STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315195	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN LAKE HEALTHCARE AT BERKELEY HEIGHTS	35 COTTAGE STREET BERKELEY HEIGHTS, NJ 07922

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to inform and offer a resident's guardian, the opportunity to formulate an Advance Directive. This deficient practice was identified for Resident #37, 1 of 6 residents reviewed for Advance Directives and was evidenced by the following: Review of the Admission Record revealed Resident #37 was admitted to the facility on ,[DATE] with [DIAGNOSES REDACTED]. Review of the County Surrogate's Court record, dated 03/2010, revealed Resident #37's family member was deemed his/her guardian. The document further revealed, In conclusion, taking the time to consider, and even execute, basic advance directive can be a valuable tool for you, your family, friends, and trusted confidantes as they try to honor your wishes and make decisions on your behalf when you are unable to do so. Review of Resident #37's Order Summary Report, Care Plan, Medication Administration Record, [REDACTED]. During an interview with the surveyor on 09/17/2020 at 1:57 PM, the Director of Nursing (DON) stated there was no Advance Directives that the facility was aware of for Resident #37. The DON acknowledged someone should have addressed the Advance Directive at some point, since the resident was admitted in 2018. During an interview with the surveyor on 09/18/2020 at 11:04 AM, the DON stated that the previous Social Worker (SW) documented about addressing the Advance Directive with Resident #37's guardian and that the guardian wanted to execute an Advance Directive. The DON stated she had called the guardian who informed the DON that he was under the impression the POLST (physician's orders [REDACTED]. The DON acknowledged that the Advance Directive and the POLST were not the same. The DON stated Resident #37 had been in the hospital and was readmitted to the facility on ,[DATE] but there was no record of an Advance Directive being addressed at that time either. During a telephone interview with the surveyor on 09/18/2020 at 11:20 AM, Resident #37's guardian stated he/she would have liked to have an Advance Directive and was under the impression the POLST was the same thing. The guardian stated someone may have mentioned Advance Directives but he/she did not receive additional information about them. The guardian stated he/she was interested in an Advance Directive for Resident #37. During an interview with the surveyor on 09/18/2020 at 12:04 PM, the SW stated she was not the SW when Resident #37 was admitted or readmitted to the facility. The SW stated she spoke to the guardian and educated him/her on Advance Directives. The SW stated the guardian informed her he/she was never provided with papers explaining Advance Directives. The SW further stated the guardian was interested and was going to begin the process. The SW stated she was unable to provide documentation that the guardian had been provided the Advance Directive information or any follow up conversation. During an interview with the surveyor on 09/22/2020 at 9:37 AM, the Licensed Practical Nurse Unit Manager (LPN/UM) stated that an Advance Directive addressed living wills and power of attorney, where as, a POLST addressed a code status for emergency treatment. The LPN/UM stated that the SW would be responsible for obtaining the Advance Directive and that if a resident had an Advance Directive, it would be kept in the physical medical chart. The LPN/UM stated that Advance Directive was part of the Interdisciplinary Team Care Plans (ITCP) with the Minimum Data Set (MDS) coordinator. The LPN/UM reviewed the 05/14/2019, 06/18/2019 and 05/29/2020 ITCP summaries, located in the physical medical chart, and noted the there was conflicting information regarding the Advance Directive. The 06/18/2019 summary indicated there was an Advance Directive, while the 05/14/2019 and 05/29/2020 summaries indicated there was not an Advance Directive. The LPN/UM acknowledged she had signed all three forms. During an interview with the surveyor on 09/22/2020 at 9:51 AM, the MDS coordinator Registered Nurse (MDS/RN) stated that she would usually check no under Advance Directive unless she saw the Advance Directive in the physical medical chart. The MDS/RN stated she would be the one to verify the information on the form and could not speak to why the ITCP, dated 06/18/2019, was checked yes for Advance Directive. The MDS/RN acknowledged she had signed all three forms. Review of the Social Service Admission/Readmission Note, dated 05/05/2018, revealed, resident's (family member) states that (he/she) does not have an advanced directive however would like one. Resident's (family member) is appointed POA (Power of Attorney). Review of the facility Advance Directives policy, dated 10/2019, revealed that upon admission, the resident (or if resident was incapacitated and unable), the legal representative, would be provided with written information to formulate an advance directive if they choose to do so. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The plan of care for each resident will be consistent with his or her documented treatment preference and/or advance directive. NJAC 8:39-4.1(a)(31)(iii)(33)(b), 9.6(d)(e)(f)
