STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315207		09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT KRESSON VIEW, LLC	2601 EVESHAM ROAD VOORHEES, NJ 08043

(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	F 000		
	STANDARD SURVEY: 09/07/21 CENSUS: 170 SAMPLE SIZE: 37 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. A COVID-19 Focused Infection Control Survey was conducted in conjunction with the recertification survey. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.			
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to maintain the call bell within reach for one resident. This deficient practice was identified for 1 of 2 residents (Resident #[redacted]) reviewed for falls and was evidenced by the following:	F 558	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because they require it.	9/28/21

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

Electronically Signed — 09/29/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 558	Continued From page 1 On 08/25/2021 at 11:50 AM, the surveyor observed Resident [redacted] lying in bed, with the call bell on the floor. On 08/27/2021 at 9:25 AM, the surveyor observed Resident [redacted] sitting up on the side of the bed, with the call bell on the floor. On 08/30/2021 at 10:00 AM, the surveyor observed Resident [redacted] lying in bed with the call bell hanging over the side rail, away from the resident, and pointed down, towards the floor. The resident stated he/she knew how to use the call bell, but that he/she could not locate it to demonstrate the process to the surveyor. According to the Admission Record, Resident [redacted] was admitted with diagnoses that included, but not limited to,[redacted] Review of the resident's Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted], included that Resident #[redacted] was [redacted] and that the resident had [redacted] without injury since the last assessment. Review of the resident's Care Plan, dated [redacted], included a focus of '[redacted]," with interventions that included "Place call light within reach while in bed," dated [redacted] and "[Resident [redacted]] was reminded to use the call light for all transfer or activity," dated [redacted] During an interview with the surveyor on 08/30/31	F 558	Complete Care at Kressonview - F558 Reasonable Accommodations Needs/Preferences Residents affected by deficient practice: 1. The call bell for resident [redacted] was secured and placed within resident's reach. Identifying other Residents who could be affected by the deficient practice: 2. All call bells were audited in the facility to ensure each call bell was secured and within reach of each resident. Measures or systemic changes to ensure that the deficiencies will not recur: 3. Call bells will be monitored by staff with each resident contact and ensure the call bell is secured within reach of each resident when unattended. All center personnel will be re-educated as to the process for call bell securement and ease of reach for each resident when unattended. The nurse educator will conduct monthly audits to ensure call bell compliance. Monitoring the continued effectiveness of the systemic change: 4. The process for adherence to call bell securement and ease of reach for all residents when unattended will be conducted via monthly audits by the nurse	

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F 558	Continued From page 2 at 10:06 AM, the Certified Nursing Assistant (CNA) stated that the resident uses the call bell when he/she needs assistance. The CNA further stated that she places the call bell on the side of the resident's bed prior to leaving the room, but that the resident can knock it off the bed. During an interview with the surveyor on 08/30/2021 at 10:15 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #2) stated the resident can use the call bell, to ask for assistance. The LPN/UM #2 further stated that he expected staff to secure the call bell to prevent the call bell from falling out of reach. During an interview with the surveyor on 08/30/2021 at 11:08 AM, the Director of Nursing (DON) stated that the resident can use the call bell, but he doesn't always use it. The DON further stated that staff should have ensured Resident #[redacted]s call bell was secured and placed within reach of the resident. Review of the facility's policy, "NSG101 Call Lights," revised 06/01/21, reflected that "patients will have a call light or alternative communication device within their reach at all times when unattended." NJAC 8:39-31.8 (c) (9)	F 558	educator. The report will be presented monthly at Quality Assurance and Improvement meeting. Date of Completion - 9/28/2021	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		9/28/21

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F 658	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to follow professional standards of clinical practice during medication administration. This deficient practice was identified for 1 of 3 nurses on 1 of 3 Units [redacted] Unit) observed during medication pass and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing a medical regimen as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."	F 658	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because they require it. Complete Care at Kressonview - F658 Services Provided Meets Professional Standards Residents affected by deficient practice: 1. Resident [redacted] was evaluated by the RN to determine any adverse effects related to not receiving prescribed medications and strength. The Physician was notified of the occurrence and that no adverse effects were relayed by the resident #[redacted]. LPN #4 was provided with re-education related to medication administration. Identifying other Residents who could be affected by the deficient practice: 2. All residents receiving medication will be assessed to ensure that all measures are taken by the licensed nurse to ensure proper medication administration. Re-education on proper medication administration will be conducted for all licensed nurses. Measures or systemic changes to ensure	

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F 658	Continued From page 4 On 08/26/2021 at 8:20 AM, the surveyor observed the Licensed Practical Nurse (LPN #4) administer medications to Resident [redacted]. LPN #4 dispensed five medications, including two tablets of [redacted]) [redacted] mg (milligrams). LPN #4 then administered the medications to the resident and returned to the medication cart to sign the Medication Administration Record (MAR). Afterwards, the surveyor made a request to review the [redacted] order with LPN #4. LPN #4 read the physician's order and acknowledged the order was for "[redacted] Tablet [redacted] MG [redacted] Give 2 tablet by mouth two times a day for [redacted]." When asked if the [redacted] administered was consistent with the [redacted] ordered, LPN #4 stated, "I am supposed to give [redacted] mg two tabs to equal [redacted] mg." During a follow-up interview with the surveyor on 08/26/2021 at 9:00 AM, LPN #4 stated that he ensures he administers the correct medication to the resident by checking the medication name and dosage against the physician's order in the MAR. Review of Resident #[redacted] MAR revealed the physician's order for "[redacted] Hour [redacted] Tablet [redacted] MG [redacted]) Give 2 tablet by mouth two times a day for [redacted]," with an order date of [redacted] During an interview with the surveyor on 08/26/2021 at 12:34 PM, the Registered Nurse	F 658	that the deficiencies will not recur: 3. Medication administration of licensed nurses will be conducted by the pharmacy consultant and nurse educator monthly. All licensed nurses will receive re-education related to proper medication administration. Monitoring the continued effectiveness of the systemic change: 4. The process for adherence to proper medication administration via the medication observation tool will be reviewed by the nurse educator monthly and the finding reported at the monthly Quality Assurance and Performance Improvement meeting.	

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F 658	Continued From page 5 (RN) in charge of the unit, stated that the medication nurse should perform three checks by comparing the medication to the physician's order in the MAR, to ensure the resident receives the right medication and dose. The RN then reviewed Resident [redacted]s medication orders to verify the aforementioned [redacted] order and stated that [redacted] mg two tablets was not the correct dosage, according to the physician's order. The RN further stated that it is important for the nurse to perform the three checks to prevent medication errors and that the LPN should have "caught that." During an interview with the surveyor on 08/26/2021 at 12:45 PM, the Director of Nursing (DON) stated that the medication nurse should perform checks to ensure the right resident receives the right medication and dose. The DON further stated that the LPN should have checked the medication against the physician's order in the MAR, prior to dispensing and prior to administering the medication. Review of the facility's Medication Administration: Oral policy, revised 06/01/2021, included, "Verify medication order on Medication Administration Record (MAR) with medication label for: Correct: Patient, Drug, Dose, Route, and Time." NJAC 8:39-27.1(a)	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		9/28/21

