STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315120		C 02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HILLS SUBACUTE CARE CENTER	415 SOUTHERN BLVD CHATHAM, NJ 07928

(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 #: NJ148569, NJ149955, NJ148201 Census: 98 Sample Size: 6 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. A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey date: 02/21/2022	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ149955 Based on record review, interviews, and facility policy review, it was determined the facility failed	F 684	F684 SS: D Quality of Care Based on record review, interviews, and facility policy review, it was determined the facility failed to ensure that pain medication was	3/31/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/23/2022

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

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F 684	Continued From page 1 to ensure that pain medication was administered as ordered for 9 of 26 scheduled doses of [redacted] medication in November 2021 for one (Resident #1) of three residents reviewed for [redacted] medication. Findings included: 1. Resident #1 was admitted to the facility with diagnoses that included [redacted] The resident was discharged home on [redacted] The discharge Minimum Data Set (MDS), dated [redacted], revealed the Brief Interview for Mental Status (BIMS) score was [redacted] out of [redacted] indicating the resident was [redacted]. The MDS indicated the resident required supervision for eating, limited assistance for bed mobility and personal hygiene, extensive assistance with walking, dressing, and toileting, and was totally dependent for transfers and bathing. A record review of Resident #1's care plan, with an initiated date of [redacted], indicated the resident was at risk for [redacted] related to a recent hospitalization, [redacted] and a decrease in [redacted]. Interventions included administration of medications as ordered by the physician, monitor and/or document a probable cause of each [redacted] episode, and to monitor/record/report to the nurse if the resident complains of [redacted] or requests a [redacted] treatment. A review of Resident #1's [redacted] physician's orders indicated the resident was to receive [redacted] milligrams (mg) of [redacted] as needed (PRN) every 8 hours, with a start date of	F 684	administered as ordered for 9 of 26 scheduled doses of [redacted] medication in November [redacted] for one (Resident #1) of three residents reviewed for [redacted] medication Resident # 1 no longer resides at the facility LPN # 1 and LPN # 2 were educated regarding [redacted] management policy and procedure, timely administration of medication including pain medication, timely medication administration documentation, [redacted] medication pre and post [redacted] assessment for monitoring medication effectiveness All residents on [redacted] medication may be affected by this deficit practice All current residents on [redacted] medication will be audited for timely medication administration, timely documentation, and monitoring [redacted] medication effectiveness. All findings will be addressed accordingly Policy titled [redacted] Clinical Protocol, [redacted] Assessment and Management and Medication Administration was reviewed by DON. Licensed Nursing Staff will be educated regarding above policy. Unit Managers will be responsible to oversee timely medication administration, timely documentation, and monitoring [redacted] medication effectiveness Unit Managers/Designee will review PCC EMR report on a daily basis to ensure timely medication administration including [redacted] meds and required documentation Director of Nursing or Designee will audit	

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F 684	Continued From page 2 [redacted] and stop date of [redacted]. The resident's order for [redacted] changed from PRN to routine with an order of [redacted] mg three times a day, with a start date of [redacted]. There were no orders for [redacted] l prior to [redacted]. The resident also had an order to receive [redacted] mg of [redacted] every six hours, with a start date of [redacted] and a stop date of [redacted]. The resident also had an order for [redacted] ([redacted]) and mix the cream with [redacted]) cream and a [redacted] cream and to apply every six hours for [redacted] with a start date of [redacted]. A review of Resident #1's [redacted] medication administration record (MAR) indicated Resident #1 received the PRN [redacted] on 11/06/2021 at 6:22 PM, 11/07/2021 at 1:35 AM, and 11/09/2021 at 1:00 AM. Resident #1 received the routine [redacted] at 9:00 AM, 1:00 PM, and 5:00 PM starting on 11/09/2021 and ended on 11/17/2021. Out of 26 opportunities to administer the routine [redacted], one dose was missed on 11/12/2021 at 1:00 PM, per the MAR. In a review of Resident #1's narcotic log, the sign-out sheet for the tramadol indicated the following: - On 11/09/2021, the resident received the 5:00 PM dose at 9:00 PM. - On 11/12/2021, the resident received the 5:00 PM dose at 7:00 PM. - On 11/13/2021, the resident received the 1:00 PM dose at 4:00 PM. - On 11/14/2021, the resident received the 1:00 PM dose at 3:00 PM. In a review of the Medication Administration Audit Report, which noted the time at which the	F 684	randomly 10 residents on pain medications weekly X4 then monthly X3 for timely medication administration, timely documentation, and monitoring pain medication effectiveness. Results of Audits will be submitted to QAPI committee on a monthly basis for review and Feedback. Responsible Party: DO	

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F 684	Continued From page 3 medication was to be given, as well as the time it was actually administered, Resident #1 received the routine [redacted] at the following dates/times: - On 11/09/2021 at 5:00 PM, the time administered was 8:15 PM, which was three hours and fifteen minutes late. [redacted]" was documented on the [redacted] level rating. - On 11/10/2021 at 5:00 PM, the time administered was 7:31 PM, which was two hours and thirty-one minutes late. [redacted]" was documented on the [redacted] level rating. - On 11/11/2021 at 5:00 PM, the time administered was 7:36 PM, which was two hours and thirty-six minutes late. [redacted] was documented on the [redacted] level rating. - On 11/12/2021 at 5:00 PM, the time administered was 6:25 PM, which was one hour and twenty-five minutes late. [redacted] was documented on the [redacted] level rating. - On 11/14/2021 at 5:00 PM, the time administered was 8:01 PM, which was three hours and one minute late. [redacted]" was documented on the [redacted] scale rating from [redacted]. - On 11/16/2021 at 5:00 PM, the time administered was 7:40 PM, which was two hours and forty minutes late. [redacted]" was documented on the [redacted] scale rating. In an interview on 01/18/2022 at 9:57 AM, Licensed Practical Nurse (LPN) #1 stated Resident #1 complained of [redacted] as well as generalized [redacted]. LPN #1 acknowledged the resident had an order for tramadol and [redacted] for [redacted], as well as having a previous order for [redacted]. LPN #1 stated they would assess the resident approximately thirty minutes after administration of a [redacted] medication to see if it was effective and the resident was able to verbalize if they were in any [redacted]. LPN #1 was unaware if	F 684		

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F 684	Continued From page 4 they provided any [redacted] medication at a later time than when prescribed. In an interview on 01/18/2022 at 10:20 AM, LPN #2 stated the resident "always" complained of [redacted] in their [redacted]. LPN #2 stated, "Every time I would do an assessment, I would look for a wound but there was just redness there [at the rectum]." LPN #2 stated Resident #1 had [redacted] plus an unknown narcotic that the resident took for [redacted]. LPN #2 stated Resident #1 would verbally tell LPN #2 that the [redacted] was relieved and/or downgraded on the number scale. LPN #2 stated they were not aware of any [redacted] medication that was provided late. In an interview on 01/18/2022 at 10:58 AM, Nurse Practitioner (NP) #1 stated that Resident #1 had complained of [redacted] "all the time." NP #1 terminated the interview, and no more information was obtained. In an interview on 01/18/2022 at 11:12 AM, Medical Doctor (MD) #1 stated Resident #1 had [redacted] from a [redacted] in their [redacted] before being admitted to the facility. Resident #1 also complained of [redacted] in the [redacted] area. MD #1 stated that Resident #1 was receiving [redacted], and a topical ointment for [redacted] MD #1 stated that during an assessment, they asked the resident if they were in [redacted], and Resident #1 stated they were. MD #1 asked Resident #1 if they ever asked for their PRN [redacted] and Resident #1 stated they did not ask for the medication because they did not want to bother the nurses. MD #1 stated that they changed the PRN [redacted] to routine to ensure the resident received the medication. MD #1 stated that the resident was previously on PRN	F 684		

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F 684	Continued From page 5 [redacted] but Resident #1 did not like the way it made them feel, so that was why MD #1 discontinued the [redacted] and started the PRN [redacted] In an interview on 01/18/2022 at 11:56 AM, the Director of Nursing (DON) stated Resident #1 complained of [redacted] in the resident's [redacted] and thought the resident received [redacted] for the [redacted] The DON stated they had never administered the medication, but if the resident ever complained of [redacted], the DON would notify the nurse working. The DON stated that after a [redacted] medication was administered, the nurse should check on the resident thirty minutes after administration. The DON stated that Resident #1 expressed [redacted] relief after administration. When Resident #1 would indicate they were in [redacted], there were no non-verbal cues of [redacted], only the resident verbally stating they were in [redacted]. The DON stated their expectations were that staff should administer medication between one hour before and one hour after the scheduled administration time unless a resident refused. The DON stated that by giving the medication as ordered, it ensured medication was not administered too soon before the next administration of that same medication. LPN #2 was interviewed on 01/19/2022 at 9:00 AM. Per the MAR Audit, LPN #2 had administered five of the six late doses as noted above. LPN #2 was asked specifically about the [redacted] administered late by the LPN. LPN #2 stated, "Many times it was given after it was supposed to be given. There's not a reason. It used to be PRN. [Resident #1's] room was at the end of the hall. I had twenty-five patients to take care of and that's a lot. If someone stops you	F 684		

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F 684	Continued From page 6 during med pass, you have to assist them." In an interview on 01/19/2022 at 10:58 AM, the Administrator (ADM) stated their expectations were that medications should be administered "timely." A review of the facility policy titled, "Administering Medications," with a published date of 02/22/2021, indicated, "4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience ...7. Medications are administered within one (1) hour of their prescribed time ...21. If a drug is withheld, refused, or give at a time other than the prescribed time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose" New Jersey Administrative Code 8:39-29.2(d)	F 684		