STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315249	A. BUILDING _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK CARE CENTER	499 PINE BROOK ROAD LINCOLN PARK, NJ 07035

(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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Standard Survey: 8/9/22 Census: 481 Sample Size: 38 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide access to a call bell for a 3-week period for 1 of 35 residents (Resident #320) reviewed. The evidence for the deficient practice is as follows:	F 558	This response to findings outlined in the Statement of Deficiencies CMS 2567 is the facility's credible allegation of compliance. Preparation and/or execution of this response does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of	9/15/22

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

Electronically Signed | 08/25/2022

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F 558	Continued From page 1 On 7/18/22 at 11:57 AM, the surveyor knocked on the door to room [redacted]. Resident #320, in the window bed of the [redacted] bedded room, called out loudly "come in." During the interview between the surveyor and the resident, Resident #320 stated they had no call bell access since moving to the room. The resident stated that they call out when needing assistance from staff. The resident stated staff routinely responded to their verbal calls for assistance. The surveyor was unable to locate a call bell in the vicinity of the resident's bed. On 7/19/22 at 1:30 PM, the surveyor again visited the resident in their room. The resident stated they needed assistance the prior evening and had called out for assistance and staff had responded. The surveyor again observed no call bell present in the area surrounding the resident's [redacted] bed. On 7/20/22 at 10:02 AM, the surveyor observed the resident call out for staff assistance. The resident's regularly assigned Certified Nursing Assistant (CNA) responded to the resident in a timely manner. At that time, the surveyor asked the CNA what the resident's care needs were and how the resident alerted staff that assistance was needed. She replied, "I do everything for [the resident]." The CNA further stated that the resident called out to summon help from staff members. The surveyor asked the CNA to locate the resident's call bell cord. The CNA was unable to locate it. She stated she did not know how long it had been missing. On 7/20/22 at 10:19 AM, the surveyor interviewed the unit Licensed Practical Nurse (LPN). The LPN brought the surveyor into the resident's room	F 558	Deficiencies. The response is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully disagrees with these findings, notwithstanding the following actions have been taken: Element One-Corrective Action The call bell cord in Room [redacted] was immediately replaced with a cord long enough for resident #320 to reach. The staff that care for resident #320 were re-ediucated about call bell accessibility The maintenance Director conducted an audit of all rooms to be sure that all residents had easy access to their call bells. No other issues were found. Element Two- Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three The Maintenance Director revised the rounds checklist to include checking call bell cords. Maintenance staff received re-education about the revised checklist. Nursing staff received re-education about checking call bell accessibility when providing care daily and rep[orting any issues to Maintenance per facility policy. Element Four-Quality Assurance On a daily basis the Maintenance Director/Designee will check a sample of	

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F 558	Continued From page 2 and pointed out that the common call bell box was mounted on the wall above the door bed (the [redacted] of [redacted] beds in the room). The box had [redacted] call cords coming from it. Bed one and two had accessible call cords. The [redacted] call cord for bed #3 was not long enough to extend beyond the [redacted]) bed. The cord was on the floor close to the [redacted] bed. The LPN was unaware the cord did not reach to the [redacted] bed. On 7/20/22 at 10:24 AM, the surveyor interviewed the Maintenance Director. He stated his department does not perform a preventative maintenance program for call bell functioning. He stated his department responds directly to staff reports of malfunctions. The surveyor brought the Maintenance Director into Resident [redacted] room and confirmed with him the inaccessibility of the call bell cord from the call bell box above bed [redacted] to bed [redacted], the [redacted] bed. Resident #320 told the Maintenance Director that the call bell was not accessible since moving to the room. A review of the resident's medical record revealed the following information. The electronic medical record (Census tab) indicated the resident moved to the [redacted] bed on [redacted]. The [redacted] quarterly Minimum Data Set assessment tool (MDS) indicated the resident had no communication deficits and had no [redacted] or [redacted] impairment. Additionally, the resident was assessed to be dependent on staff for their activities of daily living.	F 558	rooms to assure that residents have easy access to call bells. The results of the rounds shall be reported to the Administrator on a weekly basis for Two months. On a quarterly basis the Maintenance Director will report findings to the QAPI committee for review and further direction as appropriate.	

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F 558	Continued From page 3 The Fall Risk care plan, initiated on [redacted] and revised on [redacted], included the intervention to provide "a working and reachable call light." On 07/27/22 at 02:35 PM, the surveyor discussed the concern of an inaccessible call bell with the Director of Nursing (DON) and the Administrator. On 07/28/22 at 10:05 AM ,the DON provided the surveyor with the following facility policies. The "Call Light Use" policy and procedure was initiated August 2018, revised April 16, 2021, and reviewed April 7, 2022. The "purpose" of the policy was "to assure call bell system is in proper working order" and "to respond promptly to resident's call for assistance." The "process" for the policy indicated (step 8) "when providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light." Additionally step 10 indicated staff was to "notify the maintenance department" of the malfunctioning call light. The Preventative Maintenance Program policy and procedure was initiated July 2015, revised April 16, 2021, and reviewed April 7, 2022. The "purpose" of the policy indicated the facility "has a preventative maintenance program to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public." This conflicted with the Maintenance Director's 7/20/22 statement that the facility did not have a preventative maintenance program. NJAC 8:39-31.2 (3); 31.8 (c) 9	F 558		
F 583 SS=D	Personal Privacy/Confidentiality of Records	F 583		9/15/22

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F 583	Continued From page 4 CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to	F 583	Element One- Corrective Action The door to the room of Resident #247	

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F 583	Continued From page 5 provide full visual privacy when providing personal care for, 1 of 35 residents, Resident #247. The deficient practice was evidenced by the following: On 7/19/22 at 10:51 AM, the surveyor observed from hallway, standing outside the resident's room door, a Certified Nursing Assistant (CNA) providing hygiene care to Resident #247. The door to the room was open and the privacy curtain between Resident #247's bed and the room door was partially pulled back. Resident #247 could be seen lying in the bed from the hallway exposed from [redacted]. The resident was not covered with a blanket and their gown was pulled up to their [redacted]. The surveyor observed the CNA providing hygiene care and changing the resident's [redacted]. On 7/19/22 at 10:57 AM, the surveyor observed the door and privacy curtain remained open as the CNA continued to provide hygiene care to the resident. The surveyor called the Assistant Director of Nursing (ADON) to the outside of the door of the resident's room. The surveyor interviewed the ADON and asked if she observed any concerns from the resident's room. The ADON stated the resident should not be visible from hallway and then closed the door to the room. The ADON stated the door should be closed during care and she will re-educate the CNA. The ADON further stated there were privacy curtains dividing the residents' beds that could be used. On 07/19/22 at 10:58 AM, the surveyor interviewed the CNA who came out of the room	F 583	was immediately closed by the ADON and the staff member who failed to pull the privacy curtain and close the door is no longer employed at the facility. Element Two- Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three-Systemic Changes Nursing staff immediately received re-education regarding the proper use of privacy curtains per the facility policy and ensuring Resident privacy during care. Element Four-Quality Assurance The ADON/Designee assigned to each floor will conduct walking rounds to observe resident care and ensure privacy curtains are drawn and doors closed as per facility policy for four weeks and then monthly for two months. The results of the rounds shall be reported to the DON weekly for one month and then monthly for two months. ON a quarterly basis, the DON will report care observation findings and actions to the QAPI Committee for review and further direction as appropriate.	

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F 583	Continued From page 6	F 583		

after providing care to Resident #247. The surveyor asked the CNA about providing privacy when giving care to residents and Resident #247 being visible from hallway. The CNA stated she should have provided the resident with privacy by closing the door and pulling the privacy curtain.

On 7/19/22, the surveyor reviewed the medical record of Resident # 247 which revealed the following:

The Quarterly Minimum Data Set, an assessment tool dated [redacted], revealed that the resident had a score of [redacted] out of [redacted], when a Brief Interview for Mental Status was done, which indicated that the resident has [redacted].

On 7/26/22 at 1:20 PM, the surveyor reviewed the facility's policy and procedure with a review date of 3/25/22, titled "Resident Rights". Under "Policy Interpretation and Implementation" the list of residents' right included, "d. Privacy and confidentiality". The surveyor also reviewed the facility's policy and procedure with a review date of 5/6/22, titled "Social Service Policy for Resident's Rights to Privacy". Under "Policy" it read, "Social Service assures that the resident's rights to personal privacy are enforced in conjunction with all staff". Under "Procedure", it read "Residents must be allowed to privacy when receiving treatment and Caring for personal needs."

On 7/26/22 at 2:03 PM, the surveyor discussed with the Administrator and the Director of Nursing (DON), about the above concerns. The DON stated she was made aware of the situation when it occurred, and that the CNA was no longer working at the facility.