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F 686	Continued From page 6 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) apply [redacted] (a cushioned pressure relieving device for [redacted] and position a [redacted] between the resident's [redacted] for one resident and b.) ensure that a [redacted] designed to prevent and treat [redacted]) [redacted]) was accurately set in accordance with the physician order for one resident. This deficient practice was identified for 2 of 4 residents (Residents [redacted] and [redacted] reviewed for [redacted] and was evidenced by the following: 1. During the initial tour of the 300 Unit on 08/25/21 at 1:45 PM, the surveyor observed Resident [redacted] lying in bed with the head of bed (HOB) slightly elevated. The surveyor observed that Resident # [redacted] were not [redacted] and that the resident's [redacted] were lying directly on the mattress. When interviewed, at that time, Resident [redacted] was unable to provide answers about the [redacted] application.	F 686	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because they require it. Complete Care at Kressonview - F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers Residents affected by deficient practice: 1. Resident [redacted] was assessed by the licensed nurse and resident [redacted] were [redacted] and [redacted] pads applied. Resident [redacted] pillow was placed between the [redacted] as prescribed. Resident [redacted] bed was assessed by the licensed nurse. The [redacted] was adjusted to [redacted] after verification of the Physician's order. Identifying other Residents who could be affected by the deficient practice:	

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F 686	Continued From page 7 Review of the resident's Admission Record revealed that Resident [redacted] was admitted to the facility with diagnoses which included, but were not limited to, [redacted] Review of the resident's most recent Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, completed [redacted], reflected that Resident [redacted] was [redacted] and required extensive to total assist with Activities of Daily Living. The MDS further revealed that the resident was at risk for developing pressure ulcers. Review of the Order Summary Report for Active Orders as of [redacted] reflected a physician's order (PO), dated [redacted] for [redacted] to [redacted] at all times, remove every shift for skin integrity and an order dated [redacted] position a [redacted] between resident's [redacted] check every shift for placement. Review of the [redacted] Treatment Administration Record (TAR) revealed corresponding POs for [redacted] at all times and for [redacted] between the [redacted]. The surveyor observed that the nurses signed the TAR at 1400 hours (2:00 PM) on 08/25/21, 08/27/21 and 08/30/21. A review of Resident [redacted]'s Interdisciplinary Care Plan (CP) revealed that the facility's Interdisciplinary Team identified a "Focus" that resident is "at risk for [redacted]" with an intervention to "[redacted] while in bed." The CP further reflected a "Focus" that resident "exhibits or is at risk for [redacted]	F 686	2. All residents with [redacted] mattresses, adaptive equipment and those residents care planned to be [redacted] were re-evaluated. The audit is to ensure that the [redacted] are at the proper setting and that adaptive devices per the Physician's order are in place. All residents care planned to have their [redacted] are c[redacted] was reviewed to ensure implementation of the [redacted] process. Measures or systemic changes to ensure that the deficiencies will not recur: 3. All certified and licensed staff will be re-educated as to the process for [redacted], ensuring utilization of adaptive equipment inclusive of [redacted], and [redacted] The re-education will include following Physician's orders for checking the settings of the [redacted]. Audits will be conducted monthly via the room a day audit process conducted by each unit manager. Monitoring the continued effectiveness of the systemic change: 4. The process for adherence to utilization of adaptive equipment and checking of the settings for [redacted] will be performed with the room a day audit process by each unit manager. The findings of the audits will be reported during the monthly Quality Assurance and Improvement meeting.	

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F 686	Continued From page 8 related to [redacted] changes" with an intervention to "assist resident to a position of comfort, [redacted] and appropriate positioning devices." On 08/27/21 at 12:04 PM, the surveyor observed Resident # [redacted] asleep in bed. The surveyor observed that the resident's [redacted] were not [redacted] and that the resident's [redacted] were lying directly on the mattress. On 08/30/21 at 09:18 AM, the surveyor observed Resident [redacted] asleep in bed. The surveyor observed that the resident's [redacted] were not [redacted] and that the resident's [redacted] were lying directly on the [redacted]. The surveyor observed [redacted] on a chair, positioned in front of resident. The surveyor further observed that a [redacted] was not placed between the resident's [redacted]. On 08/30/21 at 12:52 PM, the surveyor observed Resident [redacted] resting supine in bed with eyes closed, with the HOB elevated. The surveyor observed that the resident's [redacted] were not [redacted] and that the resident's [redacted] were lying directly on the mattress. The surveyor further observed that a [redacted] was not placed between the resident's [redacted]. On 09/01/21 at 11:24 AM, the surveyor observed Resident [redacted] resting in bed with the HOB elevated. The surveyor observed that the resident's [redacted] were flexed and did not observe that a [redacted] was placed between the resident's [redacted]. During an interview with the surveyor on 09/01/21 at 11:45 AM, the Licensed Practical Nurse (LPN	F 686		

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F 686	Continued From page 9 #1) stated that resident can become combative at times. LPN #1 further stated that resident has bed [redacted] to either side of the bed and a full [redacted] for positioning, which is used when the resident curls up his/her [redacted]. During a follow up interview with the surveyor on 09/01/21 at 11:58 AM, the surveyor inquired about the interventions in place when the resident crossed his/her [redacted] and the LPN #1 stated that a [redacted] would be placed between the [redacted]. The surveyor inquired if the resident had a [redacted] currently positioned between the [redacted] The LPN #1 confirmed that there was no [redacted] between the resident's [redacted] and that she would get one. During an interview with the surveyor on 09/07/21 at 12:00 PM, the LPN/Unit Manager (LPN/UM #1) stated that she expected the nurses to follow physician orders. The Certified Nurses Assistants, when giving care, should make sure that interventions are in place when they leave the room, and the nurses should check that they are in place. During an interview with the surveyor on 09/07/21 at 12:27 PM, the Director of Nursing (DON) stated that the heel booties should be removed each shift to check skin integrity. The [redacted] may have been kicked off by the resident. At a minimum, staff should ensure that the [redacted] and [redacted] are in place prior to leaving the room; and if they are not, reapply the [redacted] and [redacted] 2. During initial tour of the [redacted] Unit on 08/25/21 at 2:21 PM, the surveyor observed Resident [redacted] 1 lying supine in bed with the HOB slightly elevated. The surveyor observed that Resident [redacted] had an [redacted] that was set to [redacted]."	F 686		

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F 686	Continued From page 10 When interviewed, at that time, Resident [redacted] was unable to provide answers about the [redacted]. Review of the resident's Admission Record revealed that Resident [redacted] 1 was re-admitted to the facility with diagnoses which included, but were not limited to, [redacted] Review of the resident's most recent Quarterly MDS, dated [redacted] reflected that Resident [redacted] was [redacted] and required total assist with Activities of Daily Living. The MDS further revealed that the resident had [redacted] of the body, was at risk for developing [redacted], and had an [redacted]. Review of the Order Summary Report for Active Orders As of [redacted] reflected a PO dated [redacted] for a low air loss mattress to bed to be set at '[redacted]" and to check settings and function every shift. Review of the [redacted] and [redacted] Treatment Administration Records (TAR) reflected the corresponding PO for [redacted] to bed set at [redacted] bars" and to check settings and function every shift with the scheduled times of 6:00 AM, 2:00 PM, and 10:00 PM. Review of Resident [redacted]s Interdisciplinary Care Plan (CP) revealed that the facility Interdisciplinary Team identified a "Focus" that the resident had actual skin breakdown that was present on admission. Interventions, included but were not limited to, a [redacted] to the bed	F 686		

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F 686	Continued From page 11 to be set to '[redacted]." On 08/27/21 at 12:20 PM, the surveyor observed Resident #[redacted] resting in bed with the HOB slightly elevated. The surveyor observed that Resident #[redacted] was set to [redacted]" The surveyor made the same observation on 08/30/21 at 9:43 AM and 09/03/21 at 11:00 AM. On 09/03/21 at 11:07 AM, the surveyor observed the Licensed Practical Nurse (LPN #2) complete Resident #[redacted] treatment with the assistance of LPN/UM #1. During the [redacted] treatment observation, the surveyor observed that the resident's air mattress was set to "[redacted]." At which time, the surveyor inquired about the resident's [redacted] settings and who was responsible for monitoring the [redacted] settings and functioning. LPN/UM #1 replied that it was the responsibility of the nursing staff to monitor residents' [redacted] for settings and functioning. LPN/UM #1 further stated that she would have to check Resident [redacted]'s PO for the [redacted] setting and would have to follow up with the surveyor. At this time, LPN #2 looked at the [redacted] settings, confirmed that it was set to "[redacted]," and stated that she believed that "[redacted]" was the correct setting. During a follow-up interview with the surveyor on 09/03/21 at 12:24 PM, LPN/UM #1 stated that Resident [redacted] should have been set to [redacted]" and that they adjusted the settings in accordance with the PO. Review of the facility's "Support Surfaces: Utilization" policy, with the revision date of 10/15/20, reflected that support surfaces would	F 686		

