STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315394	A. BUILDING _____ B. WING _____	C 09/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	**2201 BAY AVENUE OCEAN CITY, NJ 08226**

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F 000	INITIAL COMMENTS COMPLAINT #: NJ 00133568, NJ 00134031 CENSUS: 51 SAMPLE SIZE: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	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: COMPLAINT # NJ 00134031 Based on interviews, record review and review of pertinent facility documentation on 09/02/20, it was determined that the facility nursing staff failed to a.) document in the progress notes, an assessment for a resident that had a change in condition, b.) document verbal orders received from the physician, and c.) follow up with the physician when a resident's medications were unavailable to administer in accordance with acceptable nursing standards of clinical practice. This deficient practice was identified for 1 of 3 sampled residents (Resident #3) and was evidenced by the following:	F 658	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. 1) Resident #3 no longer resides in the facility. RN#2 was provided a documented coaching and in-serviced by the DON on 9/3/2020 on the community's notification of changes policy with emphasis on documenting assessment of resident changes and completing physician orders.	10/9/20

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

Electronically Signed | 09/25/2020

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F 658	Continued From page 1 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 or potential 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." According to the Face Sheet, Resident #3 was admitted to the facility with diagnoses which included, but were not limited to [redacted]. Review of the Minimum Data Set, an assessment tool dated [redacted], revealed the resident was alert and oriented and required limited assistance with Activities of Daily Living. Review of the Clinical Note (CN) dated [redacted] at 10:27 AM signed by Registered Nurse (RN #1), revealed "[redacted] " Resident has a history of [redacted] was administered with no relief after one (+) hour. Temperature [redacted] The physician was notified and ordered the resident to be sent to the ER [emergency room]. The resident was transferred to the hospital at 10:00 AM and the	F 658	2)All residents have the potential to be affected by the deficient practice. An audit will be completed on all current resident medication administration records to ensure all medications orders were administered as ordered and available. Issues identified will be addressed and physician and resident representative notified as warranted. 3) All new and existing staff will be in-serviced by the Staff Development Coordinator on the facility's Notification of Change policy with emphasis on documentation of resident change in condition, and on the medication management policy and proper documentation of medication not administered and notification. All residents with changes in condition, their charts will be reviewed by the nurse mentor to ensure appropriate documentation has been completed and complete a medication administration record review of all new residents in the morning clinical meeting. Issues identified will be reviewed with the DON with appropriate corrective action of staff as needed to ensure compliance. 4) A random audit will be completed on all residents with changes in condition to ensure appropriate documentation has been completed by the DON weekly x4 and this will be a ongoing practice. An random medication administration record audit will be completed by the DON weekly x4 then monthly x 2 on 10% of the resident population to ensure medication	

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F 658	Continued From page 2 resident's representative was at bedside and will follow the resident to the hospital. During an interview with the surveyor on 09/02/20 at 11:30 AM, RN #1 stated that she did not assess Resident #3. The resident was assessed by the primary nurse (RN #2). RN #1 stated that the primary nurse should have written the assessment in the CN. RN #1 verified that she did not see the CN written by the primary nurse, the physician's order for [redacted] and a discharge order to the ER. During an interview with the surveyor on 09/02/20 at 12:42 PM, RN #2 stated that she remembered that the resident went out to the ER. The resident's family member was at the bedside and thought the resident's [redacted] RN #2 stated that she didn't find it "alarming" but the family member was insistent that the resident was sent out. RN #2 stated that the resident's breathing was not restricted. RN #2 stated she talked to the physician and received a verbal order for [redacted] and an order to send the resident to the ER. RN #2 stated that I thought I wrote a CN and entered the orders but maybe I didn't have time to do it Review of the CNs did not include documentation of an assessment of Resident #3's change in condition. Review of the physician orders for February 2020 did not reveal the verbal order of [redacted] and the discharge order to the ER. Review of the Medication Administration Record (MAR) did not reflect that [redacted] was administered on 02/20/20 by RN #2. During an interview with the Director of Nursing	F 658	not available or not administered have been addressed as per policy and in compliance. Findings will be reviewed with the NURSING HOME ADMINISTRATOR and in the monthly QAPI meeting with immediate corrective action as warranted. The frequency of the audits will be adjusted according to the outcomes.	

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(DON) on 09/02/20 at 1:45 PM, the DON stated that there should have been a CN for the nurse assessment. The DON further stated that she expected the nurse to document from the time of the change in resident condition, that the physician was notified, when the resident was sent out to the hospital, and the diagnosis from the hospital. The DON stated that if any orders were received from the physician, they should have been documented in the physician orders.

During an interview with the surveyor on 09/02/20 at 2:00 PM, the Administrator stated that the History and Physical from the hospital revealed that the resident had no [redacted] or a [redacted].

Review of Resident #3's February 2020 Medication Administration Record (MAR), which reflected the following medications were not administered on 02/18/20 and 02/19/20, in accordance with the physician orders:

1. [redacted] daily for dx (diagnosis) [redacted] on 02/19/20;
2. [redacted] for inhalation two times daily for dx [redacted] on 02/18/20 and 02/19/20;
3. [redacted] mg at hour of [redacted] for dx [redacted] on 02/18/20 and 02/19/20;
4. [redacted] mg three times daily for dx [redacted] on 02/18/20 and 02/19/20; and
5. [redacted] capsule daily for dx [redacted] on 02/19/20.

On 09/02/20 at 12:15 PM, the surveyor reviewed the February 2020 MAR with the Corporate

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Nurse. The Corporate Nurse noted that any medications that have a "grayed out" area where the nurse signed as administered would reflect a reason why the medication was not administered on a subsequent page. She verified the above medications were documented with an explanation of "Not Administered (Medication not available)."

During an interview with the DON on 09/02/20 at 1:45 PM, the DON stated that if a medication was not available, she would expect the nurse to contact the pharmacy to see when the medication would be delivered and then contact the physician to either get a new administration time for the medication, an order for a substitute medication, or a hold order. The nurse should document this conversation in the CN and document any verbal orders.

Review of the CN did not reveal documentation that the physician was notified for the medications "Not Administered (Medication not available)" on 02/18/20 and 02/19/20.

Review of the facility's Notification of Changes policy, last reviewed 09/10/19, revealed, "All changes in the resident's condition or status must be documented in the electronic health record to ensure communication onto the 24 hour report in the EHR [electronic health record]."

Review of the facility's Medication Management Program Guidelines policy, last reviewed 06/25/20, revealed, "All medications provided to a resident by administration must be ordered, in writing by the resident's healthcare provider via e-prescribing, written order, verbal or telephone order." The policy further revealed, "The

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F 658	Continued From page 5 attending physician shall be contacted by nursing for direction when delivery of a medication will be delayed or the medication is not or will not be available." NJAC 8:39-27.1 (a)	F 658		