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F 583	Continued From page 7 NJAC 8:39-4.1(a)12,16	F 583		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and review of the medical record, it was determined that the facility failed to provide the resident or resident representative	F 625	Element One-Corrective Action Written bed hold notices were sent to the resident/responsible party as appropriate	9/15/22

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F 625	Continued From page 8 written notification of the facility's bed hold policy upon transfer to the hospital for 4 of 4 residents (Resident #50, # 135, #467, # 479) reviewed for hospitalizations. The deficient practice was evidenced by the following: 1. On 7/25/22 at 1:32 PM, the surveyor reviewed the medical record of Resident # 50 which revealed the following: A New Jersey Universal Transfer Form (NJUTF) indicated the resident was sent to the hospital on [redacted] at 8:55 AM due to a change in [redacted] and an [redacted]. A Nurses Note dated [redacted] indicated the resident was re-admitted to the facility on that day. 2. On 7/25/22 at 10:00 AM, the surveyor reviewed the medical record of Resident # 135 which revealed the following: A Physician/APN (Advanced Practice Nurse) note dated [redacted] read, "Readmitting [redacted] from [redacted] hospital. [The resident] was sent out from the [redacted] unit for evaluation of [redacted] like activity during [redacted].....stabilized and discharged back to [the facility] for continuation of care and monitoring." 3. On 7/26/22 at 10:10 AM, the surveyor reviewed the medical record of Resident # 467 which revealed the following: A NJUTF indicated the resident was transferred to the hospital on [redacted] at 4:54 PM for	F 625	for residents #50, #135, #467, and #479 and copies placed in their medical record as required by facility policy. Re-education was provided to the Social Services Director, Charge Nurse, and Admissions Director to ensure that they understood who was responsible for providing written bed hold notification. The Psycho_Social Coordinator responsible for providing written bed hold notifications when a resident is transferred to the hospital was re-educated about communication with nursing regarding transfer and provision of bed hold notices per facility policy. Element Two-Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three-Systemic Changes The bed-hold policy was reviewed and clarified to designate who is responsible to provide written bed-hold notification to Residents and/or responsible parties when a resident is discharged or transferred to the hospital. Clinical and Nursing staff immediately received re-education regarding the revised policy for the provision of written bed-hold notification when a resident is transferred to the hospital. Element Four-Quality Assurance The [redacted] Coordinator will audit the medical records of all residents	

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F 625	Continued From page 9 [redacted], with [redacted] and [redacted]. An "After Visit Summary" from the hospital which indicated the resident was in the hospital from [redacted] to [redacted] 4. On 7/26/22 at 10:30 AM, the surveyor reviewed the medical record of Resident # 479 which revealed the following: A NJUTF indicated the resident was transferred to the hospital on [redacted] at 2:10 PM for [redacted], and pulling out their [redacted]. There were no documentation that the four residents' families or residents' representatives received notification of the facility's policy for bed hold that included the reserve bed payment. On 7/26/22 at 1:25 PM, the surveyor asked the Social Services Coordinator (SSC)who was responsible for providing notification of the facility's bed hold policy to the resident and/or the resident representative upon transfer to the hospital. The SSC said that nursing would call the family to notify them of the resident's transfer to the hospital, that it was not done in writing, and that nursing staff made the family aware of the bed hold policy via telephone also. On 7/26/22 at 1:31 PM, the surveyor asked the Charge Nurse (CN) who was responsible for providing notification of the facility's bed hold policy to the resident and/or the resident representative upon transfer to the hospital. The CN stated that social services was responsible to notify the family of the bed hold policy. On 7/26/22 at 1:42 PM, the surveyor spoke with	F 625	transferring to the hospital weekly for one month and then monthly for two months to ensure proper written bed-hold notice was provided per facility policy. The results shall be reported by the [redacted] l Coordinator to the Administrator weekly for one month and then monthly for three months. On a quarterly basis, the [redacted] Coordinator will report findings and actions taken to the QAPI Committee for review and further direction as appropriate	

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F 625	Continued From page 10	F 625		

the Admissions Director (AD) and asked who was responsible for providing notification of the facility's bed hold policy to the resident and/or the resident representative upon transfer to the hospital. The AD said he didn't know but admissions did not do it.

On 7/26/22 at 1:50 PM, the surveyor was approached by the Psychosocial Coordinator (PC) who stated "I work with the Director of Social Services and send discharge notification to family members when someone is admitted to the hospital and why, and I also notify the ombudsman of resident's transfer to the hospital and why." The PC also stated that she did not notify the resident or resident representative of the bed hold policy.

On 7/27/22 at 9:00 AM, the surveyor reviewed the facility's policy and procedure titled "Holding Bed Space." Under "Policy Statement" it read "Our facility shall inform residents upon admission and prior to a transfer for hospitalization or therapeutic leave of our bed-hold policy when possible." Under "Policy Interpretation and Implementation" number 1. read "Upon admission and when a resident is transferred for hospitalization or for therapeutic leave, a representative of the business office will provide information concerning our bed-hold policy." Number 2. read "When emergency transfers are necessary, the facility will provide the resident or representative (sponsor) with information concerning our bed-hold policy."

On 7/27/22 at 2:40 PM, the surveyor spoke with the Administrator and the Director of Nursing (DON) and informed them of the concern with the bed hold policy not being sent to the

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F 625	Continued From page 11 residents/resident representatives upon discharge to the hospital. The DON said it was a miscommunication about who was responsible for doing that but it had been straightened out. NJAC 8:39-5.1 (a)	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Assessment (MDS) for 1 of 2 residents reviewed for [redacted] care, Resident #85 as evidenced by the following: According to the Resident Assessment Instrument (RAI) Manual Version 3.0 of CMS guidelines, updated October 2019 under Chapter [redacted], included that, "An SCSA is required to be performed when a [redacted] resident enrolls in a [redacted] program (Medicare-certified or State-licensed hospice provide) or changes	F 637	Element One-Corrective Actions A significant change MDS Assessment was completed and submitted for Resident #85 who changed [redacted] Providers per MDS guidelines. The MDS Coordinator who was unaware of the requirement was counseled and re-educated. Element Two- Identification of at Risk Residents All residents have the potential to be affected by this practice.	9/15/22

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F 637	Continued From page 12 [redacted] providers and remains a resident at the nursing home. The Assessment reference date (ARD) must be within 14 days from the effective date of the [redacted] election (which can be the same or later that the date of the [redacted] election statement, but not earlier than) .... This is to ensure a coordinated plan of care between the [redacted] and nursing home is in place. On 7/20/22 at 10:32 AM, the surveyor observed Resident #85 in bed with eyes closed and in the presence of the Behavioral Assistant by the bedside. The surveyor reviewed the resident's records which revealed the following: An Admission Record revealed that the resident was admitted to the facility with diagnoses that included but not limited to [redacted] of [redacted]. A Physician's Orders revealed the following: Discontinue [redacted] Care Service effective [redacted] and admit to [redacted] effective [redacted] On 7/20/22 at 10:51 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who was assigned to the resident. The LPN stated that the resident is currently on [redacted]. She further stated Resident #85 was receiving [redacted] care services with [redacted] Care before switching to [redacted] as per his/her family's request. The Quarterly MDS, an assessment tool, dated [redacted] revealed a Brief Interview for Mental Status score of [redacted], which indicated that the	F 637	Element Three-Systemic Changes Nursing staff received re-education regarding the requirement to complete and submit a SCSA MDS assessment when a resident elects a change in [redacted] provider in compliance with MDS guidelines. Element Four- Quality Assurance Weekly for the next four weeks then monthly for the next two months, the MDS Coordinator will provide the DON/Designee with a copy of the MDS Report generated by the Electronic Health Record to substantiate timely completion and submission of MDS SCSA assessments in compliance with regulations. The DON/Designee will providde MDS completion statistics in aggregate at the quarterly QAPI Committee meeting for action and further guidance as appropriate	

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F 637	Continued From page 13 resident was [redacted]. Further review of the MDS revealed that there were no SCSA MDS completed when the resident switched [redacted] care providers. On 7/26/22 at 9:59 AM, the surveyor interviewed the MDS Coordinator and asked her if a SCSA was initiated when a resident switched to another [redacted] provider. She stated, "Not really. We were never told to do a SCSA when a resident changes [redacted] care provider." The MDS coordinator stated that after reviewing the latest SCSA guidelines of the RAI 3.0 manual, she agreed and confirmed that she should have initiated a SCSA MDS after the resident's change of [redacted] providers. On 7/27/22 at 2:50 PM, the surveyor expressed her concern to the Licensed Nursing Home Administrator and Director of Nursing (DON). The DON acknowledged that a significant change should have been initiated when the resident switched to another [redacted] provider.	F 637		
F 658 SS=E	NJAC 8:39-11.2 (i) 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: Based on observation, interview, and record review, it was determined that the facility failed to provide care and services according to	F 658	Element One-Corrective Actions Resident #117 The LPN who failed to correctly	9/15/22

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F 658	Continued From page 14 acceptable standards of clinical nursing practice by the following: 1.) administer and sign for medication according to physician's orders and facility policy for 4 of 4 nurses; 2.) follow the facility's policy on cleaning shared medical equipment for 1 of 1 nurse observed cleaning shared medical equipment; and 3.) failed to obtain a physician's order for a treatment performed during [redacted] care for 1 of 3 residents (Resident #193) reviewed for [redacted] care. The deficient practice is evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey states; "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 case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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	F 658	administer a medication and properly document the administration of medication on the medication administration record at the time of administration per facility policy for resident #894 was counseled and re-educated. Resident #484 Nurses who failed to follow parameters when administering [redacted] for Resident #484 were counseled and re-educated. The physician was notified, and medication errors were completed per facility policy. There was no negative outcome for Resident #484 LPN #3 LPN #3 who signed the MAR prior to the administration of medication was counseled and re-educated to sign for administration after administering the medication not before. LPN #4 LPN #4 who signed the MAR prior to the administration of medication was counseled and re-educated to sign for administration of medication after administering the medication not before. RN #2 RN #2 who failed to use a bleach wipe when disinfecting the [redacted] r was counseled and re-educated to use [redacted] bleach wipes per facility policy. The nurse immediately cleaned the [redacted] with a bleach wipe	

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F 658	Continued From page 15 registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 7/17/22 at 10:30 AM, the surveyor entered the room of Resident #894. The resident was alone in their room and no staff were present. The surveyor observed two white capsules in a medicine cup sitting on the resident's bedside table. The surveyor interviewed Resident #894 about the capsules. Resident #894 stated that they were, "not sure" what the capsules were. On 7/27/22 at 10:41 AM, the surveyor interviewed Charge Nurse/Registered Nurse (CN/RN) who stated that she was working with and training the Licensed Practical Nurse (LPN #1) who was caring for Resident #894. The surveyor asked if the CN/RN could accompany the surveyor into Resident #894's room. The surveyor and CN/RN entered Resident #894's room and the surveyor observed that the there was another LPN #2 was in the resident's room. The surveyor asked the nurses what the two capsules observed in the resident's room were. LPN #2 stated that the two capsules were [redacted] are [redacted] that are either the same or similar to [redacted]) and stated that she just gave Resident #894 the [redacted]. The surveyor asked LPN #2 if she should have left the medication at the resident's bedside and then returned to administer it. LPN #2 stated that she should have given the [redacted] right away. The CN/ RN agreed that the medication should not have been left at the bedside and should have been administered to Resident #894 before LPN #2 left the room. The [redacted] Medication Administration Record	F 658	Resident #193 A physician order was obtained to flush the [redacted] for Resident #193 and was transcribed on the Treatment Administration sheet per facility policy. Nursing staff, including LPN #5 and RN #2, that provided [redacted] care to Resident #193 were counseled and re-educated regarding obtaining physician orders before rendering care in compliance with facility policy. Element Two-Identification of at Risk Residents All residents may be affected by these practices. Element Three-Systemic Changes Nursing received re-education to assure they follow medication and treatment administration policies including provision of medications per physician orders, obtaining physician orders prior to providing treatments, signing for administration of treatments after administration and following hold parameters for medication as ordered. Nursing staff received re-education about cleaning of [redacted] using [redacted] bleach wipes per facility policy. The facility consultant pharmacist is auditing all charts making notations of missing signatures on the MARs ot TARs as part of the monthly audits. The policy for administration of medications was reviewed to ensure the	

