STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. BUILDING _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

(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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 10/05/22 Census: 144 Sample: 33 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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set, an assessment tool used to facility the management of care, to identify that the resident was on [redacted]. This deficient practice was identified for 1 of 4 residents (Resident #107) reviewed for [redacted] and was evidenced by the following: On 09/16/22 at 10:25 AM during initial facility tour,	F 641	1.Resident #107s MDS assessment was modified to reflect that resident was on [redacted] by Director of Nursing on [redacted]. MDS Department was in-serviced on [redacted] by Director of Nursing on coding any resident who received [redacted] in section [redacted] of the MDS assessment. Initiated a facility wide audit of all	11/11/22

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

Electronically Signed | 10/29/2022

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 641	Continued From page 1 Resident #107 was not in the room. The surveyor interviewed the Licensed Practical Nurse (LPN), who was assigned to Resident # 107. The LPN stated that the resident went out to [redacted] on [redacted], and [redacted] from approximately 5:00 AM and returned to the facility at approximately 10:00 AM or 11:00 AM in the morning. Review of the Admission Record reflected that Resident #107 was admitted to the facility with diagnoses which included, but were not limited to, [redacted] Review of the Admission Minimum Data Set (MDS), dated [redacted], did not reflect that Resident #107 received [redacted]. Review of the "Order Summary Report (OSR)" which reflected active physician orders as of [redacted] revealed that the resident received [redacted] at 10:30 AM. On 09/23/22 at 10:45 AM, the surveyor interviewed the Regional MDS Coordinator who stated that the Admission MDS dated [redacted] was a comprehensive assessment that was not coded accurately according to the resident's status and she did not know how the Registered Nurse (RN) completing the admission MDS did not accurately code that Resident #107 was receiving [redacted] She stated that it would be important to make sure the MDS was coded properly to assure that a complete accurate comprehensive assessment was done in order to "paint a picture of the resident." She further stated an accurate assessment would assure that a CP was completed accurately with	F 641	residents receiving renal dialysis to ensure correct coding and orders are present in EMR by Director of Nursing on 9/16/22. 2. All residents receiving dialysis have the potential to be affected 3. Director of Nursing and/or designee will conduct daily audits at clinical meeting on all new admissions/readmissions to ensure all Section [redacted] areas are accounted for and coded on the assessment and orders are in Electronic Medical Record. The Director of Nursing and the Interdisciplinary Care Plan Team including MDS department will continue to follow these new admissions and readmissions daily until assessment is submitted successfully 4. The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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F 641	Continued From page 2 interventions, and it would also be important for "payment purposes." She sadded that the purpose of the MDS was to assure that residents received an accurate assessment that was reflective of the resident's status at the time of the assessment. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, dated October 2019 reflects under "Section [redacted] Special Treatments, Procedures, and Programs," the directions to check all of the following treatments, procedures, and programs that were performed during the last 14 days while a resident of the facility and while not a resident of the facility. Section [redacted]," reflects to "Code peritoneal or renal [redacted] which occurs at the nursing home or at another facility ...".	F 641		
F 656 SS=D	NJAC 8:39 - 11.2 (e) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		11/11/22

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F 656	Continued From page 3 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to consistently revise and/or update resident care plans for 1 of 4 residents (Resident #58) reviewed for [redacted]. This deficient practice was evidenced by the following: On 09/16/22 at 10:03 AM, the surveyor observed	F 656	1.Resident #58 was a closed record Nursing Department was in-serviced on 9/16 by Director of Nursing on initiating/updating and revising a care plan. Initiated a facility wide audit of all new admissions/readmissions for completion of initial care plans in relation to specific	

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F 656	Continued From page 4 Resident #58 in bed with the head of the bed elevated. When interviewed at that time, Resident #58 stated that he/she "was always in [redacted]." According to the Admission Record, Resident #58 was admitted with diagnoses that included, but were not limited to, aftercare following explantation (revision) of [redacted]. Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed staff identified Resident #58 as [redacted], with [redacted] on one side of the [redacted] and the resident received scheduled [redacted] medication and as needed [redacted] medications for occasional [redacted]. Review of the Pain Assessment (3.0), dated [redacted] reflected that resident was assessed for [redacted]. The assessment reflected that the resident had frequent [redacted] over the last five days which made it hard to "sleep at night" and limited the resident's "day-to-day activities because of the [redacted]." The resident's [redacted] intensity was [redacted]" over the last two days voicing complaints of [redacted] p) and exhibiting [redacted] (e.g., [redacted]. Review of the Order Recap Report for orders as of [redacted] revealed a [redacted] physician order (PO) for [redacted] Tablet [redacted] mg (milligram), give two tablets every six	F 656	interventions such as [redacted] management on 9/16. 2. All residents in the facility have the potential to be affected. 3. Director of Nursing and/or designee will conduct daily audits at clinical meeting on all new admissions/readmissions for individualized care plan completion The Director of Nursing and/or designee and Interdisciplinary Care Plan Team will update the care plans based on interventions needed to meet a resident□s medical, nursing, and mental and psychosocial 4. The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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F 656	Continued From page 5	F 656		

hours as needed for mild pain and a [redacted] PO for [redacted] mg, give one tablet every six hours as needed for [redacted]

Review of the [redacted] Medication Administration Record (MAR) revealed the resident received the [redacted] on 07/28/22 at 10:21 PM and 07/31/22 at 10:48 AM. The MAR further revealed that the resident received the [redacted] on 07/29/22 at 1:20 AM.

Review of the [redacted] MAR revealed the resident received the [redacted] on 08/04/22 at 2:34 PM, 08/05/22 at 0:45 AM, 08/12/22 at 9:53 AM and 08/27/22 at 11:06 AM. The MAR further revealed that the resident received the [redacted] on 08/02/22 at 9:47 PM, 08/03/22 at 9:15 PM, 08/04/22 at 9:31 PM, 08/05/22 at 9:05 PM, 08/07/22 at 4:36 AM and 11:26 PM, 08/08/22 at 6:43 AM and 10:30 PM, 08/10/22 at 10:33 PM, 08/12/22 at 9:31 PM, 08/14/22 at 9:44 PM, 08/16/22 at 5:29 AM and 4:29 PM, 08/17/22 at 5:46 AM, 12:35 PM and 10:01 PM, 08/18/22 at 8:01 PM, 08/19/22 at 10:33 PM, 08/20/22 at 8:53 PM, 08/21/22 at 8:51 PM, 08/22/22 at 2:31 PM, 08/23/22 at 1:42 PM and 8:30 PM, 08/24/22 at 10:35 PM, 08/26/22 at 11:53 AM and 08/29/22 at 8:53 PM.

Review of the [redacted] MAR revealed the resident received the [redacted] on 09/13/22 at 5:04 PM. The MAR further revealed that the resident received the [redacted] on 09/01/22 at 1:53 PM, 09/02/22 at 9:52 PM, 09/03/22 at 10:39 PM, 09/04/22 at 8:51 PM, 09/05/22 at 8:36 PM, 09/06/22 at 12:29 PM and 10:40 PM, 09/08/22 at 10:47 PM, 09/09/22 at 10:50 PM, 09/11/22 at 7:19 PM, 09/12/22 at 11:29 PM, 09/14/22 at 10:08 PM,

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F 656	Continued From page 6 09/15/22 at 10:51 PM and 09/16/22 at 10:41 PM. Review of the [redacted] (8:25 PM) COMS-Clinical Admission Evaluation progress note reflected that Resident #58 had "Vocal complaints of [redacted] Review of the Care Plan (CP), initiated [redacted] did not include a focus with interventions for [redacted] During an interview with the surveyor on 09/21/22 at 12:45 PM, the Registered Nurse Charge Nurse (RNCN) reviewed Resident #58's CP with the surveyor. The RNCN stated that we initiate a CP for each resident on the date of admission. The RNCN confirmed there was no focus in the CP for [redacted]. She stated that she was responsible for the CP and always included [redacted] and [redacted] focus areas for each new admission. The RNCN indicated that pain should definitely have been care planned for Resident #58, as he/she had a [redacted]. During an interview on 09/29/22 at 9:09 AM, the Director of Nursing (DON) stated that any discipline in the Interdisciplinary (IDC) Team can update the care plan including nurses. If a resident comes into the facility during the evening or night shift, the evening or night supervisor will review/update the resident's care plan. Thereafter, when a member of the IDC team completed an assessment or a change in resident status, they would update the CP. The DON stated, "I know there have been inconsistencies in CPs. But we are trying." Review of the facility's Baseline Care Plan policy, with a revision date of 11/2020, reflected that the facility will develop and implement a baseline care	F 656		

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F 656	Continued From page 7 plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The policy further reflected that the facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan is developed within 48 hours of resident's admission and meets the requirements of comprehensive care plans. NJAC 8:39-27.1(a)	F 656		
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 consistently document in the Medication Administration Record (MAR). This deficient practice was identified for 1 of 5 residents (Resident #58) reviewed for unnecessary medications and was evidenced by the following: 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 case finding, health teaching,	F 658	1.Resident #58 was a closed record All licensed nurses were in-serviced on 9/23/2022 by Director of Nursing on timeliness of signing all administration orders. A facility wide EMAR audit was initiated for all administration orders for every shift by Director of Nursing on 9/23. 2. All residents in the facility have the potential to be affected. 3. Director of Nursing and/or designee will conduct a daily audit on EMAR system	11/11/22

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F 658	Continued From page 8 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." According to the Admission Record, resident was admitted to the facility with diagnoses which included, but were not limited to, aftercare following explantation [redacted] of [redacted] and [redacted]. Review of the Order Recap Report for Order Date: [redacted], the [redacted] and [redacted] MARs for Resident #58 revealed that there was no documentation to indicate that the medications were administered and/or procedures were completed as ordered: - [redacted] Day Shift. [redacted] unit/ml (unit/milliliter) (a medication used to keep [redacted]). Use [redacted] ml	F 658	every shift to ensure administration orders are being signed timely and document findings Intervention/re-education with staff if found to not be in compliance with signing by Director of Nursing and/or designee. Assistant Director of Nursing and/or designee will provide education on Medication Administration policy upon hire, annually and as needed based on performance evaluation. 4. The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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F 658	Continued From page 9 [redacted]y (administer [redacted]) every day shift for [redacted] patency. [redacted]) after [redacted] medication administration. Order dated [redacted] - [redacted] Day Shift. [redacted] (used to clean out an [redacted]). Use [redacted] every day shift for [redacted] patency. [redacted] before and after [redacted] medication administration. Order dated [redacted]. - [redacted] Day Shift. [redacted] [redacted]ml. Use [redacted] every day shift for [redacted] patency. [redacted] medication administration. Order dated [redacted] - [redacted] Day Shift. [redacted] change each day shift. Order dated [redacted]. - [redacted] Day Shift. [redacted] Use [redacted] ml [redacted] every day shift for [redacted] patency. [redacted] before and after [redacted] medication administration. Order dated [redacted] - [redacted] Day Shift. Evaluate for [redacted] signs/symptoms every shift, BP (blood pressure), HR (heart rate), RR (respiratory rate), Temp (temperature), SPO2 (percentage of oxygen in the blood), [redacted] every day and evening shift for [redacted]. Order dated [redacted]. - [redacted] Day Shift. Evaluate for [redacted] ([redacted] every shift for	F 658		

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[redacted] other signs/symptoms screening. If "Yes," evaluate further and notify MD, Infection Preventionist. Order dated [redacted]

- [redacted] Shift. May combine all crushable medications at one time mixed in (applesauce, pudding, etc.). every shift. Order dated [redacted].

- [redacted] Day Shift. Resident is on [redacted] (an [redacted] medication) for difficulty sleeping every shift. Monitor for side effects: sedation, increased/decreased [redacted], [redacted]," daytime [redacted] "Document in progress notes and notify MD." Order dated [redacted]

- [redacted] Day Shift. Resident is on [redacted] for [redacted] every shift. Observe resident for target behavior of (describe) and indicate number of occurrences throughout shift. Order dated [redacted].

- [redacted] Day Shift. Resident is on [redacted] for [redacted] every shift. Monitor for side effects: f[redacted]. Document in progress notes and notify MD. Order dated [redacted].

- [redacted] Day Shift. Resident is on [redacted] for [redacted]. Observe resident for target behavior of (describe) and indicate number of occurrences throughout shift. Order dated [redacted]

- [redacted] Evening Shift. Evaluate for [redacted] signs/symptoms every shift, BP, HR, RR, Temp,

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F 658	Continued From page 11 SPO2, [redacted] every day and evening shift for [redacted]. Order dated [redacted] - [redacted] (10:00 PM) [redacted] ml. [redacted] every [redacted] hours for [redacted]. Order dated [redacted]. - [redacted] 1400 (2:00 PM) [redacted] /ml. [redacted] unit [redacted] every [redacted] hours for [redacted]. Order dated [redacted]. - [redacted] at 1400 (2:00 PM) [redacted] one time a day for supplement, give [redacted] ml by mouth. Order dated [redacted] - [redacted] at 1400 (2:00 PM) [redacted] Tablet. Give one tablet one time a day for Supplement. Order dated [redacted] - [redacted] Evening Shift. Evaluate for [redacted] signs/symptoms every shift, BP, HR, RR, Temp, SPO2, [redacted] every day and evening shift for [redacted] Order dated [redacted]. - [redacted] at 1400 (2:00 PM) [redacted] one time a day for supplement, give [redacted] ml by mouth. Order dated [redacted] - [redacted] at 1300 (1:00 PM) [redacted] mg (milligram). Give one capsule by mouth three times a day for [redacted] Order dated [redacted]. - [redacted] at 1400 (2:00 PM) [redacted] /ml. [redacted] every [redacted] hours for [redacted]	F 658		

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VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

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F 658	Continued From page 12 [redacted] Order dated [redacted] - [redacted] at 1400 (2:00 PM) [redacted] [redacted] Tablet. Give one tablet one time a day for Supplement. Order dated [redacted] - [redacted] Day Shift. Resident is on [redacted] for [redacted]. Observe resident for target behavior of (describe) and indicate number of occurrences throughout shift. Order dated [redacted] - [redacted] at 1200 (noon). [redacted] Tablet [redacted] mg. Give one tablet by mouth every 6 hours for [redacted] Order dated [redacted] - [redacted] Evening Shift. Evaluate for [redacted] signs/symptoms every shift, BP, HR, RR, Temp, SPO2, [redacted] every day and evening shift for [redacted]. Order dated [redacted] - [redacted] Evening Shift. [redacted]. Apply to affected areas topically every day and evening shift related to [redacted]. Order dated [redacted] - [redacted] Evening Shift. Evaluate for [redacted] every shift for [redacted] other signs/symptoms screening. If "Yes," evaluate further and notify MD, Infection Preventionist. Order dated [redacted] - [redacted] at 2200 (10:00 PM). [redacted] ml. [redacted] every [redacted] hours for [redacted] (type of [redacted]. Order dated [redacted]	F 658		

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F 658	Continued From page 13 - [redacted] Evening Shift. May combine all crushable medications at one time mixed in (applesauce, pudding, etc.). every shift. Order dated [redacted]. - [redacted] Evening Shift. Resident is on [redacted] for [redacted] every shift. Monitor for side effects: [redacted] "Document in progress notes and notify MD." Order dated [redacted] - [redacted] Evening Shift. Resident is on [redacted] for [redacted]. Observe resident for target behavior of (describe) and indicate number of occurrences throughout shift. Order dated [redacted] - [redacted] Evening Shift. Resident is on [redacted] for [redacted] Monitor for side effects: [redacted]. "Document in progress notes and notify MD." Order dated [redacted] - [redacted] Evening Shift. Resident is on [redacted] for [redacted] every shift. Observe resident for target behavior of (describe) and indicate number of occurrences throughout shift. Order dated [redacted] - [redacted] Night Shift. 24 hour chart check on the 11:00 PM-7:00 AM shift every night shift. Order dated [redacted] - [redacted] at 2100 (9:00 PM) [redacted]	F 658		

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F 658	Continued From page 14 Tablet. Give [redacted] mg by mouth at bedtime related to [redacted] Order dated [redacted] - [redacted] at 2100 (9:00 PM) [redacted] mg. Give one tablet by mouth at [redacted] for [redacted]). Order dated [redacted] - [redacted] Evening Shift. [redacted]. Apply to affected areas topically every day and evening shift related to [redacted] Order dated [redacted] - [redacted] at 2100 (9:00 PM) [redacted] mg. Give one tablet by mouth every 12 hours for [redacted]). Order dated [redacted]. - [redacted] at 2100 (9:00 PM) [redacted] mg. Give one capsule by mouth every [redacted] hours for [redacted] (caused by damage or injury [redacted]). Order dated [redacted] - [redacted] Evening Shift. Evaluate for [redacted] every shift for [redacted] other signs/symptoms screening. If "Yes," evaluate further and notify MD, Infection Preventionist. Order dated [redacted] - [redacted] Night Shift. Evaluate for [redacted] every shift for [redacted] other signs/symptoms screening. If "Yes," evaluate further and notify MD, Infection Preventionist. Order dated	F 658		

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[redacted]

- [redacted] at 2200 (10:00 PM). [redacted] /ml. [redacted] every [redacted] hours for [redacted]. Order dated [redacted]

- [redacted] Evening Shift. May combine all crushable medications at one time mixed in (applesauce, pudding, etc.) every shift. Order dated [redacted]

- [redacted] Night Shift. May combine all crushable meds at one time mixed in (applesauce, pudding, etc.) every shift. Order dated [redacted]

- [redacted] Evening Shift. Resident is on [redacted] for [redacted] every shift. Monitor for side effects: [redacted] "document in progress notes and notify MD." Order dated [redacted]

- [redacted] Night Shift. Resident is on [redacted] for [redacted] every shift. Monitor for side effects: [redacted] "document in progress notes and notify MD." Order dated [redacted]

- [redacted] Evening Shift. Resident is on [redacted] for [redacted]. Observe resident for target behavior of (describe) and indicate number of occurrences throughout shift. Order dated [redacted].

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- [redacted] Night Shift. Resident is on [redacted] for [redacted]. Observe resident for target behavior of (describe) and indicate number of occurrences throughout shift. Order dated [redacted].

- [redacted] Evening Shift. Resident is on [redacted] for [redacted] Monitor for side effects: [redacted]. Document in progress notes and notify MD. Order dated [redacted].

- [redacted] Night Shift. Resident is on [redacted] for [redacted] Monitor for side effects: [redacted]. Document in progress notes and notify MD. Order dated [redacted].

- [redacted] Evening Shift. Resident is on [redacted] for [redacted]. Observe resident for target behavior of (describe) and indicate number of occurrences throughout shift. Order dated [redacted]

- [redacted] Night Shift. Resident is on [redacted] for [redacted] Observe resident for target behavior of (describe) and indicate number of occurrences throughout shift. Order dated [redacted]

- [redacted] Day Shift. [redacted] /ml. Use [redacted] ml [redacted] every day shift for [redacted] patency. [redacted] after [redacted] medication administration. Order dated [redacted]

- [redacted] Day Shift. [redacted] change daily

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every day shift. Order dated [redacted]

- [redacted] at 6:30 AM. [redacted] Tablet [redacted] mg. Give one tablet by mouth one time a day for [redacted] ([redacted]). Order dated [redacted]

- [redacted] Day Shift. [redacted]. Use [redacted] every day shift for [redacted] patency. [redacted] before and after [redacted] medication administration. Order dated [redacted]

- [redacted] at 6:00 AM. [redacted] Solution [redacted] /ml. [redacted] every [redacted] hours for [redacted]. Order dated [redacted].

- [redacted] at 0000 (midnight). [redacted] Tablet [redacted] mg. Give one tablet by mouth every [redacted] hours for [redacted]. Order dated [redacted].

- [redacted] at 6:00 AM. [redacted] Tablet [redacted] mg. Give one tablet by mouth every [redacted] hours for [redacted]. Order dated [redacted]

- [redacted] at 1800 (6:00 PM). [redacted] Tablet [redacted] mg. Give one tablet by mouth every [redacted] hours for [redacted]. Order dated [redacted]

[redacted] at 1800 (6:00 PM) [redacted] Tablet [redacted] mg. Give one tablet by mouth one time a day for [redacted]. Order dated [redacted]

During an interview with the surveyor on 09/23/22 at 11:58 AM, Licensed Practical Nurse #4 stated that the process was to administer a medication and then sign that the medication was

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F 658	Continued From page 18 administered in the Electronic Medical Record (EMR), because if the medication was not signed, it was not given. During an interview with the surveyor on 09/28/22 at 11:14 AM, the Director of Nursing stated that she expected the nurse to sign the EMR once an order was administered because if the EMR was not signed, it was not done. Review of the facility's Medication Administration policy, revised 11/2020, reflected to sign the MAR after the medication was administered. NJAC 8:39-27.1(a)	F 658		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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 staff delivered meal trays to the correct residents. This deficient practice was identified for 2 of 2 residents observed during lunch meal services (Resident #34 and #36) and was evidenced by the following:	F 675	1.Resident #36 was assessed for d[redacted] on [redacted] by Assistant Director of Nursing. MD notified by Assistant Director of Nursing on [redacted] with new orders. Resident #34 was assessed on [redacted] by Assistant Director of Nursing and was	11/11/22

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F 675	Continued From page 19 On 09/19/22 at 12:27 PM, the surveyor observed Resident #36 lying in bed with his/her lunch meal tray on the overbed table. Resident #36 stated they had finished their partially eaten lunch and needed assistance to bring the Styrofoam cup filled with water closer. On 09/19/22 at 12:29 PM, the surveyor observed Resident #36's roommate, Resident #34, walking around in the room. Resident #34 used a walker and walked towards the meal tray on the overbed table. The surveyor tried to get the attention of Resident #34, but the resident did not acknowledge the surveyor. At that time, the surveyor observed the meal ticket for Resident #34 was for Resident #36. On 09/19/22 at 12:49 PM, the surveyor brought the Assistant Director of Nursing (ADON) into the room the residents shared. The ADON confirmed the identity of both Resident #34 and Resident #36. The surveyor showed the ADON the meal ticket that was on the meal tray for Resident #36 which reflected Resident #34's name and therapeutic diet of [redacted]) advance diet (food of nearly regular textures but still needs to be moist and should be in [redacted] " pieces for [redacted]). The surveyor then showed the ADON the meal ticket that was still on the meal tray for Resident #34 which reflected Resident #36's name and therapeutic diet of regular [redacted] (foods can be [redacted] . At that time, the ADON acknowledged that the meal trays were switched. The ADON stated the nurses and Certified Nursing Assistants (CNAs) were responsible for passing out the meal trays. She further stated	F 675	found with no concerns. MD notified on [redacted] by Assistant Director of Nursing with new orders. On 9/19/2022 all staff involved with meal pass was in-serviced on tray accuracy Registered Dietitian and Director of Nursing. 1:1 Education on process of passing trays to residents was provided to Food Service Director on 9/19/2022 Regional Registered Nurse, Ambassador of Dietary Services, and Administrator. Initiated a facility wide audit of resident identification, i.e., name bracelets, door tags, and diet slips by Director of Nursing on 9/19. 2. All residents in the facility have the potential to be affected 3. Administrator and/or designee will conduct daily meal pass audits to ensure compliance with the tray accuracy process in place Immediate intervention and education to be provided if found to not be in compliance with process by Director of Nursing and/or designee. Assistant Director of Nursing and/or designee will provide continued education on meal pass/tray delivery process employees upon hire, annually and as needed based on performance evaluation.	

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F 675	Continued From page 20 both Residents #34 and #36 were able to feed themselves. The ADON asked Resident #36 how he/she felt. Resident #36 stated he/she felt "fine," but they just wanted the water closer to them, but no one came into the room to assist them. The surveyor observed Resident #34 who was still walking around in the room. On 09/19/22 at 1:05 PM, the ADON went around asking the staff who delivered the trays to the roommates, but no one knew. The ADON stated she would look at the recorded camera to confirm who passed the lunch meal trays. When asked about the process for passing meal trays, the ADON stated that staff should confirm with the name on the door and ask the resident their names. She further stated, if the resident was not able to identify themselves, then the staff would confirm the resident by the room number on the door. On 09/19/22 at 1:11 PM, the surveyor interviewed License Practical Nurse (LPN #6) who stated that usually the CNAs passed out the meal trays to the residents and that staff were required to check the tickets prior to giving the trays to the residents. She explained it was important for staff to read the meal ticket to assure that the right consistency of food was provided to the right resident, because if a resident was given the wrong diet, the resident could choke on the food or have an allergic reaction. On 09/19/22 at approximately 1:14 PM, LPN #7 stated she was on orientation but that the facility had educated her on the importance of reading the meal ticket. LPN #7 stated that it was important to read the meal ticket because some residents had swallowing problems and they were	F 675	4. The audits will be monitored by the Administrator and/or designee as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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on a special diet. She further stated that if a resident was given the wrong tray, it could be harmful to them because they could choke or get an obstruction from the wrong consistency of food.

On 09/19/22 at 1:16 PM, Registered Dietitian (RD #1) stated she did dietary assessments on residents during mealtimes and assisted with passing out the meal trays to the residents if the nursing staff needed help. RD #1 stated that if residents received the incorrect therapeutic diet, they are at risk for food allergies, chewing and swallowing concerns, and aspiration (when food, liquid, or some other material enter the airway or lungs). RD #1 stated there was a difference between the two textured diets but that the speech therapist would know the actual textures and what residents could or could not have.

On 09/19/22 at 1:22 PM, the surveyor interviewed RD #2 who stated that the CNAs, nurses and sometimes the RDs were responsible for passing out the meal trays. RD #2 stated that the process for passing the trays was to check the name label and the room number to make sure it matched the name on the room door. She further stated that prior to passing the meal tray to the resident, staff should check the meal ticket to make sure it matched the meal on the tray. RD #2 emphasized "I would check the name on the menu, the name on the door and ask the resident their name." She explained it was important to give the right tray to the right resident, so the resident doesn't choke or have an allergic reaction.

On 09/19/22 at 1:25 PM, the surveyor interviewed CNA #3 who stated prior to passing out the meal tray, they should look for the resident's name,

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room number and which bed either bed 1 or bed 2. CNA #3 stated that they also look to assure the resident received the correct diet because if the resident received the wrong type of food or liquid they could choke.

On 09/19/22 at 1:26 PM, RD #1 reviewed Resident #36's chart in the Electronic Medical Record (EMR) with the surveyor which revealed on [redacted] that the resident was upgraded from a [redacted]) to the [redacted] diet.

A review of the [redacted] Order Summary Report for Resident #36 reflected a regular diet [redacted], thin [liquid] consistency diet.

A review of the September [redacted] Order Summary Report for Resident #34 reflected a regular diet [redacted] thin [liquid] consistency diet.

On 09/20/22 at 10:01 AM, the ADON confirmed a Regional Dietary Staff (RDS) member delivered the meal trays to the roommates. The surveyor interviewed the ADON again regarding the process of checking the meal trays prior to passing them. The ADON stated the nurses and dietitians were responsible for checking the accuracy of the meal tray verses the physician's order (PO). She further stated all staff was trained for checking the meal ticket prior to passing the meal trays to the residents.

On 09/20/22 at 10:19 AM, in the presence of the survey team, the RDS member who identified himself as a Food Service Director (FDS) for

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F 675	Continued From page 23	F 675		

another facility stated he used to be the FSD for this facility[redacted] years ago. The RDS/FDS confirmed he was responsible for delivering the wrong meal trays to Resident #34 and Resident #36. He stated everything had changed since he left and he "got confused" because they used to use the kitchenettes on the floor. The RDS/FDS explained he was following the meal trucks from the kitchen to the floors to assure all meal trays were being delivered. He further explained since it was "all hands-on deck" he picked up the meal trays and accidentally delivered "the wrong tray to the wrong resident." The RDS/FDS acknowledged he should have engaged the residents and confirmed it was the correct resident prior to passing out the meal tray. He concluded passing out the wrong tray placed the residents at risk for choking, aspiration, or an allergic reaction.

On 09/20/22 at 10:35 AM, in the presence of the survey team, the Speech Language Pathologist (SLP) stated the [redacted] advance and [redacted] diets were similar. She stated the only difference on the meal tickets from [redacted] for both residents were the [redacted] bread and cake for the [redacted] diet. The SLP explained Resident #36 was on a [redacted] diet, but he/she was evaluated and cleared to be upgraded to a [redacted] advance diet, but due to dental issues, it was Resident #36's preference to remain on the [redacted]t diet. The SLP stated since Resident #36 could have upgraded to the same diet as Resident #34, the resident was not at risk for [redacted] and did not feel that the meal was "unsafe".

On 09/23/22 at 8:47 AM, the Director of Nursing

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F 675	Continued From page 24 (DON) stated the importance of delivering the meal trays to the right resident was to make sure the residents received the correct diet. She stated that if the consistency or diet was incorrect, the residents were at risk for aspiration. The DON stated the process for passing meal trays were nursing and the dietitians were responsible to check the meal ticket during meal pass to ensure the accuracy of the meal tray. She acknowledged that staff should ensure they delivered the right meal tray to the right residents. A review of the in-service Meal Pass/Tray Delivery dated 04/14/22, provided by the Licensed Nursing Home Administrator (LNHA) included ...."1. Identify each resident. Check the diet card against the items on the tray for accuracy and food preferences .....5. Check identity of resident." A review of the facility's policy, Serving A Meal revised 11/2019, included ...."check to be sure everything is included on the meal tray that is required by the diet card, and the resident's preference ...."	F 675		
F 690 SS=D	NJAC 8:39-17.4(a)(1); NJAC 8:39-27.1(a) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is	F 690		11/11/22

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F 690	Continued From page 25 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that an [redacted] bag [redacted] bag) was stored in a way to prevent the spread of infection. This deficient practice was identified for 1 of 3 residents reviewed for the use of [redacted] (Resident #56) and was evidenced by the following:	F 690	1.Resident #56□s was assessed by RN on 9/16 for any adverse effects. None was noted. [redacted] changed on 9/16 by LPN. All licensed Nurses and Certified Nursing Assistants were re-educated on 9/16/2022 by the Director of Nursing on [redacted] and interventions to	

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F 690	Continued From page 26 According to the Admission Record, Resident #56 had diagnoses that included, but were not limited to: encounter for attention to other openings of [redacted] Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) of [redacted] which indicated that the resident was [redacted]. Further review of the MDS revealed the resident had a [redacted]r. On 09/16/22 at 11:00 AM, the surveyor observed Resident #56's [redacted] bag hanging from the bed in a [redacted] bag and the [redacted] used to empty the bag touched the floor. On 09/19/22 at 12:14 PM and on 09/21/22 at 9:09 AM, the surveyor observed Resident #56's [redacted] bag not attached to the bed with the bag lying directly on the floor. Review of Resident #56's September 2022 Physician Order Summary included an order for a [redacted] for diagnosis of [redacted], dated [redacted] During an interview with the surveyor on 09/22/22 at 11:13 AM, the Certified Nursing Assistant (CNA #1) stated that a [redacted] bag should be attached to the resident's bed, should be in a [redacted] bag and not lying directly on the floor. During an interview with the surveyor on 09/22/22 at 1:09 PM, the Licensed Practical Nurse (LPN #1) stated that a [redacted] bag should never be	F 690	prevent/reduce the risk of infections All residents with [redacted] were observed by Director of Nursing on 9/16 for the deficient practice. No adverse effects noted. 2. All residents with an [redacted] have the potential to be affected 3. Director of Nursing and/or designee will conduct random visits throughout the day for those specific residents for compliance with the [redacted] bag interventions and document findings. Immediate re-education with staff/resident if found to not be in compliance with drainage bag placement by Director of Nursing and/or designee. Assistant Director of Nursing and/or designee will provide continued education for employees upon hire, annually and as needed based on performance evaluation. 4. The audits will be monitored by the Administrator and/or designee as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and	

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F 690	Continued From page 27 directly on the floor because [redacted]. During an interview with the surveyor on 09/27/22 at 12:20 PM, the Registered Nurse Charge Nurse (RNCN) stated that a [redacted] bag should be kept below the [redacted], stored in a [redacted] bag, and should not have touched the floor for infection control reasons. During an interview with the surveyor on 09/27/22 at 12:44 PM, the Director of Nursing (DON) stated that the [redacted] bag should be attached to the bed and the [redacted] bag should not have touched the floor because of infection control reasons. A review of the facility's "Indwelling Catheter, Appropriate Use of" policy, dated 09/2020, indicated that [redacted] or [redacted] will be utilized in accordance with current standards of practice, with interventions to prevent complications which include but not limited to: [redacted] infection, blockage of the [redacted] r, expulsion of the [redacted] pain, discomfort, and bleeding. NJAC 8:39 - 19.4 (a)(5)	F 690	trends will be reported to QAPI Committee.	
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		11/11/22

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F 692	Continued From page 28 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to complete weekly weights and consistently monitor a resident with a history of weight loss. This deficient practice was identified for 1 of 6 residents (Resident #15) reviewed for nutrition and was evidenced by the following: On 09/19/22 at 12:37 PM, the surveyor observed Resident #15 sitting up in bed with a lunch tray positioned on the overbed table. The resident was [redacted] and was observed feeding self without difficulty. The surveyor observed that the resident ate approximately 25% of the lunch meal. When interviewed, the resident stated the meal was alright and that he/she did not want anything else to eat. According to the Admission Record, Resident #15 was admitted with diagnoses which included, but were not limited to, [redacted]	F 692	1.Resident #15 was weighed and placed on weekly weights and assessed by dietician on 9/19/2022. Assistant Director of Nursing notified MD on 9/19/2022. On 9/19/2022 the Director of Nursing re-educated all licensed Nurses and Certified Nursing Assistants on Weight monitoring. All licensed Nurses and Certified Nursing Assistants were re-educated by the Director of Nursing on 9/29/2022 regarding weighing residents per physician orders to monitor/prevent weight loss. All licensed nurses were in-serviced by Director of Nursing on adding documentation when entering weight orders into the EMAR system on 9/29/2022 All Certified Nursing Assistants were	

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F 692	Continued From page 29 [redacted], and need for assistance with personal care. Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] revealed the resident had a Brief Interview for Mental Status of '[redacted]' indicating the resident was [redacted]. Further review of the MDS revealed the resident had a weight loss but was not on a physician-prescribed weight-loss regimen. Review of the Resident #15's "Nutrition Note," (NN) dated[redacted], reflected that the resident's monthly weight was [redacted] lbs which indicated an [redacted] weight loss in one month. The NN further reflected that "Weekly weight warranted to monitor weight trends given significant wt [weight] loss ... Will continue to follow weekly weights and po [by mouth] intakes." Review of Resident #15's "Order Summary Report" (OSR) for order date range [redacted], revealed a [redacted] physician order (order) for "Weekly weights x 4 every day shift every [redacted]y for significant wt [weight] loss until[redacted]. Review of Resident #15's "Weight and Vital Summary" report (weight report), contained within the Electronic Health Record (EHR), revealed the following: On [redacted], the resident weighed [redacted] lbs. On [redacted] the resident weighed [redacted] lbs. with a notification under "Warnings: -Comparison Weight [redacted], [redacted] lbs, -[redacted] lb.]"	F 692	re-educated by the Director of Nursing on 9/292022 on documentation of meal consumption for each meal daily. All resident□s administration orders in EMAR were reviewed for supplementary documentation. 2. All residents in the facility have the potential to be affected 3. Registered Dietician and/or designee will audit daily all residents with daily weight orders, weekly for weekly weight orders and monthly to ensure they are being completed as ordered. Director of Nursing and Registered Dietician will meet weekly to discuss potential/actual weight loss and meet bi-weekly with Interdisciplinary Care Plan team to update plan of care for any residents. Director of Nursing and/or designee will audit all new admissions/readmissions daily to ensure weight orders are correctly added to the Electronic Medication Administration Record Unit Manager will audit meal consumption documentation daily after each meal to ensure compliance and accuracy Assistant Director of Nursing and/or designee will provide continued education for nursing staff upon hire, annually and as needed, on monitoring weights as per physician□s orders, ensuring completion	

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F 692	Continued From page 30 On [redacted], the resident weighed [redacted] lbs. On [redacted], the resident weighed [redacted] lbs. The weight report did not include weights documented for the following [redacted]: 0[redacted] and [redacted] During an interview with the surveyor on 09/29/22 at 11:30 AM, the Registered Dietician (RD) stated that Resident #15's weight loss was discussed with the Unit Manager (UM) at the care conference. The RD added that nursing would report the resident's weight loss to the physician and an order would be obtained for any new interventions. The RD stated that the resident was on a downward trend and that she was monitoring his/her eating which had stabilized in [redacted]. The RD added that the resident's meal intakes had improved to [redacted] or more. When questioned about weekly weights ordered on [redacted], the RD review Resident #15 electronic medical record (EMR), in the presence of the surveyor and stated an order for weekly weights was inputted on [redacted] and was due to start on [redacted] The RD added that she did not see the weekly weights in the medical record, and they had not been completed. RD stated that she repeatedly reinforced to nursing that the resident's weekly weights needed to be completed but they still did not complete them. The RD was unable to provide any documentation that she informed nursing administration of the weekly weights not being completed. When questioned how she monitored the resident's weight loss trend, the RD stated she just monitored the resident's meal consumption. Review of Resident #15's June 2022	F 692	of weight, and documentation of meal consumption 4. The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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"Documentation Survey Report v2," provided by the Director of Nursing (DON), revealed no documentation of the resident's meal consumption on the following:

06/10/22 at 9:00 AM and 1:00 PM
06/11/22 at 9:00 AM and 1:00 PM
06/12/22 at 6:00 PM
06/13/22 at 9:00 AM and 1:00 PM
06/15/22 at 9:00 AM and 1:00 PM
06/17/22 at 9:00 AM and 1:00 PM
06/18/22 at 9:00 AM, 1:00 PM and 6:00 PM
06/19/22 at 9:00 AM, 1:00 PM and 6:00 PM
06/21/22 at 9:00 AM and 1:00 PM
06/23/22 at 9:00 AM and 1:00 PM
06/24/22 at 9:00 AM, 1:00 PM and 6:00 PM
06/25/22 at 9:00 AM and 1:00 PM
06/26/22 at 9:00 AM, 1:00 PM and 6:00 PM
06/27/22 at 9:00 AM and 1:00 PM
06/30/22 at 9:00 AM and 1:00 PM

Review of Resident #15's July 2022 "Documentation Survey Report v2," provided by the Director of Nursing (DON), revealed no documentation of the resident's meal consumption on the following:

07/01/22 at 9:00 AM, 1:00 PM and 6:00 PM
07/02/22 at 9:00 AM, 1:00 PM and 6:00 PM
07/03/22 at 9:00 AM, 1:00 PM and 6:00 PM
07/04/22 at 9:00 AM, 1:00 PM and 6:00 PM

During an interview with the surveyor on 09/29/22 at 12:11 PM, the Director of Nursing (DON) stated that all weights were reviewed monthly to identify any resident with significant weight loss or gain. Once identified, the team would review the resident's chart and meet with the RD. The DON stated they would try to identify why the resident

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F 692	Continued From page 32	F 692		

was having weight loss and if there was any underlying cause to the weight loss. They would initiate weekly weights x4 to see the trend, a calorie count to see how much the resident was eating at meals and inform the physician to see if additional labs or an in-person assessment was needed. The DON further stated the resident would be placed on the weekly weight list, a physician order would be inputted into the EMR, which would alert the nurse to inform the CNA to weigh the resident. The RD would review the weekly weights, calorie counts, and make recommendations that would then be communicated to the nursing staff. The DON stated that she expected the RD to inform the charge nurse, UM and herself that weekly weights were not being completed. The DON stated that they would have add additional weekly weights and would have made sure they were completed.

During an interview with the surveyor on 09/30/22 at 9:56 AM, the Licensed Practical Nurse/UM (LPN/UM) stated Resident #15 required extensive assist with activities of daily living but was able to feed self after staff setup of the meal tray. The LPN/UM stated the resident's meals were monitored every shift for all meals and the percentages consumed were documented in the EMR. The LPN/UM further stated the RD recommends weekly weights, the nurse confirms the order, which would then reflect on the administration record. The LPN/UM added that Resident #15's [redacted] order for weekly weights x4 order was inputted under "order type" as "no documentation required." The LPN/UM added that the order was present, but the order type not being checked resulted in it not being carried over to the administration record for nursing to

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F 692	Continued From page 33 complete. The LPN/UM stated completing a resident's weekly weights was important to determine any additional weight loss and to look further into the cause. The LPN/UM further stated that he did not recall if the RD informed him that Resident #15's weekly weights were not being completed. Review of the facility's "Weight Monitoring" policy, revised on 11/2019, indicated that "Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem." The policy reflected that weights should be recorded at the time obtained and included, but not limited to, a suggested weight schedule of daily or weekly, if clinically indicated. The policy further indicated that "Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate." NJAC 8:39-27.1 (a)	F 692		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was	F 695	1.Resident #89 was assessed by Assistant Director of Nursing with no	11/11/22

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F 695	Continued From page 34 determined that the facility failed to a.) document the size and type of resident's [redacted] on the resident's Care Plan (CP) and b.) obtain a physician order for [redacted] and include [redacted] use and care on a CP. This deficient practice was identified for 2 of 3 residents (Residents #89 and #120) reviewed for [redacted] care and was evidenced by the following: According to the Admission Record reflected that the resident was admitted to the facility with the diagnoses which included, but were not limited to, [redacted]. The annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident was [redacted] l, had [redacted], and required complete care with all aspects of activities of daily living (ADL). The MDS also reflected that the resident had a [redacted] and required [redacted] and [redacted] On 09/16/22 at 10:33 AM, during tour, the surveyor observed Resident #89 in bed with the head of bed up. The resident was observed with a [redacted] The resident was observed to be [redacted] and [redacted]. On 09/28/22 at 09:06 AM, the surveyor observed	F 695	negative outcome observed. Resident #89□s [redacted] were added to the care plan by Assistant Director of Nursing. Resident #120 was assessed by Charge Nurse on 9/23/2022. No negative outcome observed Resident #120 received order from medical doctor for [redacted]. [redacted] orders were carried out and care plan was updated On 9/23/2022 the Director of Nursing in-serviced all licensed Nurses on including [redacted] to resident□s individualized Care plan as per physician□s order. All Care plans for [redacted] residents were updated Director of Nursing and designee with [redacted] as per physician□s order. All licensed nurses were in-serviced by the Director of Nursing on 9/23/2022 on obtaining physician orders for [redacted] use and updating the care plan with amount per physician order. All residents receiving [redacted] were reviewed for orders and care plans Director of Nursing and designee. 2. All residents requiring [redacted] services in the facility have the potential to be affected 3. Director of Nursing and/or designee will audit all new admissions/readmissions daily to ensure [redacted]	

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F 695	Continued From page 35 that there was a [redacted] attached to the resident's [redacted] equipment at the bedside. The surveyor reviewed Resident #89's Care Plan (CP) which indicated that the resident had a [redacted] related to (r/t) [redacted] There was no documentation on the resident's CP indicating the [redacted] of the [redacted] On 09/28/22 at 09:18 AM, the surveyor interviewed the Registered Nurse who stated that it would have been important to include the [redacted] and [redacted] in the resident CP. On 09/28/22 at 09:25 AM, the surveyor interviewed the Registered Nurse Assistant Director of Nursing who was acting Unit Manager of the [redacted] floor who confirmed that the [redacted] and [redacted] was not documented on the resident's CP and could not explain why it was missed. She stated that it would be important to have that documented on the CP to get a full picture of what was going on with the resident and so that all staff members could also know what medical conditions or equipment the resident had. On 09/28/22 at 10:03, the surveyor interviewed the Director of Nursing (DON) who stated that it would be important to know the [redacted] of resident's [redacted] in case the [redacted] came out the nurse would know what [redacted] to replace it with. She added that it would also be important to have it documented in the CP so there was documentation regarding what [redacted] was. The DON admitted that there was no CP intervention	F 695	orders are correctly added to the Electronic Medication Administration Record and to the care plan. Assistant Director of Nursing and/or designee will provide continued education for licensed staff upon hire, annually and as needed, on [redacted] use [redacted] orders and care plans. 4. The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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for the [redacted] the resident had. She stated that when the CP was reviewed that the interdisciplinary team should have identified that there was no documentation on the CP regarding the [redacted] the resident had.

On 09/29/22 at 10:52 AM, the surveyor telephone interviewed the Respiratory Therapist, in the presence of the survey team, who stated that the facility scheduled her to come to the facility once a week but would come in at additional times if the facility needed her. She also stated that she did not know that the [redacted] of [redacted] was not documented on the resident's CP.

b.) During the initial tour of the [redacted] nursing unit on 09/16/22 at 12:19 PM, the surveyor observed Resident #120 asleep, seated in a wheelchair next to his/her bed. The resident wore a [redacted] (a medical device used for delivering [redacted] that was set at [redacted]).

On 09/19/22 at 10:15 AM, the surveyor observed Resident #120, who was seated in a wheelchair in his/her room and wore a [redacted] that was connected to an [redacted] that was set at [redacted]. The resident was awake and alert and stated that they wore [redacted] at all times. The resident also stated that they wore [redacted] of [redacted] all the time while at home as well.

On 09/20/22 at 09:51 AM, the surveyor observed Resident #120, who was seated in a wheelchair

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in their room and wore a [redacted] that was connected to an [redacted] that was set at [redacted].

On 09/21/22 at 10:10 AM, the surveyor observed Resident #120, who was seated in a wheelchair in their room and wore a [redacted] that was connected to an [redacted] that was set at [redacted].

On 09/22/22 at 12:45 PM, the surveyor observed Resident #120, who was seated in a wheelchair in their room and wore a [redacted] that was connected to an [redacted] that was set at [redacted].

According to the Admission Record, Resident #120 was admitted to the facility with diagnoses that included, but were not limited to, [redacted].

A review of the Admission MDS, dated [redacted], revealed Resident #120 was [redacted], needed the assistance of one person for mobility and received [redacted] treatments.

A review of the Order Summary Report, dated [redacted], failed to include a physician order for the use of [redacted].

A review of the CP, initiated on [redacted] failed to contain an entry for the use and care of [redacted].

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A review of the progress notes, dated [redacted] through [redacted] revealed documentation of [redacted] levels that were administered to Resident #120, included the following:

- On [redacted] at 05:32 AM, a Licensed Practical Nurse (LPN #4) documented the resident had [redacted] in place.
- On [redacted] at 08:30 AM, the Nurse Practitioner (NP) documented the resident was on [redacted] at [redacted].
- On [redacted] at 06:47 AM, LPN #4 documented the resident had [redacted] maintained.
- On [redacted] at 09:27 AM, the NP documented the resident was on [redacted] at [redacted].
- On 09/14/22 at 14:28 (2:28 PM), the NP documented the resident was on [redacted] at [redacted].
- On [redacted] at 18:56 (6:56 PM), LPN #2 documented the resident had [redacted].
- On [redacted] at 09:30 AM, the NP documented the resident was on [redacted].
- On [redacted] at 06:55 AM, LPN #5 documented the resident was on [redacted]
- On [redacted] at 15:43 (3:43 PM), LPN #2 documented the resident had [redacted]
- On [redacted] at 07:19 AM, LPN #5 documented [redacted] on [redacted].

On 09/23/22 at 10:30 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #2) assigned to Resident #120. CNA #2 acknowledged the resident was on [redacted] and that she got report from the nurse to let her know how much [redacted] the resident wore.

On 09/23/22 at 10:43 AM, the surveyor interviewed LPN #2 assigned to Resident #120. The surveyor accompanied LPN #2 into the

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resident's room and LPN #2 acknowledged that the resident was wearing [redacted]. LPN #2 stated that when [redacted] was ordered by the physician that it appeared on the Treatment Administration Record (TAR) and that a resident's response to a treatment was required to be documented in the progress notes. LPN #2 stated the physician's order specified how much [redacted] the resident was to receive. In the presence of the surveyor, LPN #2 reviewed the resident's Order Summary Report that contained active orders as of [redacted] and LPN #2 acknowledged that there was no order for [redacted] LPN #2 also reviewed the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated [redacted] and acknowledged that [redacted] was not documented. LPN #2 stated that the resident should have had an order for [redacted] and that it was important to have an order to show how much [redacted] should have been administered. LPN #2 reviewed the resident's CP and acknowledged that the resident did not have a [redacted]. LPN #2 stated that everyone should have had a CP because it was a document that listed the care provided to residents, and that [redacted] should have been on the CP.

On 09/23/22 at 10:54 AM, the surveyor interviewed the [redacted] nursing unit Charge Nurse (CN) who stated that if a resident needed [redacted], a physician order should have been obtained and the nurse or CN would set up the [redacted] for the resident. The CN stated the nurse would know a resident was on [redacted] from the shift report and from the TAR and that it would have been documented on the 24-hour report for every nurse to review. In the presence of the

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surveyor, the CN reviewed Resident #120's Order Summary Report that contained active orders as of [redacted], and the CN acknowledged that there was no order for [redacted]. The CN also reviewed the resident's MAR and TAR dated [redacted] and acknowledged that [redacted] was not documented. The CN stated that if a resident was on [redacted] an order should have been obtained and documented so that the resident was treated correctly. The CN reviewed Resident #120's CP and acknowledged [redacted] was not on the CP. The CN stated that a CP contained actions pertinent to a resident's care and that [redacted] should have been on Resident #120's CP so that the resident was treated correctly.

On 09/29/22 at 10:50 AM, the surveyor interviewed the Director of Nursing (DON) and informed her of Resident #120's [redacted] observations and interviews with staff. In the surveyor's presence, the DON reviewed the resident's Order Summary Report that contained active orders as of [redacted] and she acknowledged that there was no [redacted] order. The DON stated that she was unsure how much [redacted] the resident should have been on and that it was important to obtain a physician order for [redacted] so that the resident was provided the correct amount of [redacted]. The DON reviewed the resident's CP and acknowledged [redacted] was not on the CP and that it should have been. The DON stated that the CP showed what interventions should have been used and that the CP was important because it provided the resident with the required care.

The facility policy titled "[redacted] Care" and dated 11/2021 indicated that the facility would

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ensure that residents who need [redacted] care, including [redacted] care and [redacted], is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. The policy also indicated that the facility would provide necessary [redacted] care and services, such as [redacted] therapy, treatments, [redacted] ventilation, [redacted] y care and or [redacted]. [redacted] care will be provided according to physician's orders, comprehensive assessment, and individualized care plan such as monitoring for resident specific risk for possible complications, psychosocial needs as well as [redacted] as appropriate. General considerations include: Provide [redacted] care as ordered per physician. According to the policy, based upon resident assessment, attending physician orders and professional standards of practice, the facility in collaboration with the resident/representatives will develop a care plan what includes appropriate interventions for respiratory care.

Review of the facility policy, [redacted] Administration," revised 09/2021, revealed Policy: [redacted] is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans ...Policy Explanation and Compliance guidelines: 1. [redacted] is administered under orders of a physician ...4. The resident's care plan shall identify the interventions for [redacted] therapy, based upon the resident's assessment and orders, such as, but not limited to: A. type of [redacted] system. B. When to administer, such as [redacted] or [redacted] and/or when to discontinue. C. Equipment setting for the

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F 695	Continued From page 42 prescribed [redacted]. D. Monitoring of SpO2 ([redacted]) levels and/or vital signs, as ordered. E. Monitoring for complications associated with the use of[redacted] Review of the facility policy, "Comprehensive Care Plans," revised 09/2021, revealed Policy: It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. N.J.A.C 8:39- 11.2 (d), 1, 2	F 695		
F 697 SS=E	NJAC 8:39-27.1(a) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to consistently monitor and manage a resident's[redacted] consistent with professional standards of practice or develop a comprehensive person-centered care plan for 1 of 4 residents who exhibited signs and symptoms of[redacted], Resident # 55. This deficient practice was	F 697	1.Resident #55□s care plan was updated to reflect resident□s [redacted] location and interventions were added to reduce/relieve [redacted] and a [redacted] assessment was performed by Director of Nursing on 9/21/2022 and MD was notified.	11/11/22

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F 697	Continued From page 43 evidenced by the following: Reference: New Jersey Statutes, 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 case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist:" Reference New Jersey Statutes, 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 task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 09/16/22 at 10:37 AM during tour, the surveyor observed Resident #55 in bed with the head of bed (HOB) up and a wash basin was in his/her [redacted]. The resident was [redacted] however, was able to communicate with [redacted] gnals. Resident #55 was pointing to their [redacted] area and making [redacted] that they [redacted]. The surveyor observed a [redacted] at [redacted]. The surveyor notified the dietician who was standing in the hall and informed her that the resident was making gestures that she	F 697	All licensed Nurses were re-educated on Pain management by the Director of Nursing on 9/21/2022. On 9/21/2022 the Director of Nursing educated all licensed nurses on recognition, assessment, treatment, monitoring and documenting resident□s pain. A facility wide audit was initiated on all residents receiving [redacted] management by Director of Nursing and designee on 9/21/2022. Pain assessments were completed by Director of Nursing and designee on 9/21/2022 on all residents receiving [redacted] management. 2. All residents in the facility have the potential to be affected 3. Director of Nursing and/or designee will audit all new admissions/readmissions daily for initiation of individualized care plans for [redacted] management Director of Nursing and/or designee will audit all new admissions/readmissions weekly to ensure pain management is effective and to revise/update the care plan accordingly Unit Managers and/or designee will audit all long-term care residents on [redacted] management weekly to reassess and revise the regimen and plan of care as	

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F 697	Continued From page 44 was not feeling well, and the dietician stated that she would get the nurse. The nurse came to the resident's room and stated that the resident was probably in [redacted] and that she would provide the resident with [redacted] medication. The Admission Record reflected that Resident #55 was admitted to the facility with diagnoses which included, but were not limited to, [redacted] The quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident was [redacted] and required extensive to total assistance with all activities of daily living (ADLs). The MDS also reflected that the resident was not exhibiting [redacted] The surveyor reviewed Resident #55's Care Plan (CP) which did not reflect Resident #55 had complaints of [redacted] or interventions related to [redacted] reduction or relief. The surveyor reviewed the physician "Order Summary Report" with active orders as of [redacted] which revealed the resident had the following orders: 1.) Order dated [redacted] for [redacted] ml, give [redacted] ml via (by way of) [redacted]) every 6 hours as needed for [redacted] give [redacted] mg [redacted] ml, not to exceed [redacted] grams in [redacted] hours from all sources. 2.) Order dated [redacted] for [redacted] tablet [redacted] mg, give [redacted] tablet via [redacted] every [redacted] hours as	F 697	needed Assistant Director of Nursing and/or designee will provide inservicing of facility's [redacted] management policy for nursing staff upon hire, annually and as needed on [redacted] management documentation 4. The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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needed for [redacted] and monitor for [redacted] while administering [redacted]

3.) Order dated [redacted] to observe and evaluate for signs and symptoms of [redacted] every shift and notify the MD for unrelieved [redacted].

4.) Order dated [redacted] to observe and evaluate for signs and symptoms of [redacted] one time a day on the last day of the month every month on the [redacted] Management Summary to evaluate effectiveness of routine and PRN (as needed) [redacted] medication.

The surveyor reviewed the Medication Administration Record (MAR) dated [redacted] which revealed the following documentation:

The MAR indicated that Resident #55 received [redacted] ml give [redacted] ml [redacted] ([redacted] for a [redacted] of [redacted] indicating [redacted]. The MAR further reflected the nurses documented on every shift (day, evening, and nights) indicated that the resident had no complaints [redacted]. There was no location of [redacted] documented in the progress notes.

The MAR reflected on 07/06/22, 07/11/22, 07/14/22, 07/16/22, 07/18/22, 07/20/22, and 07/21/22 there was documentation that Resident #55 received [redacted] tablet [redacted] mg for [redacted] to [redacted]. The MAR further reflected on 07/14/22, 07/16/22, 07/18/22, 07/20/22 and 07/21/22 that the nurses documented on every shift (day, evening, and nights) that the resident had no complaints of [redacted] There was no location of [redacted] documented

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	315518	A. BUILDING _____ B. WING _____	10/05/2022

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VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

(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 697	Continued From page 46 in the progress notes. The surveyor reviewed the MAR dated [redacted] which revealed the following documentation: The MAR indicated that Resident #55 received [redacted] ml give [redacted] ml via [redacted] on 08/16/22, 08/23/22, 08/28/22 and 08/29/22 indicating [redacted] The MAR further reflected on 08/23/22, that the nurses documented on the MAR every shift (day, evening, and nights) that the resident had no complaints of [redacted] There was no location of [redacted] documented in the progress notes. The MAR reflected on 08/08/22, 08/10/22, 08/11/22, 08/13/22, 08/16/22, 08/17/22, 08/18/22, 08/20/22, 08/23/22, 08/24/22, 08/25/22, 08/28/22 that there was documentation that Resident #55 received [redacted] tablet [redacted] mg for [redacted] The MAR further reflected on 08/10/22, 08/11/22, 08/13/22, 08/17/22, 08/18/22, 08/20/22, 08/23/22,08/25/22 that the nurses documented on the MAR every shift (day, evening, and nights) that the resident had no complaints of [redacted] There was no location of [redacted] documented in the progress notes. The surveyor reviewed the Medication Administration Record (MAR) dated [redacted] which revealed the following documentation: The MAR indicated that Resident #55 received [redacted] ml give [redacted] ml [redacted] on 09/03/22, 09/04/22, 09/06/22, 09/08/22 indicating [redacted]. The MAR further reflected on 09/03/22, that the	F 697		

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nurses documented on the MAR every shift (day, evening, and nights) that the resident had no complaints of [redacted]. There was no location of [redacted] documented in the progress notes.

The MAR reflected on 09/01/22, 09/04/22, 09/05/22, 09/07/22, 09/08/22, 09/12/22, 09/15/22, 09/16/22, 09/17/22, 09/18/22, 09/20/22, and 09/21/22 there was documentation that Resident #55 received [redacted] tablet [redacted] mg for [redacted]. The MAR further reflected on 09/07/22, 09/12/22, 09/15/22, 09/16/22, 09/17/22, 09/18/22, 09/20/22, and 09/21/22 that the nurses documented on the MAR every shift (day, evening, and nights) that the resident had no complaints of [redacted] There was no location of [redacted] documented in the progress notes.

On 09/19/22 at 12:35 PM, the surveyor interviewed Resident #55's Certified Nursing Assistant (CNA) who stated that she had been employed in the facility since [redacted]. The CNA stated that Resident #55 was [redacted] to [redacted]. She also stated that the resident could communicate needs [redacted]. The CNA added that Resident #55 required total care with all aspects of ADL's (activities of daily living) and was [redacted] and [redacted] and wore protective undergarments/briefs. The CNA stated that the resident did not have any [redacted] or [redacted]. The CNA further added that the resident was [redacted]. She stated that the

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resident had frequent complaints of [redacted], but the CNA did not know the causes. She added that if the resident complained of [redacted] that she would let the nurse know so that the nurse could give pain medication. The CNA stated, "Complaints of [redacted] every day, twice a day on my shift but mostly every day." The CNA stated that the family was supportive.

On 09/19/22 at 12:45 PM, the surveyor conducted a telephone interview with the responsible party (RP) who provided a history regarding Resident #55. The RP stated that the resident could [redacted] however could not use their vocal cords and therefore only used [redacted] The RP stated that there were no causes for [redacted] but it might be due to the [redacted] needing to be changed, and that when the resident was home that they often complained of [redacted] around the [redacted]. The RP further stated that the resident had taken [redacted] medications occasionally while at home.

On 09/21/22 at 11:23 AM, the surveyor interviewed the Registered Nurse (RN) who had been employed in the facility since [redacted] She stated that she was a regular employee but that she "floats" around the facility and worked where the facility put her. She explained that if a resident was in [redacted], that the nurse would assess the resident and find out where the pain was located and the resident's level of [redacted] and perform other measures to relieve pain such as repositioning. If alternative measures (repositioning) did not alleviate the [redacted] she would have administered [redacted] medication according to the level of [redacted]. She stated that the nurses documented on the Medication

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Administration Record (MAR) the level of [redacted] and what [redacted] medications were administered and then [redacted] hour later would document if the [redacted] medication was effective. She added that the nurse would also document in the nursing notes that the resident had complaints of [redacted] where the [redacted] was, the type of [redacted] medication given and the effectiveness of the [redacted] medication. She further added that it would be important to document in the nurse's progress notes because the progress notes were a form of communication with other staff such as nurses, physicians and any persons who reviewed the chart. She stated the progress notes allowed all medical personnel to be able to know what was going on medically with a resident. She further stated that a CP for [redacted] should have been developed because the resident had complaints of [redacted] and the CP was important so that the staff could have reviewed the alternative interventions to relieve [redacted] or developed interventions to relieve [redacted]. She then added that Resident #55 had complaints of [redacted] in [redacted] "all the time" because she had [redacted]. She stated that the resident was not on routine [redacted] medication just prn (as needed). She stated that the medication that was given to Resident #55 was effective at managing his/her [redacted]. The RN reviewed the MAR with the surveyor and stated that she did not know why some nurses documented that the resident was given [redacted] medication on a specific day, but then also the same day documented that the resident did not complain of [redacted]

On 09/21/22 at 11:42 AM, the surveyor interviewed the Registered Nurse/Assistant Director of Nursing/ Unit Manager (RN/ADON/UM) who stated that she was the covering the Nurse Manager position for the [redacted]

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floor (RN/ADON/UM). She explained to the surveyor the process on how the facility managed a resident that had complaints of [redacted]. She stated the following:
-The nurse would evaluate the [redacted] and develop therapeutic interventions such as position changes to manage a resident's [redacted] prior to giving [redacted] medications.
-Evaluate the resident and if the resident was able to communicate, find out the level of [redacted]) and location of [redacted].
-Documentation in progress notes to include location of the [redacted], consistency of [redacted], and level of [redacted] the resident was experiencing.
-Then the nurse would administer the [redacted] medication and evaluate 10-15 minutes after the administration to make sure that [redacted] medication was effective or not.
The RN/ADON/UM stated that the nurse should have documented the location of the [redacted] in the electronic medical record (EMAR) which would then have populated onto the nurse's progress notes that should have included all the above information. She stated that pain assessments were done every shift in the EMAR and that the MD order did not have to be specific to include location. The RN/ADON/UM further stated it was important that a nursing progress note should have been written that related to where the resident was having the pain and what type of interventions were utilized that alleviated the [redacted].

The RN/ADON/UM reviewed Resident #55's medical record with the surveyor, and she admitted that a Care Plan (CP) was not developed with interventions for Resident #55's [redacted] She stated that a CP should have been developed with interventions to help alleviate [redacted] and that the CP would have been reviewed to

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make sure the interventions were adequate. She also stated that a location of the resident's [redacted] was not documented in the progress notes up to this date for the month of [redacted]

On 09/21/22 at 12:13 PM, the surveyor interviewed the MDS Coordinator Licensed Practical Nurse MDS/LPN who stated that there was a 5 day look back period for [redacted] and that according to the MDS dated [redacted] which had a look back period from [redacted] until [redacted] the resident did not receive any medication for pain. The MDS/LPN also reviewed Resident # 55's CP and confirmed that a CP was not developed for Resident # 55's complaints of [redacted].

On 09/30/22 at 8:26 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated she has been employed in the facility since [redacted]. She stated that if a resident complained about [redacted] and was able to answer questions, the nurse would assess their level of [redacted] according to a [redacted] being low [redacted] and [redacted] being the worst [redacted]. The nurse would know what type of [redacted] medication the resident would need according to whether the resident had [redacted]; either [redacted] or a stronger [redacted] medication according to the level. LPN #1 added the nurse would find out the location of the [redacted] how long the resident had the [redacted] and the onset of [redacted]. She provided an example, "If they complain of [redacted] after therapy maybe they would need pain medicine before therapy to prevent pain." LPN #1 stated that depending how often the resident had [redacted] they may have needed routine[redacted] medication. If they needed routine medication, then the physician would need to be notified and we would would have gotten a

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routine [redacted] medication ordered. LPN #1 then stated that [redacted] was monitored based on the documentation in the MAR and whether the [redacted] medication was effective. She stated that if the resident had [redacted] during your shift and was given pain medication, the nurse would be responsible to document in both places on the MAR; the first area on the MAR indicated that you gave [redacted] medication, and the second area indicated if the resident had experienced pain during the shift. The nurse would also have documented in the progress note the level of [redacted], the location of pain, the duration of the [redacted], that [redacted] medication was administered and if the pain medication was effective. She further confirmed that if a resident had complaints of [redacted] a CP should have been developed with interventions that would include non-pharmacological and pharmacological interventions.

On 09/30/22 at 8:38 AM, the surveyor interviewed LPN #2 who administered [redacted] medications on [redacted] LPN #2 stated that if a resident complained of [redacted] the nurse would document in the MAR that the resident complained of [redacted] during that shift and what level of [redacted] resident had [redacted] being the worst. LPN #2 then stated that [redacted] medication type would depend on the level of [redacted] the resident was experiencing. The nurse would document in the MAR if the [redacted] medication was effective at relieving the resident's [redacted]. She further revealed that if a resident complained of [redacted] any time during the shift the nurse would have to document that the resident had [redacted] in the MAR. She stated that she was not sure why she documented that Resident #55 did not have complaints of [redacted] on [redacted] on day and evening shift, when she administered [redacted]

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F 697	Continued From page 53 medication to the resident. According to the policy titled, [redacted] Management" dated 11/2021, the facility must ensure that [redacted] management is provided to residents who require such services, consistent with professional standards of practices, the comprehensive person-centered care plan and the resident's goals and preferences. The policy also indicated that the staff were to identify key characteristics of pain to include duration, frequency, location, onset, pattern, and radiation. The interdisciplinary team and the resident collaborate to arrive at pertinent realistic and measurable goals for treatment. The Policy indicated that the facility was to revise pain management and plan of care as indicated. The facility policy titled, "Reviewing and Revising Care Plan" dated 11/2019, indicated that the purpose of this procedure was to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. The policy indicated that a person-centered comprehensive care plan will be developed in according with the facility policy and procedures and will be developed within 7 days after completion of comprehensive assessment, prepared by the interdisciplinary team. The policy also indicated that a comprehensive care plan will be reviewed, revised as necessary when a resident experiences a status change. The MDS Coordinator and Interdisciplinary team will discuss the residents condition and collaborate on intervention options. The team meeting discussion will be documented in the progress notes. Staff involved in the care of the resident will report resident response to new or modified interventions.	F 697		

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F 697	Continued From page 54 NJAC 8:39- 27.1 (a)	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to a.) coordinate medication administration times and [redacted]) with scheduled renal [redacted] days, b.) identify and monitor the [redacted] access site, c.) consistently maintain ongoing complete communication notes between the facility and the [redacted] center, and d.) implement a person-centered care plan for a resident on [redacted]. This deficient practice was identified for 1 of 4 residents (Resident #107) reviewed for dialysis and was evidenced by the following: On 09/16/22 at 10:25 AM during initial facility tour, Resident #107 was not in the room. The surveyor interviewed the Licensed Practical Nurse (LPN) who was outside in the hallway and indicated that she was assigned to Resident # 107 today however the resident was out to [redacted]. The LPN stated that the resident went out to [redacted] on [redacted], and [redacted] from approximately 5:00 AM and returned to the facility at approximately 10:00 AM or 11:00 AM in the	F 698	1.Resident #107 was assessed by Director of Nursing on 9/22/2022. No negative outcome observed. MD notified on 9/22/2022. Resident #107□s medication times updated to coordinate with dialysis schedule, monitoring of [redacted] was added, and a [redacted] care plan was initiated by Assistant Director of Nursing on 9/22/2022. Director of Nursing in-serviced all licensed nurses on medication administration times on [redacted] days on 9/22/2022. On 9/22/2022 Director of Nursing In-serviced all licensed nurses on types of [redacted] In-service completed on 9/22/2022 by the Director of Nursing to all licensed nurses on the [redacted] communication sheet being completed on treatment days. Re-education provided by Director of	11/11/22

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F 698	Continued From page 55 morning. The LPN further stated that the resident had an [redacted]) in the [redacted] The Admission Record reflected that Resident #107 was admitted to the facility with the diagnoses which included, but was not limited to, [redacted]). The admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] indicated that Resident #107 had [redacted] and required extensive care of two staff members for transfers and extensive care of one staff member for washing, dressing, toilet use and personal hygiene. The MDS did not reflect that the resident received [redacted] The surveyor reviewed the "Order Summary Report (OSR)" which reflected active physician orders as of [redacted] -According to OSR dated [redacted] the resident received [redacted] on [redacted], [redacted] at 10:30 AM. -According to the OSR dated [redacted] there was an order written for Type of [redacted] ([redacted] Location: (indicate site/location) Schedule: [redacted] At 5:00 AM There was no specification as to what the [redacted] was, where it was or when it was to be monitored The surveyor reviewed the Medication	F 698	Nursing on 9/22/2022 to all licensed nurses on initiating a [redacted] care plan. Facility wide audit of all [redacted] patients was completed by Assistant Director of Nursing on 9/22/2022. No other residents were affected. 2. All [redacted] residents have the potential to be affected. 3. Director of Nursing and/or designee will audit all new admissions/readmissions on [redacted] daily to ensure all medications are coordinated with dialysis schedule, monitoring of [redacted], and care plan initiation Assistant Director of Nursing and/or designee will check for full completion of communication sheet on scheduled [redacted] days Assistant Director of Nursing and/or designee will provide continued education for nursing staff upon hire, annually and as needed on the plan of care and services provided for all [redacted] residents. 4. The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance	

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F 698	Continued From page 56 Administration Record (MAR) dated [redacted] and [redacted] which revealed the following medications were plotted on the electronic medical record (EMR). -[redacted]. [redacted] one time a day for [redacted]) at 9:00 AM, and was not given on 08/26/22, 08/29/22, 09/07/22, 09/09/22, 09/12/22, 09/19/22 and 9/21/22 because the resident was out at [redacted]. There was no documentation that the physician (MD) was notified on the specific dates that the [redacted] was not administered. [redacted] capsule [redacted] mg give one capsule by mouth two times a day for [redacted]. At 10:00 AM, the medication was not given on 08/29/22, 09/07/22, 09/09/22, 09/12/22 and 09/21/22 because the resident was out of the facility at [redacted]s. There was no documentation to reflect that the MD was notified on the specific date that the [redacted] was not administered. [redacted] mg give one tablet by mouth two times a day for [redacted] At 10:00 AM, the medication was not given on 08/29/22, 09/07/22, 09/09/22, and 09/12/22 because the resident was out of the facility at [redacted]. There was no documentation to reflect that the MD was notified on the specific dates that the [redacted] was not administered. -[redacted] mg give every [redacted] hours by mouth used to treat [redacted]. At 9:00 AM, the medication was not given on 08/29/22, 09/07/22, 09/09/22, 09/12/22, 09/19/22 and 09/21/22 because the resident was out of the	F 698	threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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F 698	Continued From page 57 facility at [redacted]. There was no documentation to reflect that the MD was notified on the specific dates that [redacted] was not administered. [redacted] before meals. At 7:30 AM, the medication was not given and [redacted] were not performed on 08/29/22, 08/31/22, 09/05/22, 09/07/22, 09/09/22, 09/12/22, 09/14/22, 09/16/22, 09/19/22 and 09/21/22 because the resident was not in the facility and was out at [redacted]. There was no documentation to reflect that the MD was notified on the specific dates that [redacted] was not administered, and [redacted] were not done. [redacted] mg Give one tablet by mouth before meals for [redacted]. At 7:30 AM, the medication was not given on 08/29/22, 08/31/22, 09/05/22, 09/07/22, 09/09/22, 09/12/22, 09/16/22, 09/19/22 and 09/21/22 because the resident was at [redacted] There was no documentation to reflect that the MD was notified on the specific dates that [redacted] was not administered. [redacted] mg give two tablets by mouth three times a day for [redacted]). At 8:00 AM, the medication was not given 08/29/22, 08/31/22, 09/05/22, 09/07/22, 09/09/22, 09/12/22, 09/16/22, 09/19/22 and 09/21/22 because the resident was at [redacted] There was no documentation to reflect that the MD was notified on the specific dates that [redacted] was not administered. [redacted] as per [redacted]: if [redacted]	F 698		

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[redacted] before meals and at bedtime for [redacted]

At 7:30 AM, [redacted] were not done for sliding scale on 08/29/22, 08/31/22, 09/05/22, 09/07/22, 09/09/22, 09/12/22, 09/16/22, 09/19/22 and 09/21/22 because the resident was at [redacted]. There was no documentation to reflect that the MD was notified on the specific dates that [redacted] were not done.

The facility provided an email from the transportation company that transported the resident to and from the [redacted] center and according to the ambulance transportation audit dated 09/22/22 at 10:28 PM, the resident was picked up by the ambulance company on 09/02/22 at 05:23 AM and brought back to the facility at 10:41 AM. According to the MAR dated 09/01/22-09/30/22, the nurse documented that the resident received the following medications; however, was not in the facility at those times.

- The surveyor reviewed the MAR dated 09/02/22, and there was a nurse's signature slotted at 09:00 AM that indicated that [redacted] was [redacted] however, the resident was not in the facility and was at the [redacted] center. The Medication Administration Audit Report (MAAR) reflected that the resident received that 09:00 AM [redacted] at 14:23 (02:23 PM).

-The surveyor reviewed the MAR dated 09/02/22, and there was a nurse's signature slotted at 09:00 AM indicating that [redacted] e Tablet [redacted] MG was administered at 09:00 am; however, the resident was not in the facility at this time and

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was at the [redacted] center. Upon review of the MAAR, it reflected that the nurse gave the [redacted] at 14:19 (02:19 PM).

-The surveyor reviewed the MAR dated 09/02/22, and there was a nurse's signature slotted at 07:30 AM which indicated that [redacted] was administered; however, the resident was not in the facility and was at the [redacted] center. The MAAR reflected that the nurse administered the [redacted] at 14:20 (02:20 PM).

-The surveyor reviewed the MAR dated 09/02/22, and there was a nurse signature slotted at 07:30 AM which indicated that [redacted] mg was given; however, the resident was not in the facility and was at the [redacted] center. The MAAR reflected that the nurse administered [redacted] mg 14:19 (02:19 PM).

-The surveyor reviewed the MAR dated 09/02/22, and there was a nurse signature slotted at 08:00 AM, which indicated that [redacted] Tablet[redacted] MG [redacted] tablets was administered; however, the resident was not in the facility and was at the [redacted] center. The MAAR reflected that the nurse administered the medication at 14:19 (02:19 PM).

-The surveyor reviewed the MAR dated 09/02/22, and there was a nurse signature slotted at 07:30 AM, which indicated that the nurse took the residents [redacted]. The [redacted] documented on the MAR was [redacted] and according to the [redacted] the resident received [redacted] o[redacted] The surveyor reviewed the MAAR which reflected that the 07:30 AM[redacted] was not administered until 14:20 (02:20 PM).

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[redacted] Call MD, [redacted] before meals and at bedtime for [redacted]

According to the ambulance transportation audit dated 09/22/22 at 10:28 PM, the resident was picked up by the ambulance company on 09/05/22 at 05:21 AM and brought back to the facility at 09:59 AM. According to the documentation in the MAR dated 09/01/22-09/30/22 the resident received the following medications; however, was not in the facility at those times.

-The surveyor reviewed the MAR dated 09/05/22, and there was a nurse's signature slotted at 09:00 AM, which indicated that the resident received [redacted] however, the MAAR indicated that the nurse administered the medication outside of the timeframe at 14:01 (02:01 PM).

-The surveyor reviewed the MAR dated 09/05/22, and there was a nurse's signature slotted at 10:00 AM, which indicated that the resident received [redacted] mg; however, the MAAR indicated that the nurse administered the medication outside of the timeframe at 14:01 (02:01 PM).

-The surveyor reviewed the MAR dated 09/05/22, and there was a nurse's signature slotted at 09:00 AM, which indicated that the resident received the

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medication [redacted] mg. The MAAR reflected that the nurse administered the medication outside of the time frame at 11:23 AM.

According to the ambulance transportation audit dated 09/22/22 at 10:28 PM, the resident was picked up by the ambulance company on 09/14/22 at 04:54 AM, and brought back to the facility at 10:23 AM. According to the documentation in the MAR dated 09/01/22-09/30/22 the resident received the following medications; however, was not in the facility at those times.

-The surveyor reviewed the MAR dated 09/14/22, and there was a nurse's signature slotted at 09:00 AM, which indicated that the resident received [redacted] however, the MAAR indicated that the nurse administered the medication outside of the timeframe at 13:13 (01:13 PM).

-The surveyor reviewed the MAR dated 09/14/22, and there was a nurse's signature slotted at 10:00 AM, which indicated that [redacted] mg was administered. The MAAR reflected that the nurse administered medication outside of the timeframe at 13:14 PM (01:14 PM).

-The surveyor reviewed the MAR dated 09/14/22, and there was a nurse's signature slotted at 10:00 AM, which indicated that [redacted] mg was administered. The MAAR reflected that the nurse administered medication outside of the timeframe at 13:23 PM (01:23 PM).

-The surveyor reviewed the MAR dated 09/14/22, and there was a nurse signature slotted at 07:30 AM, which indicated that [redacted] mg was given;

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however, the resident was not in the facility and was at the [redacted] center. The MAAR reflected that the nurse administered [redacted] mg 13:13 (01:13 PM).

-The surveyor reviewed the MAR dated 09/14/22, and there was a nurse signature slotted at 08:00 AM, which indicated that [redacted] Tablet [redacted] MG 2 tablets were administered; however, the resident was not in the facility and was at the [redacted] center. The MAAR reflected that the nurse administered the medication at 13:13 (01:13 PM).

On 09/22/22 at 9:32 AM, the surveyor interviewed Resident #107 with family present. The resident explained to the surveyor that he/she was picked up for [redacted] around 4:30 AM and returned to the facility approximately 11:00 AM on [redacted]. The Resident stated that [redacted] had a [redacted] in his/her [redacted]. Resident #107 could not explain when their medications were given.

On 09/22/22 at 10:10 AM, the surveyor interviewed LPN #2 who had been employed in the facility for 2 years and stated that she was familiar with the [redacted] process. She stated that any resident admitted to the facility on [redacted], transportation was set up for the resident to receive [redacted] at the [redacted] center. She stated that there was a communication book set up and a communication sheet was utilized to facilitate communication between the [redacted] center and the facility. She stated the communication sheet was sent out with the resident to [redacted]. The surveyor asked the LPN what type of [redacted] the resident had for [redacted] and the nurse stated that the resident had an [redacted].

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The surveyor then explained to the nurse that the resident told the surveyor he/she had a [redacted] in the [redacted] that was utilized for [redacted]. The nurse then replied, "Oh yeah, it is in the [redacted], I was wrong, I am sorry." She then stated that there was a doctor's order to monitor the [redacted], "but we do that automatically when the resident returns from [redacted] to make sure there is no [redacted] We usually check off on the Treatment Administration Record (TAR) that we are monitoring the resident [redacted]." The surveyor reviewed the physician orders and TAR in the presence of LPN #1, and she stated, "We should have had an order to monitor Resident # 107's [redacted]. I was not aware she did not have an order to monitor the site. I do not remember signing the TAR that the residents [redacted] was being monitored."

LPN #2 also stated that she worked on [redacted] and cared for Resident #107. When LPN#2 reviewed the MAR with the surveyor, she stated that she must have made a mistake and did not mean to sign the MAR that she administered the resident's medications when the resident was out to [redacted]. The surveyor questioned LPN #2 on how she was able to obtain a [redacted] for Resident #107 and administer [redacted] using the [redacted] when the resident was not present in the facility and LPN #2 could not explain to the surveyor how she documented a [redacted] and gave [redacted] to the resident when the resident was not in the facility. She stated that it must have been a mistake.

On 09/22/22 at 10:43 AM, the surveyor interviewed the Registered Nurse Assistant

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Director of Nursing Unit Manager for the [redacted] RN/ADON/UM. The surveyor asked the RN/ADON/UM regarding the facility process for dialysis and she stated the following: Set up transportation, obtain physician orders for [redacted] center confirmation, contact names, [redacted], and nurse manager at center. She stated that you would also confirm pick up times and chair times and confirm days. She explained that physician orders were required to monitor the access site for signs and symptoms (S/S) of [redacted]. She further added that the nurse was required to sign out a signature in the TAR that the [redacted] was being monitored every shift before and after [redacted] She stated that resident would take a communication sheet to and from [redacted]. She explained that the receiving facility fills out a section and the nursing home fills out the assessment section on the communication sheet before and after [redacted]. The nurse receiving the resident back to the facility should have documented in the progress note that the resident returned and the condition upon return. It would be important to completely fill out the communication sheet for that the resident returning from [redacted] to assure that resident was in stable condition and there were no complications. She stated that medications should not be slotted out to be given at a time that the resident was at [redacted]. She further added that it would be important to assure that a resident was receiving all of the medications the MD ordered so that there was not a delay in care or a decline in the resident health. "It all has a trickling effect." She confirmed that there were issues regarding Resident #107's medications being slotted at a time that the resident was at dialysis and that the nurses should have notified

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the MD to get the medication times changed and that the resident did not receive medications when he/she was at [redacted]. She also confirmed that the nurses should have completed a Care Plan (CP) at the time [redacted] started. She stated that a CP was be important to meet the goals and interventions, and served a communication of care between disciplines.

On 09/22/22 at 11:35 AM, the surveyor interviewed the LPN #3 who stated that she was a "float" nurse and was not assigned to a specific unit. She reviewed the MAR with the surveyor and stated that her signature on the MAR on [redacted] reflected that she cared for Resident #107 that day. She stated that she did administer medication to Resident #107 because she documented as such on the MAR. LPN #3 stated that she documented on the MAR that medications were not administered because the resident was out to [redacted]s. She revealed that she did not give the resident [redacted] and [redacted]. She admitted that she did not call the MD to inform the doctor that the resident did not receive the [redacted] or any other medication that she did not administer. The LPN stated that she did not receive any education or competencies on what do when a scheduled medication was to be given when a resident was out to [redacted]. The LPN stated that it would have been important to call the MD about the medication times to make sure the resident got his/her medications. She also added that when a resident did not get their medication according to physician's orders that the resident could have health complications.

The surveyor reviewed the facility form titled "Dialysis Communication Record" dated

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[redacted] and the facility did not completely fill out the [redacted] section to include any changes in the resident condition post dialysis, Vital signs, [redacted] or nurses' signature that received the resident from the [redacted] center.

On 09/22/22 at 12:28 PM, the surveyor interviewed the Director of Nursing (DON) who stated that before a resident was admitted to the facility, information regarding [redacted] was obtained prior to admission. The facility received information as to which [redacted] center the resident was scheduled to receive [redacted] scheduled times and dates the resident would receive [redacted] and who would be transporting the resident to and from [redacted]. The DON stated that once the resident was admitted to the unit the nurse would put physicians' orders in the electronic medical record where the resident would receive [redacted] what time the resident would receive [redacted], where the [redacted] was, what type of [redacted] it was and how often the [redacted] would be monitored. She added that the "normal practice" for scheduling medication would be to schedule the medication time so that it did not interfere with the resident's [redacted] schedule. She stated that it would be important for residents to get their medications to maintain their health and well-being. She further added that if a nurse observed that a medication time was scheduled when a resident was at [redacted], then the nurse should call the physician and adjust the medication time. She stated that if the resident was on the medication insulin, then the physician should have been notified right away so that the resident's [redacted] could have been administered. The DON stated that nurses should not have signed the Medication

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Administration Record (MAR) that the resident received medications when the resident did not receive them because the resident was not in the facility. If a medication was not given, then the reason would need to be documented in the MAR.
The DON further stated that the [redacted] communication sheet is a form used to communicate treatments that were rendered at the [redacted] center or any recommendation from the [redacted]. She stated that it was important that the receiving nurse in the facility fill out the section of the communication form regarding the condition of the resident's [redacted], vital signs or if the resident had any [redacted] after the resident returned from [redacted] because you would want to document that the resident was stable or an any issues after returning from [redacted]. She stated that a CP should have been formulated and developed with interventions and goals as the CP drives the resident care and provided information about how to manage the resident's [redacted].

On 09/27/22 at 09:25 AM, the surveyor conducted a telephone interview with the Pharmacy Consultant (PC) for the facility since [redacted]. She stated that her job responsibilities included resident chart review, unit medication storage inspection, medication pass, in-services, and quarterly meeting (QAPI-Quality Assurance and Performance Improvement). She stated that she performed chart review, reviewed labs, checked timing of the medications, interactions, contraindications, allergies, reviewed admissions, new consults, medication changes and nursing and physician recommendations. The PC stated that if she had any recommendation for the facility that the recommendations were sent via email to the DON and some of the Corporation nurses.

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She stated that when she reviewed residents' charts that were on [redacted], she would review medications and make sure medications were administered according to the [redacted] schedule. She stated that it was important to make sure a resident got their medication correctly so that they were not getting their medication too closely together. She stated that medications should be scheduled for [redacted] days and [redacted] days. She added that the medication schedule should accommodate [redacted] because you do not want to administer medications out of the window (timeframe that a medication could be administered), or if medications must be held. The MD needs to be made aware so that the medications could be scheduled correctly. She stated that if a dose of medication was missed because the resident was out to [redacted] then the physician needed to be notified to find out what time the medication could be given. She further added that the nurse needed to document and make the physician aware and should not attempted to use their own judgement whether to give medications or not. She stated that when the nurse noticed that the residents' medications were scheduled during the time the resident was out to dialysis, they should have called MD and got the medication times adjusted according to [redacted] schedule.

The surveyor reviewed the Consultant Pharmacist's Monthly Report dated [redacted] which indicated that the PC reviewed Resident #107's medications and there were no recommendations that the Resident's medication times were not scheduled to accommodate [redacted] schedule or that medications were not administered to the resident when the resident was out to [redacted].

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On 09/28/22 at 10:19 AM, the surveyor conducted a telephone interview with the PC who explained to the surveyor that she was not sure why she did not make any recommendations to adjust Resident #107's medication times according to [redacted] schedule and would have to review this and get back to the surveyor with the information.

On 09/28/22 at 11:42 AM, the surveyor interviewed Registered Nurse (RN) who was employed for the facility since [redacted]. The RN stated that she worked on [redacted] and documented on the MAR that she administered [redacted] to Resident # 107 at 9:00 AM. She stated, "I gave the resident the [redacted] because [redacted] came back around 10 am and it was in the scheduled timeframe to give it." She stated that she signed the medication out at 14:01 because she did not have time to sign the medication out at the time that she gave it. She stated that she knows that she is supposed to sign the medication out right after she administered it but did not because she was busy and was always interrupted and does not always get time. The RN also admitted to administering the [redacted] out of the timeframe on 09/14/22 at 9:00 AM but was not sure why. "I am not sure why I did not get the medication times adjusted according to the resident's [redacted] days or call the doctor."

On 09/29/22 at 10:14 AM, the surveyor interviewed the PC who admitted that she failed to identify that the resident's medication times were not adjusted according to the resident's [redacted] time. She stated that the nursing department should have adjusted the times according to the [redacted] center and that she

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VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

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should have identified this medication discrepancy during her monthly review on 09/15/22. She stated that she would further review the residents medical record and that the resident did not experience any untoward effects and that the resident recent [redacted]).

The facility policy titled, [redacted] Policy" dated 01/22, indicated that it was the policy of the facility to ensure that residents who require [redacted] receive such services consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences. Upon admission, the nurse will ensure that the following information was located in the resident's medical record: type and location of [redacted] device, must ensure that medications and treatments were timed according to the residents' [redacted] schedule, monitor patency of [redacted], monitor for complications related to [redacted], and [redacted] communication form will be sent with the resident to [redacted] and upon return from dialysis the charge nurse will review and take note of any recommendations.

The facility policy titled, "Reviewing and Revising Care Plan" dated 11/2019, indicated that the purpose of this procedure was to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. The policy indicated that a person-centered comprehensive care plan will be developed with the facility policy and procedures and will be developed within 7 days after completion of comprehensive assessment, prepared by the interdisciplinary team.

