STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315119	A. BUILDING _____ B. WING _____	C 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARNOLD WALTER NURSING & REHABILITATION CENTER	**622 S LAUREL AVENUE HAZLET, NJ 07730**

(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 COMPLAINT # NJ149829 CENSUS: 125 SAMPLE SIZE: 3 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 VISIT.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: C#: NJ149829 Based on interview, and medical record review and review of other pertinent facility documents on 3/22/2022 and 3/30/2022, it was determined that the facility failed to follow acceptable professional standards of clinical practice by not accurately following a Physician's Order (PO) for the administration of medication. The resident was not given prescribed medication as orderd on [NJ Ex Order 26.4b1] and [NJ Ex Order 26.4b1]. Also , the facility failed to notify the Physician and to follow its policies titled "Missed Medication" and "Charting Responsibilities for Nurses for All Units." This deficient practice was identified for 1 of 3 residents (Resident #2) and was evidenced by	F 658	IMMEDIATE CORRECTION ACTION: 1) This complaint investigation is related to a missing medication for Resident #2 who was a patient on the [NJ Ex Order 26.4b1] unit, [NJ Ex Order 26.4b]. The Resident no longer resides at the Facility. 2) The Pharmacy was requested to send the medication [NJ Ex Order 26.4] stat to ensure that the Resident would not miss any additional doses of the medication. 3) As per Facility policy in October 2021, the Physician was notified only after 3 doses of the medication were missed. B) IDENTIFICATION OF OTHER	4/30/22

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

Electronically Signed | 04/21/2022

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F 658	Continued From page 1 the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." A review of Resident #2's Electronic Medical Record (EMR) was as follows: According to the "Resident Face Sheet," Resident #2 was admitted to the facility on NJ Ex Order 26.4b1 with diagnoses which included NJ Ex Order 26.4b1 [redacted] According to the "Nursing Admission /Readmission Assessment (A/RA)" dated NJ Ex Order 26.4b1, Resident #2 was NJ Ex Ord with (a) period of NJ Ex Order 26.4b1. The A/RA also showed Resident #2 was NJ Ex Order 26.4b1 and needed NJ Ex Order 26.4b1 assistance with most Activities of Daily Living (ADLs). Record Review of the "Physician's Orders" dated NJ Ex Order 26.4b1-NJ Ex Order 26.4b1 revealed Resident #2 had an order for NJ Ex Order 2 NJ Ex Order 26.4b1 capsule, delayed-release, give NJ Ex Order 26.4b1 by	F 658	RESIDENTS: 1) There were no other Residents affected by the deficient practice. C) SYSTEMIC CHANGES 1) When a medication is ordered to be given at a scheduled time, and has not been delivered by the Pharmacy, a call is placed to the provider by the nurse. The nurse requests the status of the medication, availability, and when to expect delivery. The nurse documents this and promptly notifies the MD. 2) The Physician is notified whenever a medication cannot be administered as ordered. The “Missed Medication” policy has been revised to reflect this. 3) Direction is taken from the MD to either discontinue the medication in question, provide an order for an alternative, or to give the medication when it becomes available. 4) In-service education was offered to the Nursing Staff with regard to the revision of the Missed Medication Policy. The in-service was initiated by the ADON on April 12, 2022, followed by the Nursing Supervisors on all shifts. 5) The Nursing staff will understand their responsibility to follow up with the Pharmacy provider and the Physician as soon as a medication is missed due to “unavailability”. 6) All attempts to secure the medication, and all calls to the Physician, are documented in the Progress notes.	

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F 658	Continued From page 2 oral route 3 times per day before meals. Schedule: Every Day at 7:30 a.m., 11:30 a.m., and 4:30 p.m. with an order date of NJ Ex Order 26.4b1. A review of Resident #2's "Resident Medication Administration Record (RMAR)," dated NJ Ex Order 26.4b [redacted], revealed the nurse's signature and an asterick indicating the aforementioned medication was not administered as follows: NJ Ex Order 26.4b1 capsule, delayed release, give NJ Ex Order 26.4b1 by oral route 3 times per day before meals on NJ Ex Order 26.4b1 at 7:30 a.m., 4:30 p.m. and NJ Ex Order 26.4b1 at 11:30 a.m. was administrated as ordered to the resident. A review of the RMAR on NJ Ex Order 26.4b1 Resident #2's medication was not administered as ordered at 7:30 a.m. and 4:30 p.m. because the medication was not available. The RMAR also showed the NJ Ex Order 26.4b1 dose was not administered at 11:30 a.m. because the resident was at an office visit. Further review of Resident #2's RMAR revealed on NJ Ex Order 26.4b1 at 11:30 a.m., the nurse's signature which indicated the aforementioned medication was administered. During an interview on 3/30/2022 at 10:11 a.m., when asked by the Surveyor if the 11:30 a.m. dose of the NJ Ex Order 2 was administered to Resident #2 as indicated on the RMAR, the Licensed Practice Nurse (LPN) stated she forgot to enter the code for the medication not being administered for the resident medication on NJ Ex Order 26.4b1 at 11:30 a.m. She further stated that when a resident medication was delayed or missed, the doctor (Physician) would be notified	F 658	D) MONITORING CORRECTIVE ACTION: 1) A weekly audit is done, identifying all medications which have been missed, or which have been termed “Not given” due to “Unavailable from Pharmacy”. The audit is conducted by the Charge Nurse or designee on each Nursing Unit. The audit was initiated after in-service on 4/26/2022, to the nursing staff. Every attempt is made to secure the medication. The missed medication will also be added to the 24hour Supervisors report for prompt follow up. 2) The audit tool will be sent to Nursing Administration to ensure accuracy and follow up. 3) A copy of the audit tool is also reviewed by the Pharmacy Consultant and the MD for any additional comments or suggestions with regard to medication substitutions, or medications which may be unavailable due to back order. 4) Included in the audit, is documentation that the MD has been notified in the progress notes. 5) The audit will be conducted weekly x 4, and monthly thereafter, for a period of 6 months, and then as needed. 6) The Pharmacy consultant will review all medication administration records and report her findings to the DON, ADON. 7) The Nursing staff are held responsible for compliance. Noncompliance will result in disciplinary action.	

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F 658	Continued From page 3	F 658		

and documented in the Progress Notes (PNs). Also, the LPN stated I called the doctor, but I don't remember what he said because there is no PN.

Record review of the PNs dated NJ Ex Order 26.4b1 revealed no Physician notification documentation that the NJ Ex Order 2 was not administered as ordered.

During an interview on 3/30/2022 at 9:36 a.m., the Director of Nursing (DON) stated it takes 12 hours to get the Pharmacy's medications. The medication was not kept in stock; the medication delay may have been an insurance issue. She further stated the doctor (Physician) would be notified if medications were missed. She further stated the documentation of the notifications would be in the nurse's PNs. Concerning Resident #2's office visit on NJ Ex Order 26.4b1 and the missed one dose of medication, the DON stated no one would be notified because the medication may have been spaced out or skipped depending on the Physician.

During an interview on 3/30/2022 at 10:52 a.m., the Charge Nurse/LPN who worked on NJ Ex Order 26.4b1 on Resident #2's unit stated when a medication is not available, the Pharmacy was notified first. If a medication was not administered three times, the doctor (Physician) was called. The admitting nurse would call the Pharmacy and the doctor, and it would be documented in the PNs. She further stated that the NJ Ex Order 2 would have to be ordered, but the medication was not kept in stock.

During a telephone interview on 3/30/2022 at 12:07 p.m., the Pharmacy Billing Representative

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F 658	Continued From page 4	F 658		

stated no prior authorization issues with Resident #2's insurance.

At the time of the survey, the facility's Pharmacy Consultant was not available for an interview.

During a post-survey telephone interview on 3/30/2022 at 3:00 p.m., the Physician stated he was not aware of the missed medication for Resident #2, and he did not remember if the nurse called him.

A review of the policy titled, "Missed Medication" with a review date 09/20/20 revealed Under "Policy" included: "It is the policy of the facility to dispense medications in a timely manner." Under "Purpose" indicated: "Medications are dispensed as ordered and in a timely way, to optimize the therapeutic effect of the medication." Under "Procedure" included: "The nurse notifies the pharmacy to determine the status of the medication order, availability of the medication, the expected delivery time, and the reason for the delay in delivery. If a medication is unavailable, and the patient misses three doses, the Physician is contacted."

A review of the policy titled, "Charting Responsibilities for Nurses on All Units", with a revised date 9/2020 revealed Under "Critical Care Charting:" included: " ... & MD (physician) notification ..." Under "Additional Responsibilities:" revealed: " ...Notify MD when a medication is not given for any reason and 3 doses are missed ..."

N.J.A.C.: 8:39-11.2 (b)

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315119	A. Building B. Wing	5/3/2022

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 04/30/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
3/30/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO