STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. BUILDING _____ B. WING _____	C 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT WALL	2621 HIGHWAY 138 WALL, NJ 07719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ150341, NJ149826 and NJ149047 Census: 125 Sample Size: 9 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey date: 12/20/2021 - 12/22/2021 Census: 125	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		2/5/22

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

Electronically Signed | 01/28/2022

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F 580	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ149826 Based on record review and interviews, the facility failed to provide notification of changes in	F 580	Element 1: Resident [redacted] has been discharged from the facility after a successful rehab stay.	

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F 580	Continued From page 2 a resident's plan of care to the responsible party for 1 (Resident [redacted]) of 3 residents reviewed for notification. Specifically, the facility failed to notify Resident [redacted] family/resident representative when the resident was started on [redacted] medications or when changes in medications occurred. Findings included: 1. The facility admitted Resident [redacted] with diagnoses that included [redacted] A review of the quarterly Minimum Data Set (MDS) dated [redacted], indicated the resident had a score of [redacted] on the Brief Interview for Mental Status (BIMS) assessment, indicating the resident had [redacted] impairment with no documented behaviors. A further review of the MDS indicated the resident required extensive assistance of one person for their activities of daily living (ADLs). A review of the [redacted] computerized physician orders (CPO) indicated Resident #2 received orders on [redacted] for [redacted] milligrams (mg), one tablet by mouth every eight hours for [redacted] A review of Resident [redacted] medical record revealed no documentation of Resident [redacted] or Resident [redacted] family being notified of the new medications. A further review of the record revealed no consent for the [redacted] or documentation to indicate the resident or family had been educated about the risks and benefits of taking a [redacted] medication.	F 580	Element 2: Resident receiving [redacted] medication has the potential to be affected by this practice. Chart audit was completed of current residents at the facility in November and no other residents were affected Element 3: Pharmacy consultant provided education to nursing staff on [redacted] medication use which included physician order review, documentation related to effects, risks and benefits, and gradual dose reduction inititative. The education also included family notification regarding changes in treatment. DON/designee standardlized pharmacy consultant report review process and communication of their recommendations with attending physicans. Element 4: The DON?designee will perform an audit of 5 charts weekly x 4 weeks, then 3 charts every two weeks for 4 weeks and evaluate outcome of audits DON to present results of audits at QAPI monthly x 2 months and then during first quarterly QAPI meeting Performance Improvement Committe will review audit outcomes and revise the plan if needed.	

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F 580	Continued From page 3	F 580		

A review of a [redacted] form, dated [redacted], indicated Resident [redacted] was started on [redacted] at their last hospital stay to help with behaviors. The note indicated the resident had periods of [redacted], but the behavior seemed mostly related to [redacted] due to medical condition, loss of independence, and having to be in a facility. The note indicated the resident had no evidence of [redacted] during the evaluation. The note indicated the [redacted] was to be reduced to every 12 hours for [redacted], and the resident was to start [redacted] mg for [redacted]. A further review of the note revealed no documentation of the resident's family being notified of the dosage change of the [redacted] or of the addition of [redacted]).

A review of the [redacted] CPO indicated Resident [redacted] received a new order on [redacted] for [redacted] mg give one tablet by mouth once a day for [redacted], and the order for the [redacted] was changed on [redacted] to [redacted] mg one tablet by mouth every 12 hours for [redacted] with [redacted] features.

A review of the resident's record, on [redacted], revealed no documentation of Resident [redacted] or Resident [redacted] family being notified of the dosage change of the [redacted] or the addition of the new medication [redacted]. A further review of the record revealed no consent for the [redacted] or documentation to indicate the resident or family had been educated about the risks and benefits of taking a second [redacted] medication.

A review of a nursing progress note, dated [redacted], indicated Resident [redacted] family requested the [redacted] be discontinued, and the

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F 580	Continued From page 4	F 580		

family requested to be notified of any medication changes.

During an interview with Licensed Practical Nurse (LPN) #1 on 12/21/2021 at 1:24 PM, LPN #1 stated anytime a change was made to a resident's medications or treatment plan, the family should be notified. She stated once they were notified it should be documented in a progress note.

During an interview with LPN #3 on 12/21/2021 at 3:20 PM, LPN #3 stated if a resident was started on a new medication, the physician or nurse practitioner (NP) usually reviewed the medication with the resident and sometimes the family, but it was the nurse's responsibility to be sure the resident's family was notified.

During an interview with LPN #4 on 12/21/2021 at 3:32 PM, LPN #4 stated that whenever a physician wrote orders to change a medication or start a new medication, notification should be made to the family and documented in a nursing note.

