

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1a006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2022
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NAME OF PROVIDER OR SUPPLIER HERITAGE ASSISTED LIVING, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 45 ROUTE 206 HAMMONTON, NJ 08037
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A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ 00152155, NJ 00155271, NJ00154731</p> <p>CENSUS: 81</p> <p>SAMPLE SIZE: 9</p> <p>The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

07/25/22

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00155271 and NJ00154731</p> <p>Based on interview and record review it was determined that the facility Executive Director (ED) failed to implement and enforce its policy and procedure titled, "Abuse, Neglect and Mistreatment of Residents" and "Weight policy" for 2 of 9 residents, Resident's #1 and #2. This deficient practice was evidenced by the following:</p> <p>1. On 6/7/22 at 1:05 p.m., during the tour of the Assisted Living second floor, the surveyor observed Resident #2 in his/her apartment walking from the bathroom to a recliner chair. The resident told the surveyor that the resident had difficulty with walking for a long period of time due to [REDACTED] discomfort. After Resident #2 was seated, the surveyor asked the resident about the care received at the facility. Resident #2 stated that the care was alright, however, there was a staff member [Home Health Aide, (HHA)] who was, "rude, nasty" and had a "filthy foul language mouth" and described the HHA as having "Painted red hair."</p> <p>Resident #2 stated that he/she did not get along with the HHA and that it began when the resident moved to the [REDACTED] floor approximately beginning of [REDACTED]. Resident #2 stated that he/she required the use of a wheelchair for long distance. Resident #2 continued to explain that the HHA would make the resident walk to the dining room for meals even when the resident</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>told the HHA that walking for a long period of time was difficult due to [REDACTED] discomfort. The resident reported to the surveyor that the HHA would say to the resident, "Then you won't have to eat today." Resident #2 told the surveyor that he/she missed a few meals because of the resident's inability to walk to the dining room. Resident #2 sustained a [REDACTED] weight loss from 10/2021 to 6/2022.</p> <p>Additionally, Resident #2 stated that the HHA was rough and bumped the resident's wheelchair into an elevator wall and another time, into the resident's apartment door when the HHA wheeled the resident to and from the dining room. The resident could not recall the exact date/month of the incidents while in the wheelchair. The resident added that the HHA would take snacks from the resident's apartment without asking the resident stating, "I can't get rid of her from my apartment." The surveyor then inquired if Resident #2 had informed anyone about the above incidents. The resident stated that staff members including the Executive Director (ED) and Wellness Director (WD) were aware of some of the issues with the HHA including "Attitude" and "mouth filled with foul language."</p> <p>On 6/8/22 at 11:50 a.m., the surveyor interviewed the WD regarding the resident's weights and requested the weights from October 2021 (date of admission) through June 2022. The WD provided the surveyor weights as follow: In October 2021, upon admission the weight was [REDACTED] pounds (lbs.) In February 2022, the weight was [REDACTED] lbs. In April 2022, the weight was [REDACTED] lbs. In May 2022, the weight was [REDACTED] lbs. In June 2022, the weight was [REDACTED] lbs. Weight loss from October 2021 to June 2022</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>was [REDACTED] lbs.</p> <p>The WD stated that she was not able to locate Resident #2's weights for 11/2021, 12/2021, 1/2022, and 3/2022. The WD explained that she was still new to the position and was not sure if the resident's weights for the above months were obtained.</p> <p>Surveyor review of the policy titled, "Weight policy" revealed,</p> <ol style="list-style-type: none"> 1. Residents will be weighed monthly. 2. A dietician will be in every 3 months for weight management. <p>During continued interview, the surveyor inquired about the alleged staff to resident verbal abuse and when she had become aware of Resident #2's concerns. The WD stated that it was around April of 2022, when she "overheard" staff members discussing amongst themselves about Resident #2 and the HHA. The WD told the surveyor that she could not recall the staff members and that she re-assigned the HHA to a different assignment. The surveyor inquired from the WD if she spoke with the resident regarding what she "overheard" and conducted an investigation. The WD confirmed that she did not interview the resident nor had she conducted an investigation to rule out possible staff to resident abuse.</p> <p>Surveyor review of the policy and procedure titled, "Abuse, Neglect and Mistreatment of Residents" revealed,</p> <p>"Each resident has the right to be free from mistreatment, neglect and misappropriation of property."</p> <p>Under the "Investigation", revealed,</p> <p>"The Administrator/designee is designated as the</p>	A 310		