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **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 a.) a comprehensive care plan was developed for a resident who experienced pain and b.) implement non-pharmacological interventions for a resident who did not like taking pain medication. This deficient practice was identified for Resident #23, 1 of 1 resident reviewed for pain and was evidenced by the following: On 09/16/2020 at 10:30 AM, during the initial tour, the surveyor observed Resident #23 lying in bed, eyes closed. The resident was gripping the call bell in his/her left hand. The surveyor observed that the resident's face was grimaced. On 09/17/2020 at 10:17 AM, the surveyor interviewed Resident #23 while the resident was lying supine in bed. The resident stated, I have a lot of pain, that is what it is, and they give me medicine. On 09/18/2020 at 8:16 AM, the surveyor interviewed Resident #23 while the resident was lying supine in bed. The resident stated, I am in pain with my legs practically all the time. The surveyor reviewed Resident #23's medical record: The Admission record indicated the resident was admitted to the facility with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), a tool used to facilitate the management of care, dated 07/19/2020, revealed the resident had a Brief Interview of Mental Status score of 10/15, which indicated the resident was moderately cognitively impaired. The MDS also included, under Pain Management, that the resident frequently experienced pair or hurting, received scheduled, PRN (as needed) or declined pain medication during the last 5 days and that the resident did not receive non-medication interventions for pain. Review of the Order Summary Report (OSR), dated 09/23/2020, revealed the following physician orders [REDACTED].= 50 MG; 09/18/2020 for Tylenol Extra Strength Tablet 500 MG ([MEDICATION NAME]), give 2 tablet by mouth two times a day for hip pain. Review of an admission Pain Evaluation, dated 07/13/2020, revealed the resident had mild, hip and incisional pain, which increased with movement and was relieved by repositioning and medication. The likely cause of the pain was a fracture and that the resident had a pain medication regimen that included [MEDICATION NAME] and narcotics. The current non-pharmacological interventions section indicated the resident received PT/OT (physical therapy and occupation therapy). The area for Heat/Cold, Relaxation Techniques and Distraction were left blank. The Plan of Care area indicated

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 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) there was satisfactory pain management and to continue with the current plan of care. Review of Resident #23's care plan revealed there was no care plan for pain. A care plan with a focus related to the right [MEDICAL CONDITION], initiated on 07/13/20, with a goal for the resident to remain free of infection and show signs of healing did not include interventions for pain management. A care plan with a focus of unstageable right and left heel wounds and the resident's non-compliance with repositioning was initiated on 08/21/20, with a goal of healing the wounds, included an intervention to treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort. Review of an orthopedic physician consultation, dated 07/23/2020, revealed a recommendation to Please consult pain management/palliative care for patients pain. Review of the MD/APRN/PA/NP General Notes documented in the Progress Notes (PN) revealed the following: The PN, dated 08/03/2020 at 21:57 (9:57 PM), included that the resident was hospitalized from [DATE] to 07/13/2020 after a right femoral neck fracture and underwent a right hemiarthroplasty on 07/09/2020. Patient was eager to not have pain medication and was refusing narcotics on day of discharge. On 07/16/2020, the resident stated his/her only pain is of that in (his/her) right leg from the surgery and (he/she) is developing pain in (his/her) heels . On 07/20/2020, Pt (patient) reported (his/her) pain is still not well controlled, largest complaint is abdominal discomfort and gas. Does not want to take narcotics as it affected (his/her) mental clarity. The PN, dated 08/03/2020 at 15:00 (3:00 PM), indicated, 'I get enough medicine for acute pain but I am not comfortable.' The patient reports (he/she) is afraid to take more pain medication because (he/she) wanted to be in control of things. The treatment plan revealed pain medications will be adjusted as necessary. On 09/18/2020 at 10:21 AM, the surveyor interviewed a physician who cared for Resident #23 regarding the resident's pain management. She stated that the resident complained of pain when the resident was moved. The surveyor inquired as to the recommendation received from the orthopedic physician for a pain management consultation. She stated a pain management consultation was not ordered because we asked her how her pain was and the [MEDICATION NAME] made the resident comfortable. On 