STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315359	A. BUILDING _____ B. WING _____	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	155 40TH STREET IRVINGTON, NJ 07111

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F 000	INITIAL COMMENTS Complaints : NJ 146320, NJ 149775 NJ 153225, NJ 153470 NJ 154402 Census: 125 Sample : 5 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 658 SS=G	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. This REQUIREMENT is not met as evidenced by: Complaints : NJ 146320 Based on interviews and record review, as well as review of pertinent facility documents on 6/7/22, 6/8/22, and 6/9/22, it was determined that the facility failed to follow physician's order for 1 of 3 residents (Resident #1) reviewed for physician's order. On 5/24/21 at 7:00 pm, Resident #1 complained of [redacted]. The Resident had [redacted], and [redacted].	F 658	The following Plan of Correction is submitted in accordance with applicable laws and regulations for continued Medicaid/Medicare certification and does not constitute an admission of any kind nor a statement of agreement by the facility with respect to the alleged deficiencies. I: Immediate Action: a) Unit nurses and supervisors were re-in-service on identifying change in	7/15/22

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

Electronically Signed | 07/15/2022

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F 658	Continued From page 1 Registered Nurse (RN #1) received an order from the Primary Physician (PP) to send Resident # 1 to the Acute Care Hospital (ACH) for evaluation of [redacted]. RN #1 called 911, however, the RN canceled 911 without notifying the PP. On [redacted] (the following day) at 9:45 am, Resident #1 was sent to the ACH for [redacted] and [redacted]. Resident #1 was resuscitated and was pronounced dead at 12:35 pm. This deficient practice is evidenced by the following: Reference: "New Jersey Board of Nursing Laws 45:11-23...b. 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 casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist..." 1. According to the "ADMISSION RECORD (AR)," Resident #1 was admitted on [redacted] and readmitted on [redacted], with diagnoses which included but were not limited to: [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated [redacted] showed that Resident #1's cognition was [redacted] and required total assistance with Activities of Daily Living (ADLs). The Care Plan (CP), undated, showed that	F 658	condition, timely notification and following physician orders in relation to Resident #1 II. Identification of Others: 1.) The facility respectfully states that Physician Order was not followed for Resident #1 and all residents with change in condition and not following physician's order have the potential to be affected and communicated to PP with proper documentation. Resident #1 no longer reside in the facility 2.) No other issues were identified. III. Systemic changes: a) DON and Administrator reviewed Policy and Procedure: Change in condition, communication to primary physician, charting and documentation and found to be in compliance. b.) All Nursing Staff received In-service education in relation to resident #1 and all resident on facility policy for Change in Condition, Physician Role and Charting and Documentation. Highlights of the lesson plan include reinforcement of: Following physician orders and communicating changes as deemed appropriate IV. QA Monitoring	

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F 658	Continued From page 2 Resident was [redacted] due to [redacted]. Interventions included but were not limited to: "Monitor/Document/report to MD [Medical Doctor] PRN [as needed] for GI [redacted] problems. Preventative measures..adequate communication system" The "Order Summary Report (OSR)" dated [redacted], showed a telephone physician's order to send Resident #1 to the ACH for evaluation for [redacted] The "Progress Note (PN)" showed the following: On 5/24/21 at 11:20 pm, RN #1, the staff nurse assigned on duty during 3:00 pm to 11:00 pm shift, documented that Resident #1 complained of [redacted] and [redacted]. Resident #1's [redacted] was [redacted]. The PP was made aware, RN #1 called 911. Then at 9:00 pm, RN #1 canceled 911 because Resident #1 was noted to have [redacted]. On 5/25/21 at 6:17 am, RN #2, the staff nurse assigned on duty during 11:00 pm to 7:00 am shift documented, that she received a report from RN #1 that 911 was canceled because Resident #1 had [redacted] and [redacted] medication was administered. RN #2 further documented that Resident #1's [redacted] was [redacted] were provided through the Resident's [redacted]), had [redacted], and to follow up with the PP. On 5/25/21 at 10:23 am, Licensed Practical Nurse (LPN #1), the staff nurse on duty during 7:00 am to 3:00 pm shift, documented that Resident #1's [redacted] was [redacted] and the Unit manager (RN #3/UM) was made aware. LPN	F 658	a) An audit tool was created to track change in condition for each resident as indicated. b) QA audits will be conducted by the DON/designee will be completed weekly x 4 weeks then monthly x 2 months followed by quarterly for 9 months. c) All negative findings will be corrected immediately. d) All results of the audits will be brought to the QAPI committee meetings quarterly. V. Person responsible: Director of Nursing (DON) Thank you	

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#1 called the PP. The PP asked the LPN to get the UM or Director of Nursing (DON) to assess Resident #1, and "order recieved" to send Resident #1 to ACH for further evaluation. At 9:55 am, 911 was called and at 10:15 am Resident #1 left the facility.

On 5/25/21 at 10:53 am, RN #3, who was the UM during 7:00 am to 3:00 pm shift, documented that she assessed Resident #1, at 9:00 am, Resident #1's [redacted] was [redacted] with [redacted]. The PP was made aware and "ordered" to send Resident #1 to the ACH for further evaluation. At 9:45 am the 911 was called and arrived at 10:00 am. Resident #1 left the facility in poor condition. Family was notified.

On 5/25/21 at 7:47 pm, LPN #2, documented in the PN that Resident #1 died in the hospital.

On 5/26/21 at 10:28 pm, PP, the Primary Physician and was also the Medical Director at the facility documented that on [redacted] at 8:30 pm, the PP received a call from nursing staff on 3:00 pm to 11:00 pm shift. The nurse reported that Resident #1's [redacted] was [redacted] with [redacted]. The PP advised the nursing staff to assess vital signs, do [redacted] exam, and get help from the nursing supervisor (NS) to examine Resident #1 prior to sending to the ACH. The PP further documented that nursing staff reported that [redacted] appeared [redacted], at that point the PP advised nursing staff to send the Resident to the ACH; and did not hear back from the nursing staff. The PP was under the impression the Resident was in the hospital during that time. On [redacted] (the following day) at 8:45 am, the PP received a call from nursing staff on the 7:00 am to 3:00 pm shift that the Resident

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was still at the facility with [redacted]. The PP asked why the Resident was not sent to the ACH the night before (5/24/21). She was told because the Resident had a [redacted] and the Resident's [redacted] felt softer. She then advised the nursing staff to ask the UM to assess the Resident and to send the Resident to the ACH. At 8:55 am the UM reported to her that Resident #1's [redacted] was very [redacted] and being transferred to ACH. At 2:17 pm, the PP received a telephone call from the DON that the Resident expired in the Emergency Room (ER).

Review of the facility "SUMMARY OF INVESTIGATION IN [Resident #1] SUDDEN DEATH (SISD)", date of occurrence, [redacted] showed that on [redacted] the Resident's [redacted] was [redacted] and the PP ordered to send the Resident to the ACH. RN #1 decided to stop the transfer to the ACH. The Resident's [redacted] remains [redacted]. On [redacted], the Resident's [redacted] remains [redacted] with [redacted] on palpation. The PP was called and instructed to send the Resident to the ACH.

Attached with the [redacted], a statement from RN #1, showed that on [redacted] at 5:30 pm, during [redacted] care, Resident #1 had small amount of [redacted] from the [redacted]. At 8:00 pm, Resident #1 complained of [redacted] and [redacted] was [redacted] on the [redacted]. RN #1 also stated that she administered [redacted] and few minutes later Resident #1 [redacted] RN #1 further wrote that the PP was notified with orders for Resident #1 to be assessed by the Nursing Supervisor (NS) and to call the PP back. However, RN #1 did not call the PP again. RN #4 (NS) was unable to assess Resident #1 because

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she was performing admissions to the facility. RN #1 called 911. Then prior to 911 arrival, Resident #1 had [redacted], and the Resident was monitored throughout the night. RN #1 wrote that the PP was not notified because Resident #1 felt much better after she/he had [redacted] and that the [redacted] content was not [redacted]

Attached with the SISD, Resident #1's Acute Care Medical Record (MR) from the hospital dated [redacted]. The MR showed at 11:09 am, Resident #1 was to be found [redacted]) before going into [redacted] output eventually occurs in al[redacted] patients), with high possibility of imminent or life threatening deterioration in condition. Cardiopulmonary resuscitation (CPR) and Advanced Cardiovascular Life Support (ACLS) protocol initiated immediately. [redacted] was consulted to evaluate for [redacted]; however, Resident #1 continue to be too unstable for any interventions. At 12:35 pm, Resident #1 was pronounced dead. Resident #1 had [redacted].

Attached with the MR, the ER Physician (ERP) on [redacted] documented at 1:54 pm, the MR showed that Resident #1 presented to the ER from the Nursing Home for [redacted] and [redacted]. The ERP and [redacted] Therapist at immediate bedside. The MR further indicated "..Per EMS, patient was said to have been found [redacted] at 8:30 AM today [redacted] is said to have been displaying [redacted] since yesterday [redacted], associated with multiple episodes of [redacted] today

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F 658	Continued From page 6 [redacted] ...arrived in the ED [emergency department] being [redacted] was subsequently transferred to the [redacted] The Surveyor conducted an interview with the PP on 6/8/22 at 12:31 pm, the PP confirmed what was documented on PN dated [redacted] at 10:28 pm. The PP further stated that she gave an order to send Resident #1 to ACH on [redacted] and the PP stated she was surprised that the morning [redacted] another nurse was calling her about Resident #1. The PP further stated that if her order was not followed, she expects the nursing staff to update her for any changes in condition or change in physician's order. The Surveyor attempted to conduct a telephone interview with the with RN #1 from 6/7/22 to 6/9/22, however, RN #1 was not available. The Surveyor conducted an interview with the NS on 6/13/22 at 4:56 pm. The NS confirmed the aforementioned statement dated [redacted]. NS further stated that she did not see Resident #1 on [redacted] because she was not aware that there was an order to reassess Resident #1 prior to sending to ACH. The NS added that she would have called the PP back with the reassessment update because it would be the PP's decision whether to send Resident #1 to ACH or remain in the facility. The Surveyor reviewed the facility's policy titled "CHANGE IN CONDITION", dated 4/10/22, showed "It is the policy of THIS FACILITY to identify and communicate changes in condition to the physician and other team members to implement interventions to prevent further deterioration and possibly prevent	F 658		

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F 658	Continued From page 7 hospitalization..To provide prompt and appropriate interventions to promote resident's health and well-being and positive outcomes...The nurse will contact the physician or NP, discuss findings and formulate a plan.." The Surveyor reviewed the facility's policy titled "PHYSICIAN'S ORDER", dated 3/20/22, showed "It is the policy of our center to write physician's orders to establish a plan of care to follow for the care of the patient...To ensure that the plan of care is followed in accordance with the orders established by the physician and/or nurse practitioner..." NJAC 8:39-11.2(b) NJAC 8:39-27.1 (a)	F 658		