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F 658	Continued From page 16 (MAR) for Resident #894 indicated that the resident had an order for [redacted] two capsules twice a day for [redacted] days to be administered at 9 AM and 5 PM. A further review of the MAR revealed that the LPN signed that she administered the [redacted] at 9 AM. On 7/27/22 at 10:55 AM, the surveyor observed LPN #2 exit the hallway where resident rooms were located and approach the nurse's station desk. At this time the surveyor showed LPN #2 the MAR and interviewed her. LPN #2 stated that she signed the MAR prior to giving the medication and that medications should be signed for on the MAR after they are administered. The surveyor asked what the timeframe is for when medications should be given. LPN #2 stated that medications should be given an hour before or an hour after the time when they are ordered to be given. The surveyor asked if the [redacted] was given within an hour of when it was ordered to be given. LPN #2 stated that it was a, "little bit more" than an hour. A review of the hybrid paper and electronic medical record for Resident #894 revealed the following: The Admission Record revealed that Resident #894 had diagnoses including but not limited to [redacted]). The [redacted] Admission Minimum Data Set	F 658	procedure includes the requirement to sign for all medications and treatments at the time of administration. A copy of this policy is at every nursing station to serve as a reminder. Element Four-Quality Assurance Monthly for the next three months, the ADON/Designee will audit 10 random charts to ensure that the MARs and TARs are properly completed and that there are no missing signatures for ordered medications. The ADON/Designee will provide the audit statistics in aggregate to the DON monthly for review at the quarterly QAPI Committee meeting for action and further guidance as appropriate. Monthly for the next three months, the ADON/Designee will audit the charts of residents with medication parameters to assure the ordered parameters are being followed. The ADON will provide the DON with audit statistics in aggregate to be presented at the quarterly QAPI Committee meeting for action and further guidance as appropriate. Monthly for the next three months the ADON/Designee will conduct random audits of nursing staff when cleaning [redacted] to ensure that they are using proper disinfecting wipes per facility policy. The ADON will provide the DON with audit statistics in aggregate to be presented at the quarterly QAPI Committee meeting for action and further guidance as appropriate.	

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(MDS), an assessment tool utilized to facilitate the management of care indicated that Resident #894 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that the resident was [redacted]. The MDS also indicated that the resident was receiving [redacted] (medicine that [redacted] medication.

The Physician's Orders indicated a [redacted] order to start [redacted] one capsule by mouth twice a day, and a [redacted] the order was changed to give [redacted] two caps by mouth twice a day.

The [redacted] Care Plan initiated on [redacted] indicated to, "give all meds as ordered".

On 7/27/22 at 2:14 PM, the surveyor discussed the above concern to the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). No further information was provided.

A review of the facility policy, "Administering Medications" with a revised date of 11/5/2021 indicated under the Policy Interpretation and Implementation section that 3. Medications must be administered in accordance with the orders, including any required time frame, 9. Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time, 12. The individual administering the medication must initial the resident's MAR on the appropriate line after giving the medication, and 16. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.

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2. On 7/18/22 at 2:07 PM, the surveyor interviewed Resident #484. Resident #484 was seated in a wheelchair in their room. Resident #484 was pleasant and eager to speak with the surveyor.

Review of Resident #484's Face Sheet (an admission summary) reflected that Resident #484 was admitted to the facility with diagnoses that included but were not limited to [redacted].

The Quarterly MDS dated [redacted], revealed a BIMS score of [redacted] which indicated that the resident's cognition was [redacted].

Review of the resident's [redacted], and [redacted] MAR revealed a physician's order dated [redacted] for [redacted] mg daily for [redacted].

The documentation from the [redacted] MAR indicated that on five days of the month [redacted] mg was administered when the BP was less than 120. The [redacted] MAR documented nurses signatures as administered on 5/3/22 BP [redacted], 5/16/22 BP [redacted], 5/22/22 BP [redacted], 5/23/22 BP [redacted] 5/28/22 BP [redacted], 5/29/22 BP BP [redacted]

The documentation from the [redacted] MAR indicated that on seven days of the month [redacted] mg was administered when the BP was less than 120. The [redacted] MAR documented nurses signatures as administered on 6/14/22 BP [redacted], 6/17/22 BP [redacted] 6/18/22 BP [redacted] 6/20/22 BP [redacted], 6/21/22 BP [redacted] 6/27/22 BP

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[redacted] and 6/29/22 BP [redacted]

The documentation from the [redacted] MAR indicated that on eight days of the month [redacted] mg was administered when the BP was less than 120. The [redacted] MAR documented nurses signatures as administered on 7/2/22 BP [redacted] 7/12/22 BP [redacted], 7/15/22 BP 118, 7/16/22 BP [redacted], 7/17/22 BP [redacted], 7/19/22 BP [redacted], and 7/21/22 BP [redacted]

On 7/28/22 at 2:23 PM, the surveyor informed the DON and LNHA who could not explain why nursing was administering [redacted] mg when the BP should have been held according to the physician's order. The DON verified that the [redacted] should have been held when the BP was less than 120.

On 7/29/22 at 9:25 PM, the surveyor interviewed the third floor Unit Manager (UM) in reference to [redacted] mg parameters ordered for Resident #484. The UM stated that the [redacted] mg should have been held and the nurses signature should have been circled if the BP was less than 120.

3. On 7/29/22 at 8:20 AM, the surveyor approached the [redacted] LPN (LPN #3) who was preparing to administer medication to a resident. As LPN #3 prepared the medication for administration, she signed the MAR. The surveyor continued to observe LPN #3, as she administered the medication to the resident.

On 7/29/22 at 8:30 AM, the surveyor interviewed LPN #3. LPN #3 stated that she should sign the MAR after the administration of the resident's medication, not before.

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4. On 7/29/22 at 8:37 AM, the surveyor approached the [redacted] LPN (LPN #4) who was observed flipping the pages of the MAR and signing the medication for a resident as administered. The surveyor approached LPN #4 and observed the preparation of the resident's medication for administration. LPN #4 had already signed for all the medications in the MAR before the medication was administered to the resident it was intended for.

On 7/29/22 at 8:45 AM, the surveyor interviewed LPN #4. LPN #4 stated that she should sign the MAR after the administration of the resident's medication, not before.

5. On 7/26/22 at 12:20 PM, the surveyor inspected the medication cart for unit [redacted] in [redacted] building in the presence of the Registered Nurse (RN#1).

The surveyor observed a [redacted] (a device used to measure and display the [redacted] on the top drawer of the medication cart. The RN stated to the surveyor that the [redacted] was for multi-resident use. The surveyor asked the RN how the [redacted] gets disinfected after every use. The RN explained that she uses either an alcohol prep pads or bleach wipes to disinfect.

On 7/26/22 at 12:26 PM, the surveyor observed RN #2 came out from room 210 after checking the resident's [redacted]. RN #2 then proceeded to disinfect the [redacted] using an alcohol prep pad.

On 7/26/22 at 2:15 PM, the above concern was

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discussed to the Administrator and DON. The DON verified that a bleach wipe must be used to disinfect the [redacted]

A review of the undated facility's policy and procedure titled, "Procedure for Sanitizing Blood [redacted] Device" that was provided by the DON showed '[redacted] Device must be cleaned and sanitized in between each resident use and PRN. [redacted] bleach germicidal disposable wipes are to be used, per manufacturer's instruction:"

6. On 7/18/22 at 11:33 AM, the surveyor observed Resident #193 lying in bed, alert and awake. Resident #193 had a [redacted] (a [redacted]).

The surveyor reviewed Resident #193's hybrid medical records (paper and electronic medical record) that revealed the following:

According to the Admission Record, Resident #193 was admitted with diagnoses that included [redacted].

The Quarterly MDS dated [redacted] revealed that the facility performed a BIMS which indicated that the resident had a score of [redacted] The resident was assessed to be cognitively [redacted]

On 7/20/22 at 10:27 AM, the surveyor interviewed LPN #5 who was asked about the resident's [redacted]. The LPN #5 stated the

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resident had a history of [redacted], frequent [redacted]. The LPN #5 stated that the nurses' responsibilities included changing the [redacted] once a month or as needed, monitoring [redacted], and [redacted], if needed.

The [redacted] Physician Orders Sheets and [redacted] Treatment Administration Record (TAR) revealed there was no physician's order to [redacted] the resident's [redacted].

A review of the resident's hard copy chart revealed nurse progress notes from [redacted] and [redacted] indicated the nurses [redacted] the resident's [redacted]

On 7/20/22 at 11:14 AM, the surveyor interviewed LPN #5 about the [redacted] for Resident #193. LPN #5 stated the nurses [redacted] when there were [redacted] or issues with [redacted]. The surveyor asked the LPN if there should be a PO to [redacted]. LPN #5 replied "Yes, there should be". The surveyor asked if there was a physician's order to [redacted] the [redacted] of Resident #193. LPN #5 replied, "I think there is". LPN #5 reviewed the TAR and PO with the surveyor, and no order was observed to [redacted] with [redacted]. The surveyor asked LPN #5 if the physician was aware the resident's [redacted] was being [redacted] LPN #5 replied "Yes". The surveyor asked LPN #5 how long have the nurses been [redacted] the resident's [redacted]. LPN #5 stated that she hasn't [redacted] the resident's [redacted] recently but

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(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 658	Continued From page 23	F 658		

believed it may have been since the resident's last hospitalization in [redacted]. The LPN #5 stated she would contact the physician to obtain an order to [redacted].