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F 698	Continued From page 71 The facility policy titled, "Medication Administration" dated 11/2020, indicated that medications were to be administered by licensed nurses or other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards in a manner to prevent contamination or infection.	F 698		
F 755 SS=E	NJAC 8:39 - 27.1 (a,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		11/11/22

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F 755	Continued From page 72 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 interview, record review, and review of other facility documentation, it was determined that the facility failed to follow professional standards of nursing practice by not clarifying medication orders in timely manner for 1 of 4 residents (Resident #127) reviewed for [redacted]. This deficient practice was evidenced by the following: On 09/19/22 at 12:18 PM, the surveyor observed Resident #127 in bed with the head of bed elevated. The resident had no facial grimacing and showed no signs or symptoms of distress or discomfort. According to the Admission Record, Resident #127 was admitted with diagnoses which included but were not limited to [redacted] Review of Resident #127's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], indicated the resident had a [redacted] and that the resident received [redacted] or more	F 755	1.Resident #127 was assessed by Assistant Director of Nursing on 9/29/22. No negative outcome observed. MD notification on 9/29/2022 by Assistant Director of Nursing. Resident #127 medication administration record was revised to show [redacted] as route of medication administration by Assistant Director of Nursing on 9/29/2022. All licensed nurses caring for resident #127 were educated by Director of Nursing on 9/29/2022 and medication error investigation was initiated, and physician was made aware. On 9/29/2022 the Director of Nursing in-serviced all licensed nurses on the route of administration and clarifying any order discrepancy with physician before administering. Facility wide audit was initiated on all residents with [redacted] by Assistant Director of Nursing on 9/29/2022. 2. All Residents receiving medications via g-tube have the potential to be affected	

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F 755	Continued From page 73 of [redacted]. The MDS further indicated that the average [redacted] was [redacted], or more was received by [redacted]. Review of Resident #127's Care Plan (CP) included a focus, dated [redacted] that the resident required [redacted] status. Review of Resident #127's "Speech Therapy (ST) SLP Evaluation and Plan of Treatment," dated [redacted], indicated the resident was "NPO with all means of [redacted] and was admitted to this facility [redacted]." ST recommendations included to continue [redacted] status and for medications to be administered via the resident's [redacted] Review of Resident [redacted] "Order Summary Report" revealed the following physician orders (order): 1. 08/27/22 order of "[redacted] texture." 2. 08/29/22 order for [redacted] milligrams (mg), one tablet by mouth daily. 3. 08/29/22 order for [redacted] mg, one tablet by mouth daily. 4. 09/09/22 order for [redacted]) [redacted] mg, one capsule by mouth two times a day. 5. 08/27/22 order for [redacted] mg, one tablet by mouth every 8 hours. 6. 08/29/22 order for [redacted], one tablet by mouth daily. Review of Resident #127's [redacted] and [redacted] Medication Administration Record (MAR) indicated that the resident	F 755	3. Director of Nursing and/or designee will audit all new admissions/readmissions with [redacted] daily to ensure all medications are ordered and transcribed correctly in EMAR Assistant Director of Nursing and/or designee will continue routes of medication administration education with emphasis on [redacted] patients for nursing staff upon hire, annually and as needed. 4. The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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received the following medications by mouth on the following days:

1. [redacted] was administered by mouth on 08/30/22, 08/31/22, 09/01/22, 09/02/22, 09/03/22, 09/04/22, 09/05/22, 09/06/22, 09/07/22, 09/08/22, 09/09/22, 09/10/22, 09/11/22, 09/12/22, 09/13/22, 09/14/22, 09/15/22, 09/16/22, 09/17/22, 09/18/22 and 09/19/22.

2. [redacted] mg was administered by mouth on 08/30/22, 08/31/22, 09/01/22, 09/02/22, 09/03/22, 09/04/22, 09/05/22, 09/06/22, 09/07/22, 09/08/22, 09/09/22, 09/10/22, 09/11/22, 09/12/22, 09/13/22, 09/14/22, 09/15/22, 09/16/22, 09/17/22, 09/18/22 and 09/19/22.

3. [redacted] mg was administered by mouth on 09/09/22, 09/10/22, 09/11/22, 09/12/22, 09/13/22, 09/14/22, 09/15/22, 09/16/22, 09/17/22, 09/18/22 and 09/19/22.

4. [redacted] mg was administered by mouth on 08/27/22, 08/28/22, 08/29/22, 08/30/22, 08/31/22, 09/01/22, 09/02/22, 09/03/22, 09/04/22, 09/05/22, 09/06/22, 09/07/22, 09/08/22, 09/09/22, 09/10/22, 09/11/22, 09/12/22, 09/13/22, 09/14/22, 09/15/22, 09/16/22, 09/17/22, 09/18/22 and 09/19/22.

5. [redacted] tablet was administered by mouth on 08/30/22, 08/31/22, 09/01/22, 09/02/22, 09/03/22, 09/04/22, 09/05/22, 09/06/22, 09/07/22, 09/08/22, 09/09/22, 09/10/22, 09/11/22, 09/12/22, 09/13/22, 09/14/22, 09/15/22, 09/16/22, 09/17/22, 09/18/22 and 09/19/22.

During an interview with the surveyor on 09/29/22 at 10:35 AM, the Licensed Practical Nurse (LPN)

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#2 stated that a check on the MAR indicated the medication was administered. LPN #2 added that she would hold the medication and call the physician to clarify the resident's [redacted] status if she was not sure of what route to administer the medication.

During an interview with the surveyor on 09/29/22 at 10:51 AM, LPN #1 stated that a check on the MAR indicated the medication was administered. LPN #1 further stated that she checked for the right resident, right medication, and right route when administering medications to residents. LPN #1 added she would hold the medication and call the physician to clarify the resident's [redacted] status if she was not sure of what route to administer the medication.

During an interview with the surveyor on 09/29/22 at 10:59 AM, the Registered Nurse/Charge Nurse (RNCN) stated the check on the MAR indicated the medication was administered. The RNCN further stated that nurses were to clarify medication orders with the physician if unsure of the resident's [redacted] status.

During an interview with the surveyor on 09/29/22 at 12:19 PM, the Director of Nursing (DON) stated the check on the MAR indicated the medication was administered and that nurses were to clarify medication orders with the physician if unsure of the resident's [redacted] status.

Review of Resident #127's "Progress Notes" from 08/26/22 to 09/19/22 reveal no documentation that nursing clarified the resident's "by mouth" medication orders with the physician.

Review of the facility's "Medication

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F 755	Continued From page 76 Administration" policy, revised on 11/2020, indicated to compare medication source with MAR to verify resident name, medication name, form, dose, route and time.	F 755		
F 756 SS=D	NJAC 8:39-11.2(b) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in	F 756		11/11/22

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F 756	Continued From page 77 the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to a) identify that medications were not scheduled to accommodate a resident's [redacted] schedule during the monthly CP medication review and b.) act on or respond to recommendations made by the Consultant Pharmacist (CP) in a timely manner . This deficient practice was identified for 2 of 6 residents reviewed for medication regimen review (MRR) (Residents #107 and #583) and was evidenced by the following: 1.) On 09/16/22 at 10:25 AM during initial facility tour, Resident #107 was not in the room. The surveyor interviewed the Licensed Practical Nurse (LPN #2) who was outside in the hallway and indicated that she was providing care for Resident #107 today who was out to [redacted] The surveyor was unable to interview the resident currently. The LPN #2 stated that the resident goes out to dialysis on [redacted], and [redacted] from approximately 5:00 AM and returned to the facility at approximately 10:00 AM or 11:00 AM in the morning. The LPN #2 further stated that the resident had an [redacted]) in the [redacted]	F 756	Resident #107 was assessed by Assistant Director of Nursing on 9/22/22. No negative outcome observed. MD notification on 9/22/2022 by Assistant Director of Nursing. Resident 107□s medication administration times were changed to reflect [redacted] schedule date revised and Assistant Director of Nursing. Resident # 583 assessed by Assistant Director of Nursing on 9/22/22. No negative outcome observed. MD notification on 9/22/2022 by Assistant Director of Nursing. Resident #583□s pharmacy consultant recommendation was reviewed/updated with new physician orders on 9/22/2022 by Assistant Director of Nursing. Director of Nursing re-educated all licensed nurses on 9/22/2022 on medication administration as it pertains to resident□s [redacted] schedule. Director of Nursing in-serviced all licensed	

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F 756	Continued From page 78 arm. The Admission Record reflected that Resident #107 was admitted to the facility with diagnoses which included, but were not limited to, [redacted] The admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], indicated that Resident #107 had [redacted] and required extensive care of two staff members for transfers and extensive care of one staff member for washing, dressing, toilet use and personal hygiene. The MDS did not reflect that the resident received [redacted] The surveyor reviewed the "Order Summary Report (OSR)" which reflected active physician orders as of [redacted] -According to OSR, dated [redacted] the resident received [redacted], [redacted] at 10:30 am. -According to the OSR, dated [redacted], there was an order written for [redacted] Location: (indicate site/location) Schedule: [redacted] At 5am There was no specification as to what the [redacted] was, where it was or when it was to be monitored The surveyor reviewed the Medication Administration Records (MAR) dated [redacted] and [redacted] which revealed the following medications were plotted on the electronic medical record (EMR).	F 756	nurses on completing the Pharmacy Consultant recommendations within 24 hours of receiving on 9/22/2022 2. All residents have the potential to be affected. 3. Director of Nursing and/or designee will audit the new admission/readmissions pharmacy consultant recommendations (EPIC) daily to confirm completion within 24 hours and monthly for medication regimen review within 24 hours and document findings/discrepancies Immediate re-education will be initiated by Director of Nursing and/or designee if found to be out of compliance with 24-hour completion. Assistant Director of Nursing and/or designee will incorporate education on Pharmacy consultant reviews for nursing staff upon hire, annually and as needed. 4. The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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[redacted] one time a day for [redacted] at 9:00 AM, and was not given on 08/26/22, 08/29/22, 09/07/22, 09/09/22, 09/12/22, 09/19/22 and 9/21/22 because the resident was out at [redacted]. There was no documentation that the physician (MD) was notified on the specific dates that the [redacted] was not administered.

[redacted] capsule [redacted] mg give 1 capsule by mouth two times a day for [redacted]. At 10:00 AM, the medication was not given on 08/29/22, 09/07/22, 09/09/22, 09/12/22 and 09/21/22 because the resident was out of the facility at [redacted]. There was no documentation to reflect that the MD was notified on the specific date that the [redacted] was not administered.

[redacted] give 1 tablet by mouth two times a day for [redacted]. At 10:00 AM, the medication was not given on 08/29/22, 09/07/22, 09/09/22, and 09/12/22 because the resident was out of the facility at [redacted] There was no documentation to reflect that the MD was notified on the specific dates that the [redacted] was not administered.

[redacted] mg give every [redacted] hours by mouth. At 9:00 AM, the medication was not given on 08/29/22, 09/07/22, 09/09/22, 09/12/22, 09/19/22 and 09/21/22 because the resident was out of the facility at [redacted] There was no documentation to reflect that the MD was notified on the specific dates that [redacted] was not administered.

[redacted]

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F 756	Continued From page 80 [redacted] before meals. At 7:30 AM, the medication was not given and [redacted] were not performed on 08/29/22, 08/31/22, 09/05/22, 09/07/22, 09/09/22, 09/12/22, 09/14/22, 09/16/22, 09/19/22 and 09/21/22 because the resident was not in the facility and was out at [redacted] There was no documentation to reflect that the MD was notified on the specific dates that [redacted] was not administered, and [redacted] were not done. -[redacted] mg Give 1 tablet by mouth before meals for [redacted]. At 7:30 AM, the medication was not given on 08/29/22, 08/31/22, 09/05/22, 09/07/22, 09/09/22, 09/12/22, 09/16/22, 09/19/22 and 09/21/22 because the resident was at [redacted]. There was no documentation to reflect that the MD was notified on the specific dates that [redacted] was not administered. [redacted] mg give 2 tablets by mouth 3 times a day for [redacted]. At 8:00 AM, the medication was not given 08/29/22, 08/31/22, 09/05/22, 09/07/22, 09/09/22, 09/12/22, 09/16/22, 09/19/22 and 09/21/22 because the resident was at [redacted] There was no documentation to reflect that the MD was notified on the specific dates that [redacted] was not administered. -[redacted] Call MD, [redacted] before meals and at bedtime for [redacted]. At 7:30 AM, [redacted] were not done for [redacted] on 08/29/22,	F 756		

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F 756	Continued From page 81 08/31/22, 09/05/22, 09/07/22, 09/09/22, 09/12/22, 09/16/22, 09/19/22 and 09/21/22 because the resident was at [redacted]. There was no documentation to reflect that the MD was notified on the specific dates that [redacted] were not done. The facility provided an email from the transportation company that transported the resident to and from the [redacted] and according to the ambulance transportation audit dated 09/22/22 at 10:28 PM, the resident was picked up by ambulance company at on 09/02/22 at 05:23 AM and brought back to the facility at 10:41 AM. According to the MAR dated 09/01/22-09/30/22 the nurse documented that the resident received the following medications but was not in the facility at those times. - The surveyor reviewed the MAR dated 09/02/22, and there was a nurse's signature slotted at 09:00 AM that indicated that [redacted] was [redacted] when the resident was at [redacted] at that time. The Medication Administration Audit Report (MAAR) reflected that the resident received that 09:00 AM [redacted] at 14:23 (02:23 PM). -The surveyor reviewed the MAR dated 09/02/22, and there was a nurse's signature slotted at 09:00 AM indicating that [redacted] Tablet [redacted] MG was administered at 09:00 AM when the resident was not in the facility at this time and was at [redacted]. Upon review of the MAAR, it reflected that the nurse gave the [redacted] at 14:19 (02:19 PM). -The surveyor reviewed the MAR dated 09/02/22,	F 756		

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and there was a nurse's signature slotted at 07:30 AM which indicated that [redacted] was administered when the resident was not in the facility and was at [redacted]. The MAAR reflected that the nurse administered the [redacted] at 14:20 (02:20 PM).

-The surveyor reviewed the MAR dated 09/02/22, and there was a nurse signature slotted at 07:30 AM which indicated that [redacted] mg was given when the resident was not in the facility and was at the [redacted] center. The MAAR reflected that the nurse administered [redacted] mg 14:19 (02:19 PM).

-The surveyor reviewed the MAR dated 09/02/22, and there was a nurse signature slotted at 08:00 AM, which indicated that [redacted] Tablet[redacted] MG two tablets were administered when the resident was not in the facility and was at the [redacted] center. The MAAR reflected that the nurse administered the medication at 14:19 (02:19 PM).

-The surveyor reviewed the MAR dated 09/02/22, and there was a nurse signature slotted at 07:30 AM, which indicated that the nurse took the resident's [redacted]. The [redacted] documented on the MAR was [redacted] and according to the [redacted] the resident received [redacted] o[redacted] The surveyor reviewed the MAAR which reflected that the 07:30 AM [redacted] was not administered until 14:20 (02:20 PM).
[redacted].

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F 756	Continued From page 83 [redacted] Call MD, [redacted] before meals and at bedtime for [redacted] According to the ambulance transportation audit dated 09/22/22 at 10:28 PM, the resident was picked up by ambulance company on 09/05/22 at 05:21 AM and brought back to the facility at 09:59 AM. According to the documentation in the MAR dated 09/01/22-09/30/22 the resident received the following medications when the resident was not in the facility at those times. -The surveyor reviewed the MAR dated 09/05/22, and there was a nurse's signature slotted at 09:00 AM, which indicated that the resident received [redacted]. The MAAR indicated that the nurse administered the medication outside of the timeframe at 14:01 (02:01 PM). -The surveyor reviewed the MAR dated 09/05/22, and there was a nurse's signature slotted at 10:00 AM, which indicated that the resident received [redacted] mg. The MAAR indicated that the nurse administered the medication outside of the timeframe at 14:01 (02:01 PM). -The surveyor reviewed the MAR dated 09/05/22, and there was a nurse's signature slotted at 09:00 AM, which indicated that the resident received the medication [redacted] mg. The MAAR reflected that the nurse administered the medication outside of the time frame at 11:23 AM. According to the ambulance transportation audit dated 09/22/22 at 10:28 PM, the resident was picked up by ambulance company at on 09/14/22	F 756		

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at 04:54 AM, and brought back to the facility at 10:23 AM. According to the documentation in the MAR dated [redacted] the resident received the following medications when the resident was not in the facility at those times.

-The surveyor reviewed the MAR dated 09/14/22, and there was a nurse's signature slotted at 09:00 AM, which indicated that the resident received [redacted]. The MAAR indicated that the nurse administered the medication outside of the timeframe at 13:13 (01:13 PM).

-The surveyor reviewed the MAR dated 09/14/22, and there was a nurse's signature slotted at 10:00 AM, which indicated that [redacted] mg was administered. The MAAR reflected that the nurse administered the medication outside of the timeframe at 13:14 PM (01:14 PM).

-The surveyor reviewed the MAR dated 09/14/22, and there was a nurse's signature slotted at 10:00 AM, which indicated that [redacted] mg was administered. The MAAR reflected that the nurse administered medication outside of the timeframe at 13:23 PM (01:23 PM).

-The surveyor reviewed the MAR dated 09/14/22, and there was a nurse signature slotted at 07:30 AM, which indicated that [redacted] mg was given when he resident was not in the facility and was at the [redacted] center. The MAAR reflected that the nurse administered [redacted] mg 13:13 (01:13 PM).

-The surveyor reviewed the MAR dated 09/14/22, and there was a nurse's signature slotted at 08:00 AM, which indicated that [redacted]

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Tablet[redacted] MG two tablets were administered when the resident was not in the facility and was at the [redacted] center. The MAAR reflected that the nurse administered the medication at 13:13 (01:13 PM).

On 09/22/22 at 9:32 AM, the surveyor interviewed Resident #107 with family present. The resident explained to the surveyor that he/she was picked up for [redacted] around 4:30 AM and returned to the facility approximately 11:00 AM on [redacted]. The Resident stated that he/she had a [redacted] in his/her [redacted]. Resident #107 could not explain when their medications were given.

On 09/22/22 at 10:10 AM, the surveyor interviewed LPN #2 who has been employed in the facility for[redacted] years and stated she was familiar with the [redacted] process. She stated that any resident admitted to the facility on [redacted] transportation was set up for the resident to receive [redacted] at the [redacted] center. She stated that there was a communication book set up and a communication sheet was utilized to facilitate communication between the [redacted] center and the facility. She stated the communication sheet was sent out with the resident to [redacted]. The surveyor asked the LPN what type of [redacted] the resident had for [redacted] and the nurse stated that the resident had an [redacted] in the [redacted]. The surveyor then explained to the nurse that the resident told the surveyor he/she had a [redacted] in the [redacted] that was utilized for [redacted] The nurse then replied, "Oh yeah, it is in the [redacted], I was wrong, I am sorry." She then stated that there was a doctor's order to monitor the [redacted], "but we do that automatically when the resident returns from

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dialysis to make sure there is no[redacted]". We usually check off on the Treatment Administration Record (TAR) that we are monitoring the resident [redacted] The surveyor reviewed the physician orders and TAR in the presence of LPN #1, and she stated, "We should have had an order to monitor Resident # 107's[redacted]. I was not aware the resident did not have an order to monitor the[redacted] I do not remember signing the TAR that the resident's[redacted] was being monitored."

