016) which revealed the following: Any weight change of 3% or more since the last weight assessment will be retaken in the presence of a nurse for confirmation. The Dietician will review weights on a routine basis to address changes. The Dietician will review the resident's weights monthly to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met. NJAC 8:39-11.2 (b)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ 8 Based on interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to follow and implement fall prevention interventions in accordance with the facility policy and the resident's care plan for 1 of 3 residents reviewed for falls, (Closed record, Resident #6). This deficient practice was evidenced by the following: The surveyor reviewed the Admission Record of Resident #6 which indicated that the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) (an assessment tool) revealed that Resident #6 had a Brief Intermittent Mental Status (BIMS) score of 01 which indicated that the resident was severely cognitively impaired. Further review of the document identified that the resident required extensive assistance of one person for both transfers and ambulation and utilized a walker and or wheelchair. The surveyor reviewed Resident #6's Progress Notes (PN) and noted a Health Status Note (HSN) dated 01/01/20 at 9:12 PM, which established that Resident #6 had a witnessed fall when the Certified Nursing Assistant (CNA) was with the resident. The LPN documented that the resident slipped while walking back from the bed to the bathroom and landed on his/her backside. The resident was evaluated by nursing and appeared to have no injuries. The surveyor reviewed the QA Report for the Incident which was dated 01/01/20. The Fall Details portion of the document specified that the CNA had Resident #6's hand as the resident ambulated on tile flooring back to bed from the bathroom and the resident slid on the floor landing on his/her backside. It was documented that the resident wore socks in the area designated for footwear description. The surveyor reviewed the Notes portion of the document which included an Investigation Summary written by the former Director of Nursing (DON) on 01/02/20 at 5:42 PM, which revealed the following: Resident #6 was alert and oriented to self, and was confused. The resident required extensive assistance with ADL's (activities of daily living) and mobility. The resident also had a lack of muscle coordination and difficulty walking. The DON noted that on 01/01/20 at 9:20 PM, Resident #6 had a witnessed fall, while ambulating from the bathroom to bed. He/She only had regular socks on, no shoes and a wheelchair was not in use at the time. Floor surfaces were dry/clutter free. An x-ray was obtained and was negative for dislocation or fracture and staff were educated to follow precautionary measures. The surveyor reviewed the Conclusion portion of the Investigation which added that Resident #6 ambulated with the supervision of staff or family with a walker or by holding onto someone's hand. On 01/01/20 at 5:30 PM, the resident slid on the floor while he/she ambulated from the bathroom to bed, witnessed and had no injury. The resident had proper socks on, floor was dry, free of clutter. Staff educated not to leave the resident unattended. The surveyor reviewed the Witness portion of the form which revealed that the CNA shut the door to the bathroom while holding the resident's hand. The resident slid down onto the floor onto his/her backside. The surveyor reviewed Resident #6's Care Plan which contained an entry dated 12/13/19, which revealed that the resident was at risk for falls related to poor safety awareness and generalized weakness. Included in this entry was an intervention which specified that the resident wore non-skid socks at night. Further review of the Care Plan revealed an intervention dated

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	315524	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) 12/12/19, which specified that the resident utilized a walker when ambulating and it should be kept in reach when the resident was in the chair or bed. On 09/02/20 at 11:45 AM, the surveyor interviewed the CNA who stated that residents must wear non-skid socks or shoes to walk instead of regular socks because they will slide so that the resident will not slip. On 09/02/20 at 12:59 PM, the surveyor conducted a phone interview with Licensed Practical Nurse (LPN) #1 who stated that Resident #6 couldn't walk with hand holding. She stated that if the resident walked with a walker he/she required another staff member because the resident was really confused. She stated that the resident was required to wear shoes or non-skid socks. She further stated that for safety reasons socks were not permitted for ambulation. On 09/02/20 at 1:31 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that Resident #6 should have utilized the mobility device that he/she was care planned for and had appropriate foot wear on instead of the the resident being led by the hand and wearing socks related to the 01/01/20 fall. On 09/04/20 at 9:15 AM, the surveyor interviewed the Administrator and the Director of Nursing (DON). The DON stated that Resident #6's Care Plan specified that the resident wear socks at night and the accident happened when the resident was out of bed at 7:30 PM accompanied by the CNA who held the resident's hand. She further stated that we recommend that the CNA put shoes on the resident if socks were worn. The Administrator stated that when Resident #6's shoes were removed that non-skid socks were recommended. She further stated that the CNA was reminded to ensure that shoes were worn. She further stated that the resident should have utilized the correct assistive device that was care planned for. The surveyor reviewed the facility policy, Falls and Fall Risk, Managing (Revised March 2018) which revealed the following: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try and prevent the resident from falling and to try to minimize the complications of falling. Environmental factors that contribute to the risk of falls include: Footwear that is unsafe or absent. NJAC 8:39-27.1(A)