During an interview with LPN #2 on 12/22/2021 at 9:35 AM, LPN #2 stated the resident's family should be notified any time there was a change in the resident's status, including changes in their medications. LPN #2 stated it should be documented in a progress note.

During an interview with the Director of Nursing (DON) on 12/22/2021 at 2:13 PM, the DON stated notifications should always be made to residents' families whenever there was a change in their plan of treatment and should be documented in a progress note.

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F 580	Continued From page 5 During an interview with the Nursing Home Administrator (NHA) on 12/22/2021 at 3:30 PM, the NHA agreed that nursing staff should be making all appropriate notifications when there was a change in a resident's condition. A review of the facility's policy and procedure titled, "Change in a Resident's Condition or Status," last revised May 2017, indicated the facility, "shall promptly notify the resident, attending physician, and representative of changes in the resident's medical/mental condition and/or status." New Jersey Administrative Code § 8:39-5.1(a)	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ149826 Based on interviews, record reviews, and facility policy review, it was determined that the facility failed to ensure nursing staff [redacted] medications when the resident's [redacted] was outside the parameters established by the physician for one (Resident [redacted]) of three residents reviewed for medication administration. Findings included:	F 684	Element 1 Resident [redacted] has been discharged from facility after a successful rehab stay. Element 2 Resident recieving blood pressure medication has the potential to be affected by this practice. Thirty (30) chart audits were performed in December an no other residents were affected by this practice	2/5/22

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F 684	Continued From page 6 1. A review of the medical record indicated the facility admitted Resident [redacted] with diagnoses that include [redacted]. A review of the quarterly Minimum Data Set (MDS) assessment, dated [redacted] indicated the resident had a score of [redacted] on the Brief Interview for Mental Status (BIMS) assessment, indicating the resident had [redacted] impairment. A further review of the MDS indicated the resident required extensive assistance of one person for their activities of daily living (ADLs). A review of the [redacted] computerized physician orders (CPO) indicated Resident [redacted] had the following orders: - [redacted] milligrams (mg), 2 tablets [redacted] mg) by mouth one time a day for [redacted] Hold for [redacted] This was ordered on [redacted] mg. Give one tablet by mouth every eight hours for [redacted]. Hold for a [redacted]. This was ordered on [redacted] A review of the [redacted] medication administration record (MAR) indicated Resident [redacted] received the [redacted] mg five times (24% of the time) when it should have been held for a [redacted]. Below are the doses that were given but should have been held: - On 08/25/2021 at 2:00 PM for [redacted] and at 10:00 PM for [redacted] - On 08/26/2021 at 10:00 PM for [redacted] - On 08/31/2021 at 2:00 PM for [redacted] and at 10:00 PM for [redacted]	F 684	Element 3 Education was provided to the nursing staff regarding medication with parameters which included order review prior to administering medications, documentation related to the reason the medication was withheld, and physcian notification as needed for dose adjustments or medication discontinuation Element 4 The DON/designee will perform 5 charts every week x 4 weeks, then 3 charts every 2 weeks for 4 weeks, and evaluate outcome of audits DON/designee to present results of audit at QAPI monthly x 2 months and then during first quarterly meeting Performance Improvement COmmittee will review audit outcomes and revise the plan if needed	

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F 684	Continued From page 7	F 684		

A review of the [redacted] MAR indicated Resident [redacted] received the [redacted] mg 15 times (17% of the time) when it should have been [redacted]. Below are the doses that were given but should have been held:
- On 09/06/2021 at 10:00 PM for [redacted].
- On 09/09/2021 at 2:00 PM for [redacted] and at 10:00 PM for [redacted]
- On 09/10/2021 at 6:00 AM for [redacted], at 2:00 PM for [redacted] and at 10:00 PM for [redacted].
- On 09/11/2021 at 6:00 AM for BP [redacted]
- On 09/17/2021 at 10:00 PM for [redacted]
- On 09/18/2021 at 6:00 AM for [redacted] at 2:00 PM for [redacted] and at 10:00 PM for [redacted]
- On 09/19/2021 at 10:00 PM for [redacted]
- On 09/20/2021 at 10:00 PM for [redacted]
- On 09/23/2021 at 10:00 PM for [redacted]
- On 09/25/2021 at 10:00 PM for [redacted]

A review of the [redacted] MAR indicated Resident [redacted] received [redacted] mg on 09/18/2021 at 8:00 AM (1% of the time) for [redacted] when it should have been held for a [redacted].