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A 310	<p>Continued From page 4</p> <p>individual who conducts the investigation."</p> <p>Refer to 8:36-4.1(a)(16)</p> <p>Complaint #: NJ00154731</p> <p>2. The surveyor reviewed Resident #1's medical record who moved into the facility on 11/11/2019 with diagnoses which included [REDACTED] services. According to the resident service plan (RSP) dated [REDACTED] the resident required assistance with dressing, bathing, and grooming.</p> <p>Surveyor review of the "Resident Notes" dated [REDACTED] at 2:04 p.m. revealed, "resident [REDACTED] aide noticed [REDACTED] on residents [REDACTED], resident has not had a fall. Will continue to watch."</p> <p>During surveyor interview with the Wellness Director (WD) on 6/7/2022 at 12:30 p.m. the WD stated that she was informed by the [REDACTED] aide that Resident #1 had [REDACTED] of the [REDACTED]. The WD also stated that she was unsure how Resident #1 sustained the [REDACTED]. The WD further stated that she had not initiated an investigation to rule out abuse.</p> <p>On 6/8/2022, the surveyor interviewed the [REDACTED] aide who stated that "about a week ago during morning care she observed a [REDACTED] on Resident #1's [REDACTED]." The [REDACTED] aide then stated that she reported the [REDACTED] to the WD. The [REDACTED] aide stated that she did not see any other [REDACTED] on the resident during care.</p>	A 310		

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A 310	<p>Continued From page 5</p> <p>Although Resident #1 was able to respond to simple commands, the resident was not able to be interviewed by the surveyor.</p> <p>Surveyor review of the policy and procedure titled, "Abuse, Neglect and Mistreatment of Residents" revealed, "Each resident has the right to be free from mistreatment, neglect and misappropriation of property." Under the policy for "Training and Prevention," revealed, "All new employees are oriented about resident abuse and this information is reviewed during yearly in-services. Information reviewed includes interventions, reporting, and detection of what constitutes abuse, neglect and mistreatment." "E. INVESTIGATION...The Administrator/designee is designated as the individual who conducts the investigation...Obtains written statements of staff assigned to the Resident for the shift during which allegation is noted and 16 hours prior if indicated..."</p>	A 310		
A 389	<p>8:36-4.1(a)(16) Resident Rights</p> <p>(a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:</p> <p>16. The right to be free from physical and mental abuse and/or neglect;</p>	A 389		

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A 389	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00155271</p> <p>Based on observation, interview and record review, it was determined that the facility failed to protect the resident's right to be free from verbal and physical abuse and that staff communicated with residents in a respectful manner for 1 of 9 residents reviewed for abuse, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 6/7/22 at 1:05 p.m., during the tour of the Assisted Living [REDACTED] floor, the surveyor observed Resident #2 in his/her apartment walking from the bathroom to a recliner chair. Resident #2 told the surveyor that the resident had difficulty walking for a long period of time due to [REDACTED] discomfort. After the resident was seated, the surveyor asked the resident about the care the resident received at the facility. The resident stated the care was alright, however, there was a staff member [Home Health Aide (HHA)] who was, "rude and nasty" and had a "filthy foul language mouth" and described the HHA as having "Painted red hair."</p> <p>Resident #2 stated that he/she did not get along with the HHA and that it began when the resident moved to the [REDACTED] floor approximately the beginning of [REDACTED]. Resident #2 stated that he/she required the use of a wheelchair for long distance. Resident #2 further stated that the HHA would make the resident walk to the dining room for meals even when the resident told the HHA that walking for a long period of time was difficult due to [REDACTED] discomfort. The resident told the surveyor that the HHA would say, "Then you</p>	A 389		