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 9 Based on observation, interview and record review, it was determined that the facility failed to ensure that: 1. a physician and three nursing personnel adhered to transmission-based precautions and cleaned non-dedicated equipment after use and 2. proper hand washing technique was performed during the medication pass observation. This deficient practice was observed for 2 of 2 nurses observed during medication pass on 1 of 5 nursing units, (Central Unit) and was evidenced by the following: 1. On 09/3/20 at 8:54 AM, the surveyor observed Licensed Practical Nurse (LPN) #4 as she prepared medications for Resident #13 outside of the resident's room. There was a stop sign affixed to the outside of entry way to the resident's room that cautioned the following: Contact Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also: Put on gloves before room entry. Discard gloves before exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves to care for more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. Beneath the signage there was a three drawer plastic cart that contained Personal Protective Equipment (i.e. gown, gloves, disinfectant cloth wipes). At 8:55 AM, the surveyor observed Resident #13 seated in a chair at the bedside eating breakfast that was placed on top of an overbed table that was pulled in front of the resident. There was a privacy curtain directly to the right of the resident. LPN #3 did not donn a gown or gloves before she entered the resident's room. The surveyor observed from the doorway that the resident held a napkin up to his/her right forearm and the napkin contained a small amount of bloody drainage. The resident showed LPN #4 the affected area. LPN #4 tied the privacy curtain into a knot to gain access to the resident. LPN #4 applied gloves after she noted bloody drainage on Resident #13's right forearm. She then called the Unit Manager (UM) into the room to discuss the resident's wound. The UM failed to perform hand hygiene or donn a gown and gloves prior to entry to the room in accordance with the signage located outside of the room. At 9:06 AM, the Physician approached the medication cart and discussed Resident #13's status with LPN #4. The Physician entered the resident's room without first performing hand hygiene or donning a gown. He donned a one purple glove and one clear glove. He then auscultated (listened) to the resident's heart and lungs with his personal stethoscope. The physician left the resident's room without first performing hand hygiene. At 9:08 AM, the Physician walked down the hall and called out for the UM. When interviewed the physician stated that Resident #13 was on isolation for a Staph Infection (an infection caused by bacteria found on the skin) and there were cultures (labs) pending to determine if the resident [MEDICAL CONDITION] ([MEDICAL CONDITION]-resistant staphylococcus aureus) (a bacterium with antibiotic resistance) or if she had MSSA (infection treatable with antibiotics). He further stated, We don't know because the resident [MEDICAL CONDITION] before and the resident's skin weeps. He stated that the resident had Proteus Mirabilis (gram negative bacteria). The surveyor noted that the Physician carried gloves in his left hand. When interviewed, he stated that he didn't see a trashcan inside of Resident #13's room and carried them out of the room. He further stated that he also forgot to perform hand hygiene when he left the resident's room. At 9:09 AM, the Physician asked the surveyor where he should discard the gloves before he returned to the Resident #13's room, discarded the gloves and performed hand hygiene inside of the resident's bathroom out of the line of sight of the surveyor. He apologized to the surveyor and stated that he was sorry that he forgot to perform hand hygiene and donn/doff a gown/gloves upon entry and exiting Resident #13's room. At 9:10 AM, the surveyor observed the UM and a Certified Nursing Assistant (CNA) inside of the room as they repositioned and pulled up Resident #14 (roommate of Resident #13) and neither wore a gown or gloves. The UM performed hand hygiene in the resident's bathroom out of the line of sight of the surveyor and the CNA utilized alcohol based hand rub that was affixed to the wall outside of the Resident #14's room. At 9:12 AM, the surveyor observed LPN #4 enter Resident #13's room with a hand held automated blood pressure device. LPN #4 entered the room and did not donn a gown or gloves before she obtained a blood pressure reading on the resident's left lower arm which rested on the overbed table. LPN #2 removed the blood pressure cuff and brought it out of the resident's room and placed it on top of a paper towel located on the medication cart and did not sanitize the blood pressure cuff after use. LPN #4 then accessed the medication cart without first performing hand hygiene. The surveyor observed LPN #2 as she poured a single Vascepa tablet into the cap of the bottle before she picked the tablet up with her ungloved hand and placed it into Resident #13's medication cup. At 9:28 AM, the Physician informed the surveyor that isolation was no longer needed for Resident #13 because the resident's cultures were not positive [MEDICAL CONDITION]. At 9:43 AM, LPN #4 untied Resident #13's curtain at the resident's request for privacy. She left the resident's room without first performing hand hygiene, touched her hair and pushed the medication cart down the hall. LPN #4 stated that she realized that she forgot to administer insulin to Resident #13 and returned to the resident's room. At 9:45 AM, the surveyor observed LPN #4 as she donned gloves before she entered the resident's room but failed to donn a gown before she administered insulin to the resident in the resident's abdomen. At 9:50 AM, the surveyor interviewed LPN #4 who stated that Resident #13 required