STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315358	A. BUILDING _____ B. WING _____	C 07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATION CENTER	**235 DOLPHIN AVE NORTHFIELD, NJ 08225**

(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 # NJ 141413, NJ 146527, NJ 146547 CENSUS: 116 SAMPLE SIZE: 4 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 141413 Based on interviews, review of Medical Records (MR), and review of pertinent facility documents on [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.], it was determined that the facility staff failed to follow a Physician's Order (PO) to notify the physician for [NJAC 8:43E-2.1 and Exe]	F 658	Criteria 1 LPN #1 notified the physician of the resident's elevated blood sugars. Additional insulin coverage was administered as ordered by the physician. Criteria 2 All diabetic residents who have orders for a sliding scale of insulin coverage have the potential to be affected by this	7/30/21

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

Electronically Signed | 07/31/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 1 NJAC 8:43E-2.1 and Exe, for 1 of 4 resident (Resident #2) reviewed for PO. This deficient practice was evidenced by the following: 1. According to the "Admission Record" Resident #2 was originally admitted to the facility in NJAC 8:43E-2.1 and readmitted on NJAC 8:43E-2.1 and Exec, with diagnoses which included but were not limited to: NJAC 8:43E-2.1 and E NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8:43E-2.1 and Exe The Minimum Data Set (MDS) an assessment tool dated NJAC 8:43E-2.1 and Exec revealed a Brief Interview for Mental Status (BIMS) score of NJAC 8:43E-2. which indicated that the Resident was NJAC 8:43E-2.1 and Exec Order 26, 4. b. . The MDS also showed that Resident #2 was mostly independent for Activities of Daily Living (ADL). The Physician Order Sheet (POS) dated NJAC 8:4 NJAC 8:43E-2 showed an order for NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] MD (Medical Doctor), NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8:43E-2.1 and Exec Ord . A review of Resident #2's Medication Administration Record (MAR) dated NJAC 8:43E-2.1 and revealed the following: NJAC 8:43E-2.1 and Exec Ord result was NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. During an interview on NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. the Licensed Practical Nurse #1 (LPN #1, nurse assigned to Resident#2) stated that Resident #2's NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. that	F 658	practice. Criteria 3 The MARs of all NJAC 8:43E-2.1 an residents who have orders for a sliding scale were reviewed to ensure the orders for sliding scale coverage were followed. Our review confirms that all sliding scale orders were followed. All licensed staff were educated on the importance of following orders as written. Criteria 4 The DON/ADON will conduct and audit of the MARs for all residents who have orders for sliding scale coverage on a weekly basis. The result will be discussed with the nurse involved and also in our monthly QAPI meeting for three months to determine and additional educational needs. Criteria 5 July 30, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 2 morning ([redacted]). The LPN said "It's a recurring issue for him/her [redacted], so I did not notify the doctor. It would not be something we would do every time, every day, since his/her NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. The PO was reviewed with the LPN #1 who agreed that she should have called the physician as the order indicated since the [redacted]. Further interview on 7/13/2021 at 12:00 p.m., with LPN #1 she stated that she did not write on the progress notes (PN) that she had notified the physician of the [redacted] or the Unit Manager (UM) on [redacted]. The PN did not indicate that the Resident had change in condition from [redacted]. During an interview on 7/14/2021 at 12:56 p.m., LPN #1 in the presence of the Director of Nursing (DON) verified that she had not notified the physician for the [redacted] The LPN agreed that she did not follow the physician's orders. During an interview on 7/14/2021 at 1:10 p.m., the DON provided the surveyor with a copy of the "Medication Error Form," (MEF) dated [redacted], which verified that LPN #1 did not follow the order to call the Medical Doctor with blood sugar results [redacted] involving Resident #2. The MEF showed under "Supervisor's Intervention" included: Extensive education with Education Coordinator and advised LPN to call physician as ordered.	F 658		

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F 658	Continued From page 3 N.J.A.C 8:39-27.1(a) N.J.A.C 8:39-29.2(d)	F 658		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT Y3
315358		8/3/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATION CENTER	235 DOLPHIN AVE NORTHFIELD, NJ 08225

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 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 07/30/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
7/14/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO