STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALARIS HEALTH AT KEARNY	206 BERGEN AVE KEARNY, NJ 07032

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure that four residents were offered the opportunity to formulate an Advance Directive, a written statement of a person's wishes regarding medical treatment, often including a living will be made to ensure those wishes are carried out should the person be unable to communicate them. This deficient practice was identified for 4 of 21 residents reviewed for advanced directive planning (Resident # 4, Resident #46, Resident #32, and Resident # 88) and was evidenced by the following: 1. On 09/9/20 at 12:49 PM, the surveyor, observed Resident #4, alert with some confusion. The resident stated that they could not remember if anyone had spoken to them regarding advance directives. The surveyor reviewed the medical record for Resident #4. According to the face sheet (an admission summary), the resident was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated 8/27/20, reflected that the resident had a brief interview for mental status (BIMS) score of 10, indicating Resident #4 had a moderate cognitive impairment. A review of the paper medical chart revealed that the Advance Directives tab was blank and had no information. 2. On 09/09/20 at 12:33 PM, the surveyor observed Resident # 46, who was alert and oriented and was seated in a wheelchair in a room with [MEDICAL CONDITION] and oxygen in place. The resident responded verbally and appropriately to the surveyor. The surveyor reviewed the medical record for Resident #46. According to the face sheet, the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the Admission MDS dated [DATE] reflected that the resident had a BIMS score of 15, indicating Resident #46 was cognitively intact. A review of the paper medical chart revealed that the Advance Directives tab was blank and had no information. 3. On 9/10/20 at 9:15 AM, the surveyor observed Resident #32 in bed with Oxygen Therapy being delivered. Resident #32 expressed that they were comfortable and liked being in the room. The surveyor reviewed the medical record for Resident #32. According to the resident's face sheet, the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Quarterly MDS, dated [DATE], indicated that the resident had a BIMS score of 12, indicating Resident #32 was cognitively intact. A review of the paper medical chart revealed that the Advance Directives tab was blank and had no information. On 9/15/20 at 9:40 AM, the surveyor discussed whether the facility staff ever discussed Advanced Directives with the resident. After explaining what an Advanced Directive was, Resident #32 stated that this was never discussed. 4. On 9/10/20 at 10:00 AM, the surveyor observed Resident #88 seated in a wheelchair. Resident #88 smiled and said that they were okay. The surveyor reviewed Resident #88's medical record. According to the resident's face sheet, the resident was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Quarterly MDS, dated [DATE], indicated that the resident had a BIMS score of 3, indicating that Resident #88 had a severely impaired cognition. A review of the paper medical chart revealed that the Advance Directives tab was blank and had no information. On 9/16/20 at 12:14 PM, the surveyor discussed whether the facility staff ever discussed Advanced Directives with the resident's Power of Attorney (POA), a family member. After explaining what an Advanced Directive was, Resident #88's POA stated that this was never discussed in reference to the resident. On 9/16/20 at 9:25 AM, during an interview, the Director of Social Services (DOSS) stated that Residents #4, #46, #32, and # 88 had no advance directives. The DOSS further noted that she should have discussed and had them in place for Residents #4, #46, #32, and # 88. A review of the facility's policy for Advance Directives revised 5/31/2019 provided by the DOSS reflected that the facility would establish and maintain a system for residents to formulate an advanced directive and accept or refuse medical or surgical treatment. 1. During the pre-admission process, the admissions department will inquire about the existence of advanced directives. A copy will be obtained before admission when possible. 2. Upon admission, those residents with an active advance directive will have two copies placed on their chart. Those residents who do not have an advanced directive in place will be provided with literature regarding Health Care Decisions and the types of advanced directives and be referred to social services for further assistance. 3. Health Care Decisions status will be reviewed with the resident and/or family upon admission and during quarterly/annual care conference or upon a noted change in condition. NJAC 8:39-4.1 (a) 2,4
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to develop a comprehensive, person-centered Care Plan (CP) for residents treated with Oxygen Therapy. This deficient practice was identified for 2 of 21 residents reviewed for comprehensive care plans (Resident #47 and #34) and was evidenced by the following: 1. On 09/10/20 at 10:15 AM, the surveyor observed Resident # 47 in bed with their eyes closed. The Oxygen Concentrator was in the off position with the tubing, stored in a plastic bag. The humidifier bottle was dated 09/09/20 and was stored on the left side of the resident's bed. A review of Resident #47's records revealed that the resident was admitted to the facility on [DATE] and was readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of the September 2020 Electronic Medication Administration Record [REDACTED]@ 2 Liters Per Minute (LPM)) every shift. The September 2020 EMAR also documented Oxygen saturations every shift. A review of Resident #47's most current CP