STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315216	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CEDAR GROVE	536 RIDGE ROAD CEDAR GROVE, NJ 07009

(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 Complaints #: NJ00132608, NJ00134690, NJ00136529, NJ00136482, and NJ00134469 Census: 129 Sample Size: 13 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		2/1/21

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

Electronically Signed | 02/02/2021

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F 623	Continued From page 1	F 623		

before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance

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F 623	Continued From page 2 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Complaint: NJ00132608 Based on interviews and record reviews, it was determined the facility failed to provide written notices of transfer for one (Resident [redacted]) of three residents reviewed for discharge services. Findings included: 1. Resident [redacted] had diagnoses including [redacted]	F 623	Resident #1 was transferred out of the facility on [redacted] and did not return. Other residents who are transferred out of the facility have the potential to be affected by this practice. On 1/15/2021, a 3 month lookback audit was done by the Unit Managers for Notice of Emergency Transfer Form. On 1/15/2021,Unit Managers,Nursing Supervisors and Nurses were inserviced on appropriate and timely completion of	

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F 623	Continued From page 3 [redacted]. A review of the admission Minimum Data Set (MDS), dated[redacted], revealed Resident [redacted] was moderately cognitively impaired with a Brief Interview for Mental Status score of [redacted] The resident required limited assistance for bed mobility, transfers, dressing, toilet use and personal hygiene. The resident required extensive assistance for locomotion. The resident used a wheelchair and had no impairment of the upper and lower extremities. The admission assessment had no behaviors listed for the resident. A review of medical records indicated Resident [redacted] began having behaviors that escalated throughout the resident's stay. By [redacted], the resident had physical behaviors directed toward others five days a week. The resident had[redacted] [redacted] directed at others, other[redacted] not directed at others, and wandering/exit seeking behaviors daily. The medical record revealed Resident [redacted] was transferred to a local acute care hospital several times for [redacted] evaluations by [redacted] team and had returned to the facility. Nonpharmacologic and pharmacologic interventions had been implemented for the resident's [redacted] On 11/06/2019 at 4:40 PM, the facility initiated an emergency transfer for Resident [redacted] to a local acute hospital for a [redacted] evaluation after the resident attempted to hit residents and staff. A review of records did not include documentation that a written notice of transfer had been provided to the ombudsman, the resident, or the family. Resident[redacted] returned to the facility on [redacted]	F 623	Notice of Emergency Transfer Form which includes notification of resident and the resident's representative of the transfer or discharge and the reasons for the move with a copy of the notice faxed to the Ombudsman. Nurse Managers and Nursing Supervisors will review the transfers daily for the presence and timely completion of the Notice of Emergency Transfer Form with a weekly report of the results submitted to the Director of Nursing(DON)/designee. Assistant Director of Nursing (ADON) will do random audit of the Emergency Transfer logs on a monthly basis for appropriate and timely completion of the Notice of Emergency Transfer Form. ADON will submit a report of the audit findings to the DON on a monthly basis. DON will report findings to the Performance Improvement Committee monthly for 3 months. The Performance Committee will evaluate and determine effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

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F 623	Continued From page 4 at 4:03 PM. On [redacted] at 6:20 PM, the resident used a [redacted] to threaten staff. A New Jersey Universal Transfer Form, dated [redacted], indicated Resident [redacted] had been transferred to a local hospital for a [redacted] evaluation. A review of records did not include documentation a written notice of transfer had been provided to the ombudsman, the resident, or the family. On 01/14/2021 at 3:00 PM, the Corporate Vice President stated Resident [redacted] had been transferred to a local hospital for a [redacted] evaluation. She stated the facility never refused to take the resident back, but the facility did not have a [redacted]. She stated the facility did not know the resident had been involuntarily admitted. She stated after the resident had a change of condition and was "manageable," the resident was admitted to one of the corporation's other facilities with a [redacted]. On 01/15/2021 at 10:59 AM, Assistant Vice-President #20 of the local hospital stated Resident [redacted] was transferred to the hospital for a [redacted] evaluation. She stated the [redacted] determined the resident needed to be involuntarily admitted to a hospital. She stated the facility was informed on [redacted] at 5:45 AM that the resident would not be returning. On 01/15/2021, after searching for the missing notifications of transfer, the Administrator (ADM) stated notices of transfer could not be found for either the [redacted] transfer to the local hospital.	F 623		

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F 623	Continued From page 5 New Jersey Administrative Code § 8:39-4.1 (a) (31)(i)	F 623		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Complaint: NJ00134469 Based on interviews, record review, and facility policy review, it was determined the facility failed to remain free of a significant medication error for one (Resident [redacted] of three sampled residents reviewed for medication errors. Four residents in the facility received [redacted] therapy. This had the potential to affect all residents in the facility. Findings included: 1. Resident [redacted] had diagnoses o [redacted] A review of the admission Minimum Data Set (MDS) dated [redacted] revealed Resident [redacted] was [redacted] with a Brief Interview for Mental Status score of [redacted]. The resident was admitted to the facility for rehabilitation. The resident had received [redacted] therapy seven days of the last seven days prior to the assessment. A care plan dated 03/02/2020 revealed Resident # [redacted] was at risk for injuries or complications related to the use of [redacted] therapy. An	F 760	Resident [redacted] is no longer a resident at Waterview. Other residents who are receiving [redacted] therapy have the potential to be affected by this practice. On 1/15/2021, a 3 month look back audit was done by the Unit Managers of all residents who are currently on [redacted]. No discrepancies were found. On 1/15/2021, Nurse identified with deficient practice was inserviced by the ADON to check charts and PCC for pending orders at the start and the end of the shift. On 1/15/2021, Nurse identified with deficient practice was inserviced by ADON to check the latest [redacted] result and the last order for [redacted] prior to administering [redacted] On 1/15/2021, Nurse identified with deficient practice received a Medication Administration Competency. On 1/15/2021, Licensed Nurses were inserviced by the Unit Managers to check charts and PCC for pending orders at the start and the end of the shift. On 1/15/2021, Licensed Nurses were inserviced by the Unit Managers to	2/1/21

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F 760	Continued From page 6 intervention was "[redacted] to be given as ordered." A physician's order, dated [redacted], indicated [redacted] mg (milligrams) of [redacted]), an [redacted] was to be administered every evening. The end date for this order was [redacted]. An order summary revealed, on [redacted], a physician's order had been received by telephone and indicated, [redacted] tablet [redacted] mg, give [one] tablet by mouth one time a day for [redacted] therapy." A handwritten order by Advanced Practice Nurse (APN #21), dated [redacted] at 12:45 PM, indicated "...hold [redacted] tonight..." A medication administration record (MAR) dated [redacted] indicated one [redacted] mg tablet of [redacted] had been administered to Resident [redacted] at 6:00 PM. A Medication Error Log dated [redacted] at 5:00 PM, revealed Resident [redacted] had experienced a medication error of one dose "incorrect administration." On 01/14/2021 at 11:32 AM, the Director of Nurses (DON) stated the day nurse did not see the order to discontinue the medication and did not transcribe it. The DON stated the physician and family were called, and the facility monitored the resident closely. On 01/14/2020, Licensed Practical Nurse (LPN #19) stated when he opened the MAR there was an order to administer the [redacted] so he did. He stated new written orders were typically	F 760	check the latest [redacted] result and the last order for [redacted] prior to administering [redacted]. Unit Managers and Nursing Supervisor will audit pending orders every shift with a weekly report submitted to the DON/designee. ADON will do 5 random chart audits weekly x 4 weeks then monthly x 3 months. ADON will submit a report of the audit findings to the DON monthly. DON will report findings to the Performance Improvement Committee monthly x 3months. The Performance Improvement Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring is required.	

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F 760	Continued From page 7 "flagged" so they could be transcribed. He stated he always checked for newly flagged orders before starting his shift, but he did not see one that day. On 01/15/2021 at 12:30 PM, Nurse Practitioner #19 was asked if Resident [redacted] had experienced any harm related to the dose of [redacted] being given without an order. She stated, "Not that I know of." She stated the attending physician followed up with the resident, and the resident was closely monitored. A record review indicated the resident experienced no adverse effects or harm. A facility policy titled, "Transcription of Orders," stated the purpose was to "communicate all practitioner orders to caregivers regarding patient's/resident's care and treatment." New Jersey Administrative Code § 8:39-29.2(d)	F 760		