STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315442	A. BUILDING _____ B. WING _____	C 09/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	**655 EAST JERSEY STREET ELIZABETH, NJ 07206**

(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#: NJ00157843 CENSUS: 77 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. Based on interview and review of medical records including facility surveillance camera footage for 9/4/22 and 9/5/22, it was determined that 2 of 3 facility staff (Licensed Practical Nurse [LPN #1] and Registered Nurse [RN #1]) on the [redacted] floor [redacted] unit, failed to ensure that the medications which could cause significant harm if ingested were stored, secured, and inaccessible to high -risk residents with wandering behaviors who resided on this floor. Also, the facility failed to follow their policies "Administering Medications", "Medication Storage", and "General Medication Administration Guidelines of Oral Preparations." This deficient practice was identified for 1 of 3 sampled residents (Resident #1). On 9/5/22, review of the surveillance camera (SC) showed that RN #1 (worked 11 pm- 7am shift) left her medication cart unlocked and unattended from 12:01 am to 5:23 am. As a result, Resident #1 accessed the unlocked medication drawers and took a bottle of [redacted] medication from the medication cart. Resident #1 was found [redacted] at [redacted], and an empty bottle of [redacted] medication that belonged to Resident #2	F 000		

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

Electronically Signed — 09/28/2022

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 000	Continued From page 1 (another Resident) was found in the room. At 6:45 am, the Resident was transferred to EX Order 26.4B Hospital by 911 emergency services and admitted for EX Order 26.4B1 Overdose, also known as (aka) EX Order 26.4B1 This incident of RN #1 leaving an unlocked and unattended medication cart that was accessed by Resident #1 resulted in an Immediate Jeopardy (IJ) situation. The IJ situation ran from 9/4/22 at 8:45 am to 9/9/22 at 6:15 pm. The Administrator was notified of the IJ situation on 9/9/22 at 6:45 pm. An acceptable removal plan was received on 9/12/22 at 4:00 pm. The survey team noted on the same day (9/12/22) that the removal plan has been implemented based on observations, interviews, and record review. This includes removing and terminating the employment of both RN #1 and LPN #1, facility wide inserviced about but not limited to: policies on medication administration and storage as it relates to safety awareness associated with residents with EX Order 26.4B1 (i.e., keeping medication carts lock at all times) initiated on 9/6/22, monitoring of Resident #1 every half hour and medication cart was audited on 9/7/22, 9/11/22 and 9/12/22, there were no missing medications. Therefore, the non-compliance remained on 9/12/22 as a level "D" for no actual harm with potential for minimal harm that is not immediate jeopardy.	F 000		
F 761 SS=J	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	F 761		9/30/22

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F 761	Continued From page 2 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 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: C # NJ00157843 Based on interview and review of medical records including facility surveillance camera footage for 9/4/22 and 9/5/22, it was determined that 2 of 3 facility staff (Licensed Practical Nurse [LPN #1] and Registered Nurse [RN #1]) on the EX Order floor EX Order 2c.4ii unit, failed to ensure that medications which could cause significant harm if ingested, were stored, secured, in locked compartments and inaccessible to high-risk residents with wandering behaviors. The facility also failed to follow their policies "Administering Medications", "Medication Storage", and "General Medication Administration Guidelines of Oral Preparations."	F 761	1. How the corrective action will be accomplished for the the resident found to be affected: On 9/5/22 Immediately upon discovering resident #1, the resident was assessed, vital signs taken, primary doctor and family were notified and the resident was transferred to the hospital where he was treated. Investigation was initiated on 9/5/22. On 9/6/2022, all staff were immediately re-educated regarding the importance of locking the medication carts.	

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F 761	Continued From page 3 This deficient practice was identified for 1 of 3 sampled residents (Resident #1). On 9/9/2022, the surveyors reviewed in the presence of Administrative staff , the incident that occurred on 9/5/22 that was captured on the surveillance camera (SC). It showed that RN #1 (worked 11 pm - 7 am shift) left her medication cart unlocked and unattended from 12:01 am to 5:23 am. As a result, Resident #1 accessed the unlocked medication drawers and took a bottle of EX Order 26.4B medication from the medication cart. Resident #1 was found EX Order 26.4B1 , and an empty bottle of EX Order 26.4B1 medication that belonged to Resident #2 (another Resident) was found in the room. At EX Order 26.4B1 , the Resident was transferred to EX Order 26.4B Hospital (EX Order 2 by 911 emergency services and admitted for EX Order 26.4B1 EX Order 26.4B1 , also known as (aka) EX Order 26.4B1 EX Order 26 This incident of RN #1 leaving an unlocked and unattended medication cart that was accessed by Resident #1 who was known for EX Order 26.4B1 behaviors resulted in an Immediate Jeopardy (IJ) situation. There was a total of 19 residents on the EX Orde Floor EX Order 26.4B and 2 of 19 residents including Residents #1 with EX Order 26.4B1 behaviors. The Administrator was notified of the IJ situation on 9/9/22 at 6:45 pm. The IJ situation ran from 9/4/22 at 8:45 am to 9/9/22 at 6:15 pm. An acceptable removal plan was received on 9/12/22 at 4:00 pm. The survey team noted on the same day (9/12/22) that the removal plan has been implemented based on observations, interviews, and record review. This includes removing and terminating the employment of both RN #1 and LPN #1, facility wide inservices about but not	F 761	On 9/7/22, resident returned to the facility and 1/2 hourly rounding x2weeks was initiated once resident #1 was active and ambulatory. Resident #1 was re-assessed by the interdisciplinary team on 9/26/22 to continue with hourly rounding x1mo and then to be re-assessed for on-going monitoring thereafter. The care plan was updated to reflect each change at time of change. On 9/9/22, RN #1 was was terminated, Board Of Nursing and agency were notified. On 9/12/22, follow-up call was made to the Board of Nursing and complaint process form completed and sent by certified mail to the NJ Board Of Nursing in reference to RN #1. LPN #1 resigned on NJ Exec. Order 26.4 was contacted and returned the call on NJ Exec. Order 26.4B She was educated by phone regarding her deficient practice of not locking the medication cart and leaving it unattended. The importance of locking the medication cart and the implications related to patient safety were covered in the teaching. CNA was suspended x3days and received a written warning and re-educated regarding notifying the nurse when she observes a wandering resident at the medication cart or anything unusual that may be observed. 2. How will other individuals with the	

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F 761	Continued From page 4 limited to: policies on medication administration and storage as it relates to safety awareness associated with residents with EX Order 26.4B1 (i.e., keeping medication carts lock at all times) initiated on 9/6/22, monitoring of Resident #1 every half hour and medication cart was audited on 9/7/22, 9/11/22 and 9/12/22, there were no missing medications. Therefore, the non-compliance remained on 9/12/22 as a level "D" for no actual harm with potential for minimal harm that is not Immediate Jeopardy. This deficient practice is evidenced by the following: The Facility Reportable Event (FRE) reported to the New Jersey Department of Health (NJ DOH) on 9/6/22, showed that on EX Order 26.4B1, Resident #1 was found in his/her room EX Order 26.4B1 with an empty bottle of EX Order 26.4B1 medication (belonged to Resident #2) in the room. Resident #1 was sent to the EX Ord on EX Order 26.4B1 for further evaluation. 1. According to the Resident Face Sheet (RFS), Resident #1 was admitted to the facility on EX Order 26.4B1 with diagnosis that included but was not limited to: EX Order 26.4B1 The Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1 showed that Resident #1's EX Order 26.4B1 status was EX Order 26.4B1, ambulatory, and required limited assistance from staff for Activities of Daily Living (ADL) The Physician Order Report (POR) indicated that	F 761	potential to be affected or in similar situations be identified and protected? All residents have the potential to be affected by the deficient practice. Residents will be protected through ongoing review & updating of policies and procedures. Ongoing staff education on medication administration, storage and safety. Monitoring and evaluation of high risk residents with wandering behaviors. 3. What systemic changes will ensure that the deficient practice will not recur? On 9/12/22, Policies and procedures on Administration of Medications, Medication Storage, General Medication Administration were reviewed and revised. 9/9/22-9/12/22, all staff were re-educated regarding policies on medication administration as it relates to resident safety, locking of medication carts associated with residents with EX Order 26.4B1 They were also re-educated on Abuse, neglect, maltreatment and misappropriation. All C.N.A's were instructed to alert the nurse of anything unusual that they see. All medication and treatment carts are being audited by the Nursing supervisors and department heads to ensure that they are locked when out of sight, or not in use by the medication nurse, that the carts are	

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F 761	Continued From page 5 there was no documented evidence that Resident #1 was prescribed EX Order 26.4B1 medication or any EX Order 26.4B1 medications. The progress note (PN) and Universal Transfer form dated 9/5/22 indicated that Resident #1 was transferred to EX Order due to consumption of EX Order 26.4B1 EX Order 26.4B1 medication and the Resident was admitted for EX Order 26.4B1 The EX Order medical record showed that Resident #1 was admitted on EX Order 26.4B1 to the Emergency Room for EX Order 26.4B1 (EX Order 26.4B1) with initial EX Order 26.4B1 (therapeutic range= EX Order 26.4B1 EX Order 26.4B1 r]). The Poison Control was consulted, and the Resident was placed on EX Order 26.4B1 and EX Order 26.4B1 monitoring in the hospital. On 9/7/22 at 2:45 pm, Resident #1 was readmitted to the Facility from EX Orde. 2. According to the RFS, Resident #2 was admitted to the facility on EX Order 26.4B1 with diagnosis that included but was not limited to: Other EX Order 26.4B1. The Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1, showed that Resident #2's EX Order 26.4B1 status was EX Order 26.4B1 and NJ Exec. Order 26:4.b.1 to staff for Activities of Daily Living (ADL) Resident #2's POR showed a Physician's order for EX Order 26.4B1 medication aka EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1	F 761	clearly visible to personnel administering meds and outward side is inaccessible to residents or others passing by. 4. How the facility will monitor its corrective action / performance? Two audit tools were developed: A. Medication cart audit tool was developed to be completed by each nurse at the beginning of their shift and submitted to the administrator to ensure proper storage of drugs and biologicals. B. Audit tool was developed to be completed by Nursing supervisors, ADON and department heads monitoring the medication and treatment carts to ensure that they are locked when out of sight and not in use by the medication nurse, that it is kept with the outward side inaccessible to residents or others passing by, and that it is clearly visible to the personnel administering meds. Both audits will be analyzed and findings quantified to examine whether change has been made or determine if there is opportunity for further improvement. ADON/designee will report the findings quarterly to the QAPI committee to ensure that a systemic change has been made.	

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F 761	Continued From page 6	F 761		

three times a day. The full bottle of EX Order 26.4B1 EX Order 26.4B1 .

The facility pharmacy provided the EX Order 26.4B1 EX Order 26.4B1 for the EX Order 26.4B1 medication which showed that the medication is used to EX Order 26.4B1 Furthermore, the EX Order 26.4B1 bottle for Resident #2 showed a warning label 'EX Order 26.4B1 , EX Order 26.4B1 EX Order 26.4B1

The facility's Surveillance Camera Contracted Company provided the footage on 9/9/22 at 3:15 pm to the surveyors and Administration which showed the following:

On 9/4/22, from 8:55 am to 1:37 pm, LPN #1, (worked 7 am -3 pm shift) left the EX Orde floo EX Order 26.4B (4S) medication cart unlocked and unattended in the hallway outside the dining room where staff and residents passed by.

The 4S medication cart contained but not limited to insulins, syringes/lancets, over the counter and prescribed medications in liquid and tablet forms and controlled medications (in locked box).

