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	15A003	A. BUILDING: _____ B. WING _____	C 06/10/2016

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VOORHEES SENIOR LIVING	501 LAUREL OAK ROAD VOORHEES, NJ 08043

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Standard with Complaint's #NJ00088352, NJ00088016, NJ00088106 CENSUS: 75 SAMPLE SIZE: 6 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

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

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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #88016, #88106, and #88352 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow the following policies and procedures: 1. Blood Glucose: Calibration Quality Control Testing, 2. Medication Incident Reporting Process, 3. Oxygen Utilization and Storage and failed to include procedures for the maintenance for resident's oxygen equipment. There was no policy and procedure developed and implemented for the nursing staff to follow in the event of oxygen equipment failure. There was no policy developed and implemented for the utilization of portable oxygen machines regarding the frequency of facility nursing staff monitoring the battery life and procedures to follow in case of failure. There was no policy developed and implemented for the monitoring of the resident's blood oxygen saturation level through a pulse oximetry device. 4. Resident Self-Administration of Medications. This deficient practice was evidenced by the following: 1. Review of the facility's "Blood Glucose: Calibration Quality Control Testing" policy and procedures revealed the following: Section 1.0: "To test the accuracy of blood glucose monitoring devices used in the facility." Section 3.0 revealed "2. Check the calibration of the monitor per manufacturers guidelines. 3. Run control levels per manufacturers guidelines. Quality control testing is performed:	A 310		

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A 310	Continued From page 2 e. Before using the glucometer for the first time. f. Each time a new vial of strips is opened. g. If the glucometer has been dropped. h. Whenever the results contradicts the resident's condition." Section 4.0 indicated "Document test results on the Blood Glucose Quality Control Log." On 5/25/16 at 12:15 p.m., the surveyor performed a unit inspection of the second floor medication cart which revealed the following 4 blood glucose monitoring devices: 1 "One Touch Ultra 2" 2 "Freedom Free Style" and 1 "Accucheck Aviva." The Accucheck Aviva blood glucose monitoring device had no test strips for the device. The Licensed Practical Nurse (LPN) told the surveyor that "the family provides strips for the residents when running out like 12 left I call the family." The surveyor asked the LPN how often are the blood glucose monitoring devices calibrated? The LPN stated "I'm not familiar with how they do that." The medication cart did not have test solutions in order to calibrate the devices. On 5/25/16 at 12:40 p.m., the Resident Service Director (RSD) told the surveyor we are supposed to calibrate the glucose machines every night. The surveyor asked if there was a log kept? The RSD replied "yes." The RSD returned a short while later and stated she did not have a system in place for calibrating the glucose devices. 2. Review of the facility's "Medication Incident Reporting Process" revealed section 1.0 which indicated: "A medication error will be handled in a manner to promote the safety and health of the resident. All communities will meet regulatory	A 310		

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(state and federal) reporting requirements." Section 2.0 indicated "Medication Error: A discrepancy between what the physician has ordered and the resident received. Types of Medication Errors:
a. Wrong Medication/Wrong Resident: Medication received by a resident without a physician's order..." Section 3.0 indicated:
"1. An Incident Report and Decision Matrix must be completed when any of the above situations are identified.
2. The RSD (or designee) must notify the resident, resident's physician, and responsible party of the error.
3. The resident outcome (status, condition changes, treatment, follow-up) must be documented in the resident record/file.
4. The RSD will review the report with the individual(s) involved in the incident.
5. The RSD and Executive Director must review/sign the form.
7. The RSD will review all medication administration incident reports and develop/implement an appropriate prevention action plan.
8. The RSD will maintain medication administration incident reports in an organized file."

Resident #2 moved into the facility on 3/13/15 with diagnoses which included (but not limited to) Diabetes Mellitus, Gait Dysfunction, Left Hemiparesis, and Minimal Dysphasia. Review of the resident's medical record revealed the following documentation in the Interdisciplinary Progress Notes (IDCP) dated 2/26/16 at 4 p.m.: "it was brought to the nurse attention by resident that his/her morning insulin was incorrectly administered Humalog 8 units. It should have been Novolog 8 units SQ before breakfast."

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A 310	Continued From page 4 Review of the January 2016 physician's order sheet revealed a physician's order for Novolog Flexpen inject 8 units SQ before breakfast (hold for blood sugar below 100). On 5/27/16 the Executive Director (ED) told the surveyor there was no investigation conducted into the medication error which occurred on 2/26/16. The ED said "The nurse resigned before we could terminate her." The surveyor reviewed the employee file which revealed the nurse resigned on 3/7/16. The facility failed to follow procedures 1, 4, 5, 7, & 8 of their Medication Incident Reporting Process policy. Refer to N.J.A.C. 8:36-11.4(b) 3. Review of the facility's Oxygen Utilization And Storage policy and procedures revealed section 1.0 which indicated "Provide for safe storage and utilization of oxygen." Section 3.0 indicated: "1. Residents who utilize oxygen will have written orders from the physician that specify: - Type of oxygen, - Liter flow, - Method of administration, - Time/parameters. 2. The RSD or licensed nurse will assist the resident in the coordination of ancillary services to provide all necessary equipment. Emergency back up numbers for the service will be maintained in the resident file. 3. The resident's service plan will include all of the above and level of assistance required by the staff. 4. The resident's physician will immediately be notified of any changes in resident condition and/or adverse reactions. 5. Used or unused Oxygen containers will be properly anchored to the bed, floor, wall or carrier	A 310		

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to prevent the container from falling over.
6. Oxygen -No Smoking signs will be posted outside the door of the resident's apartment.
7. No smoking/open flames will be permitted within six (6) feet of oxygen containers."
The facility's oxygen policy did not include any procedures for the maintenance of the resident's oxygen equipment such as who was responsible; frequency of the nasal cannula tubing changes; and procedures for maintaining the oxygen concentrator filters. In addition, there was no policy and procedure developed and implemented for the nursing staff to follow in the event the resident's oxygen equipment failed and to monitor the resident's blood oxygen saturation level through a pulse oximetry device. There was no policy in place for the utilization of portable oxygen machines such as the frequency to monitor the battery life.

On 5/25/16 at 10:35 a.m., during tour of the facility the surveyor observed the nasal cannula tubing of an oxygen concentrator in a resident's apartment which was discolored brownish/orange in color and the concentrator filter was observed with grayish material on it.