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A 389	<p>Continued From page 7</p> <p>won't eat today." Resident #2 told the surveyor that he/she missed a few meals for not being able to walk to the dining room. Surveyor review of Resident #2's medical record identified a [REDACTED] weight loss from October 2021 to June 2022.</p> <p>Additionally, Resident #2 stated that the HHA was rough and bumped the resident's wheelchair into an elevator wall and another time, into the resident's apartment door when the HHA wheeled the resident to and from the dining room. The resident could not recall the exact date/month of the wheelchair incidents. The resident added that the HHA would take snacks from the resident's apartment without asking stating, "I can't get rid of her from my apartment." The surveyor then inquired if Resident #2 had informed anyone about the above incidents. The resident stated that staff members including the ED (Executive Director) and WD (Wellness Director) were aware of some of the issues with the HHA's "Attitude" and "mouth filled with foul language."</p> <p>At 2 p.m., the surveyor reviewed Resident #2's medical record which revealed that the resident's move-in date was [REDACTED] with diagnoses which included [REDACTED]. The "Resident Notes" dated [REDACTED] written by a Registered Nurse (RN) documented that the resident was [REDACTED] and oriented to [REDACTED] and [REDACTED]. The RN documented that Resident #2 required a wheelchair for locomotion and would have the resident seen by therapy.</p> <p>In addition, the surveyor observed a [REDACTED] "Progress Note" dated [REDACTED] which documented that Resident #2 reported, "The staff will not feed [Resident #2], despite staff educating and encouraging [the resident] to go to the dining</p>	A 389		

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A 389	<p>Continued From page 8</p> <p>Room."</p> <p>At 2:40 p.m., the surveyor interviewed the WD in presence of the ED and inquired about the staff member with the "Painted red hair." The WD identified the HHA. During the interview, the ED stated that the HHA was verbally counseled regarding Resident #2's concerns but it was not documented. The surveyor then inquired to speak with the HHA and the WD informed the surveyor that the HHA was suspended the morning of [REDACTED] the date of survey, due to an incident with another employee. The HHA was not available for interview.</p> <p>During continued interview, the surveyor asked the WD when she become aware of Resident #2's concerns. The WD stated that it was around April of 2022, when she "overheard" staff members discussing amongst themselves about Resident #2 and the HHA. The WD told the surveyor that she could not recall the staff members and that she re-assigned the HHA to a different assignment. The surveyor inquired from the WD if she spoke with Resident #2 regarding what she "overheard" and whether she conducted an investigation. The WD confirmed with the surveyor that she did not interview the resident nor did she conduct an investigation to rule out possible staff to resident abuse.</p> <p>Also, the surveyor asked the WD if she reviewed the [REDACTED] consult dated [REDACTED] and aware of the [REDACTED] documentation. The WD stated that she only reviewed the recommendation section at the bottom of the consult and not the top. The WD explained that Resident #2 was seen by Physical Therapy and recommended to encourage the resident ambulate with a walker to the dining room for meals. The WD stated that</p>	A 389		

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A 389	<p>Continued From page 9</p> <p>staff offered the resident meals in the resident's apartment if the resident was not able to make it to the dining for any other reason.</p> <p>On 6/8/22 at 9:10 a.m., the surveyor interviewed a Licensed Practical Nurse (LPN) regarding the HHA. The LPN told the surveyor that the HHA was a problem and was rude towards residents and other staff members and nothing was being done about it and it was ongoing. Post survey on 6/15/22 at 12:19 p.m. and 12:23 p.m., the surveyor interviewed a Patient Care Assistant (PCA) #1 and PCA #2 regarding Resident #2 and whether the resident had any concerns regarding care at the facility. Both PCAs stated that the resident told them that the HHA was "rude, mean" and used curse words/foul language and nothing had been done about the HHA. In addition, PCA #2 stated that the resident told her that the HHA refused to take the resident to dining and ran the resident's wheelchair into the resident's apartment door. The surveyor then asked both PCAs if Administration was made aware. PCA #1 stated that she discussed the incident amongst other staff and could not recall if the WD was aware. PCA #2 stated the she informed the WD but could not recall the exact date/month.</p> <p>At 11:35 a.m., the surveyor reviewed the assignment sheet dated [REDACTED] through [REDACTED] provided by the WD and observed that the resident continued to be assigned to the HHA on [REDACTED] and [REDACTED]. During the interview, the WD stated that the HHA was aware not to provide care to Resident #2 and switched the assignment.</p> <p>Surveyor review of the facility policy and procedure titled, "Resident Rights" revealed, "... policy is to ensure resident rights are</p>	A 389		

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A 389	Continued From page 10 respected and protected at all times in compliance with all state and federal laws." Under the "Protecting and Ensuring Resident Rights" section revealed, 2. "... and all facility personnel are responsible for ensuring that resident rights are respected and maintained." The "Mandatory Resident Rights" revealed the right "To be free from physical abuse."	A 389		
A 517	8:36-5.6(b)(1-7) General Requirements (b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment; 2. Emergency plans and procedures; 3. The infection prevention and control program; 4. Resident rights; 5. Abuse and neglect; 6. Pain management; 7. The care of residents with Alzheimer's and related dementia conditions and	A 517		

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A 517	<p>Continued From page 11</p> <p>in accordance with N.J.A.C. 8:36-19.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00155271</p> <p>Based on interview and record review, it was determined that the facility failed to provide documented evidence that an employee received the minimum required in-service education and training upon hire for 1 of 4 employees reviewed as evidenced by the following:</p> <p>On 6/7/22 at 2:05 p.m., the surveyor reviewed a Home Health Aide's (HHA) personnel file who was hired on [REDACTED] and observed that the HHA did not receive the required training upon hire.</p> <p>At 2:20 p.m., the surveyor interviewed the Executive Director (ED) regarding the employee's required in-service education/training upon hire. The ED stated that the HHA received the required training. However, he stated that the Human Resource (HR) personnel failed to complete the</p>	A 517		

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A 517	<p>Continued From page 12</p> <p>"Employee Orientation Checklist" for the HHA upon completion of the new hire orientation.</p> <p>At 2:40 p.m., the surveyor interviewed the HR personnel and she stated that she completed the new hire orientation and had other responsibilities and forgot to complete the "Employee orientation checklist" for the HHA, "it was an oversight."</p> <p>The facility failed to provide documented evidence confirming that the employee who was involved in an alleged allegation of abuse received the required mandatory in-service training which included: Abuse/Neglect, Assisted Living Concepts, Emergency Plans/Procedures, Infection Prevention/Control, Resident Rights, Pain Management and Dementia Training upon their date of hire.</p>	A 517		
A 887	<p>8:36-10.4(a)(1) Dining Services</p> <p>(a) If indicated, according to residents' needs, a dietitian shall be responsible for providing resident care, including, but not limited to, the following:</p> <p>1. Assessing the nutritional needs of the resident. If indicated, preparing the dietary portion of the health care plan on the basis of the assessment, providing dietary services to the resident as specified in the dietary portion of the health plan, reassessing the resident, and revising the dietary portion of the health care plan. Each of these activities shall be documented in the resident's record;</p>	A 887		

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A 887	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility's Registered Nurse (RN) failed to consult a dietician to assess a resident's nutritional needs who had sustained a weight loss for 1 of 9 residents, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 6/8/22 at 11:50 a.m., the surveyor interviewed the Wellness Director (WD) regarding the Resident #2's weights and requested the weights from October 2021 (date of admission) through June 2022. The WD provided the surveyor Resident #2's following weights:</p> <p>In October 2021, upon admission the weight was [REDACTED] pounds (lbs.) In February 2022, the weight was [REDACTED] lbs. In April 2022, the weight was [REDACTED] lbs. In May 2022, the weight was [REDACTED] lbs. In June 2022, the weight was [REDACTED] lbs. Resident #2 sustained a [REDACTED] weight loss from October, 2021 through June, 2022.</p> <p>During interview, the WD stated that she was not able to locate the resident's weights for 11/2021, 12/2021, 1/2022 and 3/2022 and was not sure if the weights were obtained. Surveyor review of Resident #2's medical record failed to identify documented evidence that the nursing staff, including the RN, addressed the resident's [REDACTED] weight loss from 10/2021 to 6/2022.</p> <p>The surveyor inquired from the RN the facility's protocol for weight loss and she stated that the dietician was consulted when there were issues with weights. She stated that she was not aware</p>	A 887		

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A 887	Continued From page 14 that the resident had a [REDACTED] weight loss and confirmed that the resident had not been seen by a dietician. The WD explained that she was still new to the position. Surveyor review of the policy titled, "Weight policy" revealed, 1. Residents will be weighed monthly. 2. A dietician will be in every 3 months for weight management.	A 887		
A 961	8:36-11.5(e) Pharmaceutical Services (e) The registered professional nurse shall report medication errors and adverse drug reactions immediately to the prescriber, to the provider pharmacist and/or consultant pharmacist, and shall document the incident in the resident's record. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00154731 Based on interview and review of the medication administration records (MARs) and additional facility documents, it was determined that the facility failed to consistently initial the MARs to indicate that medications were administered and failed to notify the prescriber and the facility's consultant pharmacist when medications were not documented as administered in accordance with prescriber's orders for 2 of 3, Resident's #7 and #8. This was evidenced by the following: On 6/10/2022, the surveyor reviewed the MARs of Resident's #7 and #8. The surveyor observed	A 961		

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A 961	<p>Continued From page 15</p> <p>that there were multiple charting blanks on the MAR indicating medications were not being administered in accordance with prescriber's orders.</p> <p>The surveyor reviewed Resident #7's medical record (MR) and according to the "Resident Face Sheet (RFS)" the resident moved into the facility [REDACTED] with diagnoses which included [REDACTED].</p> <p>The surveyor also reviewed Resident #8's MR and according to the RFS the resident moved into the facility [REDACTED] with diagnoses which included [REDACTED].</p> <p>On 6/10/2022 at 1:20 p.m., the surveyor, along with the Wellness Director (WD), reviewed the MARs for Resident's #7 and #8. Multiple charting blanks were identified indicating [REDACTED] (used for the treatment of [REDACTED] was not administered in accordance with the prescriber's orders. The WD told the surveyor, " if the initials were not documented on the MAR then it was considered a medication error and the medication was not administered." The surveyor asked the WD if the physician or consultant pharmacist were notified of the missing initials and missing doses of [REDACTED] administered to Residents #7 and #8. The WD replied, "No."</p> <p>Refer to 8:36-11.5(f)</p>	A 961		
A 963	<p>8:36-11.5(f) Pharmaceutical Services</p> <p>(f) Medications shall be accurately administered and documented by properly authorized</p>	A 963		

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A 963	<p>Continued From page 16</p> <p>individuals, in accordance with prescribed orders.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ00154731</p> <p>Based on observation, interview and record review, it was determined that the facility failed to ensure that [REDACTED] (used for the treatment of [REDACTED]) was administered accurately and in accordance with prescriber's orders for 2 of 3 residents, Resident's #7 and #8, reviewed for medication administration. This deficient practice was evidenced by the following:</p> <p>On 6/10/2022 the surveyor interviewed the Wellness Director (WD) who stated that the facility used an electronic MAR (medication administration record) system since [REDACTED]. At this time, the surveyor requested the MAR's for Resident's #7, and #8. The surveyor observed several blanks, initials omitted with no explanation as to why the medication was not documented as administered. The MAR documentation omissions were as follows:</p> <p>1. The surveyor reviewed Resident #7's medical record (MR) and according to the "Resident Face Sheet (RFS)," the resident moved into the facility [REDACTED] with diagnosis which included [REDACTED]</p> <p>The surveyor reviewed Resident #7's MAR for [REDACTED] which contained an order for</p>	A 963		

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A 963	<p>Continued From page 17</p> <p>██████████ ML (milliliters) in the morning. The surveyor did not observe initials indicating the ██████████ was administered on 3/3, 3/7, 3/25, 3/26 and 3/27/2022. Resident #7 should have received ██████████ doses for March but only ██████████ doses were documented as administered to the resident.</p> <p>Resident #7 also had a prescriber's order for ██████████ ML ██████████ in the evening. The surveyor did not observe initials documenting the administration of ██████████ on 3/3, 3/4, 3/5, 3/7, 3/8, 3/9, 3/10, 3/25, 3/26, 3/27 and 3/31/2022. The resident should have received ██████████ doses of ██████████ in the evening but only ██████████ doses were documented as administered to the resident..</p> <p>The surveyor reviewed the Resident #7's MAR for ██████████ which revealed an order for ██████████ inject ██████████ units ██████████ in the morning. The surveyor did not observe initials that the ██████████ was administered on 4/1, 4/2, 4/3, 4/4, 4/6, 4/7, 4/8 and 4/11/2022. According to the MAR, this medication order was discontinued on ██████████.</p> <p>In addition, Resident #7 had a prescriber's order for ██████████ ML ██████████ in the evening. The surveyor did not observe initials that the ██████████ was administered on 4/1, 4/2, 4/3, 4/4, 4/6 and 4/12/2022.</p> <p>The surveyor also observed a new order for ██████████ units ██████████ in the morning and ██████████ with dinner. The surveyor observed that the morning dose was not documented as administered on</p>	A 963		
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A 963	<p>Continued From page 18</p> <p>4/14, 4/15, 4/16, 4/17, 4/18, 4/19, 4/20, 4/21, 4/22, 4/23, 4/24, 4/25 and 4/26/2022. The surveyor also observed that the evening dose of [REDACTED] was not documented as administered on 4/14, 4/25, 4/27, 4/28, 4/29 and 4/30/2022. The resident should have received [REDACTED] doses of [REDACTED] but only [REDACTED] doses of [REDACTED] were documented as administered to the resident.</p> <p>The surveyor reviewed Resident #7's MAR for [REDACTED] and observed a new order for [REDACTED] units [REDACTED] in the morning and [REDACTED] units with dinner. The surveyor observed that the morning [REDACTED] was not documented as administered from 5/12-5/31/2022. In addition the the evening dose of [REDACTED] was not documented as administered on 5/1, 5/2, 5/3, 5/4, 5/5, 5/6, 5/7, 5/8, 5/9, 5/10, 5/11, 5/21 and 5/22/2022. The resident should have received [REDACTED] doses of [REDACTED] but only [REDACTED] doses were documented as administered to the resident.</p> <p>The surveyor reviewed Resident #7's MAR for [REDACTED] which revealed a new order for [REDACTED] in the morning and [REDACTED] with dinner. The surveyor observed that on 6/5 and 6/7/2022 there was no documented evidence that the [REDACTED] was administered to the resident on those dates.</p> <p>2. On 6/10/22 at 12:00 p.m., the surveyor reviewed Resident #8's MR. According to the RFS, the resident moved into the facility [REDACTED] with diagnoses which included [REDACTED] and [REDACTED].</p> <p>The surveyor reviewed Resident #8's MAR for [REDACTED] which identified an order for [REDACTED]</p>	A 963		
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A 963	<p>Continued From page 19</p> <p>██████████ units ██████████ with meals. The surveyor observed blanks on the MAR providing no documented evidence that the ██████████ was administered to the resident in accordance with the prescriber's orders. The documentation on the MAR identified that ██████████ doses of ██████████ documented as administered rather than the ██████████ doses of ██████████ in accordance with the prescriber's orders.</p> <p>On 6/10/2022 at 1:20 p.m., the surveyor interviewed the Wellness Director (WD) who stated that the facility transferred from paper MARs to an electronic MAR system and that she had not reviewed any MARs for accuracy. The surveyor and the WD reviewed the MARs for Resident #7 and #8 which included the omitted signatures and the WD confirmed that the MARs failed to identify that ██████████ was administered to Residents #7 and #8 in accordance with the prescriber's orders.</p>	A 963		
A 971	<p>8:36-11.6(a)(4) Pharmaceutical Services</p> <p>(a) The facility or program shall designate a pharmacist who shall direct pharmaceutical services and provide consultation to the physician, facility, or program staff, and residents, as needed. The pharmacist shall assist the facility or program with, at a minimum, the following:</p> <p>4. Reviewing medication administration records on a quarterly basis;</p> <p>This REQUIREMENT is not met as evidenced</p>	A 971		

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A 971	<p>Continued From page 20</p> <p>by: Complaint#: NJ00154731</p> <p>Based on staff interview and review of residents' records and other pertinent facility documents, it was determined that the facility failed to ensure the consultant pharmacist (CP) reviewed residents' medication administration records (MARs) on a quarterly basis for 2 of 2 residents, Resident #'s 7 and #8. This deficient practice was evidenced by the following:</p> <p>On 6/10/22 at 10:00 a.m., the surveyor requested the MAR's for Resident #7 and #8. Upon review of the MARs, the surveyor observed several blanks where initials verifying the administration of medications had been omitted. There was no documented rationale as to why the medication was not administered in accordance with prescriber's orders.</p> <p>At 11:00 a.m., the surveyor interviewed the Wellness Director (WD) who stated that CP's latest report was [REDACTED]. The surveyor requested the CP report for review. Upon surveyor review of the CP's quarterly report, there was no documented evidence that the CP had reviewed the residents' MARs on a quarterly basis.</p> <p>At 11:15 a.m., the WD told the surveyor that she was unaware that the CP should have reviewed the residents' MAR's on a quarterly basis.</p> <p>Refer to 8:36-11.5 (f)</p>	A 971		