On 9/4/22 at 11:56 am, Resident #1 came out of his/her room and approached the unlocked and unattended 4S medication cart. From 11:58 am to 11:59 am, the Resident slowly opened and closed all the drawers from top to bottom while touching some of the medications. The SC showed no staff members were around to stop Resident #1 from opening the medication cart. At 12:01 pm, the Resident left the medication cart; at 12:02 pm, LPN #1 returned to the same medication cart

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F 761	Continued From page 7 then continued her medication pass. Further review of the SC showed that on 9/5/22, RN #1 (worked 11 pm - 7 am shift) left her 4S medication cart unlocked and unattended from 12:01 am to 5:23 am. Resident #1 approached the 4S medication cart during these time as follows: At 12:01 am and 12:50 am, the Resident came out of the room, approached the 4S medication cart and opened and closed all the drawers from top to bottom and touched some of the medications. Then the Resident walked away from the medication cart towards his/her room. At 12:55 am, Resident #1 returned to the medication cart, opened, and closed 4 drawers on the left side of the cart from top to bottom then reopened the 3rd drawer, removed a [redacted] medication bottle, closed the drawer, and took the bottle with him/her to his/her room. At 6:00 am, the staff (Certified Nurse Assistant and RN) were in and out of the Resident's room; RN #1 was seen holding a medication bottle rushing in and out of Resident #1's room. At 6:39 am, Resident #1 was picked up by 911 medical services and transported to the [redacted]. During a telephone interview with RN#1 on 9/9/22 at 2:00 pm, she stated that the medication cart should be kept closed and locked at all times. RN #1 denied that she left her medication cart unlocked and unattended. The surveyor attempted to conduct an interview with LPN #1 on 9/9/22 at 2:15 pm; However, she was not available. During review of the SC on 9/9/22 from 3:15 to	F 761		

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F 761	Continued From page 8	F 761		

6:00 pm with the Administrator and the Assistant Director of Nursing (ADON), they acknowledged that LPN #1 and RN #1 should have not left the 4S medication cart unlocked and unattended. The nurses are expected to always lock their medication carts. They explained that if the medication cart was kept locked, the Resident would not have accessed to the EX Order 26.4B1 EX Order 26 They could not give the exact amount of how much medication was left in the bottle before it was taken from the medication cart.

During a follow-up interview with Administration and the staff on 9/12/22 from 9:00 am to 12:00 pm, they stated that Resident #1 was EX Order 26.4B1 to come out of the room and EX Order 26.4B1 since he/she had returned from the hospital on EX Order 26.4B1 however, on EX Order 26.4B1, the staff observed that the Resident was EX Order 26.4B1 in the room. Therefore, beginning on 9/12/22 they put Resident #1 on every half hour monitoring for his/her whereabouts to ensure safety.

According to the facility policy titled "Administering Medications" dated 1/1/14, under "Policy Interpretation and Implementation" indicated that...16. During administration, the medication cart will be kept closed and locked when out of sight of the medication nurse. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by..."

According to the facility policy titled "Medication Storage" revised dated 3/2010, under "Policy" indicated that...D. Drugs shall be stored in an orderly manner to cabinets, drawers, or carts of sufficient size to include treatment items, shall be

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F 761	Continued From page 9 stored in a locked cabinet or room, inaccessible to residents and visitors..." According to the facility policy titled "General Medication Administration Guidelines of Oral Preparations (including Buccal, Sublingual, Liquid Preparation)" revised on 3/2017, under "Procedure" indicated that medication cart is locked when not in used and when not in view of the medication nurse..." According to the facility policy titled "Storage of Medications", undated, under "Policy Interpretation and Implementation" indicated that...2. The nursing staff shall be responsible for maintaining medication storage...in a clean, safe, and sanitary manner. 7. Compartments (including, but not limited to, drawer, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts...shall not be left unattended if open or otherwise potentially available to others..." N.J.A.C. 8:39-29.4(h)	F 761		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315442 Y1	A. Building B. Wing Y2	10/3/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITAS HOSPITAL	655 EAST JERSEY STREET ELIZABETH, NJ 07206

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 F0761	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/30/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/12/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO