STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING _____ B. WING _____	10/13/2020

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RIVERFRONT REHABILITATION AND HEALTHCARE CENTER	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

(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 DATE: 10/13/20 CENSUS: 168 SAMPLE: 38 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within	F 640		11/30/20

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

Electronically Signed | 10/22/2020

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F 640	Continued From page 1 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit Minimum Data Set (MDS) assessments in accordance with the Resident Assessment Instrument (RAI) 3.0 Manual guidelines. This deficient practice was identified for 3 of 35 residents reviewed for resident assessment (Residents #1, #2 and #108). This deficient practice was evidenced by: 1.) On 10/5/2020 at 9:00 AM, the surveyor reviewed the Admission Record (AR) for Resident #1 which revealed that Resident #1 was	F 640	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 640 SS-B What corrective actions(s) will be accomplished for those residents found to	

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F 640	Continued From page 2 admitted to the facility with diagnoses of [redacted]. Further review of the AR revealed that Resident #1 was discharged to home on [redacted]. The surveyor reviewed the Minimum Data Set (MDS) assessment history assessment tool, which included all of the completed MDSs for the resident. The MDS assessment history revealed that there was no Discharge Assessment-return not anticipated (DRNA-MDS) completed for the resident's discharge date of [redacted]. 2.) On 10/5/2020 at 9:45 AM, the surveyor reviewed the AR for Resident #2 which revealed that Resident #2 was admitted to the facility with diagnoses of Cerebral Infarction, [redacted] and was discharged on [redacted] with a length of stay at the facility of [redacted]. The surveyor reviewed the MDS assessment history assessment tool, which included all of the completed MDSs for the resident. The MDS assessment history revealed that there was no DRNA-MDS completed for the resident's discharge date of [redacted] 3. On 10/07/2020 at 9:02 PM, the surveyor reviewed the AR for Resident #108 which revealed that Resident #108 was admitted to the facility with diagnoses of [redacted] According to the Census section of the Electronic Medical Record (EMR), Resident #108 was discharged from the facility on [redacted]. At that time, the facility completed a DRNA-MDS.	F 640	have been affected by the deficient practice Resident #1 Discharge Assessment-return not anticipated has been completed and submitted Resident #2 Discharge Assessment -return not anticipated has been completed and submitted Resident #108 Entry MDS has been completed and submitted How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the same deficient practice. Facility conducted a 90-day look back to ensure MDS assessment were completed timely. No other deficient practice noted. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. MDS department was reeducated on the federal regulation regarding Encoding/Transmitting Resident Assessments. Census changes will be reviewed in morning meeting to ensure Discharge and Entry Assessment assessments are completed and transmitted in accordance with the Resident Assessment Instrument (RAI) manual guidelines.	

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F 640	Continued From page 3 The surveyor reviewed the MDS assessment history assessment tool, which included all of the completed MDSs for the resident. The MDS assessment history revealed that there was no Entry MDS completed when Resident#108 was admitted to the facility on [redacted]. During an interview with the surveyor on 10/05/20 at 10:52 AM, the lead Registered Nurse MDS Coordinator (CRC), who had been employed since September, stated that the discharge assessments for Resident #1 and Resident #2 were not completed and that she was not employed by the facility at the time these assessments were supposed to be completed. During an interview with the surveyor on 10/06/20 at 09:55 AM, the Licensed Practical Nurse MDS Coordinator (LPN MDS Coordinator) stated that the lead CRC would do the schedule for the MDS. "I did not take over the scheduling till August and even then, the CRC would check to assure the schedule was done correctly." The LPN MDS Coordinator stated that she was not sure why there were missing discharge assessments for Resident #1 and Resident #2. She stated, "We have a MDS Consultant Company that looks over our Casper Report. (A reporting application which enables facilities to connect electronically to the National Reporting Database). "I'm not sure they check the schedule, but they check our coding accuracy. I don't know why they were missed." During a follow-up interview with the surveyor on 10/06/20 at 10:10 AM, the LPN MDS Coordinator stated she was familiar with Resident #108. She stated that the resident went home and then	F 640	How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. CRC on a monthly basis will run the 3.0 missing assessment report and scheduled assessment reports in the electronic medical record to ensure no OBRA assessments are showing as late or incomplete monthly x 4. Results of the reports will be presented in monthly QAPI meeting to ensure compliance and reassessed for further action.	

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F 640	Continued From page 4	F 640		

returned to the facility. The LPN MDS Coordinator stated that there should have been an Entry MDS completed upon the resident's return to the facility.

During a follow-up interview with the surveyor on 10/06/20 at 11:00 AM, the CRC stated that an Entry MDS should have been completed for Resident #108.

During an interview with the surveyor on 10/06/20 at 12:49 PM, the Infection Control Regional Nurse stated, "I am not sure why the MDS assessments were missed."

During an interview with the surveyor on 10/06/20 at 2:03 PM, the Administrator stated that the MDS Consultant Company reviewed the Casper reports to check for compliance but was not sure if they were checking every single one. He added that the consulting company was able to check for missing or late assessments.

During a telephone interview with the surveyor on 10/06/20 at 02:14 PM, the MDS Consulting Company (CC) Supervisor stated that the company started with the facility in June 2020. The Supervisor from the CC stated that the company looks over quality measures and assured that coding for the MDS was done accurately. "We don't run the missing assessments from the Casper report. We don't have access to the Casper Reports. So we would not know if an assessment was missing. We're working on trying to clean this up and think it was a problem during Covid pandemic. We are now getting systems in place so this can be corrected."

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The facility's untitled policy dated 10/20 reflected that it was the facilities policy to complete the Resident Assessment Instrument (RAI) process according to the requirements and standards of the latest published RAI manual. The policy indicated that the Nurse Assessment Coordinator would schedule and open all appropriate MDSs (Admission, Quarterly, Annual, Significant Change, Significant Correction, Discharges, Entry's and Medicare Assessments) in a timely manner according to the RAI manual schedule and standards. The MDSs will be filled out accurately, after proper collection of data, in a timely manner according to the RAI manual standards. The policy also indicated that periodic checks will be performed to ensure that the MDS is opened, filled out and transmitted timely and accurately according to the RAI requirements.

The Center for Medicare/Medicaid Services (CMS) - Resident Assessment Instrument (RAI) 3.0 Manual (updated October 2019) Version 1.17.1. reveals:

page 2-11:

"Entry" is a term used for both an admission and a reentry and requires completion of an Entry tracking record.

"Entry and Discharge Reporting MDS assessments are tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they enter a nursing home, leave a nursing home, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. Entry/Discharge

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F 640	Continued From page 6 reporting includes Entry tracking record, OBRA Discharge assessments, Part A PPS Discharge assessment, and Death in Facility tracking record." page 2-14: "OBRA-Required Tracking Records and Assessments are Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting)." They include: Tracking records: Entry and Death in facility and Assessments: - Admission (comprehensive) - Quarterly - Annual (comprehensive) - Discharge (return not anticipated or return anticipated) page 2-21: "For a resident who goes in and out of the facility on a relatively frequent basis and return is expected within the next 30 days, the resident may be discharged with return anticipated. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged." N.J.A.C. 8:39-11.1	F 640		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		11/30/20

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F 695	Continued From page 7 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review and review of other pertinent facility documentation it was determined that the facility failed to provide the necessary [redacted] care for changing [redacted] for 4 of 4 resident's reviewed (Resident #61, #80, #86 and #136) and was evidenced by the following: 1.) The Admission Record (AR) dated [redacted] indicated that Resident #61 was admitted to the facility with the diagnoses that included and was not limited to [redacted]. The quarterly Minimum Data Set (MDS) an assessment tool dated [redacted], indicated that Resident #61 was cognitively intact and required limited assistance with activities of daily living (ADL's). The MDS further reflected that the resident received [redacted] and [redacted]. On 10/02/20 at 10:26 AM during the initial tour of the [redacted] unit, the surveyor observed the resident's [redacted] was labeled with a date of [redacted] the [redacted] that was used to deliver [redacted] to the resident's [redacted]	F 695	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F695 SS=E What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents #61, #80, #86 and #136 [redacted] were changed and dated correctly and physician orders were placed to change [redacted] weekly for the nurse to sign on the TAR to show that the [redacted] was changed. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.	

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F 695	Continued From page 8 was dated [redacted] and the [redacted] was not dated. Resident #61 was unable to be interviewed because he/she was out to an appointment. On 10/02/20 10:40 PM, the surveyor reviewed the Order Summary Record (OSR) for Active Orders as of [redacted]. The OSR did not reveal a physician's order to [redacted] The surveyor reviewed the October 2020 Treatment Administration Record (TAR). The October 2020 TAR did not reveal that Resident #61's [redacted] On 10/05/20 at 09:38 AM, the surveyor observed Resident #61 resting in bed with eyes closed. The [redacted] that was attached to the [redacted] was dated [redacted]. The [redacted] was undated. During an interview with the surveyor on 10/05/20 at 09:50 AM, the Licensed Practical Nurse (LPN) stated that she had been employed in the facility for only two weeks and was not educated on how often [redacted] supplies and [redacted] were supposed to be changed. "I think daily, but not sure." On 10/05/20 at 10:12 AM, the Licensed Practical Nurse Unit Manager (LPN UM) accompanied the surveyor to Resident #61's room and was interviewed at that time. The LPN UM stated that all the [redacted] should be dated and changed weekly. "I'm not sure why it's dated [redacted] because we had a [redacted]	F 695	All residents who use [redacted] have the potential to be affected by the same deficient practice. Residents who use [redacted] have been audited to ensure [redacted] has been changed and dated accordingly. No other deficient practice noted. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. The Educator will re-educate Licensed Nurses on the policy [redacted] Administration related to changing and storing [redacted]. Residents who use [redacted] or have a [redacted] will have physician orders to change [redacted] weekly for the nurse to sign on the TAR to show that the [redacted] was changed. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The Infection Preventionist, Unit Manager or designated employee will audit 100% of residents with [redacted] was changed and dated correctly and physician order was signed off weekly x 4, then monthly x 3 Results of audits will be presented in monthly QAPI meeting to ensure	

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F 695	Continued From page 9 Therapist (RT) who comes in weekly to see the residents with [redacted] and they should have changed the [redacted]. The LPN UM also added that she is not sure who the RT was because it's a contract company and there were different RTs every week. During an interview with the surveyor on 10/05/20 at 10:17 AM, the Director of Nursing (DON) who stated that it was the nursing staff's responsibility to change all the [redacted] weekly on 11-7 and not the responsibility of the RT that comes in weekly. The DON added, "If a nurse saw that the [redacted] was out of date or not dated, they should change the tubing and date accordingly." The DON confirmed that there should be a physician's order to change the [redacted] weekly and the nurse was to sign the TAR to show that the [redacted] was changed. 2.) The AR dated [redacted], indicated that Resident #80 was admitted with the diagnoses that included but was not limited to [redacted]. The quarterly MDS dated [redacted], indicated that the resident had [redacted] cognitive impairment and required complete care with all aspect of ADLs. The MDS further reflected that the resident received [redacted]. On 10/02/20 at 9:47 AM, during tour of the [redacted] unit, the surveyor observed Resident #80 sitting up in bed with [redacted] a [redacted]. The [redacted] was undated and	F 695	compliance and reassessed for further action.	

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unlabeled. The resident was unable to be interviewed at this time due to poor/impaired cognition.

On 10/05/20 at 09:29 AM, the surveyor observed Resident #80 sitting up in the bed with [redacted] observed was undated.

The OSR for Active Orders as of [redacted] revealed two physician orders. One order was dated [redacted] and indicated that the [redacted] was to be changed on night shift on Wednesday and the other order dated [redacted] indicated that the [redacted] was to be changed every Thursday morning for [redacted] therapy.

The October 2020 TAR indicated that the O2 [redacted] was to be changed on Thursday, [redacted] at 6:00 AM. The October 2020 TAR did not reflect that the nurse signed on 10/01/20 to indicate that the [redacted] was changed.

During a follow up interview with the surveyor on 10/05/20 at 12:10 PM, the DON stated that there should be a physician order to change all [redacted] and that the order should be on the TAR. The nurse should sign the TAR to indicate that he/she did in fact change the [redacted] The DON added that it was the responsibility of the RN UM on the 11 PM - 7 AM shift to assure that the process was being done. The DON also confirmed that there should be only one order to change the [redacted] in the medical record.

On 10/05/20 at 12:28 PM, the DON provided the surveyor with a undated facility form titled, "11-7 M-F Supervisor Duties" which reflected that the

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F 695	Continued From page 11 supervisor on the 11 PM-7 AM shift was to ensure that nurses changed the [redacted] supplies. The surveyor attempted to conduct a telephone interview with the Registered Nurse Supervisor on the 11 PM - 7 AM shift; with no answer. The surveyor left a message. 3.) The AR dated [redacted] indicated that Resident #86 was admitted to the facility with the [redacted]. The quarterly MDS dated [redacted] indicated that the resident was cognitively intact, required supervision with ADLs. The MDS further reflected that the resident received [redacted] On 10/02/20 at 9:58 AM, the surveyor observed Resident #86 sitting on the side of the bed. Resident #86 stated that the [redacted] on the [redacted] on the [redacted] were never changed. The Surveyor observed that the [redacted] were not labeled or dated. The OSR for Active Orders as of [redacted] revealed a physician order dated [redacted] to change the [redacted] every Thursday morning. The October 2020 TAR indicated that the [redacted] was to be changed on [redacted] at 6:00 AM. The October 2020 TAR did not reflect that the nurse signed on [redacted] to indicate that the [redacted] was changed.	F 695		

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F 695	Continued From page 12 On 10/05/20 09:31 AM, the surveyor observed the resident sitting up in bed. The surveyor observed that the [redacted] that was attached to the [redacted] on the wheelchair and the [redacted] that was attached to the [redacted] were undated. The resident stated that he/she does not remember the last time the [redacted] was changed. The surveyor observed that the [redacted] sitting on the bed was undated and the plastic bag that stores the [redacted] was dated [redacted] The resident was interviewed at this time and stated that the staff does not change the [redacted] unless the resident reminds them. He/she added that the [redacted] was changed last week but that they never changed the bag that the [redacted] was stored in, so his/her clean [redacted] had to go back into a "dirty" bag. 4.) The AR dated [redacted] indicated that Resident #136 was admitted to the facility with the diagnoses that included but was not limited to [redacted] The annual MDS dated [redacted] reflected that Resident #136 had [redacted] cognitive impairment and required total assistance with ADL's. The MDS indicated that the resident received [redacted] and required [redacted] and [redacted] On 10/02/20 at 10:08 AM, the surveyor observed Resident #136 in bed with [redacted] The surveyor observed that the [redacted] dated [redacted]. The resident was non-verbal and tracking the surveyor with eyes. The resident was not able to be interviewed due to [redacted] cognitive	F 695		

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	315225	A. BUILDING _____ B. WING _____	10/13/2020

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F 695	Continued From page 13 impairment. On 10/05/20 at 09:24 AM, the surveyor observed Resident #136 in bed and was non-verbal. The [redacted] observed was dated [redacted] and the [redacted] coming from the [redacted] attached to the [redacted] was not dated. The [redacted] was dated [redacted]. On 10/05/20 at 10:24 AM, the LPN UM accompanied the surveyor to Resident #136's room and was interviewed at that time. The LPN UM stated that all [redacted] should be changed weekly and then dated. The LPN UM then confirmed that the [redacted] coming from the [redacted] was not changed weekly according to the date that that was on the [redacted] The OSR for Active Orders as of [redacted] did not reveal a physician's order to change [redacted] or any other [redacted] The October 2020 TAR did not reveal that Resident 136's [redacted] or [redacted] to be changed. The facility policy dated 3/20 and titled, '[redacted] Administration" indicated under "Infection Control" A.) that all [redacted] and [redacted] used to deliver [redacted] -Are for single resident use only. -will be changed weekly and when visibly soiled, or as indicated by state regulation. B.) [redacted] items will be stored in a plastic bag at the residents bedside to protect equipment	F 695		

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F 695	Continued From page 14 from dust and dirt when not in use. NJAC 8:39-25.2 (b), 3, 4	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	F 756		11/30/20

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F 756	Continued From page 15 drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to act on or respond to, comments made by the Consultant Pharmacist (CP) in a timely manner. This deficient practice was identified for 2 of 6 residents reviewed (Residents #21 and # 26) for medications. This deficient practice was evidenced by: 1. According to the Admission Record (AR) dated [redacted] Resident #21 was admitted to the facility with medical diagnoses which included [redacted] he annual Minimum Data Set (MDS) and assessment tool dated [redacted] eflected that Resident #21 was cognitively intact and required limited assist with activities of daily living (ADL's). The MDS also indicated that the resident was taking routine [redacted] medications. The surveyor reviewed the medical record of Resident #21 for PRN (as needed) psychotropic medications. The Electronic Medical Record revealed a physician order dated [redacted] for the antianxiety medication [redacted] mg, give one tablet every 4 hours as needed for [redacted]. The physician order did not contain a stop date of 14 days. The July 2020 Medication Administration Record	F 756	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F756 SS=D What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #21 was reevaluated by the practitioner for continued use and a rationale of prn [redacted] medication. A new order was obtained with a duration for use noted. Resident #26 continued use for prn [redacted] medication was reevaluated by the physician and discontinued. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents on prn [redacted] medications have the potential to be	

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F 756	Continued From page 16 (MAR) revealed the [redacted] was administered to Resident #21 on 07/11/20, The August 2020 MAR documented the [redacted] was administered to Resident #21 on 08/05/20 and 08/12/20. The September 2020 MAR documented the [redacted] was administered to Resident #21 on 09/07/20, 09/09/20 and 09/10/20. The October 2020 MAR contained no documentation that the [redacted] was administered to Resident #21. A review of the CP's Therapeutic Suggestions dated [redacted] revealed a recommendation that "A duration must be specified for PRN [as needed] [redacted] medications. First order is limited to only 14 days, but if rationale documented by prescriber to continue order, then next duration may be longer, i.e. 30, 60 or 90 days. Please update order for [redacted] per CMS regulations." The document did not reflect a signature from the physician that the pharmacist recommendation was reviewed. A review of the CP's Monthly Report dated [redacted] revealed a recommendation that "Regarding the comment made on [redacted]: A duration must be specified for PRN [redacted] medications. First order is limited to only 14 days, but if rationale documented by prescriber to continue order, then next duration may be longer, i.e. 30,60 or 90 days. Please update order for Lorazepam per CMS regulations. **The Pharmacy Consult was not addressed." The document did not reflect a signature from the	F 756	affected by the deficient practice. All residents on prn [redacted] e medications have been reevaluated by a practitioner and physician orders have been updated to include a duration for those with the need for continued use. Pharmacy consultant reviews for the last 30 days, for residents on prn [redacted] medications have been reviewed to ensure there has been physician follow up. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. The Educator will reeducate licensed nurses on the facility policy on Antipsychotic Medication Use. The Educator will be re-educated Clinical Leadership on the need to ensure follow-up with Consultant Pharmacy Reviews in a timely manner. Residents with a new order for a prn [redacted] will be reviewed in clinical meeting to ensure the medication has a duration date of 14 days and any new orders to continue prn medication will have a physician note with rationale for use. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Director of Nursing, Unit Managers will audit 100% of pharmacy consultant medication reviews for residents on prn psychoactive medication monthly x 4 to ensure physician follow-up. Results of	

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F 756	Continued From page 17 physician that the pharmacist recommendation was reviewed. A review of the CP's Monthly Report dated [redacted] revealed a recommendation that "Regarding the comment made on [redacted]: A duration must be specified for PRN [redacted] medications. First order is limited to only 14 days, but if rationale documented by prescriber to continue order, then next duration may be longer, i.e. 30,60 or 90 days. Please update order for [redacted] per CMS regulations. **The Pharmacy Consult was not addressed." The surveyor noted a handwritten "Action Taken" on the CP's Monthly Report dated [redacted]. The handwritten "Action Taken" revealed "reach out to MD spoke with NP [nurse practitioner] stated she'll have MD call, spoke with MD gave d/c [discontinue] date for [redacted] to be extended until 1/8/2021." The documents did not reflect a signature from the physician that the pharmacist recommendation was reviewed. A review of the Nursing Progress Note dated [redacted] at 4:33 PM revealed "Spoke with MD stated for residents [redacted] prn order to extend for 90 days. MD will write note as to why medication is bring [sic] extended. All orders noted." A review of the Advanced Practice Nurse (APN) History & Physical (H&P) dated [redacted] revealed Resident #21 has [redacted]." The [redacted] H&P further revealed "start' [redacted] every four hours prn for [redacted] for a [redacted] ... ." A review of the APN PCP [Primary Care Physician] Progress Note - Clinical dated [redacted] and [redacted] did not address the recommendations	F 756	audits will be presented in monthly QAPI meeting to ensure compliance and reassessed for further action.	

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F 756	Continued From page 18 of the PC. A review of the Physician's PCP Progress Note - Clinical dated [redacted] did not address the recommendations of the PC. A review of the [redacted] Consultation dated [redacted] revealed to "Continue current medications." The [redacted] Consultation revealed Resident #21 was on the following medications for the diagnosis [redacted] mg daily, [redacted] mg twice daily, [redacted] mg at [redacted] and [redacted] mg at [redacted]. The [redacted] Consultation report did not address the as needed [redacted]. During an interview with the surveyor on 10/08/20 at 12:05 PM, the Licensed Practical Nurse (LPN #1) Unit Manager stated that a new PRN [redacted] order should have a stop date of 14 days and then be reevaluated by the physician. If the physician wants to continue the PRN order, we have to make sure there is a stop date and the physician documents an explanation for the medication's continued use. LPN #1 Unit Manager stated that she usually received an email with the Pharmacy Consultant's recommendations. She stated that she reviewed the recommendations; and if there was a need to call the physician, she would do so. LPN #1 Unit Manager further stated there are some some recommendations I can do myself. LPN #1 Unit Manager stated that she was not instructed when to complete the pharmacy recommendations. During an interview with the surveyor on 10/08/20 at 2:30 PM, the Infection Control Regional Nurse (IC RN) stated that the nurse will	F 756		

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F 756	Continued From page 19 address the nurse concerns. For a physician concern, the nurse will call the physician or put the recommendation in the physician's mailbox. Once it is addressed by the physician, the completed forms will be returned to the Director of Nursing (DON). The forms addressed by the physician are put in the chart. The process should be completed in one week. During an interview with the surveyor on 10/08/20 at 2:35 PM, the DON stated that he expects that PRN [redacted] is initially ordered for 14 days with an end date. During a follow-up interview with the surveyor on 10/08/20 at 2:36 PM, the IC RN stated that with the initial PRN [redacted] 14-day order, the nurses will document the behaviors. After 14 days, the physician will reevaluate the resident and may reorder the PRN medication with a rationale as to why to continue the medication and include a duration date in the order. During an interview with the surveyor on 10/09/20 at 11:32 PM, the LPN #2 stated that she works night shift and reviews the physician orders. She will check to make sure that a PRN [redacted] order had a 14-day stop date; and if not, she will call the physician and clarify. LPN #2 further stated that if a PRN Ativan is reevaluated by the physician and is reordered, she ensured that the order had a stop date and that the physician wrote a rationale to continue the medication. The facility policy dated December 2016 and titled, [redacted] Medication Use" indicated that [redacted] medications will be prescribed at the lowest possible dosage for the shortest	F 756		

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F 756	Continued From page 20 period of time and are subject to gradual dose reduction and re-review. The policy also reflected that: -Residents will not receive prn doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. -The need to continue prn for [redacted] medications beyond 14 days requires that the practitioner document the rational for the extended order. The duration of the prn order will be indicated in the order. -PRN orders for [redacted] medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication.	F 756		
F 825 SS=E	NJAC 8:39 - 29.3(a)(4) Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized	F 825		11/30/20

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F 825	Continued From page 21 rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to effectively document Restorative Nursing Program orders in the Electronic Medical Record (EMR) for 4 of 15 residents reviewed (Residents #36, #62, #109 and #135) for therapy recommendations utilizing assistive devices. This deficient practice was evidenced by: 1. The surveyor observed Resident #109 laying supine in bed with the head of the bed elevated on 10/05/20 at 9:46 AM, 10/06/20 at 08:46 AM, 10/06/20 at 10:44 AM, 10/06/20 at 12:20 PM and 10/07/20 at 8:37 AM. With each observation, the surveyor did not observe a [redacted] to the resident's [redacted]. According to the Admission Record, Resident #109 was admitted to the facility with diagnoses which include [redacted]. Review of the October 2020 Orders in the EMR, the Occupational Therapist wrote an order "[redacted] use for 6-7 hours during AM shift to promote [redacted], [redacted] and to decrease c/g [caregiver] assistance during performance of ADL tasks" dated [redacted]. The surveyor noted the EMR October 2020 Treatment administration	F 825	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F825 SS=E What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents #109, #36, #62 and #135 has an updated physician order for the use of the adaptive equipment with a corresponding area on the TAR for the nurse to sign that the adaptive equipment has been applied and removed as ordered. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents with adaptive equipment have the potential to be affected by the same deficient practice.	

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F 825	Continued From page 22 Record (TAR) did not reveal a corresponding order for the nurse to sign that the [redacted] had been applied and removed as recommended by the Occupational Therapist. The Significant Change Minimum Data Set (MDS) dated [redacted] revealed that Resident #109 was cognitively impaired, required total assistance with Activities of Daily Living (ADL) and had [redacted] The ongoing Care Plan revealed a "Focus" that Resident #109 had an [redacted] [related to] [redacted] with an intervention of "Encourage/supervise/assist The resident with the use of supportive devices [redacted] as recommended" dated [redacted] [redacted] interview with the surveyor on 10/07/20 at 8:53 AM, CNA #1 stated that she is the primary CNA for Resident #109. CNA #1 stated that she was not aware that there was an order for [redacted] In the presence of the surveyor CNA #1 searched the resident's room and could not locate the [redacted] in the resident's room. On 10/07/20 at 9:14 AM, CNA #1 showed Resident #109's [redacted] in a mesh laundry bag. CNA #1 stated that she "found the [redacted] in the laundry." 2. During tour on 10/02/20 at 12:31 PM, the surveyor observed Resident #36 lying in bed with both [redacted] The surveyor observed a [redacted] lying directly on the overbed table.	F 825	Residents with adaptive equipment orders have been reviewed and updated with a corresponding area on the TAR for the nurses to sign that the adaptive equipment has been applied and removed as ordered. Care plans have bee updated for the use of adaptive equipment. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. The Educator will reeducate the licensed nurses on the [redacted] policy. Residents with new recommendations from therapy for [redacted] will be reviewed in clinical meeting to ensure there is a new order for the adaptive equipment and there is a corresponding area on the TAR for the nurse to sign that the adaptive equipment has been applied and removed. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The Director of Nursing or Unit Managers will audit 100% of TARS of resident with [redacted] to ensure there is a physician order for services and that application and removal has been signed by the nurse weekly x 3 and monthly x 3 Results of audits will be presented in monthly QAPI meeting to ensure	

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F 825	Continued From page 23 On 10/05/20 at 9:43 AM, the surveyor observed Resident # 36 lying in bed with both [redacted] covered by the sheet and a [redacted] lying directly on the overbed table. On 10/05/20 at 12:10 PM, the surveyor observed a [redacted] lying directly on the bedside table. On 10/06/20 at 8:20 AM and at 12:34 AM, the surveyor observed a [redacted] directly on the bedside table. On 10/07/20 at 9:30 AM and at 1:24 PM, the surveyor observed a [redacted] directly on the bedside table. According to the Admission Record, Resident #36 was admitted to the facility with diagnoses which included [redacted] Review of the September 2020 orders in the EMR, the Occupational therapist wrote an order " Recommending use of [redacted] for 6-7 hour or as tolerated during AM shift without s/s [signs and symptoms] of [redacted]," dated [redacted] and signed by the attending physician on [redacted] at 3:58 PM. The surveyor noted the EMR September and October 2020 TAR did not reveal a corresponding order for the nurse to sign/document that the [redacted] had been applied and removed. The Quarterly MDS dated [redacted] revealed the resident was [redacted] cognitively impaired and required total assistance for ADLs, had [redacted]	F 825	compliance and reassessed for further action.	

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F 825	Continued From page 24 [redacted]. The ongoing care plan, dated [redacted] revealed a "Focus" that Resident #36 had a need for Restorative Nursing Program (RNP) due to decrease in ROM, presence of [redacted] with an intervention to apply [redacted] on [redacted] as ordered. During an interview with the surveyor on 10/05/20 at 12:48 PM, CNA #2 stated that Resident #36 [redacted] was contracted and had a [redacted] that therapy puts on the resident. During an interview with the surveyor on 10/07/20 at 9:30 AM, CNA #3 stated that Resident #36 does not use any [redacted] on his/her [redacted]. During an interview with the surveyor on 10/07/20 at 10:51 AM, LPN #2 stated that Resident # 36 had a [redacted] that the aides put on the resident after the resident gets washed. During an interview with the surveyor on 10/07/20 at 10:51 AM, the Occupational Therapist (OT) stated that after a resident has been evaluated and treated in therapy, they may go on restorative care. Myself and the other OTs were taught by our supervisor to write a restorative order for the resident in the EMR. We cannot take a telephone order from the physician; we put the order in the EMR, and the nurses call the physician to get the order approved. Before we put the orders in the EMR, we used to complete a written order in the paper chart and "flag" it for the nurse to address with the physician. During an interview with the surveyor on	F 825		

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10/07/20 at 11:12 AM, the Director of Rehabilitation stated that the OTs document the orders in the EMR. The Director of Rehabilitation stated that it is job of the Restorative Aid, CNA or nurse to continue the plan of care. Once the order is documented in the EMR, it will be reviewed for the nurses/physician to sign off.

During an interview with the surveyor on 10/07/20 at 1:05 PM, the LPN Unit Manager stated that she believes the 11-7 shift does the chart checks. The 11-7 nurse will run an Order Listing Report which shows all orders for the last 24 hours. The nurse would print the report daily and compare the orders with the Medication Administration Record (MARS) and the TARS so that it is an exact match.

During a follow-up interview with the surveyor on 10/07/20 at 1:10 PM, the Director of Rehabilitation stated that when a resident is on case load, therapy monitored the resident. When a resident is discharged from therapy, residents are then screened quarterly and it is up to the nursing staff to report if there is a problem with a device, i.e. skin breakdown, a lost device or the resident cannot tolerate the device.

During an interview with the surveyor on 10/07/20 at 1:23 PM, LPN #1 reviewed the order for the [redacted] LPN #1 stated that the order was a "recommendation," so she thought it was something that therapy was doing. She did not know about the order because it was not reflected on the TAR. LPN #1 stated that if she saw the order, she would have asked therapy about it. LPN #1 stated that she did not know that Resident #109 had a splint.

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F 825	Continued From page 26 During an interview with the surveyor on 10/07/20 at 12:29 PM, LPN #2 stated that there was an order for Resident #36 in the EMR, but it was a recommendation not an order and it did not transfer onto the MAR/TAR as an order. LPN #2 further stated that she did not apply the [redacted] on Resident #36 and that the nurse on night shift should have checked the orders on the 24-hour chart check. During a follow up interview with the surveyor on 10/07/20 at 2:13 PM, LPN #2 further stated that if an order in the computer does not seem correct, she would call the doctor to clarify the order. LPN #2 stated she did not call the doctor to clarify the order but did notify her unit manager. During an interview with the surveyor on 10/07/20 at 02:38 PM, the Infection Control Regional Nurse (IC RN) stated that she expected the nurses to clarify the OT order. A completed order included the start date, application time and removal time for a restorative device. The IC RN further stated that the night nurse pulled the Order Listing Report daily and reviewed each order to confirm that it was documented on the MAR/TAR, the frequency of use and the start time. There was a large notebook on each unit that contained the Order Listing Reports that were reviewed daily and signed by the nurse who completed the review. The surveyor reviewed the Order Listing Report notebook for [redacted] The surveyor observed the Order Listing Report for the order date range of [redacted] did not reveal the OT order for Resident #109 dated [redacted]. The surveyor reviewed the Order Listing Report	F 825		

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F 825	Continued From page 27 notebook for [redacted]. The surveyor observed the order Listing report for the order date range of [redacted] did not reveal the OT order for Resident #36. During a follow up interview with the surveyor on 10/08/20 at 11:18 AM, the IC RN stated that chart checks should be completed daily by night shift. The IC RN stated that the facility called the EMR company and found out that when therapy wrote an order, it was not flagged for the nurses to check. The IC RN further stated that the OT orders did not need to be verified by nursing or confirmed by the physician. The IC RN confirmed that the OT orders did not populate on the Order Listing Report. The IC RN stated that the 11-7 nurse will pull the report to complete the chart check. The IC RN stated that currently the OTs will not be writing any orders in the EMR until this has been resolved. The OTs will handwrite the order in the paper chart and flag the order for the nurse to follow up. During an interview with the surveyor on 10/09/20 at 10:58 AM, LPN #3 stated that she worked the 11-7 shift and had completed chart checks. LPN #3 stated that she ran the Order Listing Report each night. She would print the report but did not compare the orders to the MARs and TARs. LPN #3 stated that she did not do that because once the order is confirmed, it usually goes onto the MAR/TAR. The surveyor and LPN #3 reviewed Resident #109's OT order dated 10/01/20. LPN #3 stated that she would have called the physician for a clarification because the order stated that it is a "recommendation." The LPN went on to say that she usually did not see orders that had been written by the OTs.	F 825		

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F 825	Continued From page 28 On 10/08/20 at 2:15 PM, the facility provided the surveyor with copies of the OT orders written for an additional 13 residents (Residents #47, #50, #52, #54, #62, #63, #77, #93, #107, #123, #124, #130 and #135). The survey team reviewed the orders to confirm that the OT orders matched the TARs for each resident. Two of the 13 residents (Resident #62 and #135) were added to the sample for surveyor review. 3. During an interview with the surveyor on 10/09/20 at 7:50 AM, Resident #62 told the surveyor that he/she wore a [redacted] hand and that he/she had been in and out of the hospital several times with several room changes. The resident stated that the [redacted] was usually kept in the drawer and that he/she had not seen the staff member who puts the [redacted] on. According to the Admission Record, Resident #62 was admitted to the facility with diagnosis which included [redacted] Review of the October 2020 Orders in the EMR, the Occupational Therapist wrote an order for a "[redacted] approxi. [approximately] 7 hours during day hours, 3-5 x/wk. skin check pre/post orthotic application for signs of skin breakdown" dated [redacted] The surveyor noted the EMR October 2020 Treatment Administration Record (TAR) did not reveal a corresponding order for the nurse to sign that the [redacted] was applied and removed. The Order Listing Report with an Order Date Range of [redacted] did not reveal the OT order dated [redacted]	F 825		

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The Admission MDS dated [redacted] revealed the resident is cognitively intact. The ongoing Care Plan revealed a "Focus" that Resident #62 required "extensive assist x2 staff with bed mobility transfer, dressing, toileting, personal hygiene, bathing and required extensive assist x1 staff with eating and locomotion" with an intervention to '[redacted] in [sic] at start of shift, remove prior to end of shift" dated [redacted].

During an interview with the surveyor on 10/09/20 at 8:05 AM, the LPN #4 stated that Resident #62 does not wear a [redacted].

During an interview with the surveyor on 10/09/20 at 8:10 AM, the CNA #4 stated that Resident #62 does not wear a [redacted]

4. On 10/09/20 at 7:55 AM, the surveyor observed Resident #135 lying in bed asleep with the head of the bed elevated. The surveyor observed that both resident's [redacted] were under the covers.

According to the Admission Record, Resident #135 was admitted to the facility with diagnoses which [redacted].

Review of the October 2020 Orders in the EMR, the Occupation Therapist wrote an order [redacted] approx. 7 hours during daytime hours, 3-5X/wk. skin check pre/post orthotic application for signs of skin breakdown" dated [redacted]. The surveyor noted the EMR

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F 825	Continued From page 30 October 2020 TAR did not reveal a corresponding order for the nurse to sign that the [redacted] was applied and removed. The Order Listing Report with an Order Date Range of [redacted] did not reveal the OT order dated [redacted] The Significant MDS dated [redacted] revealed the resident was cognitively impaired, required total assistance with Activities of Daily Living and had [redacted] The ongoing Care Plan revealed a "Focus" that Resident #135 was "[redacted] and requires [redacted] with a "Goal" to "Apply [redacted] daily in AM and remove [redacted] each evening at bedtime through next review" revised on [redacted] During an interview with the surveyor on 10/09/20 at 8:05 AM, LPN #4 stated that Resident #135 does not wear [redacted] During an interview with the surveyor on 10/09/20 at 8:10 AM, the CNA #4 stated that Resident #135 does not wear [redacted] A review of the facility's policy titled, [redacted] dated 02/2020, revealed that a physician's order will be obtained for the use of a [redacted]. An attending physicians order for [redacted] services must be in the chart indicating: A. reason why [redacted] is needed and B. frequency and wearing schedule of the splint. The policy further reveals that the nursing department is responsible for [redacted] application and will document placement in the electronic medical record. The facility was unable to provide a policy for	F 825		

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F 825	Continued From page 31 24-hour chart checks by nursing staff. NJAC 8:39-37.1	F 825		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of	F 842		11/30/20

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F 842	Continued From page 32 abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to maintain complete and accurate medical records. This deficient practice was identified for 1 of 1	F 842	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an	

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F 842	Continued From page 33 residents who expired in the facility (Resident #152) and was evidenced by the following: According to the Admission Record, Resident #152 was admitted to the facility with diagnoses including [redacted]. The Admission Minimum Data Set dated [redacted] revealed resident was cognitively impaired and required extensive to total assistance with Activities of Daily Living. A review of the Nursing Progress Note dated [redacted] at 8:00 AM in the Electronic Medical Record (EMR) revealed that the resident expired at 7:45 AM and that the physician and family were notified. The progress note further revealed that a funeral home had not been prearranged and that the family was asked to choose a funeral home and notify the facility. The surveyor observed the EMR Progress Notes did not reveal further entries after the Nursing Progress Note dated [redacted] at 8:00 AM. The surveyor reviewed the closed paper chart for Resident #152. The paper chart did not reveal the name of the funeral home and that the resident's remains were removed from the facility. During an interview with the surveyor on 10/06/20 at 9:08 AM, the Director of Nursing (DON) reviewed the EMR progress note dated [redacted] at 8:00 am and the closed paper file. When asked where the body was, the DON could not say. He indicated that he would like to research this matter and get information from the funeral home that the body was picked up. The DON stated that his expectations were that the	F 842	admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F842 SS-B What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice Resident #152 no longer resides at the facility. The signed Release of Body Form has been obtained from the funeral home and placed in the medical record. A late entry of deposition of body and belongings added to the medical record. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents who expire have the potential to be affected by the deficient practice. All resident who have expired in house in the last 30 days, medical records have been reviewed to ensure there is documentation of disposition of body and belongings. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur.	

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F 842	Continued From page 34 nurse document the funeral home and the time the body was removed from the facility. During an interview with the surveyor on 10/07/20 at 9:29 AM, the Registered Nurse, who wrote the progress note on [redacted] stated that she probably worked overnight and the resident's remains were picked up during the day after she left. She stated that when the funeral home picked up the body, they leave a form which we have to sign. The RN further stated that when the remains were picked up, the nurse should have written a progress note and there should have been a form from the funeral home that the body was removed from the facility. Review of the facility's policy, Death of a Resident, adopted 2/19, revealed that "The name of the mortician and person removing the deceased resident must be entered in the resident's medical record." Review of the facility's policy, Charting and Documentation, adopted 2/20, revealed that "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate."	F 842	The Educator will reeducate licensed nurses on the policy Death of a Resident. Resident who expire in house, records will be reviewed in clinical meeting to ensure there is documentation of disposition of body and belongings. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Medical Records will audit residents who have expired in house, medical records for documentation of disposition of body and belongings, weekly x4, then monthly x3. Results of audits will be presented in monthly QAPI meeting to ensure compliance and reassessed for further action	
F 880 SS=D	NJAC 8:39-35.2 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		11/30/20

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F 880	Continued From page 35 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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RIVERFRONT REHABILITATION AND HEALTHCARE CENTER	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

(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 880	Continued From page 36 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other pertinent facility documentation, it was determined that the facility failed to follow appropriate infection control practices for a.) washing hands between residents and b.) disinfecting durable medical equipment in between resident use. This deficient practice was identified for 1 of 2 nurses on 1 of 2 units [redacted] during medication administration observation and was evidenced by the following: On 10/06/20 at 08:47 AM, the surveyor conducted a medication administration observation with a Licensed Practical Nurse (LPN) on [redacted]). The surveyor observed the following: The surveyor observed the LPN prepare and	F 880	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F880 SS=D What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents #202 and #203 had no	

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F 880	Continued From page 37 administer medications to Resident #202. The LPN did not perform hand hygiene (washing hands or using an alcohol-based hand rub) prior to the medication preparation. The LPN took the resident's blood pressure (BP), pulse, temperature and pulse Ox (used to measure the concentration of oxygen in the blood) with an all-in-one vital sign (VS) machine. After the LPN took the resident's VS, she was observed touching the resident's breakfast tray, cup and other resident items on the resident's bedside table. The LPN then administered the medication to Resident #202. The LPN then cleaned the blood pressure cuff and the inside of the pulse Ox with a small alcohol pad. She did not clean the thermometer part of the VS machine. The LPN then exited the room and did not perform hand hygiene. The LPN went to the next resident's room and prepared to take the vital signs of Resident #203. Prior to the LPN taking the resident's vital signs, the surveyor asked the LPN what product should she clean the VS machine with. The LPN replied, "I guess I should have cleaned it with the purple top disinfectant." The surveyor then inquired why she did not clean the thermometer with the disinfectant, and the LPN replied that she "forgot." The LPN then cleaned the VS machine with the appropriate disinfectant and went into Resident #203's room to take the resident's VS. The surveyor stopped the LPN and asked her what should she do next before touching the resident. The LPN did not respond to the surveyor. The LPN was then reminded by the surveyor that she should wash her hands or perform hand hygiene before resident to resident contact. The LPN then washed her hands, took the resident's vital signs and administered the	F 880	negative outcome from the cited deficient practice. Identified LPN on [redacted] was educated on proper handwashing and cleaning durable medical equipment during medication administration How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practice. Educator will be re-educated licensed nurses on the following policies: Handwashing/Hand hygiene, Administering Medications related to infection control and Cleaning and Disinfecting Resident-Care Items and Equipment. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Educator, Unit Manager will conduct a medication administration audit weekly x3 then monthly x4 to ensure nurses are using appropriate infection control procedures for hand hygiene and cleaning and disinfecting resident equipment. Results of audits will be presented in monthly QAPI meeting to ensure compliance and reassessed for further action	

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F 880	Continued From page 38	F 880		

medications to Resident #203.

After the LPN was finished with this resident's VS and medications she washed her hands, came out of the resident's room and signed out the medications in the Medication Administration Record (MAR). The surveyor then inquired as to what the LPN should do next. The LPN did not respond to the surveyor. The surveyor then reminded the LPN that she now had to sanitize the VS machine. The LPN responded with "O yea, I forgot."

During an interview with the surveyor on 10/6/20 at 11:28 AM, the Regional Infection Control Registered Nurse (IC RN) stated that the LPN was a relatively new nurse in the facility and that she would require some education on infection control during medication pass. The IC RN confirmed that the LPN should have washed her hands after resident-to-resident contact and should have cleaned the VS machine with disinfectant wipes after resident contact.

During an interview with the surveyor on 10/13/2020 at 11:30 AM, the Director of Nursing (DON) had no additional information to provide to the surveyor.

The facility policy dated April 2019 and titled, "Administering Medications" reflected that staff should follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.

The facility policy dated October 2018 and titled, "Cleaning and Disinfection of Resident-Care Items and Equipment" indicated that

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resident-care equipment, including reusable and durable medical equipment (DME) will be cleaned and disinfected according to current Center for Disease Control (CDC) recommendations for disinfection and OSHA Bloodborne Pathogens Standard. The policy indicated that reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment.) The policy also indicated that reusable care equipment and DME must be cleaned and disinfected before reuse by another resident and according to manufactures instructions.

The facility policy dated August 2019 and titled, "Handwashing/Hand Hygiene" indicated that the facility considers hand hygiene the primary means to prevent the spread of infection and that all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents and visitors.
The facility hand hygiene policy reflected that use of an alcohol-based hand rub containing 62% alcohol: or alternatively, soap and water for the following situations:
-Before and after direct contact with residents
-Before preparing or handling medications
-Before and after eating or handling food.
-After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident."

NJAC 8:39 - 19.4(a)