STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING _____ B. WING _____	C 02/01/2023

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ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

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F 000	INITIAL COMMENTS Complaint #: NJ160140, NJ158836, NJ156112, NJ155883, and NJ154287 Census: 92 Sample Size: 13 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. Survey date: 01/25/2023 through 02/01/2023.	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); (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)	F 580		2/10/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/27/2023

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F 580	Continued From page 1 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 #NJ154287 Based on record review, interviews, and facility policy review, it was determined that the facility failed to notify the resident's responsible party with changes in the plan of care for 1 (Resident #1) of 3 residents reviewed for notification of change in condition. Specifically, the facility failed to notify Resident #1's responsible party of abnormal lab results that were received and new orders that were implemented in response to the lab results.	F 580	F580 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The resident has since been discharged from the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 580	Continued From page 2 Findings included: Review of a facility's undated policy, titled, "Change in a Resident's Condition or Status," indicated, "Our facility promptly notifies the resident, his or her attending physician and the resident's representative of changes in the resident's medical/mental condition and/or status. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: there is a significant change in the resident's physical, mental, or psychosocial status." A review of Resident #1's "Admission Record" revealed the facility admitted the resident with diagnoses that included EX Order 26 § 4b1 [redacted] The admission record further revealed Resident #1's responsible party (RP), RP #1, was listed as the first emergency contact and RP #1 was the resident's power of attorney (POA) for care. A review of the admission Minimum Data Set (MDS), dated [redacted] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was severely cognitively impaired. The MDS indicated the resident required extensive assistance with all activities of daily living (ADLs). A review of Resident #1's care plan, initiated 04/05/2022, indicated the resident had EX Order 26 § 4b [redacted]	F 580	An audit of all lab results received during the previous 30 days was conducted and all associated medical records were checked if residents' representatives have been informed of lab results and any associated change in condition and/or physician orders. All residents' representatives have been informed of lab results received within the past 30 days and any associated change in condition and/or physician orders. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Lab results received will be reviewed each day by nurse management and clinical records checked to ensure that all residents' representatives have been informed of lab results and any associated change in condition and/or physician orders. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Nursing or designee will conduct a random audit of 3 lab results and associated medical records weekly for 3 weeks and monthly for 3 months thereafter and forward results to the administrator for review. The results of the audits will be reviewed by the facility's Quality Assurance Committee at its quarterly meeting for 6	

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F 580	Continued From page 3 EX Order 26 § 4b1 [redacted] A review of a "Nurse Practitioner Note," dated 04/29/2022 at 3:15 PM, revealed Resident #1's [redacted] from the previous day despite [redacted]. The note indicated the [redacted] the previous day. The note indicated preliminary results of the [redacted] were [redacted] in clusters and [redacted] in chains, and the second set o[redacted]. The note indicated the attending physician ordered EX Order 26 § 4b1 [redacted] The note indicated the plan of care was discussed with the resident and nursing staff. A review of Resident #1's physician orders revealed an order for [redacted], which directed staff to administer [redacted], ordered [redacted] Review of Resident #1's medical record revealed no documentation of Resident #1's responsible party being notified of the lab results or of the addition of an EX Order 26 § 4b1 to the resident's treatment plan. During an interview on 01/27/2023 at 3:55 PM, RP #1 stated they were not notified of the lab results that were received the day Resident #1 was sent out to the EX Order 26 § 4b or of the order for the additional EX Order 26 § 4b1. During an interview on 02/01/2023 at 1:58 PM, the Director of Nursing (DON) stated the residents and responsible party should be notified	F 580	months to ascertain if any trends are present and determine if any further action is needed.	