On 7/20/22 at 11:24 AM, the surveyor interviewed a Registered Nurse (RN #2), who had taken care of Resident #193 previously. The surveyor asked RN #2 if she had ever [redacted] the resident's [redacted] before and RN #2 replied "Yes". The surveyor asked RN #2 if there should be a physician's to [redacted] a resident 's [redacted] and RN #2 stated "Yes". RN #2 was informed upon review with the LPN there were no physician's order found for Resident #193. RN #2 stated the resident had been in and out of hospital a few times and maybe that was how the order was missed.

On 7/20/22 at 12:25 PM, the surveyor interviewed the Assistant Director Of Nursing (ADON), who was asked if it would be expected for there to be an order to [redacted] the resident's [redacted]. The ADON stated "It was expected for there to be an order."

On 7/26/22 at 2:03 PM, the surveyor discussed the above concern with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) of the above concern. The DON acknowledged there should have been a PO to [redacted] the resident's [redacted].

The surveyor reviewed the facility's policy and procedure with a revised date of 1/28/22, titled [redacted]". Under "Managing Obstruction" it read "[redacted] may be ordered to prevent obstruction in residents' at risk for obstruction". The surveyor also reviewed the

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	315249	A. BUILDING _____ B. WING _____	08/09/2022

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F 658	Continued From page 24 facility's policy and procedure with a revised date of 1/28/22, titled "[redacted] Care". The policy did not address obtaining a PO for [redacted] a [redacted]. NJAC 8:39-11.2 (b); 27.1 (a); 29.2(d)	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide [redacted] care in a manner that would decrease the possibility of the [redacted] deteriorating. This was found with 1 of 4 residents reviewed for [redacted] care, Resident # 9. The deficient practice was evidenced by the following: On 7/19/22 at 1:24 PM, the surveyor observed the resident in bed awake, the resident asked for food after trying for a few minutes to formulate	F 686	Element One-Corrective Actions The nurse who provided wound care for Resident #9 was counseled and re-educated regarding proper infection control practices when cleaning a [redacted] and proper sizing of [redacted] per physician orders and/or manufacturer recommendations. Element Two-Identification of at Risk Residents All residents may be affected by these practices	9/15/22

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F 686	Continued From page 25 the question. The resident was on a [redacted]. The resident was under a sheet and their [redacted] appeared [redacted]. The resident was clean. The surveyor was able to visualize [redacted] on the residents [redacted] under the sheet. The resident was laying on their back. On 7/21/22 at 10:56 AM, the surveyor observed the resident in bed with eyes closed. The resident was clean and appeared comfortable. The resident was covered with a sheet. The surveyor was able to visualize [redacted] on [redacted]. On 7/21/22 at 11:00 AM, the surveyor reviewed the resident's medical record which revealed the following: A physician's order sheet with a physician's order that read: '[redacted] Solution, Then Pat Dry and Apply [redacted] Then Cover With [redacted] Daily." The order was dated [redacted]. The quarterly Minimum Data Set an assessment tool dated [redacted], revealed that the Brief Interview for Mental Status score was [redacted], which indicated the resident had [redacted]. On 7/26/22 at 10:17 AM, the surveyor observed the Licensed Practical Nurse (LPN) perform a [redacted] treatment to the [redacted] of Resident # 9. When cleaning the [redacted], the LPN wiped the [redacted] with [redacted], the LPN wiped outside the [redacted] then inside the [redacted] with the same gauze, three times. The LPN then patted dry in and around the [redacted] with the same gauze.	F 686	Element #3 Nursing staff received re-education to assure that they follow infection control practices when cleansing and dressing a [redacted] per physician orders and/or manufacturers recommendations. The staff educator completes [redacted] care competencies on all new hires and annually to ensure nurses are competent to provide [redacted] care treatments as ordered. Element Four-Quality Assurance Monthly for the next three months, the ADON/Designee will conduct five random [redacted] care observations. The ADON will provide the audit statistics in aggregate to the DON monthly for review3 at the quarterly QAPI Committee meeting for action and further guidance as appropriate.	

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F 686	Continued From page 26	F 686		

After cleaning the [redacted], the LPN opened the [redacted] package, placed the entire sheet over the [redacted], and placed the [redacted] on top. The LPN did not cut the [redacted] to fit the [redacted] bed.

On 7/26/22 at 10:50 AM, the surveyor asked the LPN why she placed the entire [redacted] dressing under the [redacted] dressing, instead of cutting it to the size of the [redacted] bed. She said the physician's order did not say to cut the [redacted].

On 7/26/22 at 11:00 AM, the surveyor reviewed the package insert for the [redacted]. Under Description it read "Forms a [redacted] like consistency on contact with moisture, yet maintains integrity for convenient removal. Assists in maintaining a [redacted] environment." Under "To Apply" it read "2. Dressing may be cut to size prior to application."

On 7/27/22 at 2:42 PM, the surveyor spoke with the Administrator and the Director of Nursing (DON) about the [redacted] treatment observation, the inappropriate cleaning technique, and the application of the entire [redacted] pad instead of cutting it to size and placing it on the [redacted] bed. The DON said the cleaning technique the nurse used was incorrect and the nurse should have cut the [redacted] to the size of the [redacted] bed, because if it was not placed on the [redacted] bed it wouldn't work correctly if it wasn't making contact with the [redacted] bed.

On 7/28/22 at 9:00 AM, the surveyor reviewed the facility's undated policies and procedures titled, [redacted] Treatment and [redacted] Care. Neither of those policies addressed the issues

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F 686	Continued From page 27 observed during the [redacted] treatment. NJAC 8:39-27.1 (e)	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		9/15/22

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F 690	Continued From page 28 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide [redacted] care in a manner to reduce the spread of infection. The deficient practice was identified for 1 of 4 residents (Resident #120) reviewed for [redacted] and evidenced by the following: On 07/18/22 at 12:07 PM, the surveyor observed Resident #120 awake in bed. The resident's [redacted] bag was hanging from the bed frame. On 07/19/22 at 10:44 AM, the surveyor observed the resident seated at the bedside in a wheelchair. The surveyor inspected the resident's bathroom. A [redacted] bag was hung from the hand-rail next to the toilet. A used large [redacted] bag was stored in the [redacted] bag. The [redacted] bag was [redacted] and [redacted] On 07/20/22 at 11:57 AM, the surveyor observed in the resident's bathroom a [redacted] bag hung on the hand-rail next to the toilet. A used [redacted] was stored in the [redacted] bag. The uncapped end of the [redacted] rested on the floor adjacent to the base of the toilet. The surveyor summoned the regularly assigned Certified Nursing Assistant (CNA) to view the stored [redacted] bag. He stated the [redacted] should have been [redacted] He further stated he would discard the [redacted] bag. On 07/20/22 at 12:00 PM, the surveyor and the	F 690	Element One-Corrective Action The Certified Nurse Aide assigned to care for Resident #120 was immediately counseled and re-educated regarding proper positioning of [redacted] bag, proper use of [redacted] bag, proper use of the [redacted] bag, and proper [redacted] to prevent [redacted]. Element Two-Identification of at Risk Residents All residents may be affected by this practice. Element Three-Systemic Changes CNA's received re-education to assure they follow infection control practices when providing [redacted] care to residents including proper positioning of [redacted] bag, proper use of [redacted] bag, proper use of [redacted], and proper [redacted] to prevent [redacted] The Staff Educator provides catheter care in-service for all new hires and annually to ensure nurses are competent to provide [redacted] care as ordered to prevent [redacted]. Element Four-Quality Assurance Monthly for the next three months, the ADON/Designee will conduct observations of residents with [redacted] to ensure that nursing staff provide care to	

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F 690	Continued From page 29 CNA approached the resident who was lying on their back in bed. The CNA stated he changed the resident's overnight [redacted] bag to a [redacted] bag at 9:00 AM. He confirmed the resident had been in bed for three hours with the [redacted] bag in place. The surveyor and the CNA observed the [redacted] bag positioned under the resident's [redacted]. There was approximately [redacted] of [redacted] in the [redacted] bag. The CNA stated since the [redacted] bag was empty when applied, he did not think it was a problem to have the resident lay in bed for three hours with the [redacted] bag positioned at the same level of the [redacted] and under the resident's [redacted] On 07/20/22 at 12:10 PM, the Licensed Practical Nurse (LPN #1) assigned to Resident #120 entered the room. LPN #1 explained to the CNA that the [redacted] bag must be kept below the [redacted] so that gravity allows for [redacted]. LPN #1 told the CNA the bag should not be under the resident's [redacted]. LPN #1 told the CNA that the resident must be assisted out of bed to the wheelchair as soon as the [redacted] bag is applied. On 07/20/22 at 12:15 PM, LPN #2 entered the resident's room. LPN #2 stated the resident had a history of [redacted]) and [redacted]). LPN #2 stated it was important not to put the resident at risk for [redacted] LPN #2 stated the resident should be taken out of bed as soon as the [redacted] bag is applied. A review of the resident's medical record revealed the following information.	F 690	prevent [redacted]. The ADON will provide audit statistics in aggregate to the DON monthly for review at the quarterly QAPI Committee meeting for action and further guidance as appropriate	

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F 690	Continued From page 30 The [redacted] Physician's Orders contained a [redacted] order for the use of an [redacted]. The nurse documented in a [redacted] Interdisciplinary Progress Note "resident has been admitted [to the hospital] for [redacted]). The nurse documented in a [redacted] Order Form that the resident was receiving [redacted]. The [redacted] significant change Minimum Data Set (MDS) assessment tool indicated the resident utilized an [redacted]. The following diagnoses related to infections were listed as being active in the past [redacted] days ([redacted] through [redacted]): [redacted], [redacted] in the last 30 days. The MDS indicated the resident was prescribed [redacted] medication during the past [redacted] days. The [redacted] care plan, initiated on [redacted] and revised on [redacted], had the following goal, "[resident's name] will show no s/s [signs and symptoms] of [redacted] through review date." One of the interventions to prevent [redacted] was "position [redacted] at, and [redacted], the [redacted]." On 07/27/22 at 2:32 PM, the surveyor discussed the concerns of storage and placement of [redacted] bags with the Director of Nursing and the Administrator. On 07/28/22, the surveyor was provided with the [redacted] Care policy, revised 1/25/22.	F 690		

