New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02002	A. BUILDING: ______ B. WING ______	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	544 TEANECK ROAD TEANECK, NJ 07666

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. The facility was deficient in Certified Nursing Assistant (CNA) staffing for 10 of 14 day shifts and 1 of 14 evening shifts: Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	The Facility continues to follow a recruitment plan to attract Certified nurse assistants staff and licensed nurses to meet the ratio requirement. Leadership has met on ongoing basis and continue to identify staffing challenges and areas of improvement for licensed and certified nursing needs. All patients have potential to be affected. Ongoing efforts to recruit and retain staff are in place :	12/24/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/09/21

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with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:

One CNA to every eight residents for the day shift.

One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and

One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.

As per the "Nurse Staffing Report" completed by the facility for the weeks of 10/31/21 and 11/7/21, the staffing to resident ratios did not meet the minimum requirement of 1 CNA to 8 residents for 10 of 14 day shifts and 1 of 14 evening shifts as documented below:

10/31/21 had 9 CNAs for 87 residents on the day shift, required 11 CNAs.
11/01/21 had 8 CNAs for 87 residents on the day shift, required 11 CNAs.
11/02/21 had 8 CNAs for 84 residents on the day shift, required 11 CNAs.
11/03/21 had 9 CNAs for 78 residents on the day shift, required 10 CNAs.
11/06/21 had 8 CNAs for 77 residents on the

Over time /agency use, bonus shifts, referral bonus program and Cna school programs
The facility has implemented significant above market rate for nurses and certified nurse assistants including sign on bonuses and bonuses where appropriate.
The facility continues to conduct job fairs with immediate interviews and contingency offers.
The facility implemented expedited but robust onboarding process to new hires.
The facility uses agency staff ass needed to meet staffing needs.

The DON/designee meets with the staffing coordinator daily to review call outs and facility census vs staffing needs.
The DON/designee will monitor ratios weekly until the requirement is met.
The results of the audits will be forwarded to the facility Administrator and monthly QAPI committee for further recommendations.

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day shift, required 10 CNAs.
11/07/21 had 9 CNAs for 77 residents on the day shift, required 10 CNAs.
11/08/21 had 9 CNAs for 77 residents on the day shift, required 10 CNAs.
11/10/21 had 9 CNAs for 77 residents on the day shift, required 10 CNAs.
11/12/21 had 10 CNAs for 84 residents on the day shift, required 11 CNAs.
11/13/21 had 8 CNAs for 84 residents on the day shift, required 11 CNAs.
11/13/21 had 7 CNAs to 15 residents total staff on the evening shift, required 8 CNAs.

On 11/19/21 at 8:52 AM, the surveyors met with the Director of Nursing (DON) and the Staffing Coordinator (SC). The SC stated that she began working in that position approximately one month prior to the survey. The SC informed the surveyors that her responsibility was to make sure there was enough staff per shift and to check that all the employees scheduled were present. The SC stated that she worked Monday through Friday, 8:00 AM - 4:00 PM and sometimes 8:00 AM -8:00 PM, "to make sure the next day's staffing is okay." She further stated that the facility had "two agencies for nurses and CNAs." The SC stated, "I am aware of the mandated NJ law for minimum staffing," and "I make sure enough people are here to follow and cover the mandated NJ law for minimum staffing."

On that same date and time, the DON and SC both stated that "were not meeting the requirement." The DON further stated that, "like every one else we have staffing issues. We tried attempts to former shifts to offer overtime, meeting with HR for retention plan, paid extra shift, offering bonuses referral bonuses, open

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S 560	Continued From page 3 house day and on going." A review of The Facility Assessment Tool, dated 10/2017, included the following statement: "Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies 3.1 Based on the above information and programming goals, a staffing plan has been developed to meet the professional, technical and administrative needs of the center. The plan is informed by historical experience, and projected changes. The approach takes into consideration both the type of staff (licensure or other credential) and number required."	S 560		