isolation for [MEDICAL CONDITION] as the resident had opened wounds. She stated that she should have washed her hands and put on both a gown and gloves before she entered the resident's room but she did not see the isolation cart or signage. She stated that there was too much going on and she was not informed that the resident was on isolation. She further stated that staff should always wash their hands, donn gown and gloves and proceed with caution when isolation was observed. LPN #4 stated that she should have cleaned the portable automated blood pressure cuff after use. LPN #4 wasn't aware that she touched the Vascepa tablet with her ungloved hand. At 10:05 AM, in a later interview conducted outside of Resident #13's and Resident #14's room, the surveyor noted that both the isolation cart and signage were removed from the exterior of the room. The UM was interviewed and initially denied that the isolation cart and signage were present. She stated that she should have put on a gown and gloves prior to pulling up Resident #14. She further stated that she spoke with the resident's physician and he discontinued isolation precautions for the resident who completed intravenous antibiotic treatment for [REDACTED]. The UM stated that she spoke with the doctor at 8:00 AM this morning and received an order to discontinue isolation at that time but failed to do so or to document the discussion at that time. At 10:05 AM, the surveyor interviewed CNA #2 who stated that she saw the sign for isolation outside of Resident #14's room and should have donned a gown and gloves before she entered the room and pulled the resident up in bed. She further stated that she thought that she only had to do that if she provided direct care. On 09/04/20 at 8:46 AM, the surveyor interviewed the Infection Control Nurse who stated that staff should still adhere to Personal Protective Equipment usage until the results of the cultures are known and the isolation storage cart was discontinued from use and clean all non-dedicated equipment (i.e. blood pressure cuff or stethoscope) after use to avoid cross contamination. The surveyor reviewed the facility policy, Isolation-Categories of Transmission-Based Precautions (Revised October 2018) which revealed the following: Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection . Contact Precautions may be implemented for residents known or suspected to be infected with

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. When transmission-based precautions are in effect, non-critical resident-care equipment items such as a stethoscope, sphygmomanometer (blood pressure apparatus), or digital thermometer will be dedicated to a single resident (or cohort of residents) when possible. If re-use of items is necessary, then the items will be cleaned and disinfected according to current guidelines before use with another resident. 2. On 09/03/20 at 08:38 AM, during medication pass, the surveyor observed LPN #3 on the Central unit perform hand hygiene with soap and water. LPN #3 turned on the faucets, applied soap to both hands, rubbed both hands under the stream of running water for 10 seconds, used a paper towel to dry both hands and another paper towel to turn off the faucet. At 8:52 AM, during the same medication pass, the surveyor observed LPN #3 perform hand hygiene with soap and water at the resident's bathroom sink. LPN #3 turned on the faucet, applied soap to both hands and rubbed both hands under the stream of water for 6 seconds. At that time, LPN #3 stated that the paper towel holder was out of paper towels, then shook both hands in the air, obtained a piece of toilet paper, turned off the faucet with the toilet paper and then rubbed both hands downward on her upper thigh scrub pants. At that time ,the surveyor interviewed LPN #3 who stated that hand washing included turning on the faucet, applying soap to both hands, scrubbing hands outside the running stream of water for the length of time to sing happy birthday two times, drying hands with a paper towel and then turning off the faucet with another paper towel. On 09/03/20 at 9:12 AM, during the medication pass, the surveyor observed LPN #3 perform hand hygiene with soap and water in the resident's sink located in the resident's room. At that time, LPN #3 turned on the faucet, applied soap, scrubbed hands for 21 seconds, dried both hands with a paper towel then turned off the faucet with the same paper towel before discarding towel in the waste basket. On 09/03/20 at 9:25 AM, the surveyor interviewed the Unit Manager (UM) of the Central Unit who stated that handwashing technique included scrubbing hands inside the stream of water for the length of time of singing the alphabet, using a paper towel to dry both hands and another paper towel to turn off the faucet. On 09/03/20 at 2:55 PM, in the presence of the Administrator, Regional Director of Clinical Services (RDCS) and the Regional Director of Clinical Operations, the Director of Nursing (DON) stated that the handwashing procedure included to turn on the water, wet hands, apply soap to both hands, vigorously lather and scrub hands outside of the stream of running water for 20 seconds, rinse both hands inside the basin, use a paper towel to dry both hands, then use another paper towel to turn off the faucet. The DON stated that the LPN should have left and obtained more paper towels for the dispenser. The RDCD stated that LPN #3 realized that she did not do her handwashing technique correctly and should have stopped the handwashing and obtained more paper towels A review of the facility's Handwashing/Hygiene Policy with a review date of October 2016 revealed that process for washing hands included:1. Vigorously lather hands with soap and water and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer). 2. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside the sink. 3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. 4. Discard towels in trash 5. Use lotions throughout the dry to protect the integrity of the skin. NJAC 8:39-19.4(a)1