On 5/26/16 at 10 a.m., the surveyor observed Resident #5 sitting in a wheelchair with oxygen in use via nasal cannula via a portable oxygen machine. The surveyor reviewed the medical record for Resident #5 which revealed a prescription dated 3/30/16 for "oxygen via nasal cannula with humidification to maintain pulse ox greater than 92%." There was no documented evidence that the nursing staff were consistently monitoring the resident's pulse oximetry to ensure the resident maintained an SPO2 level of 92%.
On 5/26/16 at 12 p.m., the LPN told the surveyor

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"we would document the pulse ox results on the MAR."
Further review of the IDCP dated 5/16/16 at 12:14 p.m., revealed the "resident returned to (the facility) on Saturday 5/14/16...SPO2 (pulse oximetry) 88% on 3 liters per minute." The IDCP dated 5/16/16 at 9:30 p.m., revealed "pulse ox 86% on 3 liters per minute of oxygen." The IDCP notes dated 5/18/16 at 10:10 a.m., revealed "SpO2 taken and found to be 88%. 2 liter per minute oxygen was re-applied." There was no documented evidence that the resident's physician's was notified and there was no follow up documentation that resident's SpO2 was reevaluated. Furthermore, review of the readmission prescriptions dated 5/14/16 did not reveal a physician's order for oxygen. The facility failed to follow procedures 1, 3, 4, and 6 of section 3.0 of their Oxygen Utilization and Storage policy for Resident #5.

On 5/27/16 at 9 a.m., the surveyor interviewed the resident's aide who said, "we have to constantly monitor the portable oxygen machine to make sure the battery pack is charged. The aide told the surveyor, "I have a pulse ox machine on my cart. I don't check the resident's pulse ox because I don't have an order. I only take it if I observe a breathing issue or if the resident complains of an issue." Resident #5's apartment door did not have an oxygen sign posted.

On 5/27/16 the ED told the surveyor that there was one large oxygen tank stored in the first floor nursing office in the event of an emergency. The RSD told the surveyor that the aides were not monitoring the resident's pulse oximetry but the nurses do that.

On 5/27/16, neither the ED or the RSD could not

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provide additional information regarding how often the oxygen equipment was changed or maintained.

On 5/26/16 the surveyor reviewed Resident #3's closed medical record which revealed the resident moved into the facility on 5/9/15 with diagnoses which included (but not limited to) Chronic Obstructive Pulmonary Disease (COPD) and Chronic Bronchitis. Review of the admission orders revealed an order for oxygen at 2 liters per minute via nasal cannula as needed and oxygen concentrator and portable oxygen. On 5/11/15 the resident's oxygen order was changed to oxygen by nasal cannula 2 liters daily while sleeping and as needed for shortness of breath. Review of Resident #3's medical record failed to consistently document the coordination of ancillary services for the resident's oxygen equipment and the resident's use of oxygen was not included in the resident's service plan. The facility failed to follow procedures 2 and 3 of section 3.0 of their Oxygen Utilization and Storage policy for Resident #3.

Refer to N.J.A.C 8:36-15.6(b) and 7.3(c)

The facility document titled, "Notice Regarding Resident Rights," stated, "... 3. The right to have his or her independence and individuality; ... 5. The right to make choices with respect to services and lifestyle; ... 13. The right to participate, to the fullest extent that the resident is able, in planning his or her own medical treatment and care..."

The facility policy titled, "Resident Self-Administration of Medications" stated, "If a resident wishes to self-administer his/her medication, the RSD (or designees) will assess

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the resident's ability to participate, by completing a Self-Administration of Medication Assessment. The assessment must be completed upon move-in or resident request."

On 5/26/16 at 9:57 a.m., the surveyor conducted an interview with Resident #6 in her room. The resident stated that at home she had a system for taking her own medication but when she came to the facility, "they came in and took my pill box from me and now they give me my medication." The resident stated that she spoke to the RSD about being able to take her own medication and was told that that because she is on oxygen she cannot take her own medications.

On 5/27/16 at 11:30 a.m., the surveyor conducted an interview with the RSD. The RSD stated that Resident #6 was not a candidate for self-administration of medications because she was on oxygen. Upon request, the RSD could not provide documentation that stated that resident receiving oxygen could not administer their own medication. The RSD stated that it was just her understanding that if the resident could not take care of her oxygen then she could not participate in the self-medication program.

Review of Resident #6's medical record revealed an "Initial Work Sheet Evaluation," undated and unsigned. Under the medications section of the form, "Self (complete self-med assessment)" was check marked by the documenter. Upon request on 5/26/16, the RSD could not provide documented evidence that an assessment of the resident's ability to self-administer medication had been completed for Resident #6.

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A 447	Continued From page 9	A 447		
A 447	8:36-5.1(a) General Requirements (a) The assisted living residence, comprehensive personal care home or assisted living program shall provide and/or coordinate personal care and services to residents, based on assessment by qualified persons, in accordance with the New Jersey Nurse Practice Act, N.J.S.A. 45:11-23 and N.J.A.C. 13:37, this chapter, and the individual needs of each resident, in a manner which promotes and encourages assisted living values. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility Registered Nurse (RN) failed to consistently complete an assessment for 3 of 6 sampled resident's (Resident #1, #5, and #6) This deficient practice was evidenced by the following: 1. Review of Resident #1's medical record revealed an admission assessment dated 8/25/15 which was signed by a Licensed Practical Nurse (LPN) only. There was no signature by the Registered Nurse (RN) indicating that an RN assessment had been conducted. 2. Review of Resident #5's medical record revealed a readmission assessment dated 4/1/16 which was signed by the LPN. There was no signature by the RN indicating that an RN	A 447		

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A 447	Continued From page 10 assessment had been conducted. 3. Review of Resident #6's medical record revealed an admission assessment dated 10/22/15 which was signed by an LPN and an RN. The respiratory assessment revealed that the resident had "normal" breath sounds and was experiencing SOB (shortness of breath). The admission note attached to the admission assessment stated, "Resident alert oriented x 3 (person, place, and time). Able to voice out needs. Independent with ADL's (activities of daily living) and transfers. Independent with feeding. Continent of B&B (bowel and bladder). Skin clear and intact. Opening to left sacral area, small redness noted. No drainage noted. Ambulate independently using roller walker occasionally. Elevate both legs while in bed d/t (due to) swelling of legs. No c/o (complaint of) pain." The admission note was signed by the LPN only. There was no signature or documented evidence that the RN completed an initial admission assessment. The resident's shortness of breath was not addressed in the admission note.	A 447		
A 547	8:36-5.7(a)(6) General Requirements (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 6. Policies and procedures for the maintenance of personnel records for each	A 547		

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A 547	Continued From page 11 employee, including at least his or her name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, records of physical examinations, job description, records of orientation and inservice education, and evaluation of job performance; This REQUIREMENT is not met as evidenced by: Based on interview and review of employees' personnel records, it was determined that the facility failed to develop and implement a specific and comprehensive policy that is in accordance with the State regulations requiring employees' physical examinations (PE) and tuberculin (TB) test upon employment. This was evidenced by the following: On 5/27/16 at 9:40 a.m., five employees' personnel and health records were reviewed. The review of their personnel and confidential files and a "medical" binder revealed that all five employees had no PE records in their files. Additionally, one of the five employees did not have all the required TB tests completed. On 5/27/16 at 2:30 p.m., the Regional Nurse stated that the "Health/Physical are not required by the company upon employment nor once employed." The Business office manager (BOM) confirmed that the two step TB testing was required and further stated, "I did not realize the employee did not submit her two-step."	A 547		

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A 565	Continued From page 12	A 565		
A 565	8:36-5.10(a)(3) General Requirements (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following: 3. All suspected cases of resident abuse, neglect, or misappropriation of resident property, including, but not limited to, those which have been reported to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly for residents over 60 years of age; This REQUIREMENT is not met as evidenced by: Based on interview, record review and documentation provided by the facility, it was determined that the facility administrator failed to notify the Department of Health (DOH) immediately by telephone and within 72 hours with a written confirmation of a resident to resident altercation that led to a resident's physical abuse. This deficient practice was noted for 1 of 6 sampled residents as evidenced by the following: Resident #4 moved into the facility on 6/12/03 with diagnoses of Parkinson's disease, Mental Retardation, and Dementia. On 5/26/16 at 10:15 a.m., the surveyor reviewed Resident #4's medical record which revealed the following documentation in the interdisciplinary progress notes dated 12/1/15 at 6 pm:	A 565		

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A 565	Continued From page 13 "(Resident #4) was in dining room for dinner, (Resident #4) sat at a different table than usual. Server saw (Resident #4) and another resident argue and saw the other resident punch (Resident #4) in the face. Residents redirected. No sign of injury to his/her face." On 5/27/16 at 12:40 p.m., during an interview with the Executive Director (ED), the surveyor asked the ED for the reportable event regarding the resident to resident altercation. The ED replied, "I did not report it, it should have been reported." Review of the facility's "Internal Investigations of Reportable Resident Incidents" of section 3.1(3)(e) revealed that: The "Executive Director/Administrator (or designee) will notify the appropriate state enforcement/regulatory agency and/or Ombudsman within the applicable time period as required by the state law."	A 565		
A 753	8:36-7.3(c) Resident Assessments and Care Plans (c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan. This REQUIREMENT is not met as evidenced by: Complaint #88016 and #88106 Based on interview and review of documentation provided by the facility, it was determined that the facility staff failed to provide documentation to confirm that health service plan (HSP) and/or the	A 753		

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general service plan (GSP) were developed and/or updated for 5 of 6 sampled residents (Resident's #4, #3, #5, #1, and #6) to reflect specific interventions for the residents' identified needs.
1. On 5/26/16 at 10:15 a.m., review of Resident #4's medical record revealed that the resident sustained eight falls in five months: 1/4/16, 1/10/16, 1/12/16, 1/13/16, 1/14/16, 1/22/16, 4/11/16, 5/9/16. The fall on 1/14/16 resulted in a fracture of the pubis. The resident was hospitalized and returned to the facility on 4/1/16. An HSP was not developed nor was the GSP updated to include specific interventions to prevent further falls. On 5/26/16 at 1:30 pm, during an interview with the Wellness Director (WD), she told the surveyor that "I did not create an HSP for falls."
2. On 5/26/16, the surveyor reviewed the closed medical record for Resident #3 which revealed the resident moved into the facility on 5/9/15 with diagnoses which included (but not limited to) Chronic Obstructive Pulmonary Disease and Chronic Bronchitis. The resident utilized oxygen at 2 liters per minute via nasal cannula through a oxygen concentrator and a portable battery operated oxygen machine. There was no documented evidence that the resident's "Individualized Resident Service Plan (ISP) dated 5/14/15 and GSP dated 5/14/15 addressed the resident's oxygen needs. Furthermore, there was no documented evidence that the resident's GSP was updated biannually in November of 2015.

3. On 5/26/16, the surveyor reviewed Resident #5's medical record which revealed that the resident was oxygen dependent and utilized both an oxygen concentrator and a portable battery operated oxygen machine. Review of the resident's ISP dated 1/13/16 revealed "uses

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continuous oxygen." There was no documented evidence that the resident's 5/9/16 GSP addressed the resident's oxygen needs. Review of the facility's "Oxygen Utilization and Storage" policy revealed, "The resident's service plan will include all the above and level of assistance required by the staff."

On 5/27/16 at 9:45 a.m., the WD told the surveyor "we are starting to implement health service plans for oxygen use. I update the general service plan as often as I need to. When there is a change in condition. I update as I can."

Refer to N.J.A.C 8:36-3.4(a) (1)

4. Resident #1 moved into the facility on 8/25/15 with diagnoses which included (but not limited to) Lupus, Hypertension, Seizure Disorder, Anxiety, and Arthritis. Review of the resident's medical record identified no documented evidence of the resident's pain management needs in the General Service Plan dated 5/19/16 and the ISPs dated 2/7/16 and 5/19/16. The Resident Service Director (RSD) failed to provide a pain treatment plan for Resident #1 and stated that an HSP was not developed to address the resident's pain.

Refer to N.J.A.C. 8:43E-6.4(c) and 8:43E-6.4(e)

5. Resident #6 moved into the facility on 10/22/15 with diagnoses which included (but not limited to) Meatal Stenosis, Hypertension, Neurogenic Bladder, Chronic Hepatitis C, Osteoarthritis, and Cardiac Disease. The resident utilized oxygen at 2 liters per minute via nasal cannula through an oxygen concentrator and a portable oxygen tank. There was no documented evidence that the resident's GSP dated 5/14/15 addressed the resident's oxygen needs. Furthermore, there was

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A 753	Continued From page 16 no documented evidence that an HSP was developed and implemented for the resident's identified health care need for the utilization of oxygen. The Resident Service Director (RSD) told the surveyor that an HSP had not been developed to address the resident's need for oxygen.	A 753		
A 779	8:36-7.5(c) Resident Assessments and Care Plans (c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care intervention or medical care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide documented evidence that the registered professional nurse (RN) was consistently notified of changes in residents' condition for 4 of 6 sampled residents (Resident's #1, #3, #5, and #6) to ensure assessments were performed in order to determine if further nursing or medical interventions were needed. This deficient practice was evidenced by the following: 1. Resident #1 moved into the facility on 8/25/15 with diagnoses which included (but not limited to)	A 779		

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Lupus, Hypertension, Seizure Disorder, Anxiety, and Arthritis. Review of the resident's medical record revealed the following documentation by a Licensed Practical Nurse (LPN) in the Interdisciplinary Progress Notes:
-5/18/16 at 11 a.m.: "Resident found sitting on the floor. Stated, 'I don't know how it happen!' Complaint of left shoulder pain and PRN percocet given and effective. V/S (vital signs) 97.8 (temperature), 67 (heart rate per minute), 18 (breaths per minute), 146/90 (blood pressure). No sign of distress noted." There was no documented evidence that the LPN notified the Registered Nurse (RN) of the resident's fall. Also, there was no documented evidence that the RN conducted an assessment of the resident after the fall.

2. Resident #3 moved into the facility on 5/9/15 with diagnoses which included (but not limited to) Chronic Obstructive Pulmonary Disease (COPD) and Chronic Bronchitis. Review of the resident's closed medical record revealed the following documentation by a LPN in the Interdisciplinary Progress Notes:

- 8/2/15 at 1:30 pm: "It was bought to attention that resident stated he/she had shortness of breath. Med tech advised that resident no longer having any problems or complaints. Continued to monitor no signs of symptoms of shortness of breath." There was no documented evidence that the med tech or the (LPN) notified the RN of the resident's change in condition in order to assess if further medical and/or nursing interventions were needed.

- 9/18/15 at 9:45 pm: "Resident is very confused. Staff constantly had to reorient (resident) to use the hat in the toilet to collect because of

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(resident's) confusion. The info will pass to next shift to collect urine." There was no documented evidence that the LPN notified the RN of the resident's continued change in mental status in order to arrange for an assessment in order to determine if further medical and/or nursing interventions were needed.

Further documentation on 9/22/15 at 11:15 a.m. revealed that the resident had previously sustained a fall and complained of right hip pain. There was no documented evidence that the LPN notified the RN of the resident's fall. An RN assessment was revealed 7 days later, dated 9/28/15 at 2 p.m. of the resident's injuries.

- 10/18/15 at 9:30 pm: "Resident stated he/she fell during 11-7...has a small abrasion on left knee cap, dried blood. Re-educated to notify someone whenever he/she falls." There was no documented evidence that the LPN notified the RN of the injury. There was no RN assessment documented to determine if further medical and/or nursing interventions were necessary to prevent further falls.

3. Resident #5 moved into the facility on 8/28/14 with diagnoses which included (but not limited to) Oxygen Dependent, Respiratory Failure, Chronic Obstructive Pulmonary Disease (COPD), and Lung Cancer. Review of the resident's medical record revealed the following documentation by an LPN dated 1/2/15 at 11 p.m. "Resident stated that (during P.T.) he/she was going to kill Myself and strangle self with oxygen tubing. Monitored resident during 3-11 shift all staff made aware and informed on coming staff. Resident made no other statements of the like re: suicidal ideation's/statements." There was no documented evidence that the LPN immediately

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A 779	Continued From page 19 notified the RN and the resident's physician in order to arrange for an assessment to determine if immediate medical and/or nursing interventions were necessary. There was no evidence that the RN assessed the resident's change in mental status. 4. Resident #6 moved into the facility on 10/22/15 with diagnoses which included (but not limited to) Meatal Stenosis, Hypertension, Neurogenic Bladder, Chronic Hepatitis C, Osteoarthritis, and Cardiac Disease. Review of the resident's medical record revealed the following documentation by an LPN in the Interdisciplinary Progress Notes: -11/17/16 at 4 a.m.: "Resident c/o (complained of) being dizzy and sweating. Evaluated (resident).. Resident stated (he/she) has not been drinking enough water and not eating a lot. Vitals (vital signs) 127/67 (blood pressure), 75 (heart rate per minute). 97.6 (temperature), 18 (breaths per minute). Encouraged the resident to drink some water. Checked on (resident) during my med pass, (resident) was sleeping peacefully in her chair. Told the resident if he/she needs to walk during the night come down to see us." There was no documented evidence that the LPN notified the RN of the resident's condition. There was no documented evidence that the RN conducted an assessment of the resident.	A 779		
A 783	8:36-7.5(e) Resident Assessments and Care Plans (e) Each resident shall have an annual physical examination by a physician, advanced practice nurse or physician assistant, which shall be documented in the resident's record. The physician, advanced practice nurse or physician	A 783		

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assistant shall certify annually that the resident does not have needs which exceed the care that the facility or program is capable of providing.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined that the facility failed to ensure that 3 of 6 residents (Resident #1, #2, and #6) sampled had an annual physical examination and certification that their needs did not exceed the care that the assisted living facility was capable of providing.

This deficient practice was evidence by the following:

1. Resident #1 moved into the facility on 8/25/15 with diagnoses which included (but not limited to) Lupus, Hypertension, Seizure Disorder, Anxiety, and Arthritis. Review of the resident's medical record revealed that the Medical Certification section of the Medical History and Physical Examination form was not completed by the physician.

2. Resident # 2 moved into the facility on 3/13/15 with diagnoses which included (but not limited to) Diabetes Mellitus, Gait Dysfunction, Left Hemiparesis, and Minimal Dysphasia. Review of the resident's medical record revealed that the last annual physician examination and certification was dated 3/10/15 prior to the resident's move in date. There was no documented evidence of an annual physical examination and medical certification. There was no additional information provided from the Resident Service Director and the Executive

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A 783	Continued From page 21 Director. 3. Resident #6 moved into the facility on 10/22/15 with diagnoses which included (but not limited to) Meatal Stenosis, Hypertension, Neurogenic Bladder, Chronic Hepatitis C, Osteoarthritis, and Cardiac Disease. Review of the resident's medical record revealed that the Medical History and Physical Examination form was not completed. The Medical History, Medications, Physical Examination portions stated, "See Attached." There were no attachments to the form. Upon request, the facility staff could not provide documented evidence that the resident's history and physical examinations had been completed.	A 783		
A 925	8:36-11.2 Pharmaceutical Services The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations. This REQUIREMENT is not met as evidenced by: Complaint # 88352 Based on observation, interview, and record review, it was determined that the facility nursing staff failed to 1. ensure that medication was available for 1 sampled resident (Resident #2) in accordance	A 925		

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A 925	Continued From page 22	A 925		

with the prescribe's orders and
2. to ensure that blood glucose monitoring supplies were available for Resident #4.

This deficient practice was evidenced by the following:

1. On 5/27/16 at 12 p.m., Resident #2 told the surveyor "I was suppose to get my blood pressure patch last night but it was unavailable. The box was there but it was empty. This is not the first time this has happened. They don't order my medications on time" The surveyor observed a white patch on the resident's right deltoid area which was undated.

On 5/27/16 at 12:25 p.m., the surveyor inspected the second floor medication cart which revealed that Resident #2's blood pressure medication Catapres (clonidine) 0.3 mg 24 hour patch box was empty. Review of the May 2016 medication administration record MAR) revealed that the following medications on the following dates were not given due to unavailability:
5/9/16: Losartan Potassium 100 mg
5/26/16: Catapres (clonidine) 0.3 mg/24 H patch once a week

The surveyor reviewed the March 2016 MAR which revealed that the following medications on the following dates were unavailable for administration to the resident:
3/3/16: Fenofibrate Micronized 200 mg (cholesterol medication)
3/27/16: Clonidine 0.3 mg 24 H patch (blood pressure medication)

Review of the January 2016 MAR revealed that the following medication was not given due to unavailability:

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A 925	Continued From page 23 1/25/16: Levothyroxine 150 mcg (thyroid medication) Review of the December 2015 MAR revealed that the following medication was not given due to unavailability: 12/17/15: Amlodipine Besylate 5 mg (blood pressure medication) On 5/27/16 at 12:30 p.m., a Licensed Practical Nurse (LPN) working on the second floor told the surveyor "that all different nurses order medications for the resident's." The LPN on the first floor told surveyor "it is every nurses' responsibility to ensure medications are refilled for all the residents." On 5/27/16 at 2:30 p.m., the Executive Director told the surveyor that the nursing staff have been in-serviced on this particular matter and provided the surveyor with various in-service training's which included but not limited to the following: - 3/12/15: "All nurses will be check on medications on all shifts" - 11/10/15 -11/12/15: "Ordering refills on-time: Ordering refills and the status of refills is the responsibility of everyone. If you see that there are less than 4 doses left and a new order is not in, call the pharmacy regardless of whether you are on the next day or not. This can be done by med-techs and LPN's...There is no reason for us to run out of the medications. If you have to circle because its not in, this is an issue that needs immediate attention." On 5/27/16 at 2 p.m., the Resident Service Director (RSD) told the surveyor that the clonidine (blood pressure medication) was reordered for refill on 5/13/16 but the pharmacy needed a new order from the physician in order to refill the	A 925		

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A 925	Continued From page 24 clonidine for the resident. The surveyor reviewed the resident's chart in front of the RSD and the last prescription for the Catapres (clonidine 0.3 mg) was dated 3/31/16. There was no documented evidence that the resident's physician was notified in order to obtain a refill order for the resident's clonidine 0.3 mg patch. 2. On 5/25/15 at 12:45 p.m.,the surveyor inspected the 2nd floor medication cart in the presence of the LPN. The surveyor observed Resident #4's glucometer in a bag without test strips. The LPN told the surveyor when interviewed that the resident ran out of the test strips and that the RSD was aware. On 5/26/16 at 9:40 a.m., the surveyor inspected the 2nd floor medication cart again in the presence of a Certified Medication Aide (CMA), who stated that Resident #4 did not have any test strips and she had to use the glucometer and test strips belonging to another resident.	A 925		
A 935	8:36-11.4(b) Pharmaceutical Services (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations. This REQUIREMENT is not met as evidenced	A 935		

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A 935	Continued From page 25 by: Complaint # 88352 Based on interview and record review, it was determined that the facility failed to administer medications in accordance with the physician's orders for 2 of 6 resident's (Resident #1 and #2). This deficient practice was evidenced by the following: 1. Resident #1 moved into the facility on 8/25/15 with diagnoses which included (but not limited to) Lupus, Hypertension, Seizure Disorder, Anxiety, and Arthritis. Review of the resident's medical record revealed prescriber's orders dated 4/19/16 for Fentanyl 25 mcg/hr (micrograms per hour) Patch TD (Transdermal - applied to skin) every 72 hours for the diagnosis of pain. Review of the resident's Medication Administration Record (MAR) for May 2016 on 5/25/16 revealed that there was no documentation that the Fentanyl patch was administered to the resident on 5/19/16. Along with the day shift assigned to administer medications On 5/25/16 at 2:30 p.m., this surveyor, in the presence of the Licensed Practical Nurse (LPN), interviewed the resident who stated that the pain has been "really bad" and that the resident has needed to take Percocet to ease the pain. The resident showed the surveyor and the LPN the Fentanyl patch on the resident's left chest wall that was dated 5/19/16. The resident stated the staff alternate the patch from the left to the right chest area when it needs to be changed. The resident showed the surveyor and LPN that there was no new patch applied to the area. On 5/25/16 at 2:40 p.m., the LPN told the surveyor that, "I have no idea why it wasn't done that night." Review of the resident's Fentanyl declining narcotic	A 935		

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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) COMPLETE DATE
A 935	Continued From page 26	A 935		

inventory sheet revealed that there was one patch left on 5/19/16 and there was no documentation that the Fentanyl 25 mcg/hr patch was signed out on 5/22/16, the next date the medication was due to be given. The Fentanyl declining narcotic inventory sheet revealed that as of 5/19/16, there was one Fentanyl Patch remaining. On 5/25/16, one Fentanyl Patch was observed in the narcotics drawer as indicated on the declining inventory sheet.

2. Resident #2 moved into the facility on 3/13/15 with diagnoses which included (but not limited to) Diabetes Mellitus, Gait Dysfunction, Left Hemiparesis, and Minimal Dysphasia. Review of the resident's medical record revealed the following documentation in the Interdisciplinary Progress Notes (IDCP) dated 2/26/16 at 4 p.m.: "it was brought to the nurse attention by resident that his/her morning insulin was incorrectly administered Humalog 8 units. It should have been Novolog 8 units SQ before breakfast." Review of the January 2016 physician's order sheet revealed a physician's order for Novolog Flexpen inject 8 units SQ before breakfast (hold for blood sugar below 100). Further review of the IDCP notes dated 2/26/16 at 5 p.m., revealed an assessment by the Registered Nurse (RN) of the resident which indicated "resident with no signs and symptoms of adverse reaction." On 5/27/16, the Executive Director (ED) told the surveyor there was no investigation conducted into the medication error which occurred on 2/26/16. Therefore,, the source of the Humalog administered to Resident #2 could not be identified. The ED said "The nurse resigned before we could terminate her." The surveyor reviewed the employee file which revealed the nurse resigned on 3/7/16 which was 10 days after the medication error occurred.

