STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315058	A. BUILDING _____ B. WING _____	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN REHABILITATION AND NURSING CENTER	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

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F 000	INITIAL COMMENTS CENSUS: 66 SAMPLE SIZE: 20 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to a.) consistently monitor fluid restriction instructions in accordance with the physician's order and professional standards of care for 1 of 2 residents (Resident #56) reviewed for dementia care and b.) clarify conflicting physician orders for 1 of 5 residents (Resident #18) reviewed for unnecessary medications. This deficient practice was 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	F 658	Resident Number 56 fluid restriction was clarified and the correct amount of fluids were given per fluid restriction monitoring. An audit was conducted by the Director of Nursing of all resident on fluid restrictions. The audit was completed to assure that all residents on fluid restrictions were and are adhered to. The Unit Managers are to coordinate with the dietitian to review all residents on fluid restriction orders on admission, readmission and monthly. The Don/designee will conduct monthly audits on all residents on fluid restrictions. The findings of the audits will be reported to the Administrator and the Quality	1/3/22

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

Electronically Signed | 12/23/2021

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F 658	Continued From page 1 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." 1. According to the Admission Record, Resident #56 was readmitted with diagnoses that included, but were not limited to, [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed that Resident #56 had [redacted]. Review of Resident #56's Care Plan (CP) initiated on [redacted], revealed that Resident #56 had [redacted] n [redacted]. The CP further revealed an intervention initiated	F 658	Assurance Committee at the Quarterly Meeting. Resident Number 18 had had the duplicate [redacted] order Discontinued prior to the annual inspection. Psychiatrist and Pharmacy consultant were notified of the need to review all residents currently with prn medications. Nursing and Pharmacy Consultant were in-serviced by the Regional Nurse on the importance of monitoring and the documentation process of resident especially those on [redacted] medications. The nurses were advised to notify physicians with any changes in resident□s behaviors which would allow for proper medication review especially those with duplicate orders. The Don/designee in partnership with the Pharmacy consultant will conduct monthly audits to monitor for compliance with facility policy regarding [redacted] use. The findings will be reported to the Administrator and to the Quality Assurance Committee at the Quarterly meeting.	

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on 11/25/20, for fluid restriction of [redacted] (cc) (a unit of measurement).

Review of Resident #56's 12/06/21 "Order Summary Report" (OSR) revealed a physician's order (Order) dated [redacted], for [redacted] per day. The Order indicated a dietary limit of [redacted] per day and a nursing limit of [redacted] per day. The order further instructed: "dietary [redacted] per meal" and "nursing [redacted] cc per shift."

Review of Resident #56's "Food and Nutrition Services Communication Form" (Communication Form) dated [redacted], revealed the Order reflected above, for a [redacted]. The Communication Form further revealed [redacted] cc per meal for dietary and [redacted] per shift for nursing.

Review of Resident #56's October 2021 Electronic Medication Administration Record (MAR) reflected the above [redacted] Order for [redacted] per day with [redacted] per shift for nursing.

The October 2021 MAR reflected that the nurses administered fluids outside the physician ordered fluid restriction on the following dates:
[redacted]: the nurse administered [redacted] on day shift and [redacted] on evening shift.
[redacted]: the nurse administered [redacted] on day shift and [redacted] on evening shift.
[redacted]: the nurse administered [redacted] on day shift.
[redacted]: the nurse administered [redacted] on day shift.
[redacted]: the nurse administered [redacted] on day

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shift and [NJAC 8:43E-2.1 an] on evening shift.
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E-2.1] on day shift.
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E-2.1] on day shift, [NJAC 8:43E-2.1]c on evening shift, and [NJAC 8:43E-2.1] on night shift.
[NJAC 8:43E-2.1 and E] the nurse administered [NJAC 8:43E-2.1] on day shift and [NJAC 8:43E-2.1] on evening shift.
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E-2.1] on day shift.
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E-2.1] on day shift and[NJAC 8:43E-2.1 a] on evening shift.