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F 580	Continued From page 4 of any unusual lab results and new orders the doctor gives, and it should be documented in a progress note. During an interview on 02/01/2023 at 4:22 PM, the Administrator stated the resident had to be notified of changes, but the resident's responsible party only had to be notified if the resident requested it or if their power of attorney had been put into effect. New Jersey Administrative Code § 8:39-5.1(a)	F 580		
F 684 SS=E	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 #NJ154287 and #NJ156112 Based on record review, interviews, and facility policy review, it was determined that the facility failed to ensure quality care and treatment were provided for 3 (Residents #3, #4, and #1) of 13 sampled residents. Specifically, the facility failed to ensure all admission medications were implemented for Resident #3 and Resident #4 and failed to ensure accurate laboratory tests were obtained for Resident #1.	F 684	F684 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents #1, #3 & #4 have since been discharged from the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice:	2/10/23

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F 684	Continued From page 5 Findings included: 1. The facility's undated policy, titled, "Admission Criteria," indicated, "Prior to or at the time of admission, the resident's attending physician provides the facility with information needed for the immediate care of the resident, including orders covering at least medication orders, including (as necessary) a medical condition or problem associated with each medication." A review of Resident #3's "Admission record" revealed the facility admitted the resident on EX Order 26 § 4b1 with a diagnosis that included EX Order 26 § [redacted] A review of the admission Minimum Data Set (MDS), dated [redacted], revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of EX Order [redacted], indicating the resident was EX Order 26 § 4b1 [redacted]. A review of the "Discharge Form" from the hospital, dated [redacted] revealed an order for EX Order 26 § 4b1 [redacted] EX Order 26 § 4b1 [redacted] A review of Resident #3's "Order Summary Report" indicated the order for the EX Order 26 § 4b1 [redacted] was not entered and started until [redacted], nine days after the resident was admitted to the facility on EX Order 26 § 4b1. According to the order, Resident #3 was to receive [redacted]. A review of an "IDT [Interdisciplinary Team] Care	F 684	An audit of hospital, previous facility and previous provider records and facility medical records from all residents newly admitted or re-admitted during the previous 30 days was conducted. All records were checked to ensure that orders had been to confirmed and reviewed by the attending physician and that all orders were being carried out. All physician orders for current residents are being carried out. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Each day the Director of Nursing or designee will conduct a review of hospital, previous facility and previous provider records and facility medical records from all residents newly admitted or re-admitted during the previous day to ensure that orders have been confirmed and reviewed by the attending physician and that all orders are being carried out. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Nursing or designee will conduct a random audit of 2 newly admitted residents and associated medical records weekly for 3 weeks and monthly for 3 months thereafter and forward results to the administrator for review. The results of the audits will be reviewed	

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F 684	Continued From page 6 Plan Meeting Review," dated [redacted], indicated the resident was checking their [redacted] at home but was not on [redacted] at home. A review of Resident #3's [redacted] "Medication Administration Record" (MAR) revealed the [redacted] was started on [redacted] at 4:00 PM. During an interview on 01/31/2023 at 1:20 PM, Unit Manager (UM) #3 stated the facility received a list of discharge medications when a resident was admitted from the [redacted]. She stated they would go over these orders with the physician and clarify any orders if needed. She stated the night nurse did a medical record check every night to double check the orders to ensure they were correct. UM #3 reviewed Resident #3's record and stated she was not sure why the [redacted] were not ordered when the resident was admitted. During an interview on 01/31/2023 at 1:30 PM, Registered Nurse (RN) #4 stated she was a nursing supervisor for the whole building. She stated that when a resident was admitted or readmitted to the facility, they received the admission orders from the hospital. She stated she would go over the medications one by one with the physician to verify. She stated the supervisor or Director of Nursing (DON) was responsible for double checking the orders. She stated she did not remember Resident #3. During an interview on 01/31/2023 at 2:03 PM, Licensed Practical Nurse (LPN) #5 stated when a resident was admitted to the facility, their admission orders would come in a packet from the last place they were at, whether it was a hospital or another nursing facility. She stated	F 684	by the facility's Quality Assurance Committee at its quarterly meeting for 6 months to ascertain if any trends are present and determine if any further action is needed.	

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those orders were reviewed with the physician. LPN #5 stated the nursing supervisors usually put the orders in and then the other nurse reviewed them. She stated usually one nurse would do the assessment and the other would do the orders.

During an interview on 01/31/2023 at 2:54 PM, LPN #11 stated that when a resident was admitted or readmitted to the facility, they came with a packet from the hospital with orders for medications. He stated they would call the physician and go over each medication and make changes if needed. He stated the supervisor double checked the orders.

During an interview on 01/31/2023 at 4:05 PM, LPN #9 stated when a resident was admitted to the facility, they received the orders for the medications that were on the EX Order 26 § 4b1 form. She stated they would call the physician and go over the orders with them. She stated the supervisor would go over everything afterwards.

During an interview on 02/01/2023 at 1:58 PM, the DON stated they received orders for a resident that was admitting or readmitting from the outgoing facility, usually in a packet that showed all the medications. She stated those were verified with the physician and double checked with another nurse. She stated the DON, ADON, and all supervisors should help with admissions. She stated she was not aware the orders for Resident #3's EX Order 26 § 4b1 had been missed from the admission orders.

During an interview on 02/01/2023 at 4:22 PM, the Administrator stated he had only been at the facility since October 2022 and was not familiar with Resident #3. The Administrator stated

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residents came to the facility with physician orders, and those were clarified with the oncoming physician and verified. He stated he was not familiar with how the nurses double checked the orders.

2. The facility's policy, titled, "Medication and Treatment Orders," undated, indicated, "Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include the prescriber's last name, credentials, the date the time of the order."

A review of Resident #4's "Admission Record" revealed the facility admitted the resident with diagnosis that included EX Order 26 § 4b1 .

A review of the five-day Minimum Data Set (MDS), dated , revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of , indicating the resident was EX Order 26 § 4b1 . EX Order 26 § 4b1 The MDS indicated the resident received EX Order 26 § 4b1

A review of Resident #4's care plan, initiated EX Order 26 § 4b1 , indicated the resident had EX Order 26 § 4b1 . Interventions included to administer diabetes medication as ordered by the doctor and monitor and document for side effects and effectiveness.

A review of a document titled "Discharge Disposition" from the hospital record, dated EX Order 26 § 4b1 , indicated Resident #4 had orders for EX Order 26 § 4b1

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time daily.

A review of Resident #4's "Order Summary Report" for active orders as of [redacted] revealed no order for the [redacted EX Order 26 § 4b1].

A review of Resident #4's physician orders revealed an order for [redacted EX Order 26 § 4b1].

A review of Resident #4's [redacted] "Medication Administration Record" (MAR) indicated the resident did not receive [redacted EX Order 26 § 4b1] on [redacted EX Order 26 § 4b1].

A review of a "Health Status Note," dated [redacted], indicated Resident #4 had concerns regarding their [redacted EX Order 26 § 4b1] and did not think they had received their long-acting [redacted EX Order 26 § 4b1].

During an interview on 01/31/2023 at 1:20 PM, Unit Manager (UM) #3 stated the facility received a list of discharge medications when a resident was admitted from the hospital. She stated they would go over those orders with the physician and clarify any orders if needed. She stated the night nurse did a medical record check every night to double check the orders to ensure they were correct. UM #3 reviewed Resident #4's record and stated she was not sure why the [redacted EX Order 26 § 4b1] was not ordered.

During an interview on 01/31/2023 at 1:30 PM, Registered Nurse (RN) #4 stated she was a nursing supervisor for the whole building. She stated when a resident was admitted or readmitted to the facility, they received the

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admission orders from the hospital. She stated she would go over the medications one by one with the physician to verify. She stated the supervisor or Director of Nursing (DON) was responsible for double checking the orders.

During an interview on 01/31/2023 at 2:03 PM, Licensed Practical Nurse (LPN) #5 stated when a resident was admitted to the facility, their admission orders would come in a packet from the last place they were at, whether it was a hospital or another nursing facility. She stated those orders were reviewed with the physician. LPN #5 stated the nursing supervisors usually put the orders in and then the other nurse reviewed them. She stated usually one nurse would do the assessment and the other would do the orders.

During an interview on 01/31/2023 at 2:54 PM, LPN #11 stated that when a resident was admitted or readmitted to the facility, they came with a packet from the hospital with orders for medications. He stated they would call the physician and go over each medication and make changes if needed. He stated the supervisor double checked the orders.