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	315207		09/07/2021

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F 686	Continued From page 12 be used as a standard of care to provide pressure redistribution for patients. NJAC 8:39-27.1(a)	F 686		
F 690 SS=E	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 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	F 690		9/28/21

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	315207		09/07/2021

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F 690	Continued From page 13 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to consistently document catheter care treatments according to physician orders. This deficient practice was identified for 2 of 3 residents (Residents [redacted] and [redacted]) reviewed for urinary catheters and was evidenced by the following: 1. On 08/27/21 at 9:38 AM and on 08/31/21 at 9:10 AM, the surveyor observed Resident [redacted] lying in bed asleep, with a [redacted] in place. Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included that Resident [redacted] was [redacted], had a diagnosis of [redacted] Review of the Physician's Order (PO) Sheets for [redacted] and [redacted] revealed the following orders related to [redacted]: Perform [redacted] care every 8 hours (order dated 06/07/20), [redacted]e [redacted] every shift and as needed three times daily for [redacted] care (order dated [redacted] with [redacted] every shift for [redacted]ntion (order dated [redacted]), Empty [redacted]g at least once every [redacted] hours to when it becomes [redacted] full (order dated [redacted],	F 690	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because they require it. Complete Care at Kressonview - F690 Bowel/Bladder Incontinence, Catheter, UTI Residents affected by deficient practice: 1. Resident [redacted] and Resident [redacted] TARs were reviewed by the Director of Nursing due to inconsistent documentation. Identifying other Residents who could be affected by the deficient practice: 2. All residents in the facility with an [redacted] will be assessed to ensure all measures are in place for batch order entry to "Perform [redacted] care", "Empty [redacted]" and [redacted]". This review will include TAR audit to ensure consistent documentation on TAR. Measures or systemic changes to ensure that the deficiencies will not recur:	

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	315207		09/07/2021

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F 690	Continued From page 14 and Perform [redacted] care every day and evening shift (order dated 07/26/21). Review of the Treatment Administration Record (TAR), a legal record of the treatments administered to a resident, revealed incomplete information for Resident [redacted], as related to [redacted] care, for the months of [redacted] and [redacted] of [redacted] as follows: The order to "Perform [redacted] Care every 8 hours" was not documented as completed with a checkmark and initials on the following dates and times: 07/01/21 1400 (2:00 PM) , 07/02/21 1400, 07/10/21 0600 (6:00 AM), and 07/19/21 0600. The order to "Empty [redacted] every shift and as needed three times a day for [redacted]" was not documented as completed with checkmark, initials, and the amount of [redacted] in [redacted] on the following dates and times: 07/01/21 1400, 07/06/21 at 1400, 07/10/21 at 0600, and 07/19/21 at 0600. The order to '[redacted] with [redacted] of [redacted] every shift for occlusion prevention" was not documented as completed on 07/01/21 Day Shift. The order to "Empty [redacted] bag at least once every [redacted] hours to when it becomes [redacted] was not documented as completed with a checkmark, initials, and recorded amount of [redacted] on the following dates and times: 07/31/21 at 0600, 08/01/21 at 2200 (10:00 PM), 08/18/21 at 0600, 08/19/21 at 0600, 08/26/21 at 0600, and 08/28/21	F 690	3. All licensed staff will be re-educated as to the process for [redacted] care, batch order entry and consistent documentation. Monthly audit via room a day process will be conducted by each Unit Manager to ensure consistent documentation on TAR and ensure proper foley catheter batch order entry. Monitoring the continued effectiveness of the systemic change: 4. The process for adherence to batch order entry for [redacted] and consistent documentation on the TAR via the room a day process will be reported by the Nurse Educator at monthly Quality Assurance and Improvement meeting.	