The November 2021 MAR reflected that nurses administered fluids outside the physician ordered fluid restriction on the following dates:
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E-2.1] on day shift and [NJAC 8:43E-2.1] on evening shift.
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E-2.1] on day shift.
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E-2.1] on day shift and [NJAC 8:43E-2.1] on evening shift.
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E-2.1] on day shift.
[NJAC 8:43E-2.1 and E] the nurse administered [NJAC 8:43E-2.1] on day shift and [NJAC 8:43E-2.1] on evening shift.
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E-2.1] on day shift.
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E-2]c on day shift and [NJAC 8:43E-2.1] on evening shift.
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E]cc on day shift and [NJAC 8:43E-2.1] on evening shift.
[NJAC 8:43E-2.1 and E] the nurse administered [NJAC 8:43E-2.1] on day shift and [NJAC 8:43E-2.1] on evening shift.
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E-2.1] on day shift.
[NJAC 8:43E-2.1 and] : the nurse administered [NJAC 8:43E-2.1] on day shift and [NJAC 8:43E-2.1] on evening shift.

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[redacted]: the nurse administered [redacted] on day shift.
[redacted]: the nurse administered [redacted] on day shift and 600 cc on evening shift.
[redacted]: the nurse administered [redacted] on day shift and 720 cc on evening shift.
[redacted]: the nurse administered [redacted] on day shift.
[redacted]: the nurse administered [redacted] on day shift.
[redacted]: the nurse administered [redacted] on day shift.
[redacted]: the nurse administered [redacted] on day shift.
[redacted]: the nurse administered [redacted] on day shift, [redacted] cc on evening shift, and [redacted] on night shift.
[redacted]: the nurse administered [redacted] on day shift.

The December 2021 MAR reflected that nurses administered fluids outside the physician ordered fluid restriction on the following dates:
[redacted]: the nurse administered [redacted] on day shift and [redacted] on evening shift.
[redacted]: the nurse administered [redacted] on day
[redacted] the nurse administered [redacted] on evening shift.

Nursing was to administer [redacted] per shift.

During an interview with Surveyor #1 on 12/03/21 at 9:34 AM, the Unit Manager (UM) stated Resident #56 had [redacted] and would yell out for fluids. The UM further stated that the resident was currently on a fluid restriction and that the order divided the fluid restriction allowance

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F 658	Continued From page 5 between nursing and dietary services. The UM stated that nursing had a certain amount they were allowed to administer per shift and would document the amount in the MAR per shift. The UM further stated that the amount documented in the MAR was what nursing administered per shift and did not include dietary fluids. The UM stated it was important to follow the physician ordered fluid restrictions to prevent the resident from experiencing fluid overload. During an interview with Surveyor #1 on 12/03/21 at 10:49 AM, the Director of Nursing (DON) stated the fluid restriction order was broken down for dietary and nursing. The DON further stated the nurse would document the amount of fluid administered during their shift on the MAR and that the documentation did not include fluids from the resident's tray. The DON stated it was important to follow a fluid restriction order to make sure the resident did not have fluid overload or any other fluid related issues. 2. According to the Admission Record, Resident #18 had diagnoses that included, but were not limited to, NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Review of the Quarterly MDS, dated 09/04/2021, revealed Resident #18 had a Brief Interview for Mental Status of [redacted], indicating the resident's NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Review of the OSR, dated 07/01/2020 to 08/31/2020, included the following orders for NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] ation: NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]) NJAC 8:43E-2.1 and Exec Orde [redacted] by	F 658		

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F 658	Continued From page 6 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1., with a start date of [redacted] and no stop date. [redacted] Give [redacted] by mouth [redacted] as needed for [redacted], with a start date of [redacted] and a stop date of [redacted]. Review of the MAR for August 2020 revealed the resident had two active orders for [redacted] during the timeframe of [redacted] through [redacted] which included different doses and frequencies for administration, as referenced above. Further review of the MAR revealed the [redacted] were not administered on the same dates. [redacted] was administered on [redacted], [redacted], and [redacted] orders were active. Review of the Progress Notes, dated [redacted] through [redacted], did not contain clarification of the conflicting [redacted] orders. During an interview with Surveyor #2 on 12/03/2021 at 9:45 AM, the Licensed Practical Nurse (LPN) stated that if the physician ordered a medication that is active in the MAR, the nurse should discontinue the older physician's order and enter the new physician's order into the electronic medical record. The LPN further stated that the nurse on the 11:00 PM-7:00 AM shift does a 24-hour chart check to ensure physician's orders are correctly entered into the electronic medical record. The LPN then stated that if there were conflicting medication orders in the MAR, when the nurse is administering medications, the nurse should clarify the orders	F 658		