During an interview on 01/31/2023 at 4:05 PM, LPN #9 stated when a resident was admitted to the facility, they received the orders for the medications that were on the hospital discharge form. She stated they would call the physician and go over the orders with them. She stated the supervisor would go over everything afterwards.

During an interview on 02/01/2023 at 1:58 PM, the DON stated they received orders for a resident that was admitting or readmitting from the outgoing facility, usually in a packet that

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showed all the medications. She stated those were verified with the physician and double checked with another nurse. She stated the DON, ADON, and all supervisors should help with admissions. She stated she was not aware the orders for Resident #4's [redacted] had been missed from the admission orders.

During an interview on 02/01/2023 at 4:22 PM, the Administrator stated he had only been at the facility since October 2022. The Administrator stated residents came to the facility with physician orders and those were clarified with the oncoming physician and verified. He stated he was not familiar with how the nurses double checked the orders.

3. The facility's policy, titled, "Medication and Treatment Orders," undated, indicated, "Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include the prescriber's last name, credentials, the date the time of the order."

A review of Resident #1's "Admission Record" revealed the facility admitted the resident with diagnoses that included [redacted].

A review of the admission Minimum Data Set (MDS), dated [redacted] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was [redacted]. The MDS indicated the resident [redacted] The MDS indicated Resident #1 had a [redacted] and [redacted]

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EX Order 26 § 4b1 [redacted]

A review of Resident #1's care plan, initiated on [redacted], indicated the resident required EX Order [redacted]

A review of a "Health Status Note," dated [redacted], indicated a call was received from the physician with orders to do hourly EX Order 26 § 4b1 [redacted] EX Order 2 [redacted] fo EX Order 26 § 4b1 [redacted].

A review of Resident #1's physician orders revealed on order dated [redacted] for a EX Order 2 [redacted].

A review of Resident #1's medical record revealed there were no results for the EX Order 26 § [redacted] that was collected on [redacted]. According to the "Lab Results Report," the EX Order 26 § 4b1 [redacted]. A copy of the lab results was requested from the Director of Nursing (DON) on 01/30/2023 and was not provided by the end of the survey.

During an interview on 01/30/2023 at 2:47 PM, the DON stated the facility had done education and write-ups with the nurses in April 2022 due to labs not being reported to the physician and not being followed up on. The DON stated they also educated the nurses about taking verbal orders from the physician and making sure they read back the order for clarification. She said she did

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F 684	Continued From page 13 this after they had identified that lab orders were not being transcribed correctly. She stated she did not think the nurse took down the right order when she wrote the order for [redacted], and [redacted] for Resident #1 to be obtained because the physician had not mentioned it in their progress note. She stated the nurse was written up for that. During an interview on 01/31/2023 at 3:45 PM, Licensed Practical Nurse (LPN) #12 stated she would not document the physician ordered something if he did not actually order it, and she always repeated back the order to the physician for verification. She stated she did not know why the tests on Resident #1's [redacted] were not done as ordered by the physician. During an interview on 02/01/2023 at 4:22 PM, the Administrator stated he had only been at the facility since October 2022 and was not involved in the clinical aspect of the resident's care and deferred to the DON. New Jersey Administrative Code § 8:39-27.1(a)	F 684		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by	F 693		2/10/23

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F 693	Continued From page 14 enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ154287 Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to provide appropriate care and services to prevent complications of [redacted] for 3 (Residents #7, #9, and #1) of 3 residents reviewed for the use of feeding tubes. Specifically, the facility failed to ensure medications were administered through a [redacted] according to physician orders for the three residents. Findings included: Review of an undated facility policy titled, "Administering Medications through an Enteral Tube" indicated, "Administer each medication separately and flush between medications. Dilute crushed (powdered) medication with at least 30 ml [milliliters] of purified water (or prescribed amount). Administer each medication separately. If administering more than one medication, flush with 15 ml warm purified water (or prescribed amount) between medications. When the last of	F 693	F693 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 has since been discharged from the facility. LPN #1 was provided in-service education on the correct procedure for administering medication via [redacted]. Resident #7 and Resident #9 were both assessed and neither were found to have sufferered any adverse reaction due to the deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with enteral feeding tubes have the potential to be affected. All nurses were provided in-service education on the correct procedure for	