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F 690	Continued From page 31 The General Guidelines included the following, "maintain a [redacted] system" and "if breaks in aseptic technique, disconnection, or leakage occur, replace the [redacted] and [redacted] system ..." Instructions for Maintaining [redacted] Flow included "check the resident frequently to be sure he or she is not lying on the [redacted] and "the [redacted] bag must be held or positioned [redacted] than the [redacted] at all times to prevent the [redacted] in the [redacted] and [redacted] bag from flowing back into the [redacted]." The Infection Control section indicated "be sure the [redacted] and [redacted] bag are kept off the floor." NJAC 8:39-19.1 (a) ; 19.4 (a) 5.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including 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, and review of facility records, it was determined that the facility failed to ensure that a resident's [redacted] was responded to appropriately for 1 of 2 residents (Resident #159) reviewed for [redacted] care.	F 695	Element One-Corrective Actions LPN #2 was counseled and re-educated about notifying the physician when a resident on [redacted] has an [redacted] n level of [redacted] and about documenting notification of the physician in the medical record. The care plan for Residenet #159 was	9/15/22

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F 695	Continued From page 32 This deficient practice was evidenced by the following: On 7/19/22 at 1:20 PM, the surveyor observed Resident #159 awake in bed and observed that the resident was wearing a [redacted] (a device to provide [redacted]) attached to an [redacted]. The surveyor observed that the [redacted] on the [redacted] was set to [redacted] (LPM). At the same time the surveyor interviewed Resident #159. Resident #159 stated that they always wear the [redacted] and that ordinarily the [redacted] is set to [redacted] On 7/19/22 at 2:27 PM, the surveyor interviewed the Licensed Practical Nurse #1 (LPN #1) about Resident #159's use of [redacted] therapy. LPN #1 stated that Resident #159 was previously sent to the hospital because their [redacted], "dropped really bad" and that because of it, the doctor ordered the Resident to be on [redacted]. LPN #1 stated that Resident #159's [redacted] are measured every shift. On 7/20/22 at 11:00 AM, the surveyor observed the Treatment Administration Record (TAR) for Resident #159 which indicated that [redacted] was checked every shift. The TAR indicated that on the 11 PM- 7 AM shift on [redacted] and [redacted], that Resident #159's [redacted] saturation was documented as [redacted]. (For most people, a [redacted] level is between [redacted] On 7/20/22 at 11:03 AM, the surveyor observed the Interdisciplinary Progress Notes. A review of the Interdisciplinary Progress Notes failed to reveal any nursing documentation from the	F 695	updated to address their [redacted] needs including [redacted] and the use of [redacted] and was reviewed with nursing staff that provide care to Resident #159. Element Two-Identification of at Risk Residents A;ll residents may be affected by this practice. Element Three- Systemic Changes Licensed nurses were provided with re-education regarding assessment, interventions and care planning for residents with [redacted] who require [redacted]. Nurses were also re-educated about notifying the physician whena resident on [redacted] has a [redacted] level below acceptable parameters. Element Four-Quality Assurance Monthly for the next three months, the ADON/Designee will conduct random observations of residents with [redacted] orders to ensure that nursing staff assess any episodes of [redacted], notify the physician and document in the medical record. The ADON will also review the care plans to assure that they address [redacted] as appropriate. The ADON/Designee will provide the audit statistics in aggregate to the DON monthly for review at the quarterly QAPI Committee meeting for action and further guidance as appropriate.	

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[redacted] and [redacted] during the 11 PM-7 AM shifts, when the resident's [redacted] were documented as [redacted]

On 7/20/22 at 11:05 AM, the surveyor interviewed LPN #1 about the documentation in the TAR and Interdisciplinary Progress Notes. The surveyor asked LPN #1 what she would do if Resident #159's [redacted] was [redacted]. LPN #1 stated that she would call the doctor and would write a nursing progress note documenting the [redacted] level and interventions provided. The surveyor showed LPN #1 the TAR and Interdisciplinary Progress Notes. The surveyor asked who signed the TAR the two shifts where Resident #159's [redacted] was documented as [redacted]. LPN #1 stated that it was LPN #2. LPN #1 agreed that she did not see a nursing progress note corresponding to when the resident's [redacted] was [redacted].

On 7/20/22 at 11:35 AM, the surveyor interviewed Resident #159. The surveyor asked if Resident #159 ever had [redacted]. Resident #159 stated that sometimes at "3 o'clock in the morning" that they became [redacted] and had trouble [redacted] until the nurse assisted them.

On 7/20/22 at 12:20 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) regarding the [redacted]% documented on the TAR. The surveyor asked the ADON what her expectation would be if she saw that Resident #159 had an [redacted] of [redacted]%. The ADON stated that she would check to see if the resident had [redacted]). People with [redacted] generally have a goal of [redacted] from

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[redacted]). The ADON also stated that if the resident did not have that diagnosis, that she would notify the doctor, and would expect to see a nursing progress note written about the [redacted] level.

On 7/20/22 at 12:47 PM, the surveyor interviewed the Nurse Practitioner (NP). The NP stated that she works with Resident #159's physician and that she treats Resident #159. The surveyor asked what Resident #159's goals were for [redacted] level. The NP stated that Resident #159 did not have [redacted] and that [redacted] goals for an [redacted] level were to be at [redacted] or above. The surveyor asked what she would expect the nurse who was taking care of Resident #159 to do if she saw that their [redacted] was [redacted] The NP stated that she would expect that the health care provider would be notified and that the [redacted] of [redacted] would be increased. The surveyor asked if she or the physician were notified that the resident's [redacted] was at [redacted] on [redacted] and [redacted] The NP stated that, "for sure" she was not notified.

On 7/20/22 at 1:03 PM, the surveyor interviewed LPN #2 via telephone. LPN #2 stated that she floated to different units within the facility but that she had taken care of Resident #159. The surveyor asked if she remembered documenting that Resident #159's [redacted] on the 11 PM- 7 AM shift on [redacted] and [redacted] was [redacted]. LPN #2 stated, "I'm not sure I remember". The surveyor asked what LPN #2 should have done if she saw that Resident #159's [redacted] was [redacted]. LPN #2 stated that she should go back and recheck the [redacted], that she should raise the resident's head of bed, that she should speak with her nursing supervisor, and

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that she should call the physician. LPN #2 was unable to speak to which if any of these steps she did take for Resident #159. The surveyor asked LPN #2 if she should have documented anything about the [redacted]. LPN #2 stated that she should have written a nursing progress note as well.

On 7/20/22 at 1:10 PM, the surveyor reviewed Resident #159's care plan. The care plan did not have a focus on [redacted] function, [redacted], or [redacted] use.

On 7/20/22 at 1:21 PM, the surveyor re-interviewed LPN #1. The surveyor asked if she would expect that a resident with a history of [redacted] who was receiving [redacted] would have a [redacted] care plan in place. LPN #1 stated that she would expect to see a care plan in place for a resident on [redacted].

A review of the hybrid paper and electronic medical record for Resident #159 revealed the following:

The Admission Record revealed that Resident #159 had diagnoses including but not limited to [redacted].

The Physician Progress Note dated [redacted] indicated that Resident #159 had a history of [redacted]. A further review of the Physician Progress Note did not indicate that the resident had a diagnosis of

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[redacted] but did revealed that the resident was readmitted to the facility from the hospital with an admitting diagnosis of [redacted].

The [redacted] quarterly Minimum Data Set, an assessment tool utilized to facilitate the management of care indicated that Resident #159 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that the resident had [redacted]. The facility had performed a follow up BIMS assessment on [redacted] which indicated that Resident #159 had scored an [redacted], indicating that the resident had [redacted].

The Physician's Order Form Indicated that Resident #159 had a [redacted] active physician order to check [redacted] every shift and to provide [redacted] via [redacted] continuously for [redacted] with [redacted].

On 7/20/22 at 2:06 PM, the surveyor discussed the above concern with the Licensed Nursing Home Administrator and the Director of Nursing (DON). The surveyor asked what they would expect to see if a resident had an [redacted]. The DON stated that she would expect to see that the healthcare provider was notified, a nursing assessment, and documentation. The DON further stated that she always expected to see documentation especially if there was an abnormal finding.

The facility policy titled, "[redacted] (Assessing [redacted]) with a revised date of 12/3/2021 indicated under the General Guidelines section 2. [redacted] is between

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F 695	Continued From page 37 [redacted] percent" and indicated under the Steps in the Procedure section 11. If [redacted] is less than [redacted] percent to a. reposition the probe and re-evaluate readings. B. If [redacted] is less than acceptable level for resident's condition, notify the physician. NJAC 8:39-27.1 (a)	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to: 1. maintain ongoing complete communication notes between the facility and the [redacted] center and 2. maintain an assessment of a resident's condition and monitoring for complications upon return from [redacted]. This deficient practice was identified for 3 of 4 residents reviewed for [redacted], Residents #138, #108 and #135). The deficient practice was evidenced by the following: 1. On 7/18/22 at 11:46 AM, the surveyor observed Resident #138 was not in their room. The unit's Assistant Director of Nursing (ADON) informed the surveyor that the resident was at [redacted] (a process of [redacted] of a person whose [redacted] are not working	F 698	Element One-Corrective Action The licensed nurses who failed to properly document Resident #138's pre and post [redacted] vital signs and status on the communication logs and in the progress notes were counseled and re-educated regarding the facility [redacted] policy. The licensed nurses who failed to properly document Resident #108's pre and post [redacted] vital signs and status on the communication logs and in the progress notes were counseled and re-educated regarding the facility [redacted] policy. The licensed nurses who failed to properly document Resident #135's pre and post [redacted] vital signs and status on the communication logs and in the progress	9/15/22