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F 658	Continued From page 7 with the physician or nurse practitioner before administering the medication. During an interview with Surveyor #2 on 12/03/2021 at 9:50 AM, the UM stated that the nurse will enter new physician orders into the electronic medical record and if there was a conflicting order, the nurse would contact the physician or nurse practitioner to clarify the orders. The UM further stated that if there were conflicting medication orders, the nurse administering medications should clarify the order with the physician prior to administering the medication. During an interview with Surveyor #2 on 12/03/2021 at 10:50 AM, DON stated that new physician orders are transcribed to the electronic medical record by the nurse and that the 11:00 PM-7:00 AM nurse performs a 24-hour chart check to ensure the order was transcribed correctly. The DON further stated that if there was a conflicting medication order, the nurse should clarify the order with the physician to obtain the correct order prior to administering the medication. During a follow-up interview with Surveyor #2 on 12/07/2021 at 10:30 AM, the DON stated that one of the NJAC 8:43E-2.1 and Exec Or orders was for "NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1." and should be given if the other NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.. When asked how the nurse would know which order to administer first, based on the physician's orders, the DON stated, "I don't know how they would know which one to give," and, "the order should have been clarified."	F 658		

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F 658	Continued From page 8 Review of the facility's undated Administering Medications policy, revealed, "If a dosage is believed to be inappropriate ... the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns." NJAC 8:39-27.1(a)	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow an active physician's order to apply [redacted] (a cushioned pressure relieving device for heels) (heel protectors) while in bed. This deficient practice was identified for Resident #56, 1 of 2 residents reviewed for pressure ulcers and Resident #24, 1 of 1 resident reviewed for positioning and mobility and was evidenced by the following:	F 686	[redacted] were immediately placed on resident number 24 and 56. Nurses were immediately in-serviced on the importance of preventative interventions and following resident□s plan of care. All residents in the facility who were care planned for heel boots were examined to assure that they had heel boots in place.	1/3/22

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F 686	Continued From page 9 On 12/01/21 at 10:58 AM, Surveyor #1 observed Resident #56 asleep with the head of bed elevated. Surveyor #1 observed that the resident had a [redacted] applied to the [redacted] and no[redacted] on the [redacted]. Surveyor #1 further observed a [redacted] on the resident's wheelchair which was positioned near the resident's closet. According to the Admission Record, Resident #56 had diagnoses that included, but were not limited to: [redacted]. Review of the Quarterly Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated [redacted], revealed the resident had a Brief Interview for Mental Status of [redacted] which indicated that the resident had moderately impaired cognition. Further review of the MDS revealed the resident required extensive assistance of two staff for bed mobility and was at risk for developing pressure ulcer wounds. Review of the "Order Summary Report, dated 12/06/2021, included an order to [redacted] while in bed every shift for [redacted]," with a start date of [redacted] Review of the Care Plan (CP) on 12/01/21 revealed a focus that, "[Resident #56] is at risk for impaired skin integrity [related to] ... impaired physical mobility and incontinent episodes." The CP failed to address the physician ordered [redacted]	F 686	In-services were performed for all nursing personnel regarding the importance of following resident plan of care and medical necessity of preventative interventions. The Don/designee will conduct weekly audits on all residents utilizing heel boots. The findings of the audits will be reported to the Administrator and the Quality Assurance Committee at the Quarterly Meeting.	

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F 686	Continued From page 10 On 12/02/21 at 10:28 AM, Surveyor #1 observed Resident #56 asleep with the head of bed elevated. Resident #56 was easily aroused and was able to verbalize simple needs. Surveyor #1 further observed that Resident #56's [redacted] were positioned directly on the mattress. The surveyor observed [redacted] positioned on the resident's wheelchair. When interviewed, at that time, Resident #56 was unable to provide answers about the [redacted] application. On 12/03/21 at 9:16 AM, Surveyor #1 observed Resident #56 resting in bed with eyes closed and [redacted] positioned directly on the mattress. Surveyor #1 further observed a [redacted] on the resident's wheelchair. During an interview with Surveyor #1 on 12/03/2021 at 9:20 AM, the Certified Nursing Assistant #1 (CNA) stated Resident #56 was a total assist with care, had a [redacted] to the [redacted], and wore a [redacted] to the [redacted]. At that time, the CNA accompanied Surveyor #1 to the resident's room and confirmed the resident was not wearing [redacted] while in bed. During an interview with Surveyor #1 on 12/03/2021 at 9:28 AM, the Unit Manager (UM) stated that Resident #56 was a total assist with care, had a [redacted], and had an order for [redacted] when in bed. At that time, the UM accompanied the Surveyor #1 to the resident's room and confirmed the resident was not wearing [redacted] while in bed. The UM stated the resident was supposed to have [redacted]	F 686		

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[redacted] applied when in bed. The UM further stated it was important for the resident to have the [redacted] applied because it offloaded some of the [redacted]. The UM was able to find the [redacted] but was unable to locate the resident's [redacted] protector.

During a follow up interview with Surveyor #1 on 12/03/21 at 9:42 AM, the UM stated she was able to locate the Resident #56's [redacted] in the closet, behind some clothes.

On 12/01/2021 at 10:50 AM, Surveyor #2 observed Resident #24 lying in bed with his/her feet covered by the blanket. When asked, the resident stated he/she was not wearing [redacted]. With the resident's permission, the surveyor lifted the blanket to reveal the resident was not wearing [redacted] and his/her [redacted] were resting on the mattress.

On 12/03/2021 at 8:43 AM, Surveyor #2 observed Resident #24 lying in bed with his/her feet covered by the blanket. The resident gave the surveyor permission to lift the blanket, to [redacted] and his/her heels were resting on the mattress. With the resident's permission, the surveyor opened the resident's closet to reveal a heel protector was stored inside.

According to the Admission Record, Resident #24 had diagnoses that included, but were not limited to: [redacted]).

Review of the Minimum Data Set (MDS) an

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F 686	Continued From page 12 assessment tool used to facilitate the management of care, dated [redacted], revealed the resident had a Brief Interview for Mental Status of [redacted], which indicated that the resident's [redacted] was intact. Further review of the MDS revealed the resident required extensive assistance of one staff for bed mobility and did not have [redacted]. Review of the Care Plan included a focus that, "[Resident #24] is at risk for impaired skin integrity [related to] ... impaired physical mobility" with intervention for "[redacted]. Review of the Medication Review Report, dated 12/03/2021, included an order for [redacted] while in bed every shift for prevention," with a start date of [redacted] Review of the Treatment Administration Record, dated [redacted], included the aforementioned order was signed off as administered on [redacted] During an interview with Surveyor #2 on 12/03/2021 at 9:00 AM, the Certified Nursing Assistant (CNA) stated Resident #24 can make his needs known, but requires assistance with care. The CNA further stated the resident does not have any offloading devices in place. At that time, the CNA accompanied the surveyor to the resident's room and confirmed the resident was not wearing heel protectors. The CNA then opened the resident's closet and confirmed there was one heel protector stored inside. During an interview with Surveyor #2 on	F 686		