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F 693	Continued From page 15 the medication begins to drain from the tubing, flush the tubing with 15 ml of warm purified water (or prescribed amount)." 1. A review of Resident #7's "Admission Record" revealed the facility admitted the resident with diagnoses that included EX Order 26 § 4b1 [redacted] A review of the significant change Minimum Data Set (MDS), dated [redacted], revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was EX Order 26 § 4b1 [redacted]. The resident required extensive assistance with all activities of daily living (ADLs). The MDS indicated Resident #1 had a EX Order 26 § 4b1 [redacted] A review of Resident #7's care plan, initiated [redacted], indicated the resident required an EX Order 26 § 4b1 [redacted]. Interventions included to administer EX Order 26 § 4b1 as ordered; [redacted] for proper position before administering medications or EX Order 26 § 4b1 [redacted] as ordered or clinically indicated. Notify the physician or designee if above acceptable EX Order 26 § 4b [redacted]; consult dietitian as needed; consult speech therapy as needed. A review of Resident #7's "Order Summary Report" indicated orders related to the EX Order 26 § 4b [redacted] included: - EX Order 26 § 4b1 [redacted]	F 693	administering medication via enteral feeding tube. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: All Nurses will be provided annual in-service education on the correct procedure for administering medication via enteral feeding tube. All newly hired nurses will, upon hire be provided in-service education on the correct procedure for administering medication via enteral feeding tube. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Nursing or designee will conduct a random audit of the administering of medication of 2 residents with enteral feeding tubes weekly for 3 weeks and monthly for 3 months thereafter and forward results to the administrator for review. The results of the audits will be reviewed by the facility□s Quality Assurance Committee at its quarterly meeting for 6 months to ascertain if any trends are present and determine if any further action is needed.	

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EX Order 26 § 4b1 [redacted]

A medication pass observation was conducted on 01/30/2023 at 8:49 AM with Licensed Practical Nurse (LPN) #1 for Resident #7. The medications LPN #1 prepped for Resident #7 included:
- [redacted], which LPN #1 measured in a medication cup but then poured into a water cup without ensuring all the medication was removed out of the medication cup.
- [redacted] which LPN opened and poured into a medication cup.
- [redacted], which LPN #1 measured in a medication cup and then poured into a water cup.
- [redacted]
- [redacted].
- [redacted]
- [redacted].
- [redacted]

LPN #1 crushed all of the tablets together and poured the powder into a water cup. LPN #1 questioned to herself aloud at that time whether

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the medications should have been crushed separately or together. LPN #1 then took all three water cups and the medication cup into Resident #7's room. LPN #1 stopped Resident #7's [redacted]. LPN #1 then attempted to [redacted] by listening through a stethoscope for the position of the [redacted] by pushing air into the [redacted] but met resistance and had to force air into the [redacted]. She then attempted to flush the [redacted] with approximately [redacted] of water but it would not go down by gravity, so she put the plunger in the syringe and forced the water into the [redacted]. She then flushed the [redacted] with [redacted] again that went down the [redacted] by gravity. LPN #1 mixed water into the [redacted], filling the cup approximately 2/3 full, and poured it into the syringe to go into the [redacted] by gravity. She mixed water into the cup of liquid potassium approximately 2/3 full and poured it into the syringe to go into the [redacted] by gravity. She poured the medication cup of [redacted] into the water cup with the other crushed medications and filled the cup approximately 2/3 full with water and mixed it together and poured it into the syringe. LPN #1 had to keep adding water to the cup to get the medication residue off the sides of the cup and syringe.

2. A review of Resident #9's "Admission Record" revealed the facility admitted the resident with diagnoses that included [redacted].

A review of the admission Minimum Data Set (MDS), dated [redacted] revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was [redacted]

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EX Order 26 § 4b1. The MDS indicated the resident required extensive assistance with all activities of daily living (ADLs). The MDS indicated Resident #1 had a EX Order 26 § 4b1 and [redacted] EX Order 26 § 4b1 daily.

A review of Resident #9's care plan, initiated 01/07/2023, indicated the resident required EX Order 26 § 4b1 [redacted]. Interventions included to administer EX Order 26 § 4b1 as ordered; [redacted] for proper position before administering medications or feedings; check residual as ordered or clinically indicated. Notify the physician or designee if above acceptable volume; consult dietitian as needed; consult [redacted] as needed.

A review of the "Order Summary Report" indicated orders for the EX Order 26 § 4b1 included:
- [redacted] every shift with [redacted] (mL) per hour (hr.) for [redacted] hours for a total volume of [redacted] L. Up at 2:00 PM and down at 10:00 AM, ordered [redacted].
- Free water flushes of 100 mL every six hours four times a day, ordered 01/01/2023.
- May crush all medications according to guidelines and mix each medication separately in 5 mL of water every shift, ordered [redacted].

A medication pass observation was conducted on 01/30/2023 at 9:15 AM with Licensed Practical Nurse (LPN) #1 for Resident #9. The medications LPN #1 prepared for Resident #9 included:
- [redacted], which LPN #1 measured in a medication cup but then poured into a water cup without ensuring all the medication was

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removed out of the medication cup.
- EX Order 26 § 4b1 [redacted]

LPN #1 crushed all the tablets together and put them in a water cup and took the cup into the resident's room. LPN #1 checked the placement of the [redacted] by pushing air into the [redacted] with a [redacted] and listening with her stethoscope. She then flushed the tube with 30 mL of water. LPN #1 mixed the liquid [redacted] with water and put it in the syringe to go into the [redacted] via gravity. LPN #1 then mixed all the crushed medications with water and put it in the syringe to go in by gravity. She flushed the [redacted] with another [redacted] and capped off the [redacted].

3. A review of Resident #1's "Admission Record" revealed the facility admitted the resident with diagnoses that included [redacted] The admission record indicated the resident was discharged from the facility on [redacted].

A review of the admission Minimum Data Set (MDS), dated [redacted] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was [redacted]. EX Order 26 § 4b1 [redacted]

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EX Order 26 § 4b1 .

A review of Resident #1's care plan, initiated on [redacted], indicated the resident required [redacted] related to [redacted] and was on continuous [redacted]. Interventions included:
- Check for [redacted] placement and [redacted] volume per physician's orders and record. Hold [redacted] if greater than 70 cc [redacted].
- Received water flushes of 100 milliliters (mL) every eight hours.
- Dependent on [redacted] and water flushes ordered.
- Needs assistance/supervision/cueing with [redacted] and water flushes ordered. See physician orders for current [redacted] orders.
- Needs the head of the bed (HOB) elevated 30-45 degrees during and thirty minutes after [redacted].
- Listen to lung sounds per orders.
- Monitor/document/report to the physician as needed for [redacted]
- Registered dietitian (RD) to evaluate quarterly and as needed (PRN). Monitor caloric intake, estimate needs. Make recommendations for changes to [redacted] as needed.

A review of a "Health Status Note," dated [redacted], indicated the nurse was unable to flush Resident #1's [redacted] and start their [redacted], and the resident complained of [redacted] to the insertion site. The note

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indicated the resident was sent to the emergency room.

A review of an "Emergency Department Note," dated [redacted] indicated Resident #1 presented to the emergency department due to a [redacted]. The note indicated the tube was [redacted] in the emergency room and was working properly.

A review of Resident #1's April 2022 "Medication Administration Record" revealed LPN #1 had administered Resident #1's medications prior to the [redacted].

Following the medication pass observations with LPN #1 of Resident #7 and Resident #9, LPN #1 was unavailable for an interview.

During an interview on 01/31/2023 at 1:30 PM, Registered Nurse (RN) #4 stated medications could be crushed and administered at the same time to a resident with a [redacted] if the physician ordered it that way. She stated [redacted] should be flushed per the physician's orders.