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F 698	Continued From page 38 normally) and had [redacted] sessions every [redacted], and [redacted] The surveyor reviewed Resident #138's hybrid medical records (paper and electronic medical record) that revealed the following: According to the Admission Record, Resident #138 was admitted with diagnoses that included [redacted]) and dependence on [redacted] (relating to the [redacted]) [redacted]. The Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that the facility performed a Brief Interview for Mental Status (BIMS) which indicated that the resident had a score of [redacted]. The resident was assessed to be [redacted] intact. The care plan titled "Resident requires [redacted] related to [redacted]" included the intervention "Continue to monitor me upon return to [redacted] On 7/25/22 at 8:40 AM, the surveyor interviewed a Licensed Practical Nurse (LPN)who stated the resident had a [redacted] communication book. The LPN further stated the resident was scheduled to be picked up for [redacted] at 9:30 AM and usually came back to the facility between 2 to 3 PM. On 7/25/22 at 8:46 AM, the surveyor interviewed the LPN who was asked where nurses documented besides the [redacted] communication book. The LPN stated "In the 24-hour report." Resident #138's [redacted] communication book included a Communication Log (CL) form that the	F 698	notes were counseled and re-educated regarding the facility [redacted] policy. Element Two-Identification of at Risk Residents All residents may be affected by this practice. Element Three-Systemic Changes Licensed nurses received re-education regarding proper assessment pre and post [redacted] treatments and documentation of findings on the communication logs and on the progress notes per facility policy. The policy for end stage renal disease was reviewed and updated to address completion of the [redacted] communication form pre and post [redacted] treatment and licensed nurses were re-educated. The [redacted] centers used by the facility were contacted to verify that they should contact the facility if a resident comes for treatment without a communication form or one which is not properly completed. The Staff Educator provides dialysis documentation education for all new licensed nurses during orientation and annually to ensure nurses assess residents who receive [redacted] pre and post treatments on the communication logs Element Four-Quality Assurance The ADON/Designee will submit a weekly audit for Four weeks and then monthly for	

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F 698	Continued From page 39 facility used to communicate with the dialysis center for each of the resident's [redacted] sessions. The top section titled CL was to be filled out by the facility nurse before the resident was sent to [redacted] It included for the facility nurse to document the resident's vital signs (blood pressure, pulse, temperature, and respiration rate), medications given, and comments. The second section titled, [redacted] Communication Log, was to be filled out by the [redacted] center. It included for the [redacted] nurse to document the resident's pre and post [redacted] weights and vital signs, and any additional treatment information if required. There was no section for the nurse to complete vital signs assessment upon the resident's return to the facility from [redacted] On 7/25/22 at 10:30 AM, the surveyor interviewed the LPN, about the procedure for sending residents to [redacted]. The LPN stated she would take the resident's vital signs, write in the communication log the vital signs and medications the resident was given prior to going to [redacted] The LPN further stated it was documented when the resident returned from [redacted] and if the resident refused to go to [redacted] in the chart's progress note. The LPN stated the resident had a [redacted] access site which was monitored for [redacted] (to assess its function), signs and symptoms of bleeding, drainage, or infection. At that time, the surveyor reviewed the chart with the LPN where the nurses' documented. Under Interdisciplinary Progress Notes in the chart, there were entries for [redacted] when the resident returned from their [redacted] session, [redacted] when the resident refused and an entry for [redacted] at 9am when the resident was picked up by	F 698	three months of each resident who is receiving [redacted] to ensure that the necessary documentation is in place to reflect the residents' condition pre and post [redacted]. The results of this audit will be submitted to the DON/Administrator for review and recommendations. On a quarterly basis, the findings and recommendations will be presented at the QAPI for action as appropriate.	

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transport for [redacted]. The LPN was asked about her entry for the resident going to [redacted] that morning, as she previously stated she did not document in the resident's chart. The LPN stated she sometimes forgot to document in the nurses note and acknowledged she wrote an entry for today because the surveyor was asking about nurses' documentation for a [redacted] resident. The LPN was asked about the facility's policy for documentation for residents going to [redacted]. The LPN stated she wasn't sure of the facility policy for the documentation.

On 7/26/22 at 10:23 AM, the surveyor interviewed the unit's ADON and asked about what the nurses were expected to document for residents with [redacted] sessions. The ADON stated the nurses were expected to document in the nurses note of the chart upon the resident going to [redacted] and upon their return to the facility from [redacted]. The surveyor reviewed nurses' notes in the chart with the ADON. The ADON acknowledged the nurses' notes were not consistent and there were [redacted] days that were missing nurses' notes. The ADON stated the nurses were expected to document upon the resident's return from [redacted] including their blood pressure, assessment of access site, if there is any bleeding or drainage. The surveyor asked the ADON if there was anywhere else in the medical record where nurses would document. The ADON replied "No". The ADON further stated nurses may communicate between shifts using the 24-hour report but were supposed to document in the nurses note.

A review of nurses' progress notes in Resident #138's chart, revealed from [redacted] to [redacted], there was no documentation on the resident's

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F 698	Continued From page 41 vital signs or status post [redacted] for [redacted] out of [redacted] days. The nurses' notes reviewed in the resident's chart, included notes for two [redacted] days the resident refused to go to [redacted] and two notes on [redacted] days which detailed the resident's [redacted]. On 7/26/22 at 2:03 PM, the surveyor informed the Administrator and the Director of Nursing (DON) of the above concern. No additional information was provided. 2. On 7/27/22 at 10:30 AM, the surveyor interviewed Resident #108 in the resident's room. The resident informed the surveyor that they attend [redacted] on [redacted], [redacted] and [redacted] each week. Review of Resident #108's [redacted] communication book revealed CL for [redacted], and [redacted]. The CL's were completely filled out except for [redacted], that was missing documention for pre and post [redacted]. There were no other CL's for [redacted] visits prior to [redacted] Review of Resident#108's Face Sheet (an admission summary) reflected that Resident #108 was admitted to the facility with diagnoses that included but were not limited [redacted] The Quarterly MDS dated [redacted], revealed a BIMS score of [redacted] out of [redacted] which indicated that the resident was [redacted]. On 7/27/22 at 10:30 AM, the surveyor interviewed the [redacted] floor Registered RN Charge Nurse	F 698		

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(RNCN) who stated that he spoke to the [redacted] center when he realized that there were many CL missing for Resident #108. RNCN stated that the [redacted] center explained that they fill out the sheets. The RNCN could not identify the specific date that this conversation occurred. RNCN stated that the resident rips up the forms or loses the books when they go to [redacted]

The RNCN stated that the nurses should be documenting the residents [redacted] values (Weight, Blood Pressure, Pulse and Temperature) in the nursing progress notes. The RNCN could not provide any evidence that [redacted] values were completed or documented for Resident #108.

On 7/27/22 at 11:55 PM, the surveyor interviewed Resident #108 who stated that upon return to the facility from [redacted] the facility does not weigh or evaluate their vitals. Resident #108 stated that a [redacted] Communication Book accompanies the resident to [redacted] but that they were not sure what information was in the book.

On 7/27/22 at 12:30 PM, the surveyor discussed the missing information in the [redacted] Communication Book as well as the Nurses Progress Notes with the RNCN. The RNCN stated that [redacted] evaluation should be documented on the CL as well as in the resident's nursing progress notes. The RNCN stated that the facility would have to find a different way of keeping track of the CL sheets stored in the book as well as making sure that there is documentation in the Nurses Progress Notes upon return from [redacted].

3. On 7/27/22 at 1:20 PM, the surveyor observed

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Resident #135 in bed with eyes closed after returning from [redacted].

The surveyor interviewed the [redacted] Unit RN [redacted], who was assigned to care for Resident #135. The SURN informed the surveyor that Resident #135 went to hemodialysis on [redacted], and [redacted] with a chair time at 11 AM. The [redacted] explained that Resident #135 receives breakfast and medications before going to dialysis and lunch is sent with the resident. The [redacted] also stated that the resident had a [redacted] communication book that the CL for the day which was completed before and after [redacted] and added that a CNA went with the resident because sometimes there were behaviors.

The surveyor reviewed Resident #135's hybrid medical records which revealed the following:

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

The Quarterly MDS dated [redacted] revealed the facility performed a BIMS. The BIMS score was [redacted] out of [redacted], which indicated that the resident had [redacted].

The [redacted] Physician's Order Form revealed a physician's order for [redacted] s every [redacted] with [redacted] at 11 AM.

The surveyor reviewed the CL forms that the facility used to receive communication from the [redacted] center for Resident #135. The CL contained a [redacted] assessment done by the

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facility and a pre and post section completed by the [redacted] center.

The CL were completed for the dates of 7/1/22, 7/4/22, 7/6/22, 7/8/22, 7/11/22, 7/13/22, 7/15/22, 7/18/22, 7/20/22, 7/22/22, 7/25/22, and 7/29/22. Review of the Interdisciplinary Progress Notes revealed that the nurses did not document the assessment of the resident's vital signs when Resident #135 returned from [redacted], to ensure there were no complications.

A review of the resident's vitals section revealed that there were no documented assessments of vitals taken after Resident #135 returned from dialysis for the entire from July 1, 2022 to July 27, 2022.

On 7/27/22 at 2:00 PM, the surveyors discussed concerns regarding two addition residents, Resident's #108 and #135 for lack of post dialysis documentation with the Administrator and DON. No additional information was provided.

On 8/2/22 at 9:54 AM, the surveyors reviewed the facility's policy and procedure with a revised date of 1/25/22, titled "[redacted] Care". Under "Documentation" it read, "The general medical nurse should document in the resident's medical record every shift as follows: ...3. If [redacted] was done during shift ....5. Observations [redacted]". The policy did not address monitoring residents' vital signs[redacted]

The surveyors reviewed the facility's policy and procedure with a revised date of 1/25/22, titled, [redacted] Disease, Care of a Resident with". The policy did not address documentation by nurses for[redacted] residents.

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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 drug regimen review that include, but are not	F 756		9/15/22

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F 756	Continued From page 46 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 observation, interview, and record review, it was determined that 1.) the Consultant Pharmacist failed to identify the need for routine [redacted] management medication review for 1 of 38 residents reviewed, Resident #108, and 2.) the facility failed to respond to the Consultant Pharmacist recommendations for 2 of 38 residents reviewed, Resident #211 and Resident #484. The deficient practice was evidenced by the following: 1. On 7/27/22 at 10:30 AM, the surveyor interviewed Resident #108 in the resident's room. The resident informed the surveyor that they attend [redacted] on [redacted], and [redacted] each week. Resident #108 informed the surveyor that due to a previous fall prior to their facility admission and [redacted], they suffer from [redacted]. Review of Resident #108's Face Sheet (an admission summary) reflected that Resident #108 was admitted to the facility with diagnoses that included but were not limited to [redacted]. The Quarterly Minimum Data Set (MDS), an assessment tool used for the management of care dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted] which	F 756	Element One-Corrective Actions Resident #108 frequent use of prn [redacted] l a[redacted] medication for [redacted] management addressed by the consultant pharmacist was discussed with the physician and the order was changed to routine [redacted] medication. Resident #211 non-use of [redacted] prn was addressed by the physician based on the Consulting Pharmacist (CP) recommendations. The physician who did not address the consulting pharmacist's recommendations was contacted by the Medical Director to assure timely review of the consulting pharmacist recommendations. The[redacted] was discontinued. The Consulting Pharmacist addressed Resident 3484 receiving [redacted] outside of ordered parameters on occasion for several months. The physician was notified ogf the recommendations relating to the medication. Nursing management was informed of the medication errors and nursing staff that made the medication errors were counseled and re-educated. Element Two-Identification of at Risk Residents All residents have the potential to be	

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F 756	Continued From page 47 indicated that the resident was cognitively intact. The surveyor reviewed the [redacted], and [redacted] Medication Administration Record (MAR) that documented a Physician's Order dated [redacted] for [redacted] mg [redacted] mg) every 8 hours as needed (PRN) for [redacted] Review of the [redacted] MAR documented the use of [redacted] mg once to twice daily 37 times during the month. Review of the facility [redacted] Management Record (PMR) revealed that Resident #108 was documented with [redacted] of [redacted] and [redacted] out of [redacted]. Review of the [redacted] MAR documented the use of [redacted] mg once to twice daily 34 times during the month. Review of the PMR revealed that Resident #108 was document with [redacted] levels of [redacted] out of [redacted] Review of the [redacted] MAR documented the use of [redacted] mg once to twice daily 19 times during the month. Review of the PMR revealed that Resident #108 was document with [redacted] levels of [redacted] out of [redacted] On 7/27/22 at 11:55 PM, the surveyor interviewed Resident #108 who stated, "I have to go to the nurses and ask for [redacted] medication when my [redacted]." Resident #108 informed the surveyor that they would like routine [redacted] medicine. Review of the Consultant Pharmacist Evaluation sheet (CPE) with review dates of [redacted], [redacted], and [redacted] have no entries referring to the evaluation of routine [redacted] management for frequent use of as needed [redacted].	F 756	affected by this practice. Element Three-Systemic Changes The Consulting Pharmacist (CP) reviewed the charts of residents with prn medications to identify any other residents who may require a change from prn to routine [redacted] medications as applicable. The CP made recommendations as appropriate to physicians. Element Four-Quality Assurance Monthly, the consulting pharmacist reviews all resident medication orders, MARs and TARs and makes recommendations to the physician to consider a routine [redacted] medication if a resident is requesting frequent prn [redacted] medications. The CP provides a report in aggregate of the use of [redacted] medication to the DON. The Consulting Pharmacist's recommendations will be audited by the ADON/Designee and any findings will be addressed. A copy of the Report, with completed recommendations, will be presented to the Director of Nursing on a monthly basis for review and action. Results are reported in aggregate by the DON/Consulting Pharmacist at the quarterly QAPI Committee meeting for action as appropriate on an ongoing basis.	

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F 756	Continued From page 48 On 7/29/22 at 12:09 PM, the surveyor interviewed the Consultant Pharmacist (CP). The CP stated that when she reviewed the use of PRN [redacted], she should have recommended an assessment of the resident's [redacted] management regimen. The CP stated that she should have recommended a review of Resident #108's PRN [redacted] medication use "as soon as possible." 2. On 7/18/22 at 1:02 PM, the surveyor was approached by Resident #211. Resident #211 was upset and verbalizing about their frustration with renewing their [redacted] before it expired. Review of Resident #211's Face Sheet revealed that Resident #211 was admitted to the facility with diagnoses that included but were not limited to [redacted]. The Annual MDS dated [redacted], revealed a BIMS score of [redacted] which indicated that the resident's cognition was [redacted]. Review of the [redacted] Physician Order Sheet presented an order for [redacted] mg every [redacted] hours PRN for [redacted] with a start date of [redacted]. Review of [redacted], and [redacted] MARs for Resident #211 revealed no use for the [redacted] mg every [redacted] hours PRN for [redacted] order. Review of the CPE evidenced 4 entries related to the physician's orders for [redacted] mg every 6 hours PRN for [redacted]. On [redacted] and [redacted] there were entries of, "PRN [redacted]	F 756		

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duration." On [redacted] there was an entry from the CP that stated, "Follow up [redacted]

Review of the CP Therapeutic Suggestions sheets presented to the facility on [redacted], [redacted] and [redacted] presented the same statement. The statement read, "Per CMS guidelines, PRN [redacted] are limited to 14 day duration regardless of indication. If continuing with [redacted] beyond 14 days, a new prescription is required every 14 days and rationale must be documented in the clinical record. The pharmacy consult was not addressed."

On 7/29/22 at 12:09 PM, the surveyor interviewed the CP. The CP explained, "I sent recommendations to discontinue the PRN [redacted] on a monthly basis. Non use of a PRN medication is cause for discontinuation as soon as possible."

3. On 7/18/22 at 2:07 PM, the surveyor interviewed Resident #484. Resident #484 was seated in a wheelchair in their room. Resident #484 was pleasant and eager to speak with the surveyor.

Review of Resident #484's Face Sheet revealed that Resident #484 was admitted to the facility with diagnoses that included but were not limited t [redacted]

The MDS dated [redacted], revealed a BIMS score of [redacted] which indicated that the resident's cognition was [redacted].

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Review of the resident's [redacted], and [redacted] MAR revealed a PO dated [redacted] for [redacted] mg daily for [redacted] (hold for blood pressure (BP) less than 120).

The documentation from the [redacted] MAR indicated that on five days of the month [redacted] mg was administered when the BP was less than 120. The May 2022 MAR documented nurses signatures as administered on 5/3/22 BP [redacted], 5/16/22 BP [redacted], 5/22/22 BP [redacted], 5/23/22 BP [redacted], 5/28/22 BP [redacted], 5/29/22 BP [redacted].

The documentation from the [redacted] MAR indicated that on seven days of the month [redacted] mg was administered when the BP was less than 120. The June 2022 MAR documented nurses signatures as administered on 6/14/22 BP [redacted], 6/17/22 BP [redacted], 6/18/22 BP [redacted], 6/20/22 BP [redacted], 6/21/22 BP [redacted], 6/27/22 BP [redacted] and 6/29/22 BP [redacted].

The documentation from the [redacted] MAR indicated that on eight days of the month [redacted] mg was administered when the BP was less than 120. The July 2022 MAR documented nurses signatures as administered on 7/2/22 BP [redacted], 7/12/22 BP [redacted], 7/15/22 BP [redacted], 7/16/22 BP [redacted], 7/17/22 BP [redacted] 7/19/22 BP [redacted] and 7/21/22 BP [redacted].

Review of the CPE evidenced an entry related to the [redacted] mg parameter discrepancy on 5/13/22. On 5/13/22, the CP documented, "Review [redacted] parameter."

Review of the CP Therapeutic Suggestions sheets presented to the facility on [redacted] and

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[redacted] referred to the "Medication error(s)" related to the [redacted] mg. On [redacted], the CP stated "Medication error(s) noted. [redacted] is not always held as required by the physicians hold order as on 5/2/22, 5/3/22, 5/7/22, 5/8/22, and 5/11/22. Please review and follow physicians order." On [redacted], the CP stated "Medication error(s) noted. [redacted] is not always held as required by the physicians hold order. Please review and follow physician's orders [redacted] and [redacted]"

On 7/27/22 at 2:25 PM, the surveyor met with the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) to review the above findings.

On 7/29/22 at 12:09 PM, the surveyor interviewed the CP who stated that she addressed and reported the parameter discrepancy with the [redacted] to the facility. The CP added, "It was not addressed by the facility."

Review of the "Duties of Consultant" Duties included in the facility agreement section "2. iii" states, "Performing a monthly onsite review of the drug regimen of each patient on the Facility's unit census on date(s) of visit. Reports of any irregularities shall be provided to the nurse in charge and/or the attending physician, and the administrator."

Review of the "Duties of Facility" included in the facility agreement section "3. a." states, "The reports of irregularities, if any, included in the Facility's census, shall be acted upon by the nurse in charge and/or the attending physician and/or the administrator."