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F 686	Continued From page 13 12/03/2021 at 9:11 AM, the Licensed Practical Nurse (LPN) stated Resident #24 was alert and oriented, but that he/she had issues with mobility. The LPN further stated that the resident wears [NJAC 8:43E-2.1 and Exec Order 26] while in bed. The LPN then accompanied the surveyor to the resident's room and confirmed the resident was not wearing [NJAC 8:43E-2.1 and Exec Order 26]. At that time, the C/D Unit Clerk entered the room and handed the LPN a new pair of [NJAC 8:43E-2.1 and Exec Order 26] for the resident. The LPN then stated that if the resident's [NJAC 8:43E-2.1 and Exec Order 26] were in the laundry, the staff should obtain replacement [NJAC 8:43E-2.1 and Exec Order 26]. During an interview with Surveyor #2 on 12/03/2021 at 9:50 AM, the Unit Manager (UM) stated that Resident #24 was alert and oriented, but dependent on staff for bed mobility and positioning. The UM further stated the resident wears heel protectors to both feet while in bed. The UM added that if the [NJAC 8:43E-2.1 and Exec Order 26] were in the laundry when the resident goes back to bed, the staff should obtain a new pair from central supply. On 12/03/2021 at 10:02 AM, Surveyor #2 accompanied the A/B Unit Clerk to the central supply room, which contained two new sets of [NJAC 8:43E-2.1 and Exec Order 26] that were available for residents on the units. During an interview with Surveyor #2 on 12/03/2021 at 10:50 AM, the Director of Nursing (DON) stated that if a resident has an order for [NJAC 8:43E-2.1 and Exec Order 26] while in bed, the staff should ensure that the [NJAC 8:43E-2.1 and Exec Order 26] are applied and maintained while the resident is in bed. The DON further stated that if the [NJAC 8:43E-2.1 and Exec Order 26]	F 686		

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F 686	Continued From page 14 were unavailable, the staff should get a new pair from central supply. The facility was unable to provide a policy related to heel protectors. NJAC 8:39-27.1(a)	F 686		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data	F 732		1/3/22

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F 732	Continued From page 15 available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to ensure that a.) the Resident Care Staffing Report was posted on 1 of 2 nursing units (C/D unit) and b.) the posted Resident Care Staffing Report was completed for each shift on 1 of 2 nursing units (A/B unit). This deficient practice was evidenced by the following: On 11/30/2021 at 12:33 PM, the surveyor observed the Resident Care Staffing Report for the A/B unit on a bulletin board near the nurses' station. The 7a-3p shift section of the form was not completed. On 12/01/2021 at 9:30 AM, the surveyor was unable to locate the Resident Care Staffing Report at the front entrance. The Receptionist was unaware of where the Resident Care Staffing Report was located. On 12/01/2021 at 9:32 AM, the surveyor observed the Resident Care Staffing Report for the A/B unit on a bulletin board near the nurses' station. The 7a-3p shift section of the form was not completed. The surveyor then asked the A/B	F 732	Even though this deficient practice was found, no residents were affected by the deficient practice. All residents in the facility who were admitted during the time frame of 11-1-21 through 12-8-21 could potentially have been affected by this deficient practice. Unit Managers, Supervisors and HR were in-serviced on completion and posting of the daily staffing within 2 hours into their shift. The staffing continues to be monitored on a daily basis by DON and HR coordinator. The findings of the audits will be reported to the Administrator and the Quality Assurance Committee at the Quarterly Meeting.	

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F 732	Continued From page 16	F 732		

Unit Manager (UM) to make a copy of the form. The A/B UM took the form off the board, filled in the 7a-3p section, and made a copy for the surveyor. The A/B UM further stated that she is responsible for completing the form, but that she was still orienting to the unit.

On 12/01/2021 at 9:35 AM, the surveyor was unable to locate the Resident Care Staffing Report for the C/D unit. At that time, the C/D UM stated that the form was posted at the front entrance receptionist, not on the C/D unit.

During an interview with the surveyor on 12/01/2021 at 9:38 AM, the C/D Unit Clerk (UC) stated she was also the facility's Staffing Coordinator (SC). The UC/SC stated that she does not complete the Resident Care Staffing Reports and that she thought Human Resources (HR) was responsible for completing the forms. The UC/SC further stated that she believed the forms were posted at the front entrance, in the vicinity of the receptionist.

During an interview with the surveyor on 12/01/2021 at 9:42 AM, HR stated that she was not responsible for completing the Resident Care Staffing Reports and that the A/B and C/D UMs complete the forms. HR further stated that the forms were posted on bulletin boards on each unit.