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	315207		09/07/2021

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F 690	Continued From page 15 at 0600. The order to "Perform [redacted] every day and evening shift" was not documented as completed on 08/01/21 Evening Shift. Review of the resident's Care Plan, revised on 07/21/21, included a "Focus" for [redacted] care. The interventions, revised 07/21/21, included "[redacted] are q [every] 8 hours" and "Monitor urine for sediment, cloudy, odor, blood and amount." 2. On 08/25/2021 at 1:12 PM and on 08/27/2021 at 9:55 AM, the surveyor observed Resident #[redacted] lying in bed, with a [redacted] bag in place, on the side of the bed. According to the Admission Record, Resident [redacted] was admitted with diagnoses that included, but not limited to, [redacted]). Review of the resident's Significant Change MDS, dated [redacted], included the resident had an [redacted] Review of the PO Sheets for [redacted], and [redacted] revealed the following orders related to [redacted] care: Empty [redacted] at least once every [redacted] hours to when it becomes [redacted] (order dated 0[redacted] Perform [redacted] care every shift for [redacted] care and as needed (order	F 690		

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F 690	Continued From page 16 dated [redacted]), and [redacted] to be emptied every four hours - record amount (order dated [redacted] Review of the TAR revealed incomplete information for Resident [redacted], as related to [redacted], for the months of [redacted] and [redacted] as follows: The order to "Empty [redacted] bag at least once every [redacted] hours to when it becomes [redacted]" was not documented as completed with a checkmark and initials on the following dates and times: 07/01/2021 at 1400, 07/05/2021 at 0600, 07/10/2021 at 0600, 07/23/2021 at 2200, 07/29/2021 at 1400, 08/08/2021 at 0600, 08/09/2021 at 2200, 08/12/2021 at 0600, 08/16/2021 at 0600, 08/19/2021 at 2200, 08/23/2021 at 2200, and 08/25/2021 at 2200. The order to "Perform [redacted] Care every shift for [redacted] care and as needed" was not documented as completed with a checkmark and initials on the following dates and shifts: 07/01/2021 on day shift, 07/04/2021 on night shift, 07/23/2021 on evening shift, 07/29/2021 on day shift, 08/19/2021 on evening shift, and 08/23/2021 on evening shift. [redacted] every [redacted] hours - record amount" was not documented as completed with checkmark, initials, and recorded amount of [redacted] in milliliters on the following dates and times: 07/01/2021 at 0800 (8:00 AM) and 1200 (12:00 PM), 07/05/2021 at 0400 (4:00 AM), 07/23/2021 at 1600 (2:00 PM) and 2000 (8:00 PM), 07/24/2021 at 2000, 07/29/2021 at 0800 and	F 690		

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F 690	Continued From page 17 1200, 08/08/2021 at 0400, 08/09/2021 at 1600 and 2000, 08/12/2021 at 0400, 08/19/2021 at 1600 and 2000, 08/23/2021 at 1600 and 2000, and 08/25/2021 at 1600 and 2000. Review of the resident's Care Plan, dated [redacted] included directions for [redacted] care. The interventions, dated [redacted], included "[redacted] care twice a day and PRN [as needed]" and "Monitor [redacted], [redacted]." During an interview with the surveyor on 09/07/2021 at 12:00 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM #1) stated that a checkmark on the orders, along with initials when present, indicates completion of the task, corresponding to the individual completing it. LPN/UM #1 confirmed that blank spaces were present and indicate the task was not documented as required. LPN/UM #1 stated it would be her expectation that documentation of care should be completed on all shifts, during all times. The lack of documentation would be considered a problem in this regard, because "if something is not signed, it is not done." During an interview with the surveyor on 09/07/21 at 1:15 PM, the Director of Nursing (DON) stated she would expect documentation of records at the time that a task is completed. The DON further acknowledged that there were blanks present on multiple occasions, upon review of the TAR, for the time periods referenced. Review of the facility's policy, "[redacted] - Care of," revised 06/01/21, revealed that documentation of [redacted] care, amount of [redacted] if ordered, and abnormal	F 690		

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F 690	Continued From page 18 findings with subsequent notification to the physician and/or his/her designee should be documented accordingly. NJAC 8:39-27.1(a)	F 690		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure medication administration times were sequenced to accommodate a resident's hemodialysis (HD) schedule in accordance with professional standards of practice. This deficient practice was identified for Resident #315, 1 of 1 resident reviewed for hemodialysis, and was evidenced by the following: On 08/25/21 at 11:48 AM, the surveyor observed Resident [redacted] resting in bed with the head of bed (HOB) slightly elevated. The resident was able to verbalize needs and stated that he/she went to [redacted] [redacted] times a week. According to the Admission Record, Resident [redacted] was admitted with diagnoses that included, but were not limited to: [redacted].	F 698	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because they require it. Complete Care at Kressonview - F698 Dialysis Residents affected by deficient practice: 1. Resident [redacted] medications and [redacted] monitoring were reviewed by the licensed nurse. The physician was consulted, and the medication and [redacted] schedule were reviewed, and adjustments completed to accommodate time resident is out of the center for [redacted]	9/28/21

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F 698	Continued From page 19 Review of the resident's Admission Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated [redacted], included the resident was [redacted] Further review of the MDS included the resident was on [redacted] Review of the resident's Care Plan (CP) dated [redacted] revealed that the facility's Interdisciplinary Team identified a "Focus" that the resident had [redacted] and attended [redacted], and [redacted] at 10:00 AM. Review of the resident's Order Summary Report (OSR) with the active physician orders (PO) as of [redacted], revealed the following physician orders: 1. An [redacted] PO for [redacted] on [redacted], [redacted] and [redacted] with the pick up time of 10:00 AM. 2. An [redacted] PO for [redacted] (medication used to treat [redacted] or [redacted] into [redacted] three times a day for [redacted]). 3. An [redacted] PO for [redacted] medication used to treat [redacted] a condition in which [redacted] can lead to [redacted]) into [redacted] times a day for [redacted]. 4. An [redacted] PO for [redacted] milligram (mg) (medication used to [redacted]) [redacted] times a day for [redacted] caused by [redacted] 5. An [redacted] PO for [redacted] (medication used to treat [redacted] with a [redacted] for [redacted] before meals.	F 698	Identifying other Residents who could be affected by the deficient practice: 2. All residents receiving [redacted] will have a medical record review to ensure medication, treatments, and [redacted] monitoring are scheduled to accommodate time spent out of the center for [redacted] Measures or systemic changes to ensure that the deficiencies will not recur: 3. Monthly audits will be conducted via the room a day process by each unit manager. Audits will include review of medication, treatments and [redacted] monitoring to ensure administration times are scheduled to accommodate time out of the center for [redacted] Re-education will be conducted for all licensed nurses to ensure measures are taken to schedule medications, treatments and [redacted] monitoring to accommodate time spent out of the center for [redacted]. This process includes new physician orders, admission and readmission processes. Monitoring the continued effectiveness of the systemic change: 4. The process for adherence to scheduling of medication, treatments and [redacted] monitoring via room a day audit process will be reviewed monthly by the Nurse Educator at the monthly Quality Assurance and Improvement meeting.	

