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(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
F 000	INITIAL COMMENTS Complaint #: NJ000142181 CENSUS: 76 SAMPLE SIZE: 21 + 8 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 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		4/28/21

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

Electronically Signed | 04/14/2021

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F 755	Continued From page 1 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to: a.) remove controlled drugs ([redacted] bottle #1 and [redacted] bottle #2) from active inventory stored in the refrigerator in a timely manner when the controlled drugs were discontinued on 5/1/2020, 12/31/20 and 2/18/21 respectively, b.) perform accountability and reconciliation for controlled drugs ([redacted] and [redacted] bottle #1) and c.) remove a controlled drug ([redacted] bottle #2) that had expired on [redacted]. This deficient practice was identified for 1 of 2 refrigerated medication storage units reviewed and was evidenced by the following: On 3/31/21 at 11:02 AM, two surveyors reviewed the medications stored in the refrigerator on the nursing unit with the Licensed Practical Nurse (LPN) At that time, the surveyors observed in the refrigerated locked box three (3) controlled drugs: 1.) An antianxiety/sedative medication, [redacted] milligram (mg) [redacted] with a count of 15 labeled for Resident #44. 2.) An unopened bottle of an [redacted] medication [redacted]. It was a [redacted] milliliter (ml) bottle #1 of [redacted] mg per/ml	F 755	F Tag 755 No residents were affected by the deficient practice noted for F tag 755 as the medications were not being actively administered. However, the said narcotics were immediately removed from the controlled drugs inventory lock box in the refrigerator. The facility audited each CDAR for each narcotic and verified for accuracy and accountability. Those narcotics identified as expired or discontinued were brought to the Director of Nursing for appropriate destruction with the licensed nurse. The facility medication destruction policy will be updated and include timeframes for destruction. The unit managers and nursing staff were educated that any discontinued narcotics including that of expired residents and expired narcotics must be removed timely according to the facility medication destruction policy. This also includes the removal of the CDAR. To ensure this practice does not occur in the future the pharmacy consultant will perform a more detailed check of the narcotic refrigerator during monthly inspections and the unit managers will check the narcotic box and the lock box in	

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F 755	Continued From page 2 labeled for Resident #77. 3.) An opened [redacted] ml bottle #2 of [redacted] ([redacted] mg per/ml labeled for an unsampled resident with [redacted] ml remaining in the bottle and a date of [redacted] written on the bottle. At that time, the LPN stated that she was unsure if Resident #44 was still receiving the [redacted] suppositories. The LPN also stated that Resident #77 had expired in the facility and the [redacted] bottle #1 should have been removed after the resident's death. The LPN was unsure of when the resident died. The LPN explained that the date [redacted] written on [redacted] bottle #2 with [redacted] ml remaining for the unsampled resident was the date that bottle #2 had been opened and was unsure if the resident was still receiving the [redacted] At that time, the surveyor, in the presence of another surveyor, with the LPN reviewed the label of [redacted] bottle #2 which revealed that once opened the [redacted] liquid was to be discarded after 90 days of being opened. The LPN stated that she was unaware that [redacted] bottle #2 should have been removed and discarded on [redacted] The LPN added that a Controlled Drug Administration Record (CDAR) for each of the controlled drugs stored in the refrigerator was kept in a binder on the medication cart. The LPN added that the CDARs were used to complete a shift to shift count of controlled drugs to ensure accurate accountability. On 3/31/21 at 11:18 AM, the LPN provided the surveyors with [redacted] bottle #2 CDAR for the unsampled resident that she had removed from	F 755	the refrigerator weekly to ensure that there are no discontinued or expired narcotics present. The Director of Nursing or nursing designee will perform a total of 6 observation audits of each narcotic refrigerator's lock box over the course of 2 months. Following the 2 months the results of the audits will be reported and discussed during the following quality assurance program meeting to determine the need for further audits and/ or frequency of audit.	

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the binder on the medication cart. The LPN also stated that she was unable to locate the [redacted] CDAR labeled for Resident #44 and the [redacted] bottle #1 CDAR labeled for Resident #77 from the binder on the medication cart. The LPN added that she had checked both medication cart binders and that they were not there.

A review of the CDAR for the unsampled resident for [redacted] bottle #2 revealed a date received of [redacted] and a declining inventory of [redacted] ml remaining in bottle #2. Further review, revealed a cautionary statement on the label "Discard opened bottle after 90 days."

On 3/31/21 at 11:19 AM, the surveyor, in the presence of another surveyor, interviewed the Unit Manager/LPN (UM/LPN) who stated that when the CDAR was removed from the binder then the medication should be removed from active inventory. The UM/LPN stated that she would have to check with Medical Records for the CDARs for [redacted] for Resident #44 and Ativan bottle #1 for Resident #77. The UM/LPN acknowledged that the CDARs were to be kept in the binder on the medication cart and the controlled drugs were counted each shift using the CDARs. The UM/LPN acknowledged that the removal of the CDAR meant that the [redacted] ml [redacted] bottle #1 and the [redacted] suppositories stored in the refrigerator were not being accounted for and reconciled during the shift to shift controlled drug inventory count.

At that time, the UM/LPN also stated that she thought Resident #77's death occurred in [redacted]. In addition, the LPN added that she was unaware that the [redacted] bottle #2 for the unsampled resident had expired on [redacted]. The UM/LPN

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was unsure if the unsampled resident was still receiving [redacted] bottle #2. The UM/LPN stated that any medication when expired should be removed immediately from active inventory. The UM/LPN added that when a controlled drug was discontinued the medication should be removed along with the CDAR and given to the Director of Nursing (DON) for destruction with the witnessing nurse. The UM/LPN added that she usually checks the medications in the refrigerator for expiration dating and removal if discontinued.

On 3/31/21 at 1:05 PM, the UM/LPN, in the presence of the DON, provided the surveyor with the [redacted] CDAR for Resident #44 and the [redacted] bottle #1 CDAR for Resident #77 which had been retrieved and filed separately in medical records.

A review of the CDAR for Resident #44 for the [redacted] reflected a date received of [redacted] and [redacted] suppositories remaining. This coincided with the number of [redacted] suppositories the surveyors observed in the refrigerator.

A review of the electronic health records (eHR) for Resident #44 revealed an original prescription dated [redacted] for [redacted] mg suppositories, give one suppository via the [redacted] every 2 hours as needed for [redacted]." Further review of an Order Audit Report revealed a physician's order dated [redacted] for the [redacted] to be discontinued.

A review of the CDAR for the Resident #77 for the [redacted] bottle #1 reflected a date received of [redacted] and the remaining amount of [redacted] ml.

A review of the eHR for Resident #77 revealed an original physician's order dated [redacted] for

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" [redacted] mg [redacted] every [redacted] hours as needed for [redacted] Further review of an Order Summary Report revealed a physician's order dated [redacted] for the [redacted] bottle #1 to be discontinued.

A review of the eHR for the unsampled resident reflected an original physician's order dated [redacted] for "[redacted] mg/ml give [redacted] ml by mouth twice a day for [redacted] Further review of an Order Summary Report revealed physician's orders dated [redacted], [redacted] and [redacted] to change the dosage of the [redacted]. In addition, a physician's order dated [redacted] was noted for the [redacted] bottle #2 to be discontinued.

Further review of the CDAR for the unsampled resident for [redacted] bottle #2 revealed that the last date of administration of the [redacted] bottle #2 was 12/27/20.

On 4/1/21 at 10:27 AM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone. The CP stated she completed unit inspections every second Friday of each month. The CP further stated she completed a unit inspection in [redacted]. The CP acknowledged she checked the refrigerators but when it came to the control drugs, she did a "spot check" and did not check every month. She elaborated and stated that the nursing staff should be monitoring the control drugs in the refrigerator.

A review of the CP Monthly Report for [redacted] revealed that a unit inspection was not performed due to COVID 19 restrictions. A review of the Unit Inspection Reports that were performed by the CP during the months of [redacted] and [redacted] had no recording

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of expired controlled drugs in the refrigerator.

On 4/1/21 at 12:32 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the DON and the Infection Preventionist (IP). The DON stated that when a controlled drug was removed from inventory, the corresponding CDAR would also be removed from the binder and be given to her for destruction. After destruction the CDAR would have the documentation of the controlled drug being destroyed and would then be given to medical records to become part of the resident's chart. The DON stated that CDARs should not go directly to medical records. The DON added that the CP does perform unit inspections at the facility but there was a time that the CP was not on site due to COVID 19 restrictions.

On 4/6/21 at 9:47 AM, the survey team met with the LNHA, DON and IP. The DON stated that the nursing staff was responsible for removing expired medications. The DON acknowledged that the controlled drugs stored in the refrigerator were to have a CDAR in the binder for accountability and reconciliation.

A review of an undated facility policy for "Controlled Substances" provided by the DON included that the facility would comply with all laws related to storage, disposal, and documentation of controlled substances. In addition, the nursing staff must count the controlled drugs at the end of the shift.

A review of an undated facility policy for "Discarding and Destroying Medications" provided by the DON included that controlled drugs must be destroyed by the DON and

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F 755	Continued From page 7 another licensed nurse. A review of the Manufacturer's specifications for Ativan oral solution reflected that the Ativan bottles be refrigerated and to discard an opened bottle after 90 days. NJAC 8:39- 29.4(g),29.4(k), 29.7(c)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without an error rate of 5% or more. During the medication pass on 3/31/21, the surveyor observed two (2) nurses administer medications to six (6) residents. There were 34 opportunities and two (2) errors observed which calculated to a medication administration error rate of 5.8%. This deficient practice was identified for 2 of 2 nurses administering medication to 2 of 6 residents, (Resident #25 and #73). The evidence was as follows: 1. On 3/31/21 at 8:43 AM, the surveyor conducted the medication pass in the presence of a second surveyor. At that time, the surveyor observed the Licensed Practical Nurse (LPN #1), during the medication pass, preparing to administer five (5)	F 759	F Tag 759 Residents #25 and #73 were assessed by the Director of Nursing. Resident #25 did not have any adverse effects from not receiving the medication [redacted] Resident #73 also was not noted to have any adverse effects from receiving the medication [redacted] after having the meal. The medication error report was completed and the residents' physicians were informed. An audit of the Medication Administration Record for all residents was conducted to identify any other medication errors or exposed residents. The Director of Nursing or nursing administration designee will conduct	5/12/21

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F 759	Continued From page 8 medications including one tablet of [redacted]) one [redacted] gram (GM) (a medication used to treat [redacted]). The surveyor with LPN #1 observed Resident #25 sitting in a chair eating breakfast. LPN #1 reviewed the medications with the surveyor. LPN #1 stated [redacted] had an administration time of 7:30 AM in the electronic Medication Administration Record (eMAR) and was color coded red because it was one hour past the 7:30 AM scheduled timeframe to give the medication. LPN #1 stated that the resident was already eating breakfast and was not going to administer the [redacted] Upon returning to the medication cart, the surveyor asked LPN #1 how often she completed medication pass during a shift. The LPN #1 stated she did three medication passes during her 7 AM - 3PM shift and usually started her first medication pass around 7:30 AM. The surveyor continued to interview LPN #1 regarding the process for withholding medications. LPN #1 stated she wrote a progress note which stated Resident #25 was "eating" as the reason she withheld the [redacted]. LPN #1 further stated she would administer the [redacted] at lunch time because it was scheduled for three times a day before meals. (Error #1). The surveyor reviewed the medical records for Resident #25. According to the Order Summary Report for [redacted] in the electronic medical record (EMR), Resident #25 was admitted with diagnoses which included but not limited to: [redacted].	F 759	in-service training to all nursing staff, including LPN #1 and #2, on the topic of proper medication pass practices, medication error rate, and medication precautions including taking medications prior to meals and the importance of following the medication times as stated in the doctor's orders. In addition, the education will include the importance of monitoring residents post medication error for any adverse effects and how to correctly notify nursing administration and the residents' physicians. In order to prevent future medication errors, nursing staff involved in med passes will be subject to increased random med pass audits by the pharmacy consultant and/ or nursing administration to twice a month for three consecutive months to determine medication order compliance. The results of these audits and the progress of the nurses' process improvement plans will be recorded and reported to the facility's monthly Quality Assurance Performance Improvement Committee. Date of compliance is 5/12/21	

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A review of the annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated the resident had a [redacted] cognition. It further reflected that the resident required extensive assistance with most activities of daily living, including bed mobility, transferring, dressing and toileting.

A review of the resident's current Order Summary Report reflected a physician's order (PO) dated [redacted] for [redacted]) tablet one [redacted] GM, give one tablet by mouth three times a day for [redacted] "

A review of the resident's eMAR for [redacted] reflected the corresponding PO with a start date of [redacted] and was scheduled to be administered at 7:30 AM, 11:30 AM, and 4:30 PM.

On 4/1/21 at 10:02 AM, the surveyor interviewed the Director of Nursing (DON) regarding who was responsible to ensure medications where administered in a timely manner. The DON stated the nurses were to check the PO on the times to administer the medications and the Unit Managers (UM) are responsible to check and follow up with the nurses to check the accuracy of medication administration. The DON also emphasized the Consultant Pharmacist came into the facility and conducted medication passes with the nurses. The surveyor asked the DON about the process for omitted medications. The DON

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stated the nurse should notify the UM and the primary physician. In addition, to monitoring the resident for any adverse reactions. The DON concluded she would then educate the nurse to ensure appropriate administration time of the medication. The DON confirmed that the resident had no adverse outcome from the carafate not being administered.

On 4/1/21 at 10:27 AM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone. The CP stated she came into the facility monthly to conduct a medication pass with the nurses, unit inspections and [redacted] meetings with the [redacted], the DON, and the UM. She further stated she completed the medication regimen review remotely since the facility was completely paperless. The CP acknowledged there were no specific amount of times a nurse should complete medication passes during a shift. She stated nurses should administer medications according to the times they are scheduled. The surveyor asked the CP regarding the expectations if a medication was omitted. The CP stated the expectation would be to inform the UM and the physician that the resident did not receive the medication; in addition to monitoring the resident.

A review of the medication pass observation dated 3/12/21 completed by the CP reflected that the LPN #1 had a medication error for medication administered outside the time frame for meals.

A review of an in-service provided by the DON dated the same day 3/12/21 for "Medication Pass" indicated that the CP presented an in-service to LPN #1 and educated LPN #1 regarding the medication error.

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A review of an undated facility policy for "Administering Medications" provided by the DON reflected that ..."Medications must be administered in accordance with the orders, including any required time frame .....medications... must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)."

A review of the manufacturer's specifications for administration of [redacted] indicated "administered on an empty stomach at least 1 hour before a meal."

2. On 3/31/21 at 9:01 AM, the surveyor observed LPN #2, during the medication pass, preparing to administer 13 medications to Resident #73, which included one [redacted] milligram (MG) tablet of [redacted], a medication used to help [redacted]. LPN #2 stated that she was ready to administer the 13 medications to Resident #73. The surveyor with LPN #2 observed Resident #72 seated on the side of his/her bed with a breakfast meal tray in front of him/her. The surveyor observed that the breakfast had been consumed.

At 9:09 AM, the surveyor questioned LPN #2 regarding [redacted] being displayed as red in the eMAR. LPN #2 stated because it was scheduled for 8 AM and it was past the one hour window to give the medication. The surveyor further asked LPN #2 about administering [redacted] before meals. LPN #2 stated she would try to give every resident their "before meals" medications but sometimes she was not able to and so she would administer the medication during and after meals, even though the medication was ordered for

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"before meals." The surveyor asked LPN #2 how often she completed medication pass during a shift. The LPN #2 stated she did two medication passes during her 7 AM - 3PM shift at 7 AM and 1 PM.

At 9:19 AM, the two surveyors observed LPN #2 administering the 13 medications to the Resident #73, which included [redacted] which should be given before the meal. The surveyor asked Resident #73 regarding their breakfast and he/she confirmed, "I had finished my breakfast" before he/she had received the medications. (Error #2)

At 9:25 AM, the surveyor continued to interview the resident who told the surveyor sometimes he/she received their medications before meals, but it was mostly after meals.

The surveyor reviewed the medical records for Resident #73.

According to the Order Summary Report for [redacted] in the electronic medical record (EMR), Resident #73 was admitted with diagnoses which included but not limited to: [redacted]

A review of the annual MDS, dated [redacted] reflected that the resident had a BIMS score of [redacted] out of [redacted] which indicated the resident had an [redacted]. It further reflected that the resident required supervision assistance with most activities of daily living, including bed mobility, transferring, dressing and toileting.

A review of the resident's current Order Summary Report reflected a physician's order (PO) dated [redacted] for [redacted]) tablet [redacted] MG,

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F 759	Continued From page 13 give one tablet orally in the morning for [redacted] give at 8 AM." A review of the resident's eMAR for [redacted] reflected the PO started [redacted] with a time of administration for 8 AM. There was no evidence that the resident's [redacted] were adversely affected. On 4/1/21 at 10:02 AM, the surveyor interviewed the DON regarding administering medications ordered "before meals." The DON stated the nurse review the PO and administer medications according to the order for their shift. She emphasized the CP came in the facility to conduct medication passes with the nurses on each unit. The DON concluded she provided re-educations to the nurses after their medication pass observation with the CP. The DON confirmed that the resident's [redacted] were not adversely affected. On 4/1/21 at 10:27 AM, the surveyor interviewed the CP via telephone. The CP stated she was not quite sure but believed with [redacted] it was "okay" to administer to the resident if "one (1) minute before the meal or with the first bite of the meal." The CP further stated if the resident was in the middle of their meal and the medication [redacted] was administered then the expectation was for the nurse to notify the UM and physician; in addition to monitoring the resident for adverse reactions. The CP stated there were no specific amount of times a nurse should complete medication passes during a shift. She acknowledged nurses should administer medications according to the time they are scheduled.	F 759		