A review of the [redacted] MAR indicated Resident [redacted] received the [redacted] 19 times (20% of the time) when it should have been held for a [redacted]. Below are the doses that were given but should have been held:
- On 10/02/2021 at 2:00 PM for [redacted]
- On 10/04/2021 at 2:00 PM for [redacted] and at 10:00 PM for [redacted]
- On 10/05/2021 at 10:00 PM for [redacted]
- On 10/07/2021 at 10:00 PM for [redacted].

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F 684	Continued From page 8 - On 10/09/2021 at 10:00 PM for [redacted] - On 10/10/2021 at 10:00 PM for [redacted] - On 10/11/2021 at 2:00 PM for [redacted]. - On 10/13/2021 at 10:00 PM for [redacted] - On 10/14/2021 at 2:00 PM for [redacted] and at 10:00 PM for [redacted]. - On 10/17/2021 at 2:00 PM for [redacted]. - On 10/18/2021 at 2:00 PM for [redacted]. - On 10/19/2021 at 10:00 PM for [redacted] - On 10/21/2021 at 2:00 PM for [redacted] and at 10:00 PM for [redacted] - On 10/23/2021 at 10:00 PM for [redacted]. - On 10/24/2021 at 10:00 PM for [redacted]. - On 10/28/2021 at 10:00 PM for [redacted] A review of the [redacted] MAR indicated Resident [redacted] received [redacted] mg four times (4% of the time) when it should have been held for a [redacted]. Below are the doses that were given but should have been held: - On 10/03/2021 at 8:00 AM for [redacted] - On 10/12/2021 at 8:00 AM for [redacted]. - On 10/21/2021 at 8:00 AM for [redacted] - On 10/22/2021 at 8:00 AM for [redacted]. A review of the [redacted] MAR indicated Resident [redacted] received the [redacted] 11 times (12% of the time) when it should have been held for an [redacted]. Below are the doses that were given but should have been held: - On 11/03/2021 at 2:00 PM for [redacted] and at 10:00 PM for [redacted]. - On 11/04/2021 at 10:00 PM for [redacted]. - On 11/06/2021 at 10:00 PM for [redacted] - On 11/07/2021 at 10:00 PM for [redacted] - On 11/08/2021 at 10:00 PM for [redacted] - On 11/09/2021 at 2:00 PM for [redacted] and at 10:00 PM for [redacted].	F 684		

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F 684	Continued From page 9 - On 11/11/2021 at 2:00 PM for [redacted] and at 10:00 PM for [redacted] - On 11/12/2021 at 10:00 PM for [redacted] During an interview with Licensed Practical Nurse (LPN) #1 on 12/21/2021 at 1:24 PM, LPN #1 stated the nurse administering the medications should pay attention to the entire order and follow them as written. LPN #1 stated if a medication was supposed to be held when a [redacted] was below the parameters prescribed by the physician, then the nurse should hold the medication and document the reason why it was being held. LPN #1 stated if a resident's medication had to be held frequently, the physician should be notified. LPN #1 stated giving a [redacted] medication to a resident with a [redacted] that was already low could be dangerous, by causing the resident's [redacted] to drop even lower. During an interview with LPN #3 on 12/21/2021 at 3:20 PM, LPN #3 stated not all [redacted] medications required a [redacted] to be taken before they were given, but some did. LPN #3 stated she always took her own residents' [redacted] prior to administering a [redacted] medication and would hold the medication if the reading was below those ordered by the physician. LPN #3 stated if the medication was held, it should be documented on the MAR. During an interview with LPN #4 on 12/21/2021 at 3:32 PM, LPN #4 stated she always checked a resident's [redacted] prior to giving a blood pressure medication and held the medication if the resident's [redacted] reading was below the parameters set by the physician.	F 684		

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During an interview with LPN #2 on 12/22/2021 at 10:13 PM, LPN #2 stated a [redacted] medication should be held if a resident's [redacted] was below the parameters set by the physician and it should be documented on the MAR. LPN #2 stated if the resident's medication was being held frequently, the physician should be notified.

During an interview with the Director of Nursing (DON) on 12/22/2021 at 2:13 PM, the DON stated if a resident had parameters set up on their [redacted] medications for when to hold the medication, the nurse should follow those parameters and document that the medication was being held and the reason why. The DON stated the nurses took their own residents [redacted] prior to administering the medications and needed to pay closer attention to the orders to make sure they were not giving a medication when it should be held. The DON stated giving a [redacted] medication to a resident with an already [redacted] could cause the resident's [redacted] to drop even lower, causing [redacted], and other problems. The DON stated he had only been working at the facility for approximately one month. The facility had done random audits in [redacted] and identified a problem with medications that had parameters and started a performance improvement plan (PIP).

A review of the PIP, dated [redacted], indicated the clinical team performed random audits and identified areas of improvement in documentation of medication administration and not administering medications when vitals were out of parameters. It indicated the nurse must review medications with parameters prior to administering medications, and if the medication

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F 684	Continued From page 11 was withheld, the nurse should document the reason and notify the physician if needed. The PIP indicated if recurrent incidents occurred, the physician should be notified for possible medication review or dose change. The PIP indicated the staff would be in-serviced. A review of the education provided to the nursing staff on [redacted] had eight nurse signatures. During an interview with the Nursing Home Administrator (NHA) on 12/22/2021 at 3:30 PM, the NHA agreed the nurses should be following physician orders for when to hold a medication. A review of the facility's policy and procedure, titled, "Medication Administration," effective 01/2015, indicated, "The nurse takes and records any necessary vital signs as indicated for the order on the Medication Administration Record. If vital sign readings are outside the parameters established by the medication order and/or facility policy, the nurse will hold the medication and if necessary, contact the physician for further instruction."	F 684		
F 690 SS=D	New Jersey Administrative Code §8:39-29.2(d) 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 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		2/5/22

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CARE ONE AT WALL	2621 HIGHWAY 138 WALL, NJ 07719

(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 690	Continued From page 12 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 interview, record review and review of facility policies, it was determined that the facility failed to ensure there was a valid medical justification for an [redacted] for one (Resident [redacted]) of three residents reviewed for catheter use. Specifically, the facility failed to have physician's orders and a care plan for the care and use of Resident [redacted] and failed to have an assessment for the justification for the [redacted]. Findings included: 1. A review of Resident [redacted] medical record indicated the facility admitted the resident with a	F 690	Element 1 Resident [redacted] has been discharged from facility Element 2 Resident with diagnosis of [redacted] requiring [redacted] has the potential to be affected by this practice. Chart audits were conducted in November of all residents currently at the facility, and the practice was corrected/ Element 3	

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F 690	Continued From page 13 diagnosis including [redacted]. The admission Minimum Data Set (MDS), dated [redacted], indicated the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident had [redacted] impairment. A further review of the MDS indicated the resident required extensive assistance of one to two staff for activities of daily living (ADLs) including bed mobility, transfers, toilet use, and personal hygiene. The MDS assessment indicated the resident was always incontinent of bowel and bladder and did not indicate the resident had an indwelling urinary catheter. A review of the [redacted] computerized physician orders (CPO) indicated Resident #3 had an order for an [redacted] every shift, starting [redacted]. A further review of the CPO revealed no further orders for the [redacted] including the diagnosis for the [redacted], or orders for care of the [redacted]. A review of a nursing progress note, dated [redacted], indicated Resident [redacted] had a [redacted]. A physician's progress note on [redacted] indicated Resident [redacted] had an [redacted] with [redacted] and indicated the resident had [redacted]. A further review of progress notes during Resident [redacted]s stay at the facility indicated the resident had an [redacted] A review of the comprehensive care plan, dated	F 690	Education on [redacted] was provided to the nursing staff which included [redacted] care. The nursing staff were also educated regarding care plan documentation and interventions implemented. Element 4 The DON/designee will perform 5 charts every week x 4 weeks, then 3 charts every week for 4 weeks, and evaluate outcome of audits. DON to present results of audits at QAPI monthly x 2 months and then during first quaterly QAPI Performance Improvement Committee will review audit outcomes and revise the plan if needed.	

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F 690	Continued From page 14 [redacted], revealed Resident #3 did not have a care plan for the use and care of a [redacted]. A review of Resident [redacted] record revealed the resident did not have an assessment to determine the justification of the [redacted] The record indicated the facility did not attempt a trial to determine if the resident required the continuing need for the [redacted]. During an interview with Licensed Practical Nurse (LPN) #1 on 12/21/2021 at 1:24 PM, LPN #1 stated a resident with a [redacted] needed to have a medical necessity for the [redacted], such as [redacted] to [redacted] LPN #1 stated if the resident did not have a medical reason for the [redacted], it should be removed. LPN #1 stated a resident that required a [redacted] needed to have an order for the catheter that included the medical justification for the [redacted] orders when to change the [redacted], orders for the daily care of [redacted], and orders to [redacted] if needed. LPN #1 stated the use of a [redacted] should also be care planned. During an interview with LPN #3 on 12/21/2021 at 3:20 PM, LPN #3 stated a resident with a [redacted] should have orders that included the reason for the [redacted], and orders to care for it and to change it as needed. During an interview with LPN #4 on 12/21/2021 at 3:32 PM, LPN #4 stated a resident had to have a reason to have a [redacted] with documentation to justify its use. LPN #4 stated the resident also had to have orders for a [redacted] that included changing the [redacted], the	F 690		

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F 690	Continued From page 15	F 690		

[redacted]r, and the care [redacted]. LPN #4 stated a resident having a [redacted] should be care planned for it.