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F 698	Continued From page 20 6. An [redacted] PO for [redacted] ([redacted] mg (medication used to treat [redacted]) [redacted] times a day and to hold medication three hours before [redacted] 7. An [redacted] PO for S[redacted] mg three times a day for [redacted]. The OSR for active orders as of [redacted] did specify orders to sequence the scheduled medications to accommodate the resident's [redacted] schedule. Review of the electronic Medication Administration Record (eMAR) for [redacted] and [redacted] indicated the following medications were not given to the resident because the resident was "at [redacted]": 1. [redacted] was scheduled for 9:00 AM, 1:00 PM, and 9:00 PM. On 08/19/21, 08/21/21, 08/24/21, 08/26/21, 08/28/21, 08/31/21, and 09/02/21, the resident did not receive the 1:00 PM dose because the resident was out to [redacted] 2. [redacted] was scheduled for 9:00 AM, 1:00 PM, and 9:00 PM. On 08/19/21, 08/21/21, 08/24/21, 08/26/21, 08/28/21, 08/31/21, and 09/02/21, the resident did not receive the 1:00 PM dose because the resident was out to [redacted]. 3. [redacted] mg was scheduled for 9:00 AM, 1:00 PM, and 9:00 PM. On 08/19/21, 08/21/21, 08/24/21, 08/26/21, 08/28/21, 08/31/21, and 09/02/21, the resident did not receive the 1:00 PM dose because the resident was out to [redacted]. 4. [redacted] was scheduled for administration at 6:30 AM, 11:30 AM, and 4:30 PM. On 08/19/21, 08/21/21,	F 698		

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	315207		09/07/2021

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F 698	Continued From page 21 08/24/21, 08/26/21, 08/28/21, 08/31/21, and 09/02/21, the resident did not have a [redacted] at 11:30 AM because the resident was out to [redacted]. 5. [redacted] mg was scheduled for 9:00 AM, 1:00 PM, and 9:00 PM. On 08/19/21, 08/21/21, 08/24/21, 08/26/21, 08/28/21, 08/31/21, and 09/02/21, the resident did not receive the 1:00 PM dose because the resident was out to [redacted]. 6. [redacted] mg was scheduled for 9:00 AM, 1:00 PM, and 9:00 PM. On 08/19/21, 08/21/21, 08/24/21, 08/26/21, 08/28/21, 08/31/21, and 09/02/21, the resident did not receive the 1:00 PM dose because the resident was out to [redacted] The documentation on the eMAR for these medications was coded as being held, with an explanation in the eMAR and Progress Notes (PN) that the resident was at d[redacted] and not in the facility. The medications times and [redacted] monitoring were not adjusted for the days the resident was out of the facility for [redacted]. During an interview with the surveyor on 09/03/21, LPN #3 stated that she was familiar with Resident [redacted] and that the resident received [redacted] treatments on [redacted], and [redacted] LPN #3 further stated that she administered the resident's morning medications at around 8:00 AM. The surveyor inquired about the resident receiving the scheduled 1:00 PM medications. LPN #3 responded that Resident [redacted]s 1:00 PM medications were not administered on [redacted] days because he/she was out of the facility. LPN #3 further stated that she did not think the resident received the 1:00 PM medications while at the [redacted] center.	F 698		

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	315207		09/07/2021

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F 698	Continued From page 22 During an interview with the surveyor on 09/03/21 at 12:19 PM, LPN/UM #1 stated they try to schedule medication orders to accommodate the resident's [redacted] dates and times. LPN/UM #1 further stated nursing would schedule the medications to be administered before the resident leaves or after the resident returns from [redacted]. During an interview with the surveyor on 09/07/21 at 1:19 PM, the DON stated that she did not know what happened with Resident [redacted]s POs. The DON further stated it was the practice at the center to schedule medications around residents' [redacted] times. A review of the facility's policy titled "NSG305 Medication: Administration: General" policy, with the revision date of 06/01/21, revealed that medication doses would be administered within one hour of the prescribed time unless otherwise indicated by the prescriber. NJAC 8:39-11.2 (b), 27.1 (a)	F 698		