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F 000	INITIAL COMMENTS Survey Date: 11/22/2021 Census: 87 Sample: 18 + 3 closed records 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 observation, interview, and record review, it was determined that the facility failed to a.) clarify a physician order with regard to fluid consistency for 1 of 21 residents (Resident#23) and b.) label and date the [redacted] (method of [redacted] [redacted]) and [redacted] for 1 of 1 resident (Resident #69) in accordance with facility policy and procedure and professional standards of practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title	F 658	Resident #23 -order for fluid consistency was immediately obtained for resident to receive thin liquids when taking medications. Resident #69 had the [redacted] and [redacted] bottle removed and replaced with dated items Residents taking modified fluids have the potential to be affected. An audit of residents on modified fluids was completed and no other residents were affected. Residents with [redacted] have the potential for the same practice. an observation was conducted and no other	12/24/21

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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 658	Continued From page 1 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, 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 case finding; 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. On 11/15/21 at 10:31 AM, the surveyor observed Resident #23 in his bed receiving a a at a). The resident's headboard was at a 45-degree angle and the resident was observed with their eyes closed. A review of the resident's Face sheet (an admission summary), that the resident was admitted to the facility with diagnoses that included	F 658	residents were affected. Director (DON) or designee will in-service nurses on every shift on : In-service to nurses on the clarification of orders and obtaining an order when a resident /patient is on modified liquid consistencies related to . obtaining, transcribing and clarifying orders related to liquid consistency. DON (designee) will in-service nurses on every shift policy and procedure including labeling ,dating bottle and DON/designee will conduct 2 random audits for accuracy of orders weekly x4 weeks and then monthly x2 months. Outcomes of the audits will be reported at the monthly quality assurance performance improvement meetings for a period of three months. DON/designee will in-service on every shift policy and procedure including labeling and dating bottle and Don /designee will complete 2 random observation audits of bottles, to ensure proper labeling and dating, weekly basis x4 weeks then monthly x 2 months. outcomes of the audits will be reported at the monthly quality assurance performance improvement meetings for a period of three months.	

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A review of the [redacted] Order Summary Report (OSR) revealed an order dated [redacted] for a Regular diet [redacted]) texture, [redacted] consistency.

The surveyor reviewed the Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care dated [redacted] for Resident #23, which reflected the resident had a brief interview for mental status (BIMS) score [redacted] out of [redacted] indicating that the resident had a [redacted]

The surveyor reviewed Resident #23's interdisciplinary care plan (IDCP) dated [redacted] that revealed under the focus area will not take by mouth (PO) medications without thin liquids which had a goal that the resident will accept medication, treatment or procedure.

On 11/18/21 at 9:45 AM, the surveyor interviewed Resident #23 who stated that they will only take their medication with thin liquid.

On 11/18/21 at 11:40 AM, the surveyor interviewed a Licensed Practical Nurse (LPN#1) who's Resident #23's medication nurse. LPN #1 stated that Resident #23 is [redacted] but can make their needs known and the resident have a history of being non-compliant with their diet including refusing [redacted] ([redacted] LPN #1 stated that he will always attempt to give the resident [redacted]

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[REDACTED] liquid with their medications, but the resident will refuse.

Furthermore, LPN #1 stated that the physician is aware and that the resident refusal to take medications with [REDACTED] Liquid. When surveyor asked LPN #1 if he consulted with the physician about the resident receiving medications through a [REDACTED] or having the physician clarifying the physician order, the LPN #1 stated that he should have consulted with the physician and clarified the order for liquids during medication administration.

On 11/18/21 at 11:55 AM, the surveyor interviewed the Director of Rehabilitation who stated that the resident was last seen by the Speech Therapist in March. The resident had no re-evaluation because their condition hasn't improved but she stated that all residents at the facility are screened by the therapy department which includes Physical Therapy, Occupational Therapy and Speech Therapy. She stated that twice weekly they will do rounds and check on all the residents. They will have team meetings every 5 days to discuss each resident at the facility and will address any concerns that are brought up by the team. She stated that Resident #23 has a history of being non-compliant with their doctor. She stated that the physician is aware that the resident is not compliant with their diet, particularly with the [REDACTED] Liquid. She also stated that she checked on Resident #22 and the resident had no negative effects.

On 11/18/21 at 12:45 PM, the surveyor team met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The LNHA stated that the facility including the

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resident's physician have spoken to the resident on numerous occasions regarding the resident's non-compliance and the risk and benefit. The DON further stated that there was no negative effect to the resident and that the order for fluids during medication administration should have been clarified to reflect the IDCP intervention that resident can have thin liquids with a goal to accept medications.

The LNHA stated that resident is not a candidate for receiving medication through a [redacted] to the [redacted], the placement of the [redacted] and the resident's history of having their [redacted] [redacted]

A review of the facility's policy for Physician Orders: Obtaining and Transcribing dated 9/29/15 and was provided by the DON indicated the following: "Validate (a physician order) Review of a physician order that has been received or verified by another nurse to ensure it is a complete order that reflects the order (s) of the consult, referral, etc. or documented changes to those orders; that transcription of the orders is complete and correct; and that follow-through has been implemented.

NJAC: 8-39-27.1 (a)

2. During the initial tour on 11/15/21 at 11:05 AM, the surveyor observed Resident #69's [redacted] [redacted] bottle and [redacted] bag were not labeled and dated. The surveyor observed the [redacted] bottle was half empty.

A review of the resident's Face sheet, that the resident was admitted to the facility with diagnoses that included [redacted]

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A review of the CMDS dated , indicated a BIMS score of , which reflected that the resident's . The CMDS indicated that the resident had a

A review of the electronic Medical Record (eMAR) revealed an order dated for to start at 5 PM and that was discontinued and re-ordered the same date on

On 11/15/21 at 11:15 AM, the surveyor interviewed the Registered Nurse (RN#1) responsible for Resident #69. RN#1 stated that Resident #69 "is the only resident" on their assignments "who is currently receiving an and the begins during the 3-11 PM shift."

On 11/16/21 at 8:10 AM, the surveyor observed Resident #69 in their bedroom asleep with . At that time, the bottle and bag were not labeled.

On the same day at 10:25 AM, RN#1 stated to the surveyor that the bottle should be labeled with the time and date the . RN#1 further stated, "I'm not sure with the bag has to be labeled as well but would find out."

Furthermore, the surveyor and RN#1 went inside the resident's room and RN#1 acknowledged that either the bottle or bag

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were labeled. The RN also acknowledged the [redacted] bottle and [redacted] were not labeled the previous day on [redacted]

On 11/16/21 at 10:30 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) for Resident #69. The RN/UM informed the surveyor that the [redacted] bottle and [redacted] bags should be labeled with the date and time the bottle is opened and hung. The RN/UM stated that the [redacted] is good for 24 hours once opened. The RN/UM acknowledged that both the [redacted] bottle and [redacted] bag were not labeled.

On 11/17/21 at 9:45 AM, the surveyor conducted a phone interview with RN#2 who had Resident #69 during the 3-11 PM, shift on [redacted]. RN#2 stated that "I was too busy to label the [redacted] when I hung it and forgot to do it later during my shift because I was too busy with all my patients." The surveyor asked the RN if they knew about the facility's policy regarding labeling of [redacted] and RN#2 stated, "I know the policy, but I was too busy."

On the same day at 11:55 AM, the surveyor conducted a phone interview with LPN#2 who had Resident #69 during the 3-11 PM, shift on [redacted]. LPN#2 stated, "I wrote out a label for the [redacted], but did not put it on the tube [redacted] because another patient needed me and I forgot to put the label on when I went back to Resident #69." The surveyor asked LPN#2 if they knew about the facility's policy regarding labeling [redacted], and LPN#2 stated, "yes, but I forgot to go back and label the bottle."

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F 658	Continued From page 7 On 11/16/21 at 12:33 PM, the survey team met with the LNHA and the DON and were made aware of the above concerns. A review of the facility [redacted] Policy with a version date of 11/2018 that was provided by the Administrator indicated "On the [redacted] documents initials, date and time the [redacted] was hung/administered, and initial that the label was checked against the order." NJAC 8:39-19.4 (a) (1)	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 a.) provide [redacted] treatment consistent with professional standards of practice to an existing [redacted] injury and b.) implement an element of the facility policy and procedure concerning a [redacted] dressing, for 1 of 1 Resident	F 686	The physician evaluated the [redacted] of resident #46 and the [redacted] continues to improve. Residents with [redacted] treatment orders have the potential to be at risk related to this citation.	12/24/21

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(Resident#46) observed during [redacted] treatment observation.