reflected that it had been updated since the Resident's return from the hospital. The current CP, however, did not mention that the resident was receiving Oxygen or when to administer the Oxygen. The surveyor interviewed the Registered Nurse (RN) assigned to Resident #47. The RN explained that Resident #47 receives Oxygen when the resident has trouble breathing. The RN could not explain why this was not reflected or described in the CP. The RN stated that she could not locate Resident #47's CP for Oxygen Therapy. The RN further noted that it should have been included in the resident's CP. 2. On 09/10/20 at 10:20 AM, the surveyor observed Resident #34 in bed watching television. Resident #34 had an NC in place with tubing attached to an Oxygen Concentrator and set at 2 LPM. The Oxygen tubing, along with the humidifier bottle was attached to the concentrator, and was dated 09/09/20. A review of Resident #34's medical record revealed that the resident was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Nurses Progress Notes dated 06/28/20 documents, Respiration easy and on O2 at 2 LPM via NC. Review of the Nurses Progress Notes dated 6/29/20 documents, Respiration easy with no difficulty of breathing

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) with on O2 at 2 LPM via NC. A review of the September 2020 EMAR revealed a physician's orders [REDACTED].@ 2 LPM) check every shift. The September 2020 EMAR also documented Oxygen saturations every shift. A review of Resident #34's most current CP, updated since the Resident's return from the hospital, did not mention the resident was receiving Oxygen. The surveyor interviewed the RN assigned to Resident #34. The RN stated that Resident #34 receives Oxygen continuously. The RN further indicated that she could not locate Resident #34's CP for Oxygen Therapy. The RN stated that Oxygen Therapy should have been included in the resident's CP. On 9/16/20 at 2:10 PM, the surveyor discussed Oxygen therapy CP with the Director of Nursing, Administrator, VP of Operations, and Quality Assurance RN. They all agreed that there should be a CP for Oxygen Therapy for all residents receiving Oxygen Therapy. NJAC 8:39-11.2 (e)
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** Based on observation, interview, and record review, it was determined that the facility failed to review and revise a care plan to include updated interventions for a resident's safety and compliance during smoking for 1 of 21 residents (Resident #23) reviewed. This deficient practice was evidenced by the following: On 09/09/20 at 11:18 AM, the surveyor observed Resident #23, an alert and oriented resident, seated in a wheelchair in the resident's room. The resident stated that they go out to a designated area to smoke four times daily and are accompanied by a staff member who keeps the matches/lighter. The surveyor reviewed Resident #23's medical record. According to the face sheet (an admission summary), the resident was admitted to the facility on [DATE], readmitted on [DATE], and had [DIAGNOSES REDACTED]. A review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated 6/17/2020, reflected that the resident had a brief interview for mental status (BIMS) score of 15, indicating an intact cognition. The surveyor reviewed the resident's Care plan alteration in safety r/t smoking and noncompliance to the smoking and safety agreement dated 8/31/2013; revised on 8/28/20. The goal reflected: resident encouraged to adhere to facility agreement regarding smoking through the review date. The surveyor reviewed the Care Plan interventions, which revealed they had not been reviewed or updated during the most recent annual Care Plan meeting in June 2020 and included the following: 1. Educate the resident to the facility smoking policy on admission and as needed. Monitor compliance with the smoking program. Smoking assessment on admission and quarterly; (undated). 2. Re-discussed smoking policy and risk vs. benefits of smoking; offered nicotine patch-refused; agreed to the smoking apron and cigarette holder dated 7/3/17. 3. Meeting with resident regarding smoking non-compliance initiated 11/25/16; revised on 10/11/17. 4. Encouraged to wear a smoking apron for protection and safety due to disability initiated 11/17/16; revised on 2/13/20. 5. Smoking contract reviewed with the resident and signed in agreement initiated on 12/8/16; revised on 12/5/16. On 9/11/20, at 12:59 PM, the surveyor observed the staffing coordinator (SC) who had escorted Resident #23 out to the designated smoking area. Resident #23 was not wearing their Fire Resistant Smoking Apron. The staffing coordinator asked Resident #23, are we putting the apron on today? The resident replied, No, the apron hurts my neck. The Staffing coordinator then used a lighter and lit the resident's cigarette for him/her. The surveyor asked Resident #23, if requested by staff, would they be agreeable to having the apron draped over him/her without tying it around the neck. The resident replied, sure, and then said to the SC, why didn't you suggest that? The SC replied, would you have listened? The resident replied, yes, I always listen to people I like. At that time, the SC draped the fire-resistant smoking apron over the front of Resident #23. At that time, the surveyor observed an ash fall from the cigarette onto the fire-resistant apron and then onto the ground. Resident #23 explained to the surveyor that he/she told: everybody many times that the apron tie hurt my neck. On 9/14/20 at 12:58 PM, the surveyor observed Resident #23 in the hallway propelling themselves in the wheelchair with the fire-resistant Smoking Apron in place and fastened around their neck. The surveyor mentioned the smoking apron. The Resident replied, the Director of Nursing (DON) put an elastic tie on it, so it doesn't irritate my neck anymore. See how loose it is? A review of the smoking assessment dated [DATE] did not address the resident's noncompliance with the smoking agreement. On 9/15/20 at 9:55 AM, the surveyor discussed the above care plan concerns with the Administrator, DON, Regional VP of Operations, and Quality Assurance Registered Nurse. The surveyor asked why the SC didn't encourage the resident to wear the smoking apron. The surveyor further asked what other interventions the facility implemented to ensure the resident's safety and compliance during smoking. The administrator replied that they were trying to keep the resident safe, but the resident was noncompliant. The DON stated that Resident #23 was very self-directed. Again, the surveyor asked what Care Plan interventions had been implemented to ensure resident's safety. There was no response. Review of the Smoking Policy and Procedure dated 3/5/20 reflected: 1. Upon admission, the smoking policy will be reviewed. The resident will sign the facility smoking agreement acknowledging awareness of the facility's smoking policy and agreeing to abide by this policy. 2. Staff will notify the supervisor immediately if noncompliant. 3. IDC team will meet to review noncompliant resident's specific smoking practices and develop a plan to ensure safe smoking. 4. Any resident found in violation of the smoking policy may be discharged involuntary or lose smoking privileges. On 9/15/20 at 11:45 AM, during an interview, the surveyor asked the resident if they planned to use the apron each time they smoked. The resident replied, Of course, it makes sense. I'm not stupid; I don't want to burn my clothes. The surveyor asked Resident #23 if the facility staff informed them that if they refused to wear the smoking apron, they would have to leave the facility and would be given 30 days to find another home. The resident replied, No, never. On 9/15/20 at 12:53 PM, during an interview, the CNA, who was assigned to supervise the resident during smoking, stated she had been assigned to supervise Resident #23's smoking many times prior to today. The resident often refused to wear the smoking apron, but today wore it all three times she took them to smoke. The CNA further stated that the resident told her that he/she was wearing the apron because it didn't hurt his/her neck anymore and that the resident didn't want to burn his/her clothes. On 9/16/20, no further information was provided by the facility. NJAC:8:39-27.1 (a)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to adhere to accepted standards of infection control prevention for hand hygiene and the distribution of food trays to maintain sanitation in accordance with professional standards for food safety service. This deficient practice was identified for 2 of 2 units during the observation of the lunchtime meal, and was evidenced by the following: On 9/9/2020 at 11:45 AM, the surveyor observed 4th floor Certified Nursing Assistant (CNA) (#1) deliver trays to residents in their rooms; room [ROOM NUMBER], 440, 441, 442, 443. CNA #1 was observed to set up the trays, including cutting up the food, opening the liquid beverages, and opening the straws; CNA #1 did not wash or sanitize his hands in between assisting each resident. The surveyor also observed a recreation aide who delivered two trays to 2 different residents, including tray set-up. The recreation aide also failed to wash her hands in between the assistance of the two residents. On 09/14/20 at 12:10 PM, the surveyor observed the 3rd floor CNA (#2) distribute lunch trays to 4 rooms; room [ROOM NUMBER], 310, 302, 313. The surveyor observed CNA #2 go room to room and noted that she did not wash her hands in between assisting the residents. On 9/14/20 at 12:16 PM, the surveyor further observed CNA #2 return to room [ROOM NUMBER] and set up the resident's lunch. The surveyor observed CNA #2 cut the resident's food, using the resident's silverware. CNA #2 also poured a sugar packet into the resident's coffee and open the paper surrounding the resident's straw and placing it in the resident's milk carton, after opening it; CNA #2 did not wash her hands. On 9/14/20 at 12:20 PM, the surveyor interviewed CNA #2, who stated that she should have washed her hands between exiting and entering residents' rooms when delivering lunch trays. CNA #2 also said that she should have washed her hands before setting up lunch for the resident in room [ROOM NUMBER]. On 9/14/20 at 12:08 PM, the surveyor observed the 3rd floor CNA (#3) deliver five trays to different residents and set-up the trays. CNA # 3 did not wash or sanitize his hands in between each resident. At 12:49 PM, the surveyor interviewed CNA # 3, who stated that he had received training on hand hygiene during meal tray delivery. He further stated that he was supposed to wash his hands between residents, but just forgot. A review of the facility Meal Distribution Policy received on 9/15/20 at 12:39 PM revealed, Staff will distribute trays to each resident in a safe and sanitary manner in accordance to infection control

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) guidelines. Review of the facility When and How to Perform Hand Hygiene, identified Multiple opportunities for hand hygiene may occur during a single care episode. After touching a patient or the patient's immediate environment. On 9/15/20 at 2:30 PM, the surveyors met with the Regional VP Operations, the Administrator, the Director of Nursing, and the Quality Assurance Registered Nurse to discuss the passing of lunch trays without handwashing. The facility representatives acknowledged that staff should wash hands after exiting and before entering a resident's room. There was no further information supplied by the facility. NJAC: 8:39 - 17.2 (g)