During an interview with LPN #2 on 12/22/2021 at 9:35 AM, LPN #2 stated a resident had to have a medical reason for a [redacted] and required orders to care for the [redacted]

The Director of Nursing (DON) was interviewed on 12/22/2021 at 10:13 AM. The DON stated a resident that admitted to the facility with a [redacted] needed to be assessed for the need to continue the use of the [redacted] and should be removed if no longer necessary. The DON stated the resident must have documentation for the justification of a [redacted] and orders for the care of the [redacted] The DON stated the orders should include the [redacted], when to change it, whether it is routinely or PRN, and for the care of the [redacted]. The DON stated the use of a catheter should be on the resident's care plan with interventions for care. The MDS coordinator would be responsible for adding a [redacted] to the care plan if it was present during the MDS assessment; otherwise, any nurse on the floor could update the resident's care plan when needed. The DON stated the facility had done random audits in October 2021, identified a problem with [redacted], and started a performance improvement plan (PIP).

A review of the PIP, dated 10/02/2021, indicated the clinical team performed random audits and identified areas of improvement in monitoring and documentation of [redacted]. The PIP indicated the staff must document existing [redacted] on admission and new [redacted] for existing residents following protocol. The PIP indicated documentation must include [redacted]

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F 690	Continued From page 16 diagnosis, and monitoring for infection. The PIP indicated the care plan should be reviewed and updated quarterly and as needed. The PIP indicated the staff would be in-serviced. A review of the education provided to the nursing staff on [redacted] had 16 nurse signatures. During an interview with the Nursing Home Administrator (NHA) on 12/22/2021 at 3:30 PM, the NHA agreed a resident needed to have justification and orders for an [redacted]. A review of the facility's policy and procedure, titled, [redacted] Care," last revised 09/2014, revealed information on [redacted] but did not include any information on assessing the need for a [redacted]. New Jersey Administrative Code §8:39-27.1(a)	F 690		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		2/5/22

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F 758	Continued From page 17 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ149826 Based on interviews, record reviews, and review of facility policies, it was determined that the facility failed to ensure three (Resident [redacted], Resident [redacted], and Resident [redacted]) of three residents reviewed were not receiving unnecessary [redacted] medications. Specifically, the facility	F 758	Element 1 Resident [redacted] resident [redacted] and resident # [redacted] have been discharged from facility after successful rehab stay. Element 2 Resident recieving [redacted]	

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F 758	Continued From page 18 failed to ensure consents were obtained prior to administering [redacted] medications and failed to ensure behavior tracking was being documented and monitored for Resident [redacted] Resident [redacted] and Resident [redacted] Findings included: A review of the facility's policy and procedure, titled, "Psychopharmacologic Medication Policy," last revised 09/06/2018, indicated, "Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use ...Written informed consent shall be obtained for all classes of psychopharmacological medications after risks and benefits of therapy have been discussed with the resident or the resident's legal representative ...Monitor residents for targeted behaviors and medication side effects daily and document by exception as they occur. Monthly, the nurse will analyze the results of the behavior and medication side effect monitoring noting the quantity of behavioral episodes, trending of behaviors and effects of any changes in medication. Quarterly, the interdisciplinary team will assess the resident for continued need and gradual dose reduction based on the daily and monthly monitoring of behaviors, effectiveness of medications, presence of side effects and ADL and nutritional status." 1. A review of Resident [redacted] medical record indicated the facility re-admitted Resident [redacted] with diagnoses that included [redacted], and	F 758	medication has the potential to be affected by this practice. Element 3 Pharmacy consultant provided education to nursing staff on [redacted] medication use which included physician order review, documentation related to effects, risks and benefits, and gradual dose reduction initiative. The nursing staff were also educated on obtaining consents and behavior monitoring of residents on [redacted] medications Element 4 The DON/designee will perform 5 charts every week x 4 weeks, then 3 charts every 2 weeks for 4 weeks and evaluate outcome of audits. DON to present results of audits at QAPI monthly x 2 months and then during first quarterly QAPI Performance Improvement Committee will review audit outcomes and revise the plan if needed	

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F 758	Continued From page 19 [redacted]. A review of the quarterly Minimum Data Set (MDS), dated [redacted], indicated the resident had [redacted] impairment with a Brief Interview for Mental Status (BIMS) score of [redacted] with no documented behaviors. A further review of the MDS indicated the resident required extensive assistance of one person for their activities of daily living (ADLs). The resident did not take any antipsychotic, antianxiety, or antidepressant medications at the time of this assessment. A review of Resident [redacted] comprehensive care plan, dated [redacted], indicated Resident [redacted] was at risk for changes in [redacted]. Interventions included to assess for physical/environmental changes that may precipitate change in mood, observe for mental status/mood state changes when new medication is started or with dose changes, and offer choices to enhance sense of control. A review of the [redacted] computerized physician orders (CPO) indicated Resident [redacted] received orders on [redacted] for the following: - [redacted] of [redacted] milligrams (mg). Give one tablet by mouth one time a day for [redacted] - [redacted], an [redacted] mg. Give one tablet by mouth every eight hours for [redacted] The medical record revealed no documentation of Resident [redacted] or Resident [redacted] family being notified of the new medications. A further review revealed no consent for the [redacted] or documentation to indicate the resident or family had been educated about the risks and benefits of taking a [redacted] medication. The medical record did	F 758		

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not include any documentation of behavior monitoring or tracking to indicate the need for [redacted] medications.

A review of the comprehensive care plan, dated [redacted], indicated it was not updated with the resident's use of [redacted] medications

A review of a [redacted] form, dated [redacted] indicated Resident [redacted] was started on [redacted] at their last hospital stay to help with behaviors. The note indicated the resident had periods of [redacted] but the behavior seemed mostly related to [redacted] due to medical condition, loss of independence, and having to be in a facility. The note indicated the resident had no evidence of [redacted] during the evaluation. The note indicated the [redacted] was to be reduced to every 12 hours for [redacted] and the resident was to start [redacted] mg for [redacted]. A further review of the note revealed no evidence of the resident's family being notified of the dosage change of the [redacted] or of the addition of [redacted] ([redacted]).

A review of the [redacted] CPO indicated Resident [redacted] received a new order on [redacted] for [redacted] mg. The order indicated to give one tablet by mouth one time a day for [redacted]. The order for the [redacted] was changed on [redacted] mg and to give one tablet by mouth every 12 hours for [redacted].

A review of the resident's record revealed no documentation of Resident [redacted] or Resident [redacted] family being notified of the dosage change of the [redacted] or the addition of the new medication, [redacted] A further review of the record revealed no consent for the [redacted] or documentation to

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indicate the resident or family had been educated about the risks and benefits of taking another [redacted] medication.

A review of a nursing progress note, dated [redacted], indicated Resident [redacted] family requested the [redacted] be discontinued, and the family requested to be notified of any medication changes.

A review of a social service progress note, dated [redacted], indicated Resident [redacted] family expressed satisfaction with the medication reconciliation and the resident's improved [redacted] state.

A review of the [redacted] CPO indicated the [redacted] was discontinued on [redacted] per family request, and the [redacted] was discontinued on [redacted] per family request.

2. A review of Resident [redacted] medical record revealed the facility admitted Resident [redacted] on [redacted] with diagnoses that included [redacted]).

A review of the admission Minimum Data Set (MDS), dated [redacted], indicated Resident #6 had [redacted] impairment, with a Brief Interview for Mental Status (BIMS) score of [redacted] of [redacted]. The assessment indicated the resident required extensive assistance of one person for all their activities of daily living (ADLs). A further review of the assessment indicated the resident took an [redacted] six out of seven days during the assessment period. No gradual dose reduction (GDR) had been

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F 758	Continued From page 22 attempted or documented as being clinically contraindicated. A review of the comprehensive care plan, dated [redacted] and last revised [redacted] indicated Resident [redacted] was at risk for adverse effects related to [redacted] drug use of [redacted] ([redacted]) and [redacted]. Interventions included to evaluate effectiveness and side effects of medications for possible decrease/elimination of [redacted] drugs, notify physician of decline in ADL ability or mood/behavior related to a dosage change, [redacted] consult and follow-up as needed, and report to physician signs of adverse reactions such as decline in mental status, decline in positioning/ambulation ability, lethargy, complaints of dizziness, tremors, etc. A review of the [redacted] computerized physician orders (CPO) indicated Resident [redacted] was admitted to the facility with orders for: - [redacted] mg (milligrams). Give one tablet by mouth one time a day for [redacted]. - [redacted] mg. Give one tablet by mouth at bedtime for [redacted]. - [redacted] mg. Give one tablet by mouth every eight hours as needed (PRN) for [redacted] for 14 days (This medication was discontinued on [redacted]. A review of Resident [redacted] medical record revealed no consent for the [redacted], [redacted] reviewing that the risks and benefits of the medications had been obtained prior to the resident being administered the medication. A further review of the record revealed no behavior tracking was initiated or being monitored for the use of the [redacted] medications.	F 758		

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A review of the [redacted] medication administration record (MAR) indicated tracking for side effects began for the [redacted] on [redacted].

3. A review of Resident [redacted] medical record indicated the resident was admitted to the facility on [redacted] with diagnoses which included [redacted] with [redacted] symptoms and [redacted]. A review of the admission Minimum Data Set (MDS), dated [redacted], indicated the resident had [redacted], with a Brief Interview for Mental Status (BIMS) score of [redacted]. A further review of the MDS assessment revealed it was still in progress, and other sections of the assessment had not been completed yet.

A review of the comprehensive care plan, dated [redacted], indicated Resident [redacted] was a [redacted] risk related to [redacted], and prior hospitalizations for [redacted]. Interventions included to administer medications as ordered, attempt [redacted] reduction per physician orders and report any decline in ADL ability or mood, identify available resources/needs for treatment, [redacted] evaluation and treatment as needed.

A review of the [redacted] computerized physician orders (CPO) indicated Resident [redacted] was admitted with orders that included:
- [redacted] milligrams (mg), Give one tablet by mouth one time a day for [redacted].
- [redacted] mg. Give one tablet by mouth at bedtime for [redacted]

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F 758	Continued From page 24 - [redacted] mg. Give one tablet by mouth three times a day for [redacted]. - Side effect tracking for [redacted] medications. - Side effect tracking for [redacted] medications. A review of Resident [redacted] record revealed no consent for the [redacted] reviewing that the risks and benefits of the medications had been obtained prior to the resident being administered the medications. A further review of the record revealed no behavior tracking was initiated or being monitored for the use of the medications. During an interview with Licensed Practical Nurse (LPN) #1 on 12/21/2021 at 1:24 PM, LPN #1 stated she documented residents' behaviors when they occurred in the progress notes. She stated side effects were monitored daily and documented on the MAR, but no behavior tracking was done. LPN #1 stated a resident with an order for a PRN [redacted] medication could only have the order for 14 days, and then they had to be re-evaluated by the physician. LPN #1 stated all PRN [redacted] medications were supposed to be entered into the electronic record with an automatic stop date 14 days later, and then the resident must be seen by the physician to renew the order. LPN #1 stated consents should be obtained for all [redacted] medications and should be obtained before administering the medication. LPN #1 stated the nurse admitting the resident was responsible for obtaining the consent, and it could be obtained by calling the resident's family. During an interview with LPN #3 on 12/21/2021 at 3:20 PM, LPN #3 stated behavior tracking was done as a progress note on the MAR, but only if a	F 758		

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CARE ONE AT WALL	2621 HIGHWAY 138 WALL, NJ 07719

(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 758	Continued From page 25	F 758		

behavior occurred. She stated she was not sure if specific behaviors needed to be monitored or just behaviors in general. LPN #3 stated it was the nurse manager's responsibility to obtain consents for medications.

During an interview with LPN #4 on 12/21/2021 at 3:32 PM, LPN #4 stated it depended on the type of medication the resident was taking to determine what behaviors to monitor for, such as monitoring for crying and sadness if a resident took an antidepressant or monitoring for pacing and restlessness if a resident took an antianxiety medication. LPN #4 stated it was the social worker's responsibility to obtain consents for [redacted] medications.

The social worker was not available during the survey to interview.

During an interview with the Director of Nursing on 12/22/2021 at 10:13 AM, the DON stated the facility had done an ad hoc (when necessary) meeting the previous night to address behavior monitoring and side effect tracking for [redacted] care plans, and incomplete [redacted] medication consent forms.

A review of the performance improvement plan (PIP), dated [redacted], indicated the facility was to initiate behavior monitoring/side effect tracking for residents who had psychotropic medications ordered and initiate/updated [redacted] care plans on residents who had [redacted] medications ordered. The plan indicated a review of records for residents with orders for [redacted] medications would be done to ensure all consents were completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. BUILDING _____ B. WING _____	C 12/22/2021

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F 758	Continued From page 26 During a second interview with the DON on 12/22/2021 at 2:13 PM, the DON stated the facility had identified the problem with [redacted] medications during the survey, and that was why they initiated the PIP and had started doing education with the staff. The DON stated consent should be obtained for all [redacted] medications before they were administered. The DON stated the admitting nurse or the nurse taking the order from the physician should be responsible for obtaining the consent. The DON stated behavior tracking should be specific for each resident and documented routinely on the MAR. The DON stated any PRN [redacted] medication should have a 14-day stop date on it, and the resident would need to be reassessed by the physician for the medication to be continued. The DON stated the facility reviewed each resident in a [redacted] pharmacologic meeting quarterly for a possible gradual dose reduction. During an interview with the Nursing Home Administrator (NHA) on 12/22/2021 at 3:30 PM, the NHA agreed that the facility was working on getting consents for [redacted] medications, and that behavior monitoring needed to be done for any resident on [redacted] medications. New Jersey Administrative Code: § 8:39-5.1(a)	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556213	A. BUILDING: _____ B. WING _____	C 12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT WALL	2621 HIGHWAY 138 WALL, NJ 07719

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S 000	Initial Comments Complaint #: NJ149047, NJ149826, NJ150341 Census: 125 Sample Size: 9 TYPE OF SURVEY: Complaint Survey The facility is not in substantial compliance with all of 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.	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 #NJ150341 Based on interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met for 13 of 14 day shifts reviewed. This deficient practice had the potential to affect all residents. Findings included:	S 560	Element 1 The facility leadership team has met ongoing basis and continue to identify staffing challeges and areas of improvement for licensed and certified staffing needs. Element 2 All have potential to be affected. Element 3 The facility has implemented significant	2/5/22

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S 560	Continued From page 1 Reference: New Jersey Department of Health (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 aide to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties. 1. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 11/21/2021 - 12/04/2021, revealed staff-to-resident ratios that did not meet the minimum requirements as listed below: -11/21/2021 - 11 CNAs to 115 residents on the day shift, required 15 CNAs. -11/22/2021 - 11 CNAs to 115 residents on the day shift, required 15 CNAs. -11/23/2021 - 12 CNAs to 114 residents on the day shift, required 15 CNAs. -11/24/2021 - 10 CNAs to 113 residents on the	S 560	above market rate for nurses and certified nursing assistants including sign-on bonuses where appropriate. The facility continues to conduct ongoing job recruitment with immediate interviews and contigency offers. The facility implemented expedited but robust onboarding process to new hires. The facility will use agency staff as needed to meet staffing needs. Element 4 The DON/ADON meets with staffing coordinator daily to review call outs if any, facility census vs census needd The DON and ADON will monitor call outs and staffing ratios weekly until the requirement is met. The results of the audits will be forwarded to the facility Administrator and QAPI committee for further review and recoomendations.	

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S 560	Continued From page 2 day shift, required 15 CNAs. -11/26/2021 - 12 CNAs to 112 residents on the day shift, required 14 CNAs. -11/27/2021 - 11 CNAs to 112 residents on the day shift, required 14 CNAs. -11/28/2021 - 9 CNAs to 112 residents on the day shift, required 14 CNAs. -11/29/2021 - 11 CNAs to 112 residents on the day shift, required 14 CNAs. -11/30/2021 - 11 CNAs to 117 residents on the day shift, required 15 CNAs. -12/01/2021 - 10 CNAs to 116 residents on the day shift, required 15 CNAs. -12/02/2021 - 12 CNAs to 116 residents on the day shift, required 15 CNAs. -12/03/2021 - 12 CNAs to 116 residents on the day shift, required 15 CNAs. -12/04/2021 - 11 CNAs to 116 residents on the day shift, required 15 CNAs. During an interview with the Director of Nursing (DON) on 12/22/2021 at 2:13 PM, the DON stated they were aware of the state regulations for staffing and tried to meet the requirements, but sometimes it was very difficult. The DON stated they used several staffing agencies, offered bonuses, and did many other interventions to meet their staffing requirements, but it was very difficult. During an interview with the Nursing Home Administrator (NHA) on 12/22/2021 at 3:30 PM, the NHA stated the facility tried to meet the requirements of the state regulation, but sometimes it was difficult due to staff calling off at the last moment and not being able to cover the shift appropriately. The NHA stated they used staffing agencies, but they were not always able to assist with the staffing needs.	S 560		