09/18/2020 at 10:49 AM, the surveyor interviewed the Unit Manager (UM) who reviewed the resident's care plan and confirmed the resident did not have a care plan for pain. The UM stated the resident was transferred from the sub-acute unit and that should have been care planned for pain since the beginning. On 09/22/2020 at 9:27 AM, the surveyor interviewed Resident #23 who was lying supine in bed. The resident stated his/her feet did not hurt constantly, but they hurt very much, especially during the night and if he/she asked for Tylenol it was provided. The resident further stated the pain did not keep him/her awake. On 09/22/2020 at 12:07 PM, the surveyor interviewed the UM regarding non- pharmacological interventions that were available and could be considered for residents who are experiencing pain. She stated examples could be re-positioning the resident, distracting the resident and offering the resident a snack. She stated if Resident #23 had those types of interventions they would be documented in the resident's care plan. The UM located a recently initiated care plan, dated 09/18/20, with a Focus that the resident is receiving pain medication due to hip pain and foot ulcer. The Interventions included to administer medications as ordered and did not include non-pharmacological interventions. On 09/23/2020 at 8:23 AM, the surveyor interviewed the Certified Nurse Aide (CNA #1) who stated she had not taken care of the resident in a few weeks and there were no complaints of pain at present. She stated she used to take care of the resident when the resident was admitted and the resident had complaints of pain. On 09/23/2020 at 9:12 AM, the surveyor interviewed Resident #23, who was sitting upright in bed, in the resident's room. The resident stated he/she did not like taking pain medication because he/she did not like the way it made him/her feel. The resident was interviewed about other options that he/she thought would help alleviate pain. The resident stated the first time that the facility discussed non-pain medication options to help him/her alleviate pain was yesterday. On 09/23/2020 at 9:42 AM, the surveyor interviewed the Rehabilitation Director who stated the resident was not presently on the caseload. The Rehabilitation Director provided the surveyor with the resident's initial Occupational Therapy Assessment, dated 07/14/2020, which revealed the resident had pain at a level of 7 out of 10 at that time. She stated to the surveyor that 7 out of 10 was a high level of pain and that 5 was in the middle. She stated the resident was not currently receiving therapy. The Rehabilitation Director stated she was part of the interdisciplinary team and that the rehabilitation department was available to be consulted for pain management. She stated rehabilitation could be consulted by the physician or nursing and that depending on the appropriateness, there were other options that rehabilitation could offer for pain management. Options could include ice/heat packs, cooling gels and electrical stimulation. She stated that on 09/21/2020, a therapy screen was received for Resident #23. The screening was specific to multi podus boots (orthotic foot boot) to assist the resident with standing and walking. She stated the boots would help to relieve pressure and maybe help with pain when the resident was standing or walking and could make the resident more comfortable. Further review of the Occupational Therapy Evaluation, dated 07/14/2020, revealed a verbal pain assessment was completed by the occupational therapist and the resident verbalized intermittent throbbing and aching pain in the right hip and lower extremity at a pain level of 7 out of 10 at rest. Pain upon movement increased to a pain level of 8 out of 10 and was constant. The pain limited bed mobility, transfers and self-care tasks. The pain management was over-the-counter remedies and sitting, standing, and prolonged activity exacerbated the pain. On 09/23/2020 at 9:50 AM, the survey team conducted a telephone interview with Resident #23's attending physician. The attending physician stated that initially we thought the resident had pain from the [MEDICAL CONDITION], and then the resident developed diverticulitis and then pain on both heels and the depression is definitely contributing to the resident's pain. She further stated that the non-pharmacological interventions for pain were that the staff went in and spoke with the resident. She stated non-pharmacological interventions for pain were always important and should always be taken into consideration. Review of the Pain-Clinical Protocol Policy, reviewed and updated 11/2019, revealed under Treatment/Management, With input from the resident to the extent possible, the physician and staff will establish goals of pain treatment; for example, freedom from pain with minimal medication side effects, less frequent headaches, or improved functioning, mood, and sleep. The physician will order appropriate non-pharmacologic and medication intervention to address the individual's pain. Staff will provide the elements of a comforting environment and appropriate physical and complimentary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain. 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.** Based on observation, interview and document review, it was determined that the facility failed to a.) label and date potentially hazardous food to ensure they are not used beyond their use by date, b.) maintain the ice machine in a manner to prevent microbial growth and cross contamination, and c.) store resident food items in a unit refrigerator in a manner to ensure they are not used beyond their date of expiration. This deficient practice was evidenced by the following: On 09/16/2020 at 8:54 AM, the surveyor began touring the kitchen with a Cook (Cook #1) and observed the following: Inside the walk-in refrigerator on a wheeled cart was the following: A cardboard box, labeled keep frozen, contained a bag of defrosted diced chicken which was dated 8/18, use by 11/18. Cook #1 stated she could not locate a date the chicken was defrosted or a use by date. Three bags containing raw chicken breasts. One bag was opened and re-sealed. There was no use by date on any of the bags. Cook #1 confirmed the chicken was not dated. On 09/16/2020 at 9:24 AM, two managers (M#1 and M#2) from the food service management company joined the tour. On 09/16/2020 at 9:26 AM, the surveyor interviewed a Cook (Cook #2) who stated that when you take something out of the freezer, you date it as soon as you pull it out. He then showed the surveyor a pull sheet and stated the chicken items were not listed. A metal pan containing defrosted chicken thighs did not contain a use by date. M#1 confirmed she could not locate a date. The surveyor observed a pink substance on the corner of the baffle located inside of the large ice machine. The pink substance was able to be removed with a paper towel. M #1, M #2 and Cook #1 were present and stated the ice machine was not clean. On 09/16/2020 at 12:23 PM, two surveyors toured the A-unit pantry with the Unit Manager (UM) and observed the following manufacturer expiration dates on small yogurt containers: 1-07/13/2020; 1-01/19/2020; 2-01/28/2020; 2-08/14/2020; and 1-09/12/2020. The yogurts were stored inside a plastic bag with Resident #23's name on them. The freezer contained a pint of ice cream that was un-labeled and un-dated. The container was filled with ice build-up on top of the ice cream. The UM stated the kitchen was responsible for monitoring the refrigerator and she would discard all of the items. On 09/16/2020 at 2:00 PM, the district manager for the food service management company provided the surveyor with the following policies: Labeling and Dating Inservice, undated, which revealed that all foods should be dated upon receipt. Before being stored, food labels must include the food item name, the date of preparation/receipt of removal from freezer. Items that are removed from a labeled case in the freezer and placed in the refrigerator for thawing should be labeled with the date of removal from the freezer and an appropriate

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) use by date. The Food Storage: Cold Foods Policy, dated 5/2014, revealed all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. The Ice Policy, dated 05/2014, revealed ice will be prepared and distributed in a safe and sanitary manner. Ice bins will be cleaned monthly and as needed. The Food Brought by Family/Visitors Policy, undated, revealed the food service staff was responsible for discarding perishable foods on or before the discard date. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, date received, and the discard' date. NJAC 8:39-17.2(g)
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** Based on observation, interview, record review, and review of pertinent facility documentation, it was identified that the facility failed to ensure staff appropriately donned and doffed Personal Protective Equipment for a resident on droplet Transmission-Based Precautions. This deficient practice was identified for Resident #168, 1 of 2 residents reviewed for infection control practices for new and re-admissions to the facility and was evidenced by the following: On 09/16/2020 at 9:14 AM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) regarding the facilities infection control practices for new and re-admissions into the facility. The ADON/IP stated that all new and re-admissions that entered the facility were monitored for 14 days for signs and symptoms of COVID-19. The ADON/IP stated that the facility only admitted residents from the hospital that had tested negative for COVID-19. The ADON/IP further stated that the Personal Protective Equipment (PPE) the staff were required to wear when caring for the new and re-admission residents included a gown, N95 or KN95 mask, gloves, goggles, and a face shield. On 09/16/2020 at 10:44 AM, the surveyor observed signage posted outside of Resident #168's door that indicated the resident was on transmission-based-precautions and specific PPE needed to be applied prior to entering the resident's room. The sign indicated to stop before entering the room because the resident was on droplet precautions and in addition to standard precautions everyone must clean hands when entering and leaving the room, wear a mask, wear eye protection, wear a gown, and wear gloves. Pictures of hands utilizing ABHR, a person wearing a mask, goggles, a gown, and gloves were also displayed on the signage. Outside of the resident's room the surveyor observed a plastic bin stocked with PPE which included disposable gowns, washable gowns, K95 masks, face shields, and gloves. During that time, the surveyor observed Resident #168 lying in bed. A facility staff member was observed standing next to the resident's bed wearing a gown, gloves, and a surgical mask. The surveyor did not observe the staff member wearing a face shield, goggles, a KN95 or N95 mask. At 10:45 AM, the surveyor interviewed the staff member after she exited the room. The NP identified herself as the resident's Nurse Practitioner (NP). The NP stated that the resident's COVID-19 test was negative and the resident had been residing at the facility for 10 days. The surveyor inquired about droplet precautions. The NP stated that she had to wear a gown, gloves, N95 mask, and a face shield when she was in the room with the resident. The NP stated she was not wearing a N95 mask or a face shield when she was in the room with the resident because she did not have them available. On 09/16/2020 at 11:28 AM, the surveyor interviewed the resident who stated that he/she had been residing at the facility for about a week and everything was good. On 09/17/2020 at 10:02 AM, the surveyor observed a housekeeping staff member (HKSM) exit Resident #168's room without removing his PPE. The HKSM was observed wearing a surgical mask, face shield, gown, and gloves. After exiting the room, the HKSM walked across the hallway to the housekeeping cart, picked up a mop and then re-entered the resident's room and began to mop the floor. After mopping the floor, the surveyor observed the HKSM exit the resident's room, without removing his PPE, walk over to the housekeeping cart across the hall, gather additional cleaning supplies and then re-enter the resident's room. The surveyor observed that the PPE bin outside of the resident's room was stocked with PPE. On 09/17/2020 at 10:42 AM, the surveyor interviewed the HKSM who stated that before exiting the resident's room he was required to remove his PPE and wash his hands. The surveyor reviewed the medical record for Resident #168. A review of the resident's Admission Record indicated that the resident was recently admitted to the facility and had [DIAGNOSES REDACTED]. A review of the resident's most recent admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 09/12/2020, reflected that the resident had a Brief Interview of Mental Status (BIMS) score of 12, which indicated the resident was alert with confusion. A review of the resident's September 2020 Treatment Administration Record (TAR) revealed a Physicians Order (PO) dated 09/06/2020 for droplet precautions for COVID-19 [MEDICATION NAME] every shift for prevention for 14 days. A further review of the September 2020 TAR reflected that the nursing staff signed that droplet precautions were maintained for the resident. A review of the resident's laboratory results dated [DATE] indicated that COVID-19 was not detected. A review of the resident's Care Plan (CP), dated 09/07/2020, reflected that the resident had a focus area for isolation precautions for droplet precautions. The goal of the CP reflected that the resident was on droplet precautions to prevent the transmission of infectious agents to other residents' and the environment. The interventions for the CP included staff would adhere to hand hygiene policy, dedicate equipment to the resident, and staff to wear protective gear as needed and ordered. On 09/23/2020 at 11:57 AM, the Director of Nursing stated that the NP and housekeeping staff were in-serviced on appropriate usage of PPE and hand hygiene. A review of the in-service education provided by the facility, dated 09/22/2020 and timed at 3:00 PM, indicated that the housekeeping staff members were educated on Infection Control Practices. The in-service indicated, Policy and Procedure was reviewed with employees that when cleaning an isolation room staff must wear full PPE before entering in droplet precaution room; KN95's, gowns, face shield, gloves, and proper hand washing. Also proper clean and disinfect or sterilize reusable equipment before use of another resident's room. Employees must keep the housekeeping cart directly to the room that has been worked on, and PPE must be remove(d) before exit the room. A review of an e-mail communication between the facilities Administrator and NP, dated 09/22/2020 and timed at 6:41 PM, reflected that the NP was made aware of CDC guidelines regarding the proper use of PPE and isolation precautions for resident's and self. A review of the facility's Policy and Procedure titled, Monitoring New and Re-Admissions for Possible COVID-19, dated 05/14/2020, indicated that new and readmitted residents would be screened for COVID-19 and be placed in an isolation room for 14 days with Droplet isolation precautions instituted, with Full PPE when providing care. IE (mask, gown, gloves, eye shield). NJAC 8:39-27.1(a)