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F 759	Continued From page 14 A review of the medication pass observation dated 3/22/21 completed by the CP reflected that the LPN #2 had a medication error for medication administered. A review of an in-service provided by the DON dated 3/22/21 for "Medication Pass" indicated that the CP presented an in-service to the LPN #2 and educated the LPN #2 regarding the medication error. A review of an undated facility policy for "Administering Medications" provided by the DON reflected that ..."Medications must be administered in accordance with the orders, including any required time frame ....medications... must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)." A review of the facility's policy, Medication Error Reporting dated September 2018 included, ..."medication errors are documented and reported .....in the event of a medication error immediate action is taken as necessary, to protect the resident's safety and well being ... ...the attending physician group is notified of the error for any further directions ...." A review of the manufacturer's specifications for administration of Starlix, indicated "should be taken 1 to 30 minutes prior to meals." NJAC 8:39-29.2 (d)	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		4/30/21

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F 760	Continued From page 15 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure: a.) a long-acting scheduled dose of an [redacted] medication [redacted] was administered every 28 days in accordance with a resident's psychiatric plan of care, and b.) a comprehensive care plan was in place to address the resident's [redacted] medication [redacted]. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #227). The evidence was as follows: On 3/31/21 at 8:25 AM, the surveyor observed Resident #227 seated on the edge of the bed in his/her room. The resident appeared comfortable and was well-groomed. The surveyor observed that the resident was wearing a [redacted] a [redacted] device (a medical device that provides [redacted]. The resident had slurred speech and spoke in a quiet tone stating that he/she was going to the [redacted] center today. The surveyor continued to interview the resident who answered yes or no questions but was not willing to elaborate further on yes or no questions asked. The resident denied any concerns with his/her medication regimen at the facility. The surveyor reviewed the hospital medical records for Resident #227.	F 760	F Tag 760 The Director of Nursing reviewed resident #227 chart and confirmed that the resident did not receive the long acting [redacted] dosage during the [redacted] stay. Through this audit we were able to confirm that the resident didn't have any ill behaviors. The Director of Nursing also called the resident's next of kin on 4/1/2021 to determine if resident #227 was having any adverse effects and/ or behaviors as the resident was admitted to the facility on [redacted] and discharged on [redacted] (post being hospitalized [redacted] and per the next of kin, the resident was not having any behaviors and remained stable. I confirmed with the next of kin that the resident generally receives the dose of [redacted] at the [redacted] Health Clinic and next of kin was aware that the resident did not receive the dose but could not give me the exact date that it was missed. Director of Nursing was able to get in contact with the [redacted] health clinic's representative on [redacted] and was notified that resident's last dose administration was [redacted] and the missed dose was scheduled for [redacted]. The Director of Nursing requested their representative to contact the next of kin to ensure that resident #227 has a follow up appointment as soon as possible since due to the next of kin's schedule the family wanted to make the	

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F 760	Continued From page 16 A review of the Hospital After Visit Summary dated [redacted] reflected that the resident was hospitalized from [redacted] to [redacted] and was a new admission to the facility on [redacted]. A review of the resident's History and Physical dated on admission to the hospital on [redacted] and conducted by the Physician's Assistant (PA) revealed that the resident had an unspecified [redacted] diagnosis and that they were going to hold the monthly dose of an [redacted] medication [redacted] because they "not sure when [his/her] last dose was given, tried calling [redacted] facility [redacted] health clinic name redacted] where shot is administered but was closed." The PA documented that they were going to resume the resident's oral dose of [redacted] (an [redacted] medication) and behavioral health was consulted. A review of the hospital [redacted] consult dated [redacted] reflected that the resident was seen due to a history of [redacted] and was currently being treated with [redacted] with the "last dose TBD [to be determined] at [behavioral health clinic name redacted]." The consult further included that the resident was "stable on [his/her] current regimen and per collateral, has not exhibited any changes in...[redacted] will refer for outpatient [redacted] follow up...no sign of [redacted] noted during today's interview...Patient is stable from a [redacted] standpoint for discharge...continue with current [redacted] medications..." A review of the Hospital Discharge Medication List reflected that the resident was to continue on his/her medication regimen which included:	F 760	appointment personally. The Director of Nursing followed up with resident's next of kin and was informed that the next injection appointment is scheduled for 4/14/2021. Nursing administration completed an audit for the last 30 days of admissions to ensure that medications were reconciled from transfer sheet. The Director of Nursing or nursing administration designee re-educated the staff nurses on the policy for medication reconciliation (admission and discharge) and transfer orders related to follow up appointments. The facility will revise the admission checklist to include medication and appointment reconciliation. The facility will continue with the monthly [redacted] / gradual dose reduction meetings to ensure residents medication and behaviors are being monitored and treated. The Director of Nursing or Nursing administration designee will complete a random audit weekly on the admission checklists including the accuracy of medication and appointment reconciliation for three months. The results and trends of these audits will be reported monthly to the Quality Assurance Performance Improvement Committee. Following the three months the committee will determine the frequency for future audits. Compliance date is 4/30/2021.	

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[redacted] milligrams (mg) / milliliter (mL) injection; administer [redacted] mg into the muscle every 28 days. The order specified that the last dose was administered at a specific [redacted] healthcare clinic in the community. The prescribing physician of the [redacted] from the [redacted] healthcare clinic and the phone number was written with the [redacted] order. In addition, administer [redacted]), an oral [redacted] medication, tablets by mouth to total [redacted] mg at bedtime.

The surveyor reviewed the facility's medical record for Resident #227.

A review of the resident's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted] (an infection in the [redacted] and [redacted]

The surveyor attempted to review the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, but the MDS had not yet been submitted as complete.

A review of a Brief Interview for Mental Status (BIMS) assessment dated [redacted] revealed that the resident had a score of [redacted], indicating fully [redacted].

A review of the resident's individualized care plan dated [redacted] did not address that the resident received [redacted] medication including the [redacted] in the community, what his/her target behaviors were, or interventions specific to address his/her diagnosis of [redacted]

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A review of the physician's order sheet for [redacted] did not address a physician's order for the resident's long-acting [redacted] medication, [redacted] mg/mL [redacted] every 28 days, a hold order, or any projected date for the administration of the [redacted] in accordance with the resident's [redacted] plan of care for [redacted] and discharge medication list. According to the physician's order sheet, there were no other changes to the residents oral [redacted] medication regimen.

A review of the electronic Medication Administration Record (eMAR) for [redacted] did not reflect documented evidence that the resident received [redacted] or that there was a projected date for the administration of the [redacted] mg/mL.

A review of the electronic Progress Notes (ePN) did not reflect documented evidence that attempts to call the resident's [redacted] health clinic in the community to determine the date of the last dose of [redacted] to ensure continuity of care were made. An ePN dated [redacted] at 9:55 AM reflected that [redacted] was called to discuss the resident's medication regimen and that the [redacted] stated "It would be beneficial for this patient to be maintained on [his/her] current dose of [redacted] due to the threat of decompensation. The staff will continue to monitor behaviors and document any event." However the ePN did not address the long acting [redacted] dose received every 28 days.

On 3/31/21 at 8:35 AM, the surveyor interviewed the resident's assigned Certified Nursing Aide (CNA) who stated that the resident was alert and oriented and was able to make his/her needs

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known. The CNA stated that she assists the resident with morning care by setting up all the materials and that he/she performs the tasks independently and that she cleans up after him/her and puts items away in their respective places. The surveyor inquired if the resident had any known behaviors, and the CNA stated that the resident was compliant with care but that that the resident refused to allow her to assist in any physical care. She stated that she didn't think that it was a behavior but a preference. The CNA denied that the resident had any behaviors. She stated that she was not told to monitor for any behaviors either, but that if the resident had a change she would let the nurse know.

At 8:40 AM, the surveyor interviewed the resident's assigned Licensed Practical Nurse (LPN). The LPN and the surveyor reviewed the resident's medication regimen together on the eMAR for [redacted]. The LPN confirmed that the resident was receiving the [redacted] medication [redacted] mg total at bedtime. The surveyor asked why the resident was receiving that dose and the LPN looked in the order and stated that it was for his/her [redacted]. She stated that the resident had a diagnosis of [redacted] The surveyor asked the LPN if she knew what the resident's target behaviors were for the [redacted], and the LPN stated that she was not sure. She stated that the resident's [redacted]" and that there was nothing to monitor because he/she was stable. The LPN added that if there was a change in behavior, they would document in the eMAR and in a progress note that the resident exhibited a change in behavior and notify the family representative and Attending Physician. She reviewed what [redacted] medications the resident was

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currently taking and it did not include the [redacted] mg/mL. The LPN stated that the resident had just been transferred to her wing and was being discharged home today, but further questions on the residents history could be answered by the LPN/Unit Manager (LPN/UM) who has known the resident a little longer.

At approximately 8:45 AM, the surveyor interviewed the LPN/UM who stated that when a resident is admitted to the facility on [redacted] medications, she would call the consulting [redacted] to notify her of the list of medications the resident was being admitted on, and monitor for any behaviors. She stated that hospital records would be reviewed to determine if there were any behaviors there as well. She stated that target behaviors for each medication would get recorded for the resident and go inside her [redacted] Medication book. The LPN/UM showed the surveyor the monthly [redacted] Medication book and opened it, and there was no [redacted] Medication regimen review for Resident #227. The LPN/UM confirmed that there was none in that book yet for Resident #227 because the resident had only been at the facility from [redacted] until [redacted]. She stated that it had not been 30 days yet to review the resident's monthly [redacted] summary that happens at the beginning of each month and discussed in the monthly [redacted] meetings. She surveyor asked what the resident's target behaviors were, and the LPN/UM stated that she read in the hospital records that the resident had behaviors of [redacted], but the LPN/UM could not provide documented evidence of where that was documented in the resident's past medical history, hospital records or facility documentation. The surveyor and the LPN/UM

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reviewed the resident's [redacted] medications together and the LPN/UM confirmed that the resident received a routine dose of [redacted] mg at bedtime while a resident at the facility and that there had been no adjustments to the dose during admission. She further added that the resident was on [redacted] every 28 days in the community, but that the resident did not receive the [redacted] here at the facility. The surveyor asked when the last dose of [redacted] was, and the LPN/UM stated that she was not sure. The LPN stated that the reason the resident was admitted to the facility was for [redacted] care management and [redacted] therapy. The surveyor reviewed the care plan with the LPN/UM who stated that she was responsible for initiating the comprehensive care plans, but that the admission nurse does the baseline care plan. The LPN/UM confirmed that the care plan did not address the [redacted] or the target behaviors. The LPN stated the resident had not exhibited any unwanted behaviors while a resident here at the facility.

At 11:03 AM, the surveyor conducted a phone interview with the resident's Case Manager assigned at the [redacted] health center clinic in the community. The Case Manager stated that the resident was being administered a long acting dose of [redacted] mg [redacted] every 28 days for a diagnosis of [redacted]. She stated that the last dose was administered on 2/16/21 and was due to receive the next dose on 3/17/21. The Case Manager stated that she became aware that the resident was in a skilled nursing center when the resident did not show up for the appointment which was not like him/her, and so she called the resident on [redacted] and again on [redacted] She stated that she was able to speak to the resident on [redacted] and the

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resident informed her that he/she was currently at the skilled nursing facility. The Case Manager stated that typically when a resident is admitted in a nursing facility, the admitting Physician would address the [redacted] dose and that their clinic wouldn't necessarily be involved further until they were discharged from the nursing facility. The Case Manager stated that no one from the facility had attempted to contact them regarding when the last dose of [redacted] was given to Resident #227 and that she would have been the one that would have contacted the facility back to verify when the next dose was due if the physician wanted it to be given. She stated that residents who are admitted to skilled nursing facilities do not leave the facility to get their injections at their clinic and return back to the facility. She added that facilities handle doses that are due internally at the facility with the resident's Attending Physician. The Case Manager stated that as far as she knew the resident had been stable on the prescribed medication regimen.

On 4/1/21 at 10:13 AM, the surveyor conducted a phone interview with the facility's consulting [redacted] The [redacted] stated that when a resident is admitted to the facility on [redacted] medications, they do a drug regimen review to determine whether the medication is necessary or not and they discuss the case by phone. She further stated that clinical decisions are made on a case-by-case basis and is dependent on many factors. She stated that typically if a resident is admitted to the facility on an [redacted] medication, they continue on it initially and are monitored for any behaviors. She stated that she was not formally consulted for Resident #227 because the resident was stable on his/her [redacted] medication regimen. She stated that

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during the [redacted] medication review consultation on admission, the suggestion was to continue all the residents current [redacted] medications and a gradual dose reduction (GDR) was not recommended to avoid [redacted]. She added that she was familiar that the resident was engaged in a community behavioral health clinic and that if the resident had an order for a long-acting [redacted] to be given intramuscularly every 28 days, the facility would determine the date of the last dose, and "we would put the order in for [Resident #227] to receive it" as previously scheduled. She stated that they had done that in the past with the long acting [redacted] for stabilizing [redacted] The [redacted] stated that sometimes nurses may mistake their understanding of [redacted] and that there was a long-acting [redacted], and an immediate-acting [redacted] which is restricted to the extent possible. The [redacted] stated that the 28-day dose doesn't work in the same manner as the immediate acting [redacted] She added that if the [redacted] deck was ordered, sometimes family can bring it in if there was a formulary issue. The [redacted] could not be sure if the resident received the dose of [redacted] mg every 28 days or if he/she was supposed to receive the dose of [redacted] in the future. She stated that if the resident did not receive it on a due date, that 14 days or so without the dose would be "okay" because the resident was also on [redacted] orally for the [redacted]. She stated that the resident did not have a change in behaviors during the admission at the facility and had the resident had any changes in behaviors during that time, she would not have given the resident the long-acting [redacted] dose, she would just adjust the oral [redacted] dose while a resident in the facility. At 10:46 AM, the surveyor interviewed the

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LPN/UM a second time. The LPN/UM stated that Resident #227 was discharged yesterday during the 3 PM to 11 PM evening shift and that she went over all the medications with the resident's representative who picked him/her up. She stated that the facility never gave the [redacted] dose because "We don't give [redacted] here." The surveyor asked who told her that, and the LPN/UM stated that she thought it was the Psychiatrist but couldn't be sure. She confirmed that she never called the [redacted] health clinic to find out when it was due to be given within the 28 day cycle. The LPN/UM stated that she didn't see it on the discharge medication list from the hospital and that was also the reason. The surveyor and the LPN/UM reviewed the resident's discharge instructions dated [redacted] which also did not address the [redacted] to be continued or instructions on scheduling the [redacted] health clinic appointment for the [redacted] dose on discharge. The LPN/UM stated that she believed that the family representative was already aware of it, but acknowledged she didn't document instructions regarding the long acting [redacted] dose for discharge.

On 4/1/21 at approximately 1:00 PM, the surveyor discussed the findings with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA).

On 4/6/21 at 9:57 AM, the DON stated that she was finally able to get in touch with the [redacted] health clinic and that the resident's last dose of [redacted] was given on 2/16/21 and that the resident was due to receive it by 3/17/21. The DON acknowledged that the resident was admitted to the facility from [redacted] until [redacted] and did not receive the long acting [redacted] mg deck, nor

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	315217	A. BUILDING _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

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F 760	Continued From page 25	F 760		

was it addressed in the physician's orders or progress notes indicating a reason as to why it was not going to be given. The DON confirmed that if the resident was supposed to receive it by [redacted] that it was a period of 15 days after it was due that the resident had not yet received the dose. She acknowledged that there was no documented evidence of that attempts to call the [redacted] Health Clinic to determine that last scheduled dose, nor was it addressed in the resident's discharge instructions. She stated that she had called the family representative on 4/1/21 to inform them about scheduling the next dose of [redacted] in the community at the behavioral health clinic. The DON stated that the resident never had any behaviors or adverse effects from not receiving the dose of [redacted] and that he/she would be getting it in the community. The DON confirmed that the LPN/UM should have attempted to call the clinic to get the date the last dose it was given and if they couldn't reach the clinic, she should have notified the [redacted] to address the long acting [redacted] The DON acknowledged that there was no reason it should not have been addressed whether the resident needed the [redacted] here at the facility or if it was going to be held until discharge back to the community.

A review of the facility's Admission Medication Reconciliation Process dated 5/1/17 included, "When a resident is admitted or readmitted from the hospital, the hospital medication orders will be reconciled with the attending physician at the time of admission to the skilled nursing center ... Review medications listed on the hospital transfer form with the attending physician, covering physician or physician extender. Note changes on the hospital transfer form, if applicable ...The

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F 760	Continued From page 26 nurse on the following shift and/or Unit Manager or designee will complete a second review/reconciliation using hospital transfer record and compare to orders entered into electronic health record. The nurse confirming admission medications will enter a note into the medical record indicating review and confirmation of hospital transfer orders with the physician as well as any ordered changes to the hospital medications." NJAC 8:39-11.2(b), 29.2(d)	F 760		