This deficient practice was evidenced by the following:

On 11/15/21 at 10:40 AM, the surveyor was informed by Resident #46 that there was a [redacted] on their [redacted] area that "I was not sure if 100% healed."

On 11/16/21 at 9:48 AM, the surveyor interviewed the Registered Nurse (RN) who informed the surveyor that Resident#46 was [redacted] with [redacted]. The RN stated that the resident had a [redacted] to the [redacted] and "I will get back to you with the [redacted] of the [redacted] She further stated that the resident was being seen by a [redacted] doctor who comes "I think every [redacted]" She indicated that she was not sure if the [redacted] was [redacted]

On that same date and time, the RN informed the surveyor that Resident#46 was on a [redacted] [redacted] on both bed and wheelchair, and [redacted] care to promote [redacted] The RN stated that "the [redacted] is getting better."

On 11/16/21 at 9:53 AM, the surveyor observed the resident seated in a [redacted] wheelchair in their room. The resident informed the surveyor that it was the nurse who does [redacted] care treatment to their [redacted] and that the [redacted] was getting better.

A review of the resident's Face sheet (an admission summary), reflected that the resident was admitted to the facility with diagnoses that

F 686

DON/designee to in-service nursing staff on :
1. wound care treatment with clean technique and complete competency with return demonstration.
2. facility policy and procedures concerning [redacted] dressing technique

Don/designee will complete 4 random audits on [redacted] care treatments. Audits will be completed on a weekly basis x 4 weeks then twice monthly x 2 months. Outcomes of the audits will be reported at the monthly quality assurance performance improvement meetings for a period of three months.

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	315502	A. BUILDING ____ B. WING ____	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	544 TEANECK ROAD TEANECK, NJ 07666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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included [redacted].

A review of the Comprehensive Minimum Data Set (CMDS), an assessment tool dated [redacted] indicated that a Brief Interview for Mental Status (BIMS) score of [redacted], which reflected that the resident's cognition [redacted] The CMDS showed that the resident had an [redacted] that was not a facility acquired.

A review of the [redacted] Physician's Orders dated [redacted], revealed an order to cleanse the [redacted] with [redacted]), pack with [redacted] soaked gauze, then apply [redacted] (an [redacted] skin cleanser) to the [redacted] area and cover with dry gauze and [redacted]

A review of the [redacted] consult dated [redacted] signed by the Medical Assistant (MA) revealed that the [redacted] was improving.

On 11/16/21 at 10:40 AM, the surveyors observed the RN perform a [redacted] treatment to Resident #46's [redacted] with the assistance of the Infection Preventionist Nurse (IPN). The RN disinfected the first table, let the table dry, and place the NS, gauze, and [redacted]. The RN did not disinfect the second table inside the resident's room where the RN placed clean gloves, alcohol-based hand rub (ABHR), and the foam dressing. The table that was not disinfected had the resident's water container and tissue paper box. The surveyors observed the IPN did not change gloves and perform hand hygiene after

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F 686	Continued From page 10 touching the resident's wheelchair, bed, and surrounding environment, and immediately touched the resident's [redacted] area to help the RN after the RN cleansed the [redacted] with [redacted] Afterward, the RN took her pen from her uniform pocket, signed the [redacted] dressing, and returned the pen to her uniform pocket without disinfecting the pen before and after use. The RN then took and used the gloves from the undisinfected table, apply [redacted] gauze to the [redacted] applied [redacted] to the [redacted], and covered the [redacted] with a [redacted] dressing. The RN discarded unused supplies into the garbage. The RN and the IPN performed hand hygiene, and the RN disposed of the garbage outside the resident's room. Both the RN and the IPN did not disinfect the two tables used in [redacted] treatment. On 11/16/21 at 11:07 AM, during the interview, the IPN informed the surveyors that "as a standard of practice even though not our facility policy; the tables to be used for treatment should be disinfected first." Both the IPN and the RN acknowledged that both tables inside the resident's room that were used for [redacted] treatment should have been disinfected before and after treatment. On that same date and time, the surveyor asked the RN why she did not disinfect her pen before and after use when she took and returned it to her uniform pocket and the IPN stated "it's okay for her not to disinfect the pen because she doesn't share her pen." Furthermore, the surveyor asked the IPN why she did not change her gloves and perform hand hygiene after touching the resident's immediate environment and before touching the resident's [redacted] area after the RN cleaned the [redacted] the IPN stated	F 686		

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F 686		F 686		

Continued From page 11
"that's a good point."

On 11/16/21 at 12:33 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and discussed the above observations and concerns.

On 11/18/21 at 11:51 AM, the surveyors met with the LNHA and the DON. The DON stated that it was the facility policy to disinfect tables before and after [redacted] treatment, the pen should be disinfected before and after use, and hand hygiene should be appropriately done during the [redacted] treatment observation. The LNHA further stated that the IPN should have stopped the [redacted] treatment at that time and followed the appropriate [redacted] treatment procedure.

A review of CDC Hand Hygiene in Healthcare Settings guidance for Healthcare Providers page last reviewed January 8, 2021, included, "When and How to Wear Gloves: Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene immediately after removing gloves. Changes gloves and perform hand hygiene during patient care, if gloves become damaged, ...moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs ...."

A review of the facility Clean Dressing Change Policy with a revision date of 4/29/16, provided by

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F 686	Continued From page 12 the DON included, "A clean dressing change technique will be used as clinically appropriate. Purpose: To promote [redacted] healing; prevent infection; assess the healing process; and protect the [redacted] from mechanical trauma. Process..#2 Prepare for the procedure: ...2.2. Clean the surface of the over bed table and dry thoroughly ...#4. Prepare supplies using clean technique: 4.1. Prepare a clean field using a clean drape, disposable pad, towel, etc, on which to prepare supplies."." NJAC 8:39-27.1 (b)	F 686		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		12/24/21

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F 761	Continued From page 13 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in two (2) of two (2) medication refrigerators that were inspected. This deficient practice was evidenced by the following: On 11/16/21 at 9:50 AM, the surveyor inspected the [redacted] floor medication room refrigerator in the presence of a Registered Nurse (RN). The surveyor observed two opened vials of [redacted] [redacted] that were opened and not dated. The surveyor also observed an opened vial of [redacted] that had an opened date of [redacted] and was expired. The surveyor interviewed the RN who stated that once a vial of [redacted] is opened that it should be dated because an opened vial of [redacted] only have a 30-day expiration date. On 11/16/21 at 10:30 AM, the surveyor inspected the [redacted] floor medication room refrigerator in the presence of a Licensed Practical Nurse (LPN). The surveyor observed two opened vials of [redacted] that were not dated. The surveyor interviewed LPN who stated that an opened vial of [redacted] should have been dated. A review of the Manufacturer's Specifications for the following medications revealed the following: 1. An opened vial of [redacted] have an expiration	F 761	The [redacted] vial used on the resident was discarded. all other [redacted] vials opened without dates were immediately discarded Residents receiving a [redacted] have the potential to be affected. DON/designee will inservice nurses on dating, labeling and storage of drugs and biologicals used in the facility. DON/designee will complete random audits on medication refrigerators weekly x 4 weeks then twice monthly x 3 months. outcomes of the audits will be reported at the monthly quality assurance performance improvement meetings for a period of three months.	

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F 761	Continued From page 14 date of 30-days. On 11/16/21 at 1:00 PM, the surveyor met with the Licensed Nursing Home Administrator and the Director of Nursing (DON) and no further information was provided by the facility. A review of the facility's policy for Labeling of Medication Containers dated 4/30/19 that was provided by the DON indicated the following: "Labels for stock medications include all necessary information, such as: The expiration date when applicable." NJAC: 8:39-29.4 (a) (h) (d)	F 761		