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F 756	Continued From page 52 On 8/2/22 at 10:20 AM, the surveyor interviewed the [redacted] floor Charge Nurse (CN3) who stated that another charge Nurse (CN) was responsible for reviewing and following up with the CP recommendations. CN3 added that the CN responsible for this task was no longer working at the facility. CN3 could not recall when CN's employment ended. On 8/2/22 at 12:20 PM, the DON informed the surveyor that CN ended her employment with the facility sometime in [redacted]. The DON could not explain why no other employee was assigned the task of reviewing and following up with CP recommendations. No further information was submitted by the DON or LNHA to explain why the CP recommendations were not reviewed and addressed. No further information was submitted by the CP to explain why the PRN [redacted] medications for Resident #108 were not reported to the facility. NJAC 8:39 - 29.3 (a 1, 6)	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		9/15/22

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F 761	Continued From page 53 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly store medications meant to be refrigerated in 2 of 13 medication carts inspected. The deficient practice is evidenced by the following: 1. On 7/26/22 at 9:41 AM, the surveyor inspected the [redacted] medication cart in the presence of Licensed Practical Nurse (LPN) #1. The surveyor observed a bag labeled "Refrigerate". Inside the bag, the surveyor observed a [redacted] used to treat [redacted] milligrams/ milliliter bottle labeled, "Must Be Refrigerated". The surveyor observed that the [redacted] bottle felt room temperature. At that time, the surveyor interviewed LPN #1 who stated that her shift started at 7 AM and that she did not take the [redacted] out of the	F 761	Element One-Corrective Actions No resident received the [redacted] found in the med cart on [redacted] Floor. The LPN indicated another bottle in the refrigerator was used. The unrefrigerated bottle was immediately discarded. The vial of insulin requiring refrigeration until opened was found in a med cart on [redacted] was immediately discarded. Nursing staff on the [redacted] Floor and on [redacted] received immediate re-education regarding proper labeling and storage including refrigeration of medications per manufacturer recommendations. Element Two-Identification of at Risk Residents All residents have the potential to be affected	

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F 761	Continued From page 54 refrigerator. LPN #1 stated that the nurse who worked the previous shift told her that he could not find the [redacted] in the refrigerator and that he gave a dose from the backup stock of medications because he did not know that the medication was in the cart. LPN #1 stated that the [redacted] should not be in the cart and should be in the refrigerator. 2. On 7/26/22 at 10:14 AM, the surveyor inspected the [redacted] medication cart with LPN #2. The surveyor observed an orange medication bottle labeled "Refrigerate Until Opened". The surveyor opened the medication bottle and observed an unopened vial of [redacted] (a medication that works to [redacted] which felt room temperature. The surveyor also observed a sticker on the [redacted] vial which read "Date Opened" and was completed in black marker, '[redacted] At that time, the surveyor interviewed LPN #2 who acknowledged that the [redacted] should be in the refrigerator and that the medication was not opened so it should not have an opened date written on it. The surveyor reviewed the Medication Guides for the [redacted] and [redacted] medications which revealed the following: The Firvanq Medication Guide indicated under Important Administration and Storage Instructions to, "Store the reconstituted solutions of [redacted] at refrigerated conditions, 2° C (celsius) to 8° C (36° F (fahrenheit) to 46° F) when not in use." The [redacted] Medication Guide indicated under Storage and Handling that, "Not in-use	F 761	Element Three The consulting pharmacist completed a full house med cart inspection to assure proper storage and labeling of all medications in the med carts. Nursing staff received re-education about storage, labeling, dating of multidose medications when opened and proper disposal of medications not properly refrigerated. The DON implemented a medication storage reference document for easy reference by nursing staff who received education. A copy of the reference tool was placed on each nursing unit. Element Four-Quality Assurance Unit managers are checking medication and treatment carts each week to be sure all medications, insulins, and treatment products are properly labeled and stored. Findings are acted upon by the Unit Manager and reported at morning clinical meeting. Monthly, the consulting Pharmacist is conducting med cart checks to be sure that all medications are properly stored and labeled and providing immediate one to one education as needed based on the results of the observations. Cart audit results are provided to the DON along with the monthly consulting pharmacist report. The DON/Designee reviews all reports and based on the results confirms if additional education is required. Results	

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F 761	Continued From page 55 (unopened) [redacted] should be stored in a refrigerator (36° F- 46° F [2° C- 8°C])." On 7/26/22 at 2:06 PM, the surveyor expressed her concern to the Licensed Nursing Home Administrator and Director of Nursing (DON). The surveyor asked if this is how the DON expected for medications to be stored. The DON stated that if medications say refrigerate on them that they should be refrigerated. On 7/29/22 at 12:23 PM, the surveyor interviewed the Consultant Pharmacist via telephone. The surveyor asked if she would expect to see [redacted] solution stored at room temperature in the medication cart or if she would expect to see unopened [redacted] stored in the medication cart when there is a label on it to refrigerate it until it is opened. The Consultant Pharmacist stated, "of course not". The "Storage of Medications" facility policy with a reviewed date of 12/20/21 indicated under the Policy Interpretation and Implementation section 10. "Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurse's station or other secured location." NJAC 8:39-29.4 (h)	F 761	are reported in the aggregate by the DON at the quarterly QAPI Committee meeting for action as appropriate on an ongoing basis	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.	F 849		9/15/22

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(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to

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alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK CARE CENTER	499 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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F 849	Continued From page 58	F 849		

and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the

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F 849	Continued From page 59 medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to consistently provide coordination between facility staff and [redacted] agency staff to meet the resident's nursing needs. The deficient practice was identified for 1 of 2 residents (Resident # 9)	F 849	Element One-Corrective Actions The [redacted] company was immediately contact top request copies of all nursing visit notes, assessments and care plans and other required documentation be placed in the medical record of Resident	

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F 849	Continued From page 60 reviewed for [redacted]. The deficient practice was evidenced by the following: On 7/19/22 at 1:24 PM, the surveyor observed Resident # 9 in bed and awake. The resident asked for food after trying for a few minutes to formulate the question. The resident was on a [redacted] mattress. The resident was under a sheet. The resident was clean. On 7/20/22 at 9:15 AM, the surveyor spoke with the Licensed Practical Nurse (LPN) who was assigned to the resident. The LPN said the [redacted] Nurse went to the facility very often, 2 times per week, and the [redacted] aide went to the facility every morning. The LPN stated "when I come in at 7 AM she is already there." The surveyor asked the LPN where the [redacted] care plan was located. The LPN stated "I have never seen the [redacted] care plan. You can ask her (the [redacted] nurse) or I can ask her for it." On 7/20/22 at 9:30 AM, the surveyor reviewed the resident's record which revealed the following: A quarterly Minimum Data Set Assessment dated [redacted]. In that assessment, the Brief Interview for Mental Status score was [redacted] which indicated the resident had [redacted]. Nineteen [redacted] Communication/Continuation notes were reviewed with the following dates 3/19/22, 3/30/22, 4/5/22, 4/8/22, 4/22/22, 4/26/22, 4/28/22, 5/10/22, 5/12/22, 5/17/22, 5/18/22, 6/9/22, 6/14/22, 6/21/22, 6/28/22, 6/30/22, 7/5/22, 7/12/22, and 7/13/22. Three of the nineteen notes were completed by the [redacted]. Sixteen of the	F 849	#9. The [redacted] company was instructed to notify the DON/ADON if there was no room for the documents or if the chart was not available at the time of the visit to assure coordination of care and services. The Interdisciplinary care plan includes the [redacted] plan of care and was reviewed and updated for Resident #9. Nurses that provide care to Resident #9 were immediately instructed to ask the [redacted] nurse for copies of the nurses notes at each [redacted] visit. Element Two-Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three-Systemic Changes Nursing styaff received re-education regarding coordination of services with [redacted] nurses for residents that receive [redacted] services. Medical records staff were instructed to thin all charts of residents on [redacted] to assure that there is adequate room in the medical record for [redacted] documentation. Element Four-Quality Assurance Weekly, for one month and monthly for two months, the ADONs will audit the charts of all residents receiving [redacted] services to ensure that visit notes, [redacted] assessments, and care plans are included in the residents' medical record to ensure coordination between the	

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F 849	Continued From page 61 nineteen notes were completed by either the [redacted] Registered Nurse (RN) or Licensed Practical Nurse (LPN). There should have been thirty three notes by the RN/LPN according to the twice per week schedule reported by the resident's LPN. On 7/20/22 at 11:21 AM, the surveyor called the [redacted] provider and spoke with the medical records clerk. The surveyor asked what documentation from the [redacted] provider was put in the resident's medical record at the facility. The medical records clerk stated "I try to keep the facility updated on the documentation we have for the resident, as soon as we get the certification of [redacted] signed, which happens in the week of admission, the medical director document we get 2 weeks after admission, when I get both of those documents signed, I print those out, the DNR/DNI is right at admission or within a week, I print those out, the consents the family signs, those are printed out. The plan of care is printed out within 2 weeks of admission and then every two weeks after that we print out the interdisciplinary group meeting notes and updated plan of care. I send those with the liaison to the facility to be placed in the resident's record." On 7/20/22 at 11:43 AM, the surveyor spoke with the hospice RN/Case Manager (RN/CM) at the facility and asked where she documented the nursing visits and where the care plan and admission assessment was. The RN/CM stated "I have a computer like you and I have all my notes in there. Sometimes I come here and I don't see [the resident's] chart so I can't put the notes in." The surveyor asked the RN/CM for the care plan and the date the resident was admitted to	F 849	[redacted] company and facility staff. The ADONs will provide the DON with findings on a monthly basis. The DON will act upon the findings of the chart audits and will communicate with the [redacted] provider as appropriate. Results are reported in aggregate by the DON at the quarterly QAPI meeting for action as appropriate on an ongoing basis.	

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F 849	Continued From page 62 [redacted] The RN/CM stated the resident was admitted to [redacted] on [redacted], the surveyor asked the RN/CM why there was a note in the chart written by the [redacted] LPN and dated [redacted], the RN/CM did not know. The RN/CM stated "My LPN wrote that and she may have made a mistake with the date." The RN/CM further stated that the [redacted] provider changed their computer system on [redacted] first. She said she didn't know why the chart was missing the admission note and the care plan. The RN/CM stated "I have all of the documentation in my computer, the liaison brings the paper copy and puts it in the chart. The resident is scheduled to be seen twice a week. Once a week it's me and once a week it's the LPN. I have a note here dated [redacted] that I have to put in the chart because at the time I couldn't find the chart. In other places, they have a separate chart for [redacted] notes, they don't want that here. They don't thin the charts here so we have this problem where you can't fit the paperwork in the chart I guess." The surveyor asked the RN/CM if she would expect to see the admission assessment and note as well as the care plan in the chart. The RN/CM said yes, it should have been in there. On 7/27/22 at 2:14 PM, the surveyor discussed the above concern with Administrator and Director of Nursing. No additional information was provided. On 7/28/22 at 9:00 AM, the surveyor reviewed the facility's policy and procedure with a revision date of December 2011 and titled [redacted] Program." Under Policy Interpretation and Implementation" number 4. read; " The [redacted] agency retains overall professional management responsibility	F 849		

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F 849	Continued From page 63 for directing the implementation of the plan of care related to the [redacted] and related conditions, which includes: a. Designation of a [redacted] Registered Nurse to coordinate the implementation of the plan of care." NJAC 8:38-27.1 (a)	F 849		