LPN #2 also stated that she worked on [redacted] and cared for Resident #107. When LPN #2 reviewed the MAR with the surveyor, she stated that she must have made a mistake and did not mean to sign the MAR that she administered the resident's medications when the resident was out to[redacted] The surveyor questioned LPN #2 on how she was able to obtain a[redacted] for Resident #107 and administer[redacted] using the[redacted] when the resident was not present in the facility and LPN #2 could not explain to the surveyor how she documented a[redacted] and gave[redacted] to the resident when the resident was not in the facility. She stated that it must have been a mistake.

On 09/22/22 at 10:43 AM, the surveyor interviewed the Registered Nurse/Assistant Director of Nursing/Unit Manager (RN/ADON/UM) for the[redacted] RN/ADON/UM. She stated that medications should not be slotted out to be given at a time that the resident was at[redacted]s. She further added that it would be important to assure that a resident was receiving all the medications the MD ordered so that there was not a delay in care or a decline in the resident health. "It all has

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a trickling effect." She confirmed that there were issues regarding Resident #107's medications being slotted at a time that the resident was at [redacted] and that the nurses should have notified the MD to get the medication times changes and that the resident did not receive medications when he/she was at [redacted]

On 09/22/22 at 11:35 AM, the surveyor interviewed the LPN #3 who stated that she was a "float" nurse and was not assigned to a specific unit. She reviewed the MAR with the surveyor and stated that her signature on the MAR on 09/19/22 reflected that she cared for Resident #107 that day. She stated that she did administer medication to Resident #107 because she documented as such on the MAR. LPN #3 stated that she documented on the MAR that medications were not administered because the resident was out to [redacted]. She revealed that she did not give the resident [redacted] and [redacted]. She admitted that she did not call the MD that the resident did not receive the [redacted] or any other medication that she did not administer. The LPN stated that she did not receive any education or competencies on what do when a scheduled medication was to be given when a resident was out to [redacted]. The LPN stated that it would have been important to call the MD about the medication times to make sure the resident got his/her medications. She also added that when a resident did not get their medication according to physician's orders that the resident could have health complications.

On 09/27/22 at 09:25 AM, the surveyor conducted a telephone interview with the Pharmacy Consultant (PC) for the facility since [redacted]. She

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stated that her job responsibilities included resident chart review, unit medication storage inspection, medication pass, in-services, and quarterly meeting (QAPI-Quality Assurance and Performance Improvement). She stated that she performed chart review, reviewed labs, checked timing of the medications, interactions, contraindications, allergies, reviewed admissions, new consults, medication changes and nursing and physician recommendations. The PC stated that if she had any recommendation for the facility that the recommendations were sent via email to the DON and some of the Corporation nurses. She stated that when she reviewed residents' charts that were on [redacted], she would review medications and make sure medications were administered according to the [redacted] schedule. She stated that it was important to make sure a resident got their medication correctly so that they were not getting their medication too closely together. She stated that medications should be scheduled for [redacted] days and [redacted] days. She added that the medication schedule should accommodate [redacted] because you do not want to administer medications out of the window (timeframe that a medication could be administered), or if medications must be held. The MD needs to be made aware so that the medications could be scheduled correctly. She stated that if a dose of medication was missed because the resident was out to [redacted] then the physician needed to be notified to find out what time the medication could be given. She further added that the nurse needed to document and make the physician aware and should not attempt to use their own judgement whether to give medications or not. She stated that when the nurse noticed that the residents' medications were scheduled during the time the resident was

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out to [redacted], they should have called the MD and got the medication times adjusted according to the [redacted] schedule.

The surveyor reviewed the Consultant Pharmacist's Monthly Report (CPMR) dated [redacted] which indicated that the PC reviewed Resident #107's medications and there were no recommendations that the resident's medication times were not scheduled to accommodate the [redacted] schedule or that medications were not administered to the resident when the resident was out to [redacted]

On 09/28/22 at 10:19 AM, the surveyor telephone interviewed the PC who explained to the surveyor that she was not sure why she did not make any recommendations to adjust Resident #107's medication times according to the [redacted] schedule and would have to review this and get back to the surveyor with the information.

On 09/28/22 at 11:42 AM, the surveyor interviewed Registered Nurse (RN) who was employed for the facility since [redacted] The RN stated that she worked on [redacted] and documented on the MAR that she administered [redacted] to Resident #107 at 9:00 AM. "I gave the resident the [redacted] because [redacted] came back around 10:00 AM and it was in the scheduled timeframe to give it." She stated that she signed the medication out at 14:01 because she did not have time to sign the medication out at the time that she gave it. She stated that she knows that she is supposed to sign the medication out right after she administered it but did not because she was busy and is always interrupted and doesn't always get time. The RN also admitted to administering the [redacted] out of

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the timeframe on 09/14/22 at 9:00 AM but was not sure why. "I'm not sure why I did not get the medication times adjusted according to the resident's [redacted] days or call the doctor."

On 09/29/22 at 10:14 AM, the surveyor interviewed the PC who admitted that she failed to identify that the resident's medication times were not adjusted according to the resident's [redacted] time. She stated that the nursing department should have adjusted the times according to the [redacted] center and that she should have identified this medication discrepancy during her monthly review on [redacted]. She stated that she would investigate this and that when further reviewed the residents medical record and that the resident did not experience any untoward effects and that the resident recent [redacted]) was [redacted].

The form titled "Consultant Pharmacist Responsibilities" and dated [redacted] indicated that the Pharmacy Consultant was responsible to perform monthly reviews of the drug regimen of each resident with reports of any irregularities, ongoing assessment of all areas of pharmaceutical services and staff performance with recommendations and plans for implementation.

2.) According to the Electronic Pharmacist Information Consultant (EPIC) report dated [redacted], the CP made three (3) recommendations for Resident #583 as follows:

a. [redacted] (a medication used by men to treat the

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symptoms of an [redacted]) should be administered 30 minutes after a meal. Swallow the capsules whole with a drink of water; do not crush, open or chew.

b. [redacted] must be swallowed whole. Do not crush, chew or open. If this medication cannot be changed, please obtain a physician's order of "may open capsule".

c. Resident is taking [redacted] and requires it to be administered [redacted]. Since [redacted] is not recommended to be given this way, consider having the order changed to an alternative [redacted] medication, such as [redacted] which can be opened or given [redacted].

A further review of the EPIC report reflected the nursing signature, and the date and time was left blank.

According to the Consultant Pharmacist Evaluation report dated [redacted], the Pharmacy Consultant (PC) noted the same [redacted] recommendation from the EPIC report dated [redacted] for Resident #583, which revealed the recommendation was still not addressed.

A review of the [redacted] OSR reflected [redacted] capsule [redacted] mg ([redacted] [generic name for [redacted]]) Give one (1) capsule via [redacted] in the evening for [redacted].

A review of the [redacted] MAR revealed the nurses administered the daily [redacted]

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A review of the Physician's Orders sheet reflected that the PC's [redacted] recommendation was not addressed during the 24-hour chart check.

On 09/23/22 at 10:10 AM, the Assistant Director of Nursing (ADON) stated the nursing staff was responsible for following up with the PC's recommendations once it was received. The ADON further explained the staff nurse and/or supervisor would follow up with the PC's recommendations and notified the primary care physician (PCP); and once the staff reviewed the recommendations, then they would make comments on it, then sign and date it to acknowledge the PC's recommendations were reviewed. The ADON stated to ensure that the recommendations were followed up, the night shift (11:00 PM to 7:00 AM) nurse conducted the 24-hour chart check. She further stated the 24-hour chart check ensured orders and recommendations were completed.

On 09/23/22 at 11:38 AM, the Director of Nursing (DON), provided the PC's monthly report for [redacted] for the third floor. The DON stated that the ADON was still working on the PC's recommendations for [redacted] and would provide it later.

On 09/27/22 at 8:43 AM, the DON stated once the staff nurse received the PC's recommendation, they were to review it. She further stated that once the PC completed her monthly MRR, a few days later, the PC would send her final report via email. The DON stated within a few days of receiving the final report, the nurses should follow up with the recommendations from the PC to the PCP.

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VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

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F 756	Continued From page 93 A review of the [redacted] CPMR dated [redacted] with a printed date [redacted] revealed the following: - Resident is taking [redacted] and requires it to administered [redacted] Since [redacted] is not recommended to the given this way, consider having the order changed to an alternative [redacted] medication, such as [redacted], such can be opened or given [redacted]. Action Taken: [redacted] inserted. A further review of the MAR reflected after surveyor inquiry regarding the missed PC's recommendations from [redacted] and [redacted], the [redacted] medication was discontinued. On 09/27/22 at 9:24 AM, the surveyor interviewed the PC via telephone in the presence of the survey team. The PC stated her role included reviewing resident's charts for labs, the timing of medications, interactions, and contraindication between medications, conduct unit inspections, medication administration pass and in-service the nurses. The PC stated the EPIC report was done within 24 to 48 hours of admission and then reviewed again either by herself or the EPIC department if she does the admission review. The PC further stated the nurses should follow up with the PCP and sign the EPIC report to acknowledge the recommendations were reviewed and then place the form in the resident's chart. The surveyor continued to interview the PC regarding what the process was if any recommendations were not addressed? She stated if a recommendation were not addressed, she would have brought it to the nurse's attention	F 756		

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F 756	Continued From page 94	F 756		

to follow up and then placed it on the monthly report again. She further stated her monthly reports were emailed to the DON and ADON, but the EPIC reports were sent via fax. The PC explained her recommendation was to get a PCP order for an alternative [redacted] medication or get an order that stated, "may open capsule". The PC emphasized they always followed the recommendations according to the manufacturer's guidelines which for [redacted] was "not to open or crush" it.

During a follow up interview with the surveyor on 09/28/22 at 9:24 AM, the ADON stated once the nursing staff received any PC recommendations, they should inform the PCP that day. Then once it was reviewed, the nurse should have signed and dated the form. The surveyor and ADON reviewed the EPIC report dated [redacted] together and the ADON acknowledged the nursing signature and date line was left blank and should have been addressed that day.

The surveyor continued to interview the ADON on 09/28/22 at 9:28 AM, who stated that once she received the CPMR that was when she reviewed all the PC's recommendations. She stated she received [redacted] report sometime last week and explained they were given 24 to 48 hours to review the entire packet. The ADON stated the PCP was notified on 09/23/22, and that the [redacted] was discontinued on [redacted]. The ADON clarified the rationale for "[redacted]" was that Resident #583 had a [redacted] and no longer needed the [redacted] medication for [redacted]. The ADON concluded that staff was educated on following up on PC recommendations and would provide it.

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On 09/28/22 at 9:34 AM, LPN #3 who identified herself as a night shift nurse, stated when they received a recommendation, they called the PCP to inform them of the recommendation. She stated the nurse should address each recommendation by going through each one and then initial the completed ones. LPN #3 stated once all the recommendations were completed, then the nurse would sign and date it and place the report in the resident's chart. LPN #3 stated if the recommendations were not completed, then the form should have been flagged in the chart and the nurse should have informed the next shift. The surveyor and LPN #3 reviewed Resident #583's EPIC report together and she further stated that if the recommendation was not addressed, then during the 24-hour chart check, which was done by the night nurses, should have been picked it up. LPN #3 confirmed that it was not addressed, but stated she never cared for Resident #583 and was unaware the EPIC was not addressed. LPN #3 emphasized any shift nurse could have picked up that the recommendation was not addressed.

On 09/28/22 at 11:55 AM, the DON, in the presence of the survey team, stated the staff nurses were supposed to address the PC recommendations as soon as they received them. She stated if a staff nurse needed assistance with addressing the recommendations, then they should inform a supervisor. She further stated the nurses received the EPIC report and the ADON received the CPMR. She stated the nurses were educated on following up with PC recommendations which was done by the ADON. The DON acknowledged that the EPIC report from [redacted] and PC follow up recommendation from [redacted] for Resident

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F 756	Continued From page 96 #583 were not addressed and could have also been picked up during the 24-hour chart check review. A review of the additional information the PC provided via email on 09/29/22 at 11:26 AM, on her rationale for the [redacted] recommendation revealed, "we always use manufacturer's package insert as primary reference for our recommendations." She attached the [redacted] [generic name for [redacted] package insert which indicated that the capsule should not be opened to be administered [redacted]. The facility was unable to provide any education regarding addressing the PC recommendations until after surveyor inquiry. A review of the facility's policy, Pharmacy Consultant Services, dated 3/2020, included ...."use outside resources to furnish pharmacy services for each resident .....and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event."	F 756		
F 812 SS=E	NJAC 8:39-29.3 (a) (b) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		11/11/22

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F 812	Continued From page 97 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe, consistent manner designed to prevent foodborne illness. This deficient practice was evidenced by the following: On 09/16/22 at 10:00 AM, the surveyor, in the presence of the Food Service Director (FSD) and Ambassador of Dietary Services (ADS), observed the following during the kitchen tour: 1. A food service worker (FSW) was observed walking in the kitchen with a blue baseball cap with hair sticking out the back. When interviewed, the FSD stated the FSW's hair should be covered. 2. A stack of uncovered coffee filters was stored directly on the shelf and a second stack of uncovered coffee filters was stored in a bin containing coffee packets. When interviewed, the FSD stated the stacks of coffee filters should be stored in plastic.	F 812	1-All dietary staff have been in-serviced by Food Service Director (FSD) on proper uniform and hair being covered on 9/16/2022. 2-3: All dietary staff have been in-serviced on proper handling of food items by FSD on 9/16/2022 All coffee filters and plastic lids that were improperly stored were thrown out on 9/16/2022. 4-5, 8-11, 13-14, and 16: All opened un-dated and opened past the used date items were thrown out on 9/16/2022 All Dietary Staff have been in-serviced on the policy on labelling and dating by FSD on 9/16/2022. 6: All dietary staff have been in-serviced on proper cleaning of the equipment items by FSD on 9/16/2022. Mixer was cleaned by FSD on 9/16/2022.	

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F 812	Continued From page 98 3. A stack of uncovered plastic lids was stored directly on the shelf and a second stack of uncovered plastic lids was stored directly on the shelf behind the coffee machine. When interviewed, the FSD stated the stacks of plastic lids should be stored in plastic. 4. In the second snack refrigerator, 10 undated pieces of cakes wrapped in plastic was stored on a shelf. When interviewed, the FSD stated the cakes should have been dated. 5. In the second snack refrigerator, a box containing 26 undated vanilla health shakes was stored on a shelf. When interviewed, the FSD stated the health shakes should be dated with a pull date and that staff forgot to label them. 6. The mixer was covered with plastic. When interviewed, the FSD stated the mixer was clean and sanitized. Upon inspection, the mixer was noted covered with debris. When interviewed, The ADS stated a clean and sanitized mixer should not have debris on it. 7. The left-side oven had a box containing clear film, three rolls of black trash bags, and package of roasted peanuts stored inside. The right-side oven had an aluminum bin containing scoops, a package of Styrofoam plates, three aluminum bins with plastic forks and napkins, an open and undated bag of potato chips, an aluminum bin with coffee packages and an open package of disposable plates stored inside. When interviewed, the ADS stated the left and right stoves were not being used and pointed to the signage posted that indicated the "Not in Use." The ADS added that it was not normal practice to store items inside either oven.	F 812	7. All dietary staff have been in-serviced on proper storage of dietary equipment on 9/16/2022 by FSD. All items were removed from the broken stove on 9/16/2022. 12. All dietary staff have been in-serviced on the personal food policy by FSD on 9/16/2022. Staff beverage was taken out and thrown away on 9/16/2022. 15. All dietary staff have been in-serviced on ware washing by FSD on 9/28/2022. Lids were immediately replaced with dry lids and lids were rewashed and dried correctly. 2. All residents have the potential to be affected by the same deficient practice. 3. - All staff has been in-serviced on hairnets and beard restraints and how to wear them effectively at all times in the kitchen by the FSD. FDF and/or designee with monitor hairnets and beard restraints daily to ensure compliance. In-servicing by Food Service Director and/or designee to continue monthly for all staff. 2-3: All dietary staff will be in services on proper handling of food items monthly for	

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F 812	Continued From page 99 8. On the spice rack, an open and undated package of creamy rice wrapped in plastic was stored on a shelf. When interviewed, the FSD stated the package should have been labeled with an open date. 9. On the spice rack, an open and undated package of brown sugar wrapped in plastic was stored on a shelf. When interviewed, the FSD stated the package should have been labeled with an open date. 10. In the walk-in refrigerator, a box containing two undated vanilla health shakes was stored on a shelf. When interviewed, the ADS stated the health shakes should be labeled with a pull date and use by date. 11. In the walk-in refrigerator, an aluminum bin containing speared pickles had a use by date of 09/10/22. When interviewed, the FSD stated it should not have been in the walk-in refrigerator. 12. In the walk-in freezer, a personal can of soda was stored on a shelf. When interviewed, the FSD stated the can of soda was for an employee and that it should not be stored in the walk-in freezer. 13. In the walk-in freezer, an open and undated package of breaded eggplant wrapped with plastic was stored on a shelf. When interviewed, the ADS stated the package was supposed to be labeled with a date. On 09/28/22 at 11:33 AM, the surveyor inspected the nourishment stations on the units and observed the following:	F 812	6 months and continue quarterly by FSD and/or designee. FSD and/or designee will conduct audit daily on all proper handling of food items. 4-5, 8-11, 13-14, and 16: All Dietary Staff has been in-serviced on the labeling & dating policy by the FSD on 9/16/2022. Re In-servicing will be completed monthly for 6 months and continue quarterly. Review of all labeling & dating of all food items will continue 2x daily by FSD and/or designee. 6: FSD will in-service all dietary staff on proper cleaning of the equipment monthly for 6 months and continue quarterly. FSD will conduct audits to ensure all equipment is properly cleaned daily. 7. FSD will in-service all dietary staff on proper storage of all dietary equipment monthly for 6 months and continue quartely. FSD will conduct audits to all equipment are properly stored 12. All Dietary Staff has been re in-serviced on the Personal Food/Beverage policy by the FSD on 10/3/2022. Re In-servicing will be completed monthly for 6 months and continue quarterly by the FSD and/or designee. Review of all personal items stored in the kitchen will continue 2x daily by FSD and/or designee to ensure compliance	

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F 812	Continued From page 100 14. In the [redacted]loor nourishment station, an open and undated package of rolls were stored in a cabinet. 15. In the second-floor nourishment station, two stacks of clear plastic tray lids were stored on a counter. The stacks of clear plastic tray lids were visible were not dry and wet nesting. 16. In the [redacted] nourishment station refrigerator, two undated muffins wrapped in plastic were stored on a shelf. During an interview with the surveyor on 09/28/22, the ADS stated the clear plastic tray lids were not supposed to be stored in that manner and that they should have been fully dried. Review of the facility's "Ware Washing HCSG policy 025" policy, dated May 2014, indicated that the FSD would ensure that all dishware is air dried and properly stored. Review of the facility's "Staff Attire HCSG Policy 024" policy, revised on 02/05/18, revealed that all staff members will have hair confined in a hair net. Review of the facility's "Equipment HCSG policy 030" policy, dated May 2014, indicated that the FSD would ensure that all equipment is routinely cleaned. Review of the facility's "Food Storage: Cold HCSG Policy 022" policy, dated May 2014, indicated that the FSD would ensure that all food items are stored properly in covered containers, labeled, and dated.	F 812	15. All Dietary Staff have been in-serviced on 10/2/2022 on the Ware Washing policy by the FSD. Re In-servicing will be completed monthly for 6 months and continue quarterly by the FSD and/or designee. Review of all ware washing items will continue 2x daily by FSD and/or designee. 4. The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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F 812	Continued From page 101	F 812		
F 881 SS=E	NJAC 8:38-17.2 (g) Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) utilize an infection assessment tool for 4 of 4 residents (Resident # [redacted], and [redacted]) prescribed antibiotic medications in the facility, and b.) monitor and review actual antibiotic use according to the facility's Antibiotic Stewardship Program. This deficient practice was evidenced by the following: Review of the Antibiotic Stewardship Meeting Minutes, dated [redacted], provided by the Infection Preventionist (IP), revealed a section titled "Discussion" with the following listed below it: Antibiotic Stewardship Program Goals, Antibiotic Use Reports, Antibiotic Resistance	F 881	Education was provided to the Infection Preventionist by the Director of Nursing on the Antibiotic Stewardship assessment tools used on 9/27/2022 Monthly meetings are coordinated with Medical Director to discuss findings as it relates to antibiotic use, starting date needed on 9/27/2022 Director of Nursing re-educated the licensed nurses on the antibiotic use protocol and system to monitor antibiotic use on 9/27/2022. 2. All residents have the potential to be affected 3. Infection Preventionist and Director of	11/11/22

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F 881	Continued From page 102 Reports, Newly Diagnosed Infection Report, C Difficile Report (Outcome Measure Review), and Antibiotic Prescription Review. However, the only documents attached to the meeting minutes were Infection Control Logs of the residents who were on antibiotics during the month of [redacted] There were no reviews or reports related to antibiotic use attached to the meeting minutes. Review of the Antibiotic Stewardship Meeting Minutes, dated [redacted], provided by the Infection Preventionist (IP), revealed a section titled "Discussion" with the following listed below it: Antibiotic Stewardship Program Goals, Antibiotic Use Reports, Antibiotic Resistance Reports, Newly Diagnosed Infection Report, C Difficile Report (Outcome Measure Review), and Antibiotic Prescription Review. However, the only documents attached to the meeting minutes were Infection Control Logs of the residents who were on antibiotics during the month of [redacted] and [redacted]. There were no reviews or reports related to antibiotic use attached to the meeting minutes. Further review of the logs attached to the Antibiotic Stewardship Meeting Minutes included the following information related to residents who were prescribed antibiotics while at the facility: -Resident #[redacted] was admitted on [redacted] and was started on antibiotics on [redacted] for a [redacted] -Resident #[redacted] was admitted on [redacted] and was started on antibiotics on [redacted]. -Resident [redacted] was admitted on [redacted] and was started on antibiotics on [redacted] for [redacted]). -Resident #[redacted] was admitted on [redacted] and was started on antibiotics on [redacted] for a[redacted]	F 881	Nursing will audit the antibiotic tracking log and Electronic Medication Administration Record daily to confirm appropriate antibiotic use on new admissions, readmissions and in house residents. Any findings/discrepancies will be evaluated and discussed with Medical Director. Infection Preventionist will prepare reports with outcomes and trends to be presented with the QAPI team monthly Infection Preventionist will re-educate nursing staff annually and as needed on Antibiotic stewardship program and protocols 4. The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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F 881	Continued From page 103	F 881		

During an interview with the surveyor on 09/27/22 at 11:40 AM, the IP stated she was unsure what infection assessment tool the facility used to assess residents for antibiotic treatment. At that time, the surveyor requested the infection assessment tools that were used prior to prescribing antibiotics for Resident #[redacted] #[redacted]

At 1:17 PM, the IP stated she was unable to provide any completed infection assessment tools and stated, "it fell through the cracks," and acknowledged that the assessments were not completed for Resident #[redacted], and [redacted] The IP then provided a blank copy of the Loeb's Minimum Criteria for Starting Antibiotic Therapy in LTC (Long Term Care) and stated that it was the form that should have been completed for those residents.

During a follow-up interview with the surveyor on 09/28/22 at 11:35 AM, the IP stated her responsibilities related to the Antibiotic Stewardship Program included reviewing antibiotic logs, educating nurses on antibiotics, collecting antibiotic logs from the pharmacy, and ensuring antibiotic orders are written correctly. She then explained that if a resident is suspected of having an infection, the nurse should contact the Infectious Disease (ID) physician, contact the resident's physician, contact the resident's family, and transcribe any antibiotic orders given. When asked if the nurse should complete an infection assessment tool, the IP stated the nurse should complete the Loeb's Minimum Criteria form and document it in the resident's progress notes. The IP further stated that if the resident did not meet the criteria, the resident should not be put on an

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	315518	A. BUILDING _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENETIAN CARE & REHABILITATION CENTER, THE	275 JOHN T O'LEARY BOULEVARD SOUTH AMBOY, NJ 08879

(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 881	Continued From page 104	F 881		

antibiotic.

During the same interview, the IP stated that antibiotic usage was tracked using the Infection Control Logs and the facility's pharmacy also sends a log of antibiotics used in the facility. The IP further stated that the Infection Control Logs, which tracked how many residents were on antibiotics and the type of infection being treated, were reviewed monthly at the Antibiotic Stewardship Program meetings. The IP also stated that the purpose of the Antibiotic Stewardship Program was to prevent residents from being prescribed antibiotics "if they don't need it" because it could make the resident worse with the side effects from the medication. When asked for the facility's annual report on antibiotic usage, the IP stated she would not have that because she has only worked at the facility for two months.

During an interview with the surveyor on 09/28/22 at 12:02 PM, the Director of Nursing (DON) explained that when a resident is suspected of having an infection, the nurse should assess the resident, call the physician, and consult the ID physician. When asked if the nurse should complete an infection assessment tool, the DON stated the nurse should complete the Loeb's Minimum Criteria to prevent the unnecessary use of antibiotics.

During the same interview, the DON stated that the IP was responsible for reviewing antibiotic use monthly. The DON also stated that antibiotic use was discussed monthly during the Antibiotic Stewardship Program meetings and quarterly during the QAPI (Quality Assurance and Performance Improvement) meetings. The DON

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F 881	Continued From page 105	F 881		

further stated that the facility's annual report on antibiotic usage included all the antibiotics used in the year and that the ID physician was consulted to determine interventions to prevent repeated infections. The DON then stated that the Antibiotic Stewardship Program was important to prevent further infections and treat infections appropriately.

On 09/28/22 at 1:19 PM, the IP sent the surveyor an email with the subject line of "Annual ABT [antibiotic] & Physician Data Report." The email contained two attachments - Antibiotics Dispensed [redacted] and Antibiotics Dispensed [redacted] Both attachments contained a log of residents who were prescribed antibiotics, their room location, their physician, the antibiotic prescribed, the timeframe for the antibiotic, and the instructions for the antibiotic. The attachments did not contain feedback on antibiotic use in the facility.

On 09/29/22 at 11:10 AM, the surveyor again requested any reviews and/or reports related to the antibiotic usage since the facility had only provided antibiotic tracking logs to the surveyor.

During an interview with the surveyor on 09/29/22 at 11:20 AM, the Medical Director (MD) stated the purpose of the Antibiotic Stewardship Program was to reduce the use of unnecessary antibiotic treatments. He further stated that he does not attend the monthly Antibiotic Stewardship Program meetings but attends the quarterly QAPI meetings to discuss the usage of antibiotics. When asked, the MD was unsure what infection assessment tool was used by the facility and could not recall ever receiving an annual antibiotic

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F 881	Continued From page 106 use data report from the facility. During a follow-up interview with the surveyor on 09/30/22 at 9:35 AM, the DON stated that since the IP started working at the facility two months ago, she had not completed any antibiotic reviews or reports. The DON then provided a Performance Improvement Plan (PIP) titled [redacted]," dated [redacted], that assessed the number of [redacted] in the facility for [redacted] only. The PIP did not include all antibiotics prescribed in the facility or a timeframe longer than one month. When asked if there was an annual report on antibiotic usage since the [redacted] PIP, the DON stated there was not because the facility did not have an IP at the time the report was due. The facility was unable to provide any reports or reviews related to the antibiotic usage in the facility over the last year. Review of the facility's Antibiotic Stewardship Program policy, revised 09/2020, included, "The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use." The policy also included, "Nursing staff assess residents who are suspected to have an infection and complete an SBAR [Situation Background Assessment Recommendation] form prior to notifying the physician," and, "The Loeb Minimum Criteria are used to determine whether to treat an infection with antibiotics." Further review of the policy included a section about monitoring antibiotic use which included, "At least one outcome measure associated with antibiotic use will be tracked monthly, as	F 881		

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F 881	Continued From page 107 prioritized from the facility's infection control risk assessment and other infection surveillance data." The policy also included, "At least annually, feedback shall be provided on the facility's antibiotic use data in the form of a written report shared with administration, medical and nursing staff, resident and family council, and the QAA Committee," and, "At least annually, each attending physician shall be provided feedback on his/her antibiotic use data in the form of a written report (i.e 'antibiotic report card')."	F 881		
F 882 SS=F	NJAC 8:39-19.4(d) Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee.	F 882		11/11/22

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F 882	Continued From page 108 The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on facility staff interviews and review of other facility documentation, it was determined that the facility failed to ensure that the designated Infection Preventionist (IP) had completed specialized training in infection prevention and control and was qualified by certification and experience for 1 of 1 staff member reviewed in accordance with the facility job description, Center for Medicare and Medicaid Services (CMS) and New Jersey State guidelines. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health Executive Directive No 20-026-1 dated October 20, 2020, revealed the following: ii. Required Core Practices for Infection Prevention and Control: Facilities are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; or	F 882	1 Infection Preventionist completed the required CDC training on 10/24/2022. Certifcation was completed and placed in staff members file for future reference (see attached). 2. All residents have the potential to be affected 3. Administrator and Human Resources will review new hires credentials to ensure that all requirements are met before start date Human Resources will conduct new hire audits for credentialing, education, and training Infection Preventionist will continue to complete education and training to maintain an effective infection control program. 4. Administrator and Human Resources will monitor these audits bi weekly x2 and monthly x3 The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive	

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F 882	Continued From page 109 b. A Physician who has completed an infectious disease fellowship; or c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of Infection Control experience. iv. Facilities with 100 or more beds or on-site hemodialysis services must: 1. Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to the hiring no later than [redacted] On 09/22/22 at 11:17 AM, the surveyor interviewed the IP who stated that she had been a nurse for [redacted], recently obtained a [redacted] of [redacted], and began working at the facility in the role of IP on [redacted]. The IP stated that she did not possess an infection control certification nor had she completed an infection control course. The IP stated that the Director of Nursing (DON) supported her in the role of IP, although she was unsure if the DON possessed any sort of Infection Control Certification. The IP further stated that she previously worked as an emergency room nurse and her job duties included IP training related to COVID-19 testing and vaccination of staff. The surveyor requested to view the IP's Job Description, resume, and supporting documentation. The surveyor reviewed the IP's Resume which indicated that the IP worked as an [redacted] Nurse from [redacted] through [redacted] and failed to demonstrate that the IP	F 882	months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

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F 882	Continued From page 110 received infection prevention training as the IP previously indicated or that she had [redacted] years of experience as an IP. On 09/22/22 at 11:48 AM, the surveyor interviewed the Administrator and asked if he assisted the IP with her job duties. The Administrator stated that he did not have a clinical background and his role in infection control was limited to "reporting the numbers." He further stated that the DON did not possess any type of infection prevention experience or certification. On 09/27/22 at 10:00 AM, the surveyor interviewed the DON who stated that the Administrator and the Regional Staff were involved in assisting the IP. The DON stated that she was unsure if they held any sort of infection control certification. The DON further stated that she may have completed the Center for Disease Control Training Course (CDC TRAIN), but would have to confirm successful completion of the course with a former employer. The DON was unable to provide documented evidence that she or the Regional Staff completed an infection control training course. On 09/27/22 at 11:54 AM, the surveyor interviewed the Human Resources Liaison (HRL) via speaker phone (with permission) in the presence of the survey team. The HRL stated that she covered in the position for the former HRL who resigned on [redacted]. The HRL stated that to the best of her knowledge, when the facility hired they looked for experience. The HRL stated that she was removed from clinical, was not involved in the hiring of IP staff, and was not aware of the requirements that were set forth.	F 882		

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F 882	Continued From page 111 Review of the facility provided job description revealed the following: Position Summary: The essential functions of the job for an Infection Preventionist are to develop, implement, and maintain a facility-wide infection prevention and control program. Required Qualifications included: A professionally-trained nurse that has earned a certificate/diploma or degree in nursing; ...Education, training, experience, or certification in infection control and prevention. Completed specialized training in infection prevention and control through accredited continuing education. NJAC 8:39-20.2	F 882		

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	060234	A. BUILDING: _____ B. WING _____	C 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

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S 000	Initial Comments Complaint #: NJ151035, NJ148557, NJ150492 Census: 120 Sample Size: 6 TYPE OF SURVEY: Complaint and Focused Infection Control The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations. Survey Date: 01/21/2022	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: Complaint Intake #: NJ151035 Based on interview, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 09/19/2021, it was determined the	S 560	S 560 What corrective action(s) will be accomplished for those residents found to	2/18/22

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S 560	Continued From page 1 facility failed to maintain direct care staff-to-resident ratios as mandated by New Jersey State Law. This was evident for 14 out of 14 day shifts reviewed. This had the potential to affect all residents. Findings included: Reference: NJDOH memo, dated 01/28/2021, "Compliance 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 certified nurse aid (CNA) to every eight residents for the day shift. 1. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 01/02/2022 - 01/15/2022, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -01/02/2022 had 10 CNAs for 110 residents on the day shift, required 14 CNAs. -01/03/2022 had 10 CNAs for 110 residents on the day shift, required 14 CNAs. -01/04/2022 had 11 CNAs for 110 residents on the day shift, required 14 CNAs. -01/05/2022 had 11 CNAs for 110 residents on the day shift, required 14 CNAs. -01/06/2022 had 11 CNAs for 110 residents on the day shift, required 14 CNAs. -01/07/2022 had 11 CNAs for 110 residents on	S 560	have been affected by the deficient practice? The facility will contract with a staffing agency that currently has employed, Certified Nurse Aides available to work in the Bergen County Area. The facility will schedule with the Agency, sufficient CNA's to work the vacant shifts required to meet the minimum staffing ratios. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. An audit of current staffing schedule was conducted and request for required CNA's to meet minimum staffing ratios was sent to agency. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice will not recur? The Staffing coordinator will prepare a rolling staffing schedule two weeks in advance, updated weekly and forward to the agency the vacancies that require filling to meet the minimum staffing ratios. The staffing coordinator will update the contracted agency daily of any changes in the number vacant shifts that cannot be filled by the facility's current staffing pool. How the corrective action(s) will be	

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S 560	Continued From page 2 the day shift, required 14 CNAs. -01/08/2022 had 10 CNAs for 110 residents on the day shift, required 14 CNAs. -01/09/2022 had 8 CNAs for 118 residents on the day shift, required 15 CNAs. -01/10/2022 had 11 CNAs for 118 residents on the day shift, required 15 CNAs. -01/11/2022 had 13 CNAs for 118 residents on the day shift, required 15 CNAs. -01/12/2022 had 13 CNAs for 118 residents on the day shift, required 15 CNAs. -01/13/2022 had 12 CNAs for 128 residents on the day shift, required 16 CNAs. -01/14/2022 had 12 CNAs for 128 residents on the day shift, required 16 CNAs. -01/15/2022 had 13 CNAs for 129 residents on the day shift, required 17 CNAs. During an interview with the Director of Nursing (DON) on 01/24/2022 at 1:35 PM, she stated it had been difficult to staff and the facility uses agency, and those workers will call out the last minute or just not show up. The DON indicated they had staff working double shifts when they could. She further stated that the facility now had a certified nursing assistant program and faculty and will be applying for approval with New Jersey for the facility to train their own CNAs.	S 560	monitored to ensure the deficient practice will not recur i.e., what program will be put into place to monitor the continued effectiveness of the systemic change? The Administrator or designee will audit the schedule weekly for 6 weeks for any vacancies that were not able to be filled. The results of the audit will be presented to the quarterly QA committee for review.	