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A 935	Continued From page 27 3. On 5/27/16 at 12 p.m., Resident #2 told the surveyor "I was supposed to get my blood pressure patch last night but it was unavailable. The box was there but it was empty. This is not the first time this has happened. They don't order my medications on time" The surveyor observed a white patch on the resident's right deltoid area which was undated. On 5/27/16 at 12:25 p.m., the surveyor inspected the second floor medication cart which revealed that Resident #3's blood pressure medication Catapres (clonidine) 0.3 mg 24 hour patch box was empty. Refer to N.J.A.C 8:36-11.2	A 935		
A 963	8:36-11.5(f) Pharmaceutical Services (f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders. This REQUIREMENT is not met as evidenced by: Complaint # 88352 Based on interview and review of pertinent documentation, it was determined that the facility nursing staff failed to document the administration of medications as given upon administration in accordance with the facility policy and physician's orders for Resident #2.	A 963		

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A 963	Continued From page 28 This deficient practice was evidenced by the following: On 5/27/16, the surveyor reviewed the May 2016 Medication Administration Record (MAR) for Resident #2 which revealed the following scheduled medications were not documented as given with no explanation for the omission: - On 5/2/16 Glipizide 10 mg scheduled for 5 p.m. was not documented as given with no explanation for the omission. - On 5/5/16 Clonidine 0.3 mg 24 hour patch scheduled for 9 p.m. was not documented as given with no explanation for the omission. - On 5/8/16 Amlodipine Besylate 5 mg scheduled for 9 p.m. was not documented as given with no explanation provided for the omission. - On 5/16/16 Levemir insulin 15 units scheduled for 9 p.m. was not documented as given with no explanation for the omission. - On 5/19/16 Hydralazine HCL 25 mg scheduled for 3 p.m. was not documented as given with no explanation for the omission. - On 5/19/16 Warfarin Sodium 1 mg and 5 mg to equal a total of 6 mg scheduled for 5 p.m. was not documented as given with no explanation for the omission. Review of the March 2016 MAR revealed the following scheduled medications were not documented as given with no explanation for the omission: - On 3/9/15, 3/24/16, and 3/29/16 Zetia 10 mg scheduled for 9 p.m. was not documented as given with no explanation for the omission. - On 3/21/16 Plavix 75 mg scheduled for 9 a.m. was not documented as given with no explanation for the omission. - On 3/21/16 Colace 100 mg scheduled for 9 a.m.	A 963		

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A 963	Continued From page 29 was not documented as given with no explanation for the omission. - On 3/24/16 Amlodipine Besylate 5 mg and Fenofibrate Micronized 200 mg scheduled for 9 p.m. were not documented as given with no explanation for the omission. - On 3/24/16 Hydralazine HCL 25 mg scheduled for 10 p.m. was not documented as given with no explanation for the omission. Review of the December 2015 MAR revealed the following scheduled medications were not documented as given with no explanation provided for the omission: - On 12/19/15 and 12/20/15 Levemir insulin scheduled for 9 p.m. was not documented as given with no explanation for the omission. - On 12/18/15, 12/19/15, and 12/22/15 Zetia 10 mg scheduled for 9 p.m. was not documented as given with no explanation for the omission. - On 12/18/15 and 12/19/15 Fenofibrate Micronized 200 mg scheduled for 9 p.m. was not documented as given with no explanation for the omission. -On 12/19/15 and 12/20/15 Hydralazine HCL 25 mg scheduled for 10 p.m. was not documented as given with no explanation for the omission.. The physician's order indicated to "hold for systolic blood pressure less than 130."On the following dates: 12/2/15, 12/6/15, and 12/13/15 the Hydralazine HCL 25 mg scheduled for 10 p.m. was documented as given but the blood pressure was not documented on the MAR.	A 963		
A 981	8:36-11.7(a)(4) Pharmaceutical Services (a) The administrator shall provide an appropriate and safe medication storage area, either in a common area or in the resident's unit, for the	A 981		

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A 981	Continued From page 30	A 981		

storage of medications that are not self-administered by the residents. The storage area requirement may be satisfied through the use of a locked medication cart.

4. Each resident's medications shall be kept separated within the storage area, with the exception of large volume medications which may be labeled and stored together in the storage area.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined that the facility nursing staff failed to store ointments and creams separately for each resident within the medication cart.

This deficient practice was evidenced by the following:

On 5/25/16 at 1 p.m., the surveyor inspected the third floor medication cart which revealed the following creams, ointments, and powders stored together inside the medication cart:
1. Two Lidocaine 2.5% cream
2. Hydrocortisone cream 1 %
3. Two Econazole Nitrate cream 1%
4. Ketoconazole cream 2%
5. Triamcinolone 0.1% ointment
6. Clotrimazole & Betamethasone ointment
7. Bacitracin ointment
8. Vaseline ointment 3.75 oz
9. Two Nystatin powders

The nurse for the third floor medication cart was unable to provide an explanation for the commingling of residents' treatments.

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A 983	8:36-11.7(a)(5) Pharmaceutical Services (a) The administrator shall provide an appropriate and safe medication storage area, either in a common area or in the resident's unit, for the storage of medications that are not self-administered by the residents. The storage area requirement may be satisfied through the use of a locked medication cart. 5. Medications shall be stored in accordance with manufacturer's instructions, and/or extemporaneously applied pharmacy labels and/or directions, and/or United States Pharmacopoeia Drug Information (USP DI) Volume I, Drug Information for the Health Care Professional, 2005, incorporated herein by reference, as amended and supplemented and USP DI Volume II: Advice for the Patient, incorporated herein by reference, as amended and supplemented. USP DI Volume I: Drug Information for the Health Care Professional and USP DI Volume II: Advice for the Patient can be obtained by contacting Thomson-Micromedex, 6200 S. Syracuse Way, Suite 300, Greenwood Village, CO 80111, (303) 486-6400. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that some medications were not stored in accordance with manufacturer's specifications. This deficient practice was evidenced by the	A 983		

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A 983	Continued From page 32 following: 1. On 5/25/16 at 1 p.m., the surveyor inspected the third floor medication cart which revealed Xalatan 0.005% eye drops open and not dated. Xalantan ophthalmic solution is to be dated when open and any unused portion needs to be discarded after 4 weeks from the date of opening. 2. On 5/25/16 at 12:15 p.m., the surveyor inspected the second floor refrigerator which contained several boxes of unopened insulin pens for residents. The back of the refrigerator had a build up of ice. The refrigerator did not have a thermometer inside and there were no temperature logs maintained. The second floor LPN stated "I know we're suppose to." There was no documented evidence of temperature recordings to ensure the proper storage of the unopened insulin pens.	A 983		
A 985	8:36-11.7(b)(1) Pharmaceutical Services (b) All medications shall be kept in their original containers and shall be properly labeled and identified. 1. The label of each resident's prescription medication container shall be permanently affixed and contain the resident's full name, prescriber's name, prescription number, name and strength of medication, lot number, quantity, date of issue, expiration date, manufacturer's name if generic, directions for use, and cautionary and/or accessory labels. Required information appearing on individually packaged medications or within an alternate medication	A 985		

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A 985	Continued From page 33 delivery system need not be repeated on the label. This REQUIREMENT is not met as evidenced by: Complaint # 88352 Based on observation and interview, it was determined that the facility nursing staff failed to ensure the prescription medication found in the medication cart had a permanently affixed label that contained the resident's full name, prescription number, date of issue and directions for use for 1 sampled resident (Resident # 2). This deficient practice was evidenced by the following: On 5/25/16 at 12:15 p.m., the surveyor inspected the second floor medication cart which revealed a clear plastic bag which had two insulin pens inside for Resident #2. The label for Levemir flex touch insulin pen had been torn off. There was no label located on either the plastic bag or the insulin pen to identify the resident's full name, prescribe's name, prescription number, and date of issue. The Licensed Practical Nurse (LPN) was unable to provide an explanation.	A 985		
A 999	8:36-11.7(e) Pharmaceutical Services (e) Discontinued or expired medications shall be destroyed within 30 days in the facility, or, if unopened and properly labeled, returned to the pharmacy for credit, if allowable, and in	A 999		

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A 999	Continued From page 34 conformance with N.J.A.C. 13:39 and other State and Federal laws, codes, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility nursing staff failed to remove one expired medication (Humalog Kwikpen 100 units/ml insulin pen) from the third floor medication cart This deficient practice was evidenced by the following: On 5/25/16 at 1 p.m., the surveyor inspected the third floor medication cart which revealed Humalog Kwikpen 100u/ml insulin pen which was opened and dated 2/7/16. The Manufacturer specifies that Humalog insulin be dated when opened and any unused portion expires in 28 days. The Humalog Kwikpen insulin was in the medication cart for 80 days after the expiration date. The Licensed Practical Nurse (LPN) was unable to provide an explanation.	A 999		
A1047	8:36-14.3(d) Emergency Services and Procedures (d) Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers' and applicable NFPA requirements and N.J.A.C. 5:70. Each fire extinguisher shall be labeled to show the date of	A1047		

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A1047	Continued From page 35 such inspection and maintenance. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined the facility failed to perform and document on the tag attached to the fire extinguisher a monthly visual examination for 3 of 19 fire extinguishers inspected, as required by code and National Fire Protection Association (NFPA) requirements. Evidence of this includes the following: During the building tour on 6/10/2016 in the presence of the Maintenance Director (MD), the surveyor inspected 19 fire extinguishers located in various locations in the building. This inspection identified on the tags attached to 17 fire extinguishers were last annually inspected August 2015 and 2 fire extinguishers were last annually inspected September 2015. The surveyor observed the following, 1. At 12:40 a.m. the surveyor observed one ABC type fire extinguisher in the first floor elevator mechanical room, had no evidence of a monthly visual examination performed and documented on the inspection tag for May 2016. 2. At 12:50 p.m., the surveyor observed one ABC type fire extinguisher in the main electrical room that was last annually inspected September 2015, had no evidence of a monthly visual examination performed and documented on the inspection tag for May 2016. 3. At 1:25 p.m., the surveyor observed one ABC type fire extinguisher in the first floor Residents	A1047		

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A1047	Continued From page 36 Living room that had no evidence of a monthly visual examination performed and documented on the inspection tag for May 2016. According to NFPA 10- 4-3.4, "At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguisher."	A1047		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced by: Complaint # 88016 and 88106 Based on interview and record review, it was determined that the facility nursing staff failed to consistently document the coordination of oxygen services to ensure functionality and maintenance of the oxygen equipment for 2 resident's (Resident #5 and #3). This deficient practice was evidenced by the following:	A1073		

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A1073	Continued From page 37 1. Resident # 5 moved into the facility on 8/28/14 with diagnoses which included (but limited to) oxygen dependent, Respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), and Lung Cancer. Review of the Interdisciplinary Progress Notes (IDCP) dated 11/14/14 at 10:30 pm revealed "CNA reported concentrator not working. Flow gage on zero. Humidity bottle removed and oxygen concentrator was able to be set at 2 liters without water bottle. Message left at oxygen company to come check machinery." There was no further documented evidence concerning the functionality of the resident's oxygen equipment documented in the resident's medical record. Review of the IDCP dated 12/2/14 at 1:15 pm revealed, "Resident oxygen portable tank was empty. Resident was assisted to room via wheelchair and placed on oxygen concentrator." There was no further documentation in the resident's medical record until 12/9/14 (7 days later) which revealed, "Call placed to home town medical equipment...concerning oxygen not staying charged and the script for the resident to be evaluate for conserving device of oxygen. Was informed...they will take care of it." Further documentation revealed the nursing staff requesting permission from the resident's family to change oxygen company. However, there was no further documentation in the resident's medical record regarding the new oxygen company information and the functionality of the resident's portable oxygen machine. 2. Resident #3 moved into the facility on 5/9/15 with diagnoses which included (but not limited to) Chronic Obstructive Pulmonary Disease (COPD) and Chronic Bronchitis. Review of the closed medical record revealed the resident had	A1073		

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A1073	Continued From page 38 admission orders for oxygen at 2 liters per minute via nasal cannula as needed and oxygen concentrator and portable oxygen. On 5/11/15, the resident's oxygen order was changed to oxygen by nasal cannula 2 liters daily while sleeping and as needed for shortness of breath. However, the 5/11/15 prescription was written by the resident's physician from Florida. Review of the IDCP notes dated 5/28/15 at 9 p.m. indicated, "family requests... a portable oxygen. Doctor was sent requests." Further documentation dated 6/1/15 at 12:30 p.m., indicated "call placed to (doctor) for RX and portable oxygen." Documentation dated 6/15/15 at 12 p.m. indicated, "portable oxygen still on back order per (vendor) resident on waiting list and will call when oxygen be delivered." Documentation on 6/16/15 at 1 p.m. indicated "POA want oxygen company changed...call placed to (new oxygen vendor company) needs new oxygen saturation testing script and face to face notes to see if resident qualifies." Documentation dated 6/23/15 which was 7 days later revealed a new order for oxygen saturation testing. Dx: shortness of breath." Documentation dated 6/22/15 at 3:45 p.m. indicated, "Resident family members POA inquiring regarding oxygen." There was no further documentation in the medical record addressing the saturation testing and whether or not the resident was qualified by the oxygen company or any follow up documentation regarding the resident's oxygen equipment.	A1073		
A1089	8:36-16.3(b) Physical Plant (b) Means of ventilation shall be provided for every bathroom or water closet (toilet) compartment. Ventilation shall be provided either by a window with an openable area or by	A1089		

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A1089	Continued From page 39 mechanical ventilation. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility failed to ensure that ventilation was present in the bathroom for 1 of 8 resident apartment bathrooms sampled, as evidenced by the following: During the building tour on 6/10/2016 with the facility's Maintenance Director (MD.), an inspection of 8 Resident apartments bathroom was performed. This inspection identified 1 resident's bathroom exhaust systems, when tested by turning on the switch for the exhaust fan, did not function properly in the following location: 1) At 11:23 a.m. Sampled Resident #7's bathroom exhaust did not function properly when the surveyor switched on the exhaust fan. The bathroom had no windows with an area that would open and relied on mechanical ventilation. All apartments were occupied at the time of survey.	A1089		
A1299	8:36-18.3(a)(5) Infection Prevention and Control Services	A1299		

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VOORHEES SENIOR LIVING	501 LAUREL OAK ROAD VOORHEES, NJ 08043

(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) COMPLETE DATE
A1299	Continued From page 40 (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 5. Techniques to be used during each resident contact, including handwashing before and after caring for a resident; This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy and procedures, it was determined the facility Licensed Practical Nurse (LPN) failed to wash her hands or use other effective hand sanitation techniques after resident contact during the medication pass. This deficient practice was evidenced by the following: On 5/25/16 at 12:30 p.m., the surveyor observed the LPN don gloves and check the blood sugar for Resident #2. The LPN removed the donned gloves and proceeded to dial the Novolog insulin pen to 4 units without washing her hands. The LPN failed to wash her hands after checking the resident's blood sugar. The LPN then donned a new pair of gloves and proceed to administer the Novolog insulin into the resident's left upper arm. The LPN did not wash her hands before and after administering the insulin to the resident. Review of the facility policy and procedures titled "Hand Washing" revealed section 1.0 which indicated: "Proper hand washing technique must be used at all times when indicated. Hand washing is the	A1299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A003	A. BUILDING: _____ B. WING _____	C 06/10/2016

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A1299	Continued From page 41 most important component for managing the spread of infection." Review of section 3.0 indicated: "The use of gloves does not eliminate the need to wash hands." Review of section 5.0 indicated the following: "1. "Hand Washing is performed: c. Before and after providing resident service. d. Wash hands if moving from a contaminated body site to a clean site during resident care. e. After contact with soiled or contaminated articles, such as articles that are contaminated with body fluids. f. After contact with an object or source where there is a concentration of microorganisms such as mucous membranes, non-intact skin, body fluids, or wounds. m. Before taking part in a medical procedure. o. Before applying and after removal of medical/surgical or utility gloves." The LPN failed to sanitize her hands with either an alcohol handrub or sanitizer after the removal of gloves from checking Resident #2's blood sugar and prior to administering the resident's insulin.	A1299		
H1180	8:43E-6.4(c) PAIN MGMT PROCDURS: PAIN ASSESMNT PROCDURS If pain is identified, a pain treatment plan shall be developed and implemented within the health care facility or the patient/resident shall be referred for treatment or consultation. This REQUIREMENT is not met as evidenced	H1180		

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H1180	Continued From page 42	H1180		

by:
Based on observation, staff and resident interviews, and review of pertinent documentation, it was determined that the facility failed to develop and implement a pain treatment plan for Resident #1.

This deficient practice was evidenced by the following:

1. Resident #1 moved into the facility on 8/25/15 with diagnoses which included (but not limited to) Lupus, Hypertension, Seizure Disorder, Anxiety, and Arthritis. Review of the resident's medical record revealed prescriber's orders dated 4/19/16 for Fentanyl 25 mcg/hr (micrograms per hour) Patch TD (Transdermal - applied to skin) every 72 hours for the diagnosis of pain. Review of the resident's Medication Administration Record (MAR) for June 2016 on 5/25/16 revealed that there was no documentation that the Fentanyl patch was administered to the resident on 5/19/16. During an interview with the Licensed Practical Nurse (LPN) on 5/25/16 at 2:40 p.m., he/she stated, "I have no idea why it wasn't done that night." Review of the resident's Fentanyl declining narcotic inventory sheet revealed that there was no documentation that the Fentanyl 25 mcg/hr patch was signed out on 5/22/16, when the medication was due to be given.

During an interview with Resident #1 on 5/25/16 at 2:30 p.m., the resident stated that his/her pain had been "really bad" and that he/she needed to take Percocet to ease the pain.

Review of the MAR for May 2016 revealed that the resident received one tablet of oxycodone-acetaminophen (Percocet)10 mg (milligram)-325 mg tablet on the following dates:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A003	A. BUILDING: _____ B. WING _____	C 06/10/2016

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H1180	Continued From page 43 5/1/16; 5/2/16; 5/3/16; 5/4/16 at 10 a.m. and 9:00 p.m.; 5/5/16; 5/6/16; 5/10/16; 5/11/16; 5/12/16; 5/13/16 at 10 a.m. and 9 p.m.; 5/15/16; 5/16/16 at 10 a.m. and 9 p.m.; 5/17/16; 5/18/16; 5/19/16; 5/20/16 at 10 a.m. and 9 p.m.; 5/21/16; 5/22/16; 5/24/16 at 10 a.m. and 9 p.m.; and 5/25/16. A review of the resident's General Service Plan (GSP) dated 5/11/16 and the Individualized Resident Service Plan (ISP) dated 2/7/16 and 5/19/16 revealed that the resident's pain management needs were not addressed and documented. Upon request from the surveyor on 5/25/16 and 5/27/16, the Resident Service Director (RSD) failed to provide a pain treatment plan for Resident #1.	H1180		
H1200	8:43E-6.4(e) PAIN MGMT PROCDURS: PAIN ASSESMNT PROCDURS Pain assessment findings shall be documented in the patient's/resident's medical record. This shall include, but not be limited to, the date, pain rating, treatment plan and patient/resident response. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and review of pertinent documentation, it was determined that the facility failed to document pain assessment findings in the resident's medical record. This deficient practice was evidenced by the following:	H1200		

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H1200	Continued From page 44 1. Resident #1 moved into the facility on 8/25/15 with diagnoses which included (but not limited to) Lupus, Hypertension, Seizure Disorder, Anxiety, and Arthritis. During an interview with Resident #1 on 5/25/16 at 2:30 p.m., the resident told the surveyor that his/her pain has been "really bad" and that he/she has needed to take Percocet to ease the pain. Review of the Medication Administration Record (MAR) for May 2016 revealed that the resident received one tablet of oxycodone-actaminophen (Percocet)10 mg (milligram)-325 mg tablet on the following dates: 5/1/16; 5/2/16; 5/3/16; 5/4/16 at 10 a.m. and 9:00 p.m.; 5/5/16; 5/6/16; 5/10/16; 5/11/16; 5/12/16; 5/13/16 at 10 a.m. and 9 p.m.; 5/15/16; 5/16/16 at 10 a.m. and 9 p.m.; 5/17/16; 5/18/16; 5/19/16; 5