During an interview with the surveyor on 12/01/2021 at 9:52 AM, the Director of Nursing (DON) stated that the Resident Care Staffing Reports are posted on the wall of each unit. The DON then accompanied the surveyor to the C/D unit and confirmed that the form was not posted

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F 732	Continued From page 17 on the unit. The DON then stated that the 11p-7a nurse initiates the Resident Care Staffing Report and then the DON or UM completes the 7a-3p shift and the 3p-11p shift sections of the form. The DON further stated that the forms were specific to each unit and that each shift section should be completed "sometime" after the shift starts. On 12/01/2021 at 11:45 AM, the surveyor received the original copies of the November 2021 Resident Care Staffing Reports for the A/B unit from HR, who confirmed that the forms were the originals taken from the unit, as they contained pin holes from being posted to the bulletin board. When asked where the original forms for the C/D unit were, HR stated she had to go to the unit and get them. On 12/01/2021 at 11:47 AM, HR accompanied the surveyor to the C/D unit to obtain the original copies of the November 2021 Resident Care Staffing Reports. HR asked the UC/SC for the original copies and the UC/SC stated, "I don't think we have them." Review of the November 2021 Resident Care Staffing Reports for the A/B unit revealed the following: The 7-3 shift and 3-11 shift sections were not completed on: 11/01/2021; 11/02/2021; 11/03/2021; 11/04/2021; 11/05/2021; 11/08/2021; 11/09/2021; 11/10/2021; 11/11/2021; 11/12/2021; 11/15/2021; 11/16/2021; 11/17/2021; 11/18/2021; 11/19/2021; 11/20/2021; 11/22/2021; 11/23/2021; 11/24/2021; 11/25/2021; 11/27/2021; 11/28/2021; 11/29/2021; and 11/30/2021.	F 732		

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F 732	Continued From page 18 The forms were missing for: 11/06/2021 (Saturday); 11/07/2021 (Sunday); 11/13/2021 (Saturday); 11/14/2021 (Sunday); and 11/21/2021 (Sunday). During an interview with the surveyor on 12/01/2021 at 12:03 PM, the DON reviewed the November 2021 Resident Care Staffing Reports for the A/B unit and stated that there was not a designated person responsible for completing the Resident Care Staffing Reports and that the forms should have been completed for each shift. Review of the facility's Posting Direct Care Daily Staffing Numbers policy, dated 03/2019, revealed, "Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents," and, "Within two (2) hours of the beginning of each shift, the number of Licensed Nurses ([Registered Nurse], [Licensed Practical Nurse], and [Licensed Vocational Nurse]) and the number of unlicensed nursing personnel ([Certified Nursing Assistant]) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors)." NJAC 8:39-41.2 (a)	F 732		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		1/3/22

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F 756	Continued From page 19 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to act on or respond to, comments made by the Pharmacist Consultant in a timely manner. This deficient	F 756	Resident number 31 Pharmacy consultant recommendations were addressed by the MD and rationale documented on Pharmacy consultant	

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F 756	Continued From page 20 practice was identified for 1 of 7 residents (Resident #31) reviewed for unnecessary medications and was evidenced by the following: According to the Pharmacist Consultant's Therapeutic Suggestions dated [NJAC 8:43E-2.1 and E], the Pharmacist Consultant (PC) made a recommendation for Resident #31 "As per CMS guidelines, is a taper of [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] indicated? If a taper of this medication is contraindicated, include the rationale in your response to this request." A review of the Order Summary Report for Active Orders as of 07/01/2021 revealed that Resident #31 had an order dated 01/12/21 fo [NJAC 8:43E-2.1 and Exec] A review of the 07/21, 08/21, 09/21, 10/21, and 11/21 Medication Administration Records (MAR) revealed Resident #31 received the medication daily. A review of the 12/21 MAR revealed that Resident #31 received the medication on 12/01/21, 12/02/21, 12/03/21, 12/04/21 and 12/05/21. A review of the Physicians Progress Notes dated 07/17/21, 08/19/21, 09/22/21, 10/27/21 and 11/24/21 revealed "Psychotropic medication titration IS NOT indicated at this time." The Physicians Progress Notes did not reflect a rational addressing the PC [NJAC 8:43E-2] recommendation. During an interview with the surveyor on 12/02/21 at 1:06 PM, the Licensed Practical	F 756	report. All residents in the facility who currently receive Pharmacy consultant recommendations were reviewed to assure all recommendations were followed by the MD. Unit Managers, DON and Pharmacy consultant Consultant were in-serviced on policy and procedure for Pharmacy consultant recommendations and documentation process. The DON/designee in partnership with Pharmacy consultant will conduct monthly audits of Pharmacy consultant medication reviews to assure the recommendations are addressed and done in a timely manner. The findings of the audits will be reported to the Administrator and the Quality Assurance Committee at the Quarterly Meeting.	

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F 756	Continued From page 21 Nurse (LPN) stated that the PC reviewed the medications for each resident monthly and provided the Director of Nursing (DON) with a report. The DON then reviewed the report and addressed the PC recommendations with the physician. During an interview with the surveyor on 12/02/21 at 1:11 PM, the DON stated that she is responsible to complete the monthly PC recommendations. The DON stated that she printed the recommendations and tried to make sure they were all completed. There is a form for the physician to review the PC recommendation and document if the physician agreed or disagreed with the PC recommendation. The DON stated that she would provide further documentation. After surveyor inquiry, the DON provided a physician progress note dated 12/07/21 which reflected "Depression continue with [redacted]" The progress note did not reflect a rationale addressing the PC [redacted] recommendation. Review of the facility's undated Psychotropic Medication Policy and Procedure reflects that the PC "Monitors psychotropic drug use in the facility to ensure that medications are not used in excessive doses or for excessive duration." The policy further reflects that the physician "documents" a "rationale" for psychotropic medication use. NJAC 8:39 - 29.3	F 756		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		1/3/22

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F 812	Continued From page 22 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe, consistent manner designed to prevent foodborne illness. This deficient practice was evidenced by the following: On 11/29/21 at 9:52 AM, the surveyor, in the presence of the Food Service Director (FSD), observed the following during the kitchen tour: 1. In the dessert refrigerator, an undated turkey and cheese sandwich wrapped in clear plastic was stored on a shelf.	F 812	1. Upon being made aware of the deficient practice the undated turkey and cheese sandwich wrapped in clear plastic in the dessert refrigerator was discarded. 2. The undated Styrofoam cup containing dessert and the undated Styrofoam cup containing lemonade were discarded. 3. The opened bottle of ginger ale in the dessert refrigerator was discarded. 4. The opened and undated bottle of water in the dessert refrigerator was discarded. 5. The undated food platter wrapped in a plastic bag in the dessert refrigerator was discarded.	

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F 812	Continued From page 23 2. In the dessert refrigerator, an undated styrofoam cup containing dessert and an undated styrofoam cup containing lemonade was stored on a shelf. 3. In the dessert refrigerator, an opened bottle of ginger ale was stored on a shelf. 4. In the dessert refrigerator, an opened and undated bottle of water was stored on a shelf. 5. In the dessert refrigerator, an undated food platter wrapped in a plactic bag was stored on a shelf. When interviewed, the FSD stated that staff was suppose to label and date all personal items when stored in the dessert refrigerator. 6. A scooper and its holder were stored directly on top of the ice machine and the surveyor observed the holder to be wet inside. The surveyor observed the ice scooper was not in a position to allow for draining. When interviewed , the FSD stated that this was the manner in which they normally store the ice scooper and holder. 7. In the dry storage room, an opened and undated package of marshmallows was stored on a multi-tiered cart. 8. In the dry storage room, an opened and undated package of buttermilk biscuit was stored on a multi-tiered cart. 9. In the dry storage room, an opened and undated package of coffee cake mix was stored on a multi-tiered cart. When interviewed, the FSD stated that the staff were supposed to wrap opened items in plastic and label the items with	F 812	6. The ice scooper was thoroughly cleaned and mounted vertically on the side of the ice machine to allow for proper drainage. 7. The opened and undated package of marshmallows stored on a multi-tiered cart in the dry storage room was discarded. 8. The opened undated package of buttermilk biscuit stored on a multi-tiered cart in the dry storage room was discarded. 9. The opened and undated package of coffee cake mix stored on a multi-tiered cart in the dry storage area was discarded. 10. The opened and undated package of whip cream in the walk-in refrigerator was discarded. 11. The box containing 11 expired vanilla healthshakes stored on a multi-tiered cart in the walk-in refrigerator were discarded. 12. The 7 expired vanilla healthshakes on the red tray in the walk-in refrigerator were discarded. 13. The 9 expired vanilla healthshakes on a pink tray in the walk-in refrigerator were discarded. 14. The opened and undated package of hot dogs in the walk-in refrigerator was discarded. 15. The can opener blade and holder were thoroughly cleaned of all debris. All residents within the facility who are on a by mouth diet have the potential to be impacted by this deficient practice. All food storage and preparation areas have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315058	A. BUILDING _____ B. WING _____	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN REHABILITATION AND NURSING CENTER	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

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F 812	Continued From page 24 an open date. 10. In the walk-in refrigerator, an opened and undated package of whipped cream was stored on a multi-tiered cart. 11. In the walk-in refrigerator, a box containing 11 vanilla healthshakes was stored on a multi-tiered cart. The healthshakes had a pull date of 11/13/21 and a discard date of 11/27/21. 12. In the walk-in refrigerator, a red tray containing seven vanilla healthshakes was stored on a multi-tiered cart. The healthshakes had a pull date of 11/13/21 and a discard date of 11/27/21. 13. In the walk-in refrigerator, a pink tray containing nine vanilla healthshakes was stored on a multi-tiered cart. The healthshakes had a pull date of 11/13/21 and a discard date of 11/27/21. When interviewed, the FSD stated that the health shakes were not supposed to be in the walk-in refrigerator and should have been discarded on 11/27/21. 14. In the walk-in freezer, an opened and undated package of hotdogs wrapped in plastic was stored on a multi-tiered cart. When interviewed, the FSD stated the package of hot dogs should have been labeled when opened. 15. The can opener blade and holder was soiled with debris of an unknown substance. A review of the facility's undated "Food Receiving and Storage" policy indicated that dry foods that are stored in bins will be removed from original	F 812	the potential to be impacted by this deficient practice. Dietary staff have been in serviced on the proper policy and procedure for food storage, labeling and dating of food products and discarding expired items. Dietary and maintenance staff have been in-serviced on the proper procedure for Kitchen cleaning and sanitation. Dietary staff have been in serviced on not storing personal items in the kitchen Refrigerators. Dietary staff and nursing staff have been in serviced on proper storage of the ice machine scoop. Dietary director or designee will conduct quarterly in servicing on all the above for six months to include return demonstration to ensure competency of staff. Dietary director or designee will conduct a weekly check of kitchen and equipment cleanliness, storage, labeling practices, expired items and refrigerators for six months to ensure compliance. Findings of said audits will be presented at the quarterly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315058	A. BUILDING _____ B. WING _____	12/08/2021

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F 812	Continued From page 25	F 812		

packaging, labeled, and dated ("use by" date). Such foods will be rotated using a "first-in-first out" system. All foods stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date). Beverages must be dated when opened and discarded after twenty-four (24) hours. Other opened containers must be dated and sealed or covered during storage. Partially eaten food may not be kept in the refrigerator."

A review of the facility's undated "Dating and Labeling Policy" policy indicated that the kitchen was to assure food safety by maintaining proper dates and labels to all ready to eat food products. The policy further indicated that the facility was to discard all foods that expired immediately.

A review of the facility's undated "Health Shakes" policy indicated that all health shakes must be dated with a 14-day expiration date and to discard all expired foods immediately.

A review of the facility's "Sanitation" policy, dated May 2021, indicated all utensils, counters, shelves, and equipment should be kept clean.

A review of the facility's "Ice Machines and Ice Storage Chests" policy, updated March 2021, revealed that the ice distribution containers will be used and maintained to assure a safe and sanitary supply of ice.

NJAC 8:39-17.2(g)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315058 Y1	A. Building B. Wing Y2	3/8/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN REHABILITATION AND NURSING CENTER	438 SALEM-WOODSTOWN ROAD SALEM, NJ 08079

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658	Correction	ID Prefix F0686	Correction	ID Prefix F0732	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.35(g)(1)-(4)	Completed
LSC	01/03/2022	LSC	01/03/2022	LSC	01/03/2022
ID Prefix F0756	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	01/03/2022	LSC	01/03/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/8/2021	☐ YES ☐ NO