During an interview on 01/31/2023 at 2:03 PM, Licensed Practical Nurse (LPN) #5 stated medications given through a [redacted] should be crushed individually and mixed with a small amount of water, and then the [redacted] should be flushed in between each medication with [redacted]. She stated the [redacted] should be flushed before and after giving medications.

During an interview on 01/31/2023 at 2:54 PM, LPN #11 stated medications given through a [redacted] should be crushed and given

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separately with 15 mL of water between each medication.

During an interview on 02/01/2023 at 1:58 PM, the Director of Nursing (DON) stated medications, whether given orally or through a feeding tube, should be given according to the physician's orders. She stated the medications could be crushed and given together if that was what the physician's order said. The DON stated LPN #1 should have administered the medications per the physician's orders.

During an interview on 02/01/2023 at 4:22 PM, the Administrator stated LPN #1 should have followed the facility's policy when administering the medications through the feeding tube like she was trained and obtained clarification from a nursing supervisor if she had questions on how to do the procedure correctly.

New Jersey Administrative Code § 8:39-29.2(d)

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S 000	Initial Comments Complaint #: NJ160140, NJ158836, NJ156112, NJ155883, and NJ154287 Census: 92 Sample Size: 13 TYPE OF SURVEY: Complaint 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.	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 #NJ156112 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 2 of 42 shifts reviewed. This deficient practice had the potential to affect all residents.	S 560	S560 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified.	2/10/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/27/23

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S 560	Continued From page 1 Findings included: 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 aid 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. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 01/08/2023 - 01/21/2023, revealed staff-to-resident ratios that did not meet the minimum requirements as listed below: 01/17/2023 - 7 CNAs to 88 residents on the evening shift. 01/18/2023 - 8 CNAs to 86 residents on the evening shift.	S 560	How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Staffing Coordinator will review staffing schedules for one week in advance daily to identify any potential shortfall in scheduled certified nursing assistants and call certified nurse aides and licensed nurses in staffing pool to fill vacant shifts. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Facility will take the following measures: • Advertise open positions. • Offer sign-on bonuses for newly hired certified nurse aides. • Offer bonuses for existing staff who refer newly hired certified nurse aides. • Sponsor qualified candidates to complete an approved Nurse Aide in Long Term Care Facilities Training and Competency Evaluation Program. • Offer free transportation for day and evening shifts to select locations. • The facility Director of Nursing and Scheduler will meet daily during the week to review recruitment efforts and current and following weeks staffing schedule. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Administrator / Designee will	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 During an interview on 01/31/2023 at 1:20 PM, Unit Manager (UM) #3 stated she had no concerns with the facility staffing at that time and felt like the facility had been doing well getting staff and maintaining staff. During an interview on 01/31/2023 at 1:30 PM, Registered Nurse (RN) #4 stated she was a nursing supervisor for the whole building. She stated she felt they had plenty of staff to meet the needs of the residents. She stated they would have call offs occasionally, but they were usually able to cover them and if not, then the supervisors would assist. During an interview on 02/01/2023 at 1:58 PM, the Director of Nursing (DON) stated she over staffed to make sure the resident's needs were met. She stated she tried to be on the floor as much as possible to help out also. She did not feel like they had any staffing issues. During an interview on 02/01/2023 at 4:22 PM, the Administrator stated staffing was challenging in any facility, but this facility seemed to have "strong staff." The Administrator denied concerns with their staffing and stated they had occasional call offs but tried to meet the needs of the residents on a consistent basis.	S 560	complete an audit of staffing and resident care needs / preferences 5 times per week for 2 weeks, then 3 times per week for 2 weeks. Additional audit frequency will be determined based on audit findings. Audit results will be submitted monthly to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315497 (Y1)	A. Building B. Wing (Y2)	3/13/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0580 Reg. # 483.10(g)(14)(i)-(iv)(15) LSC	Correction Completed 02/10/2023	ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 02/10/2023	ID Prefix F0693 Reg. # 483.25(g)(4)(5) LSC	Correction Completed 02/10/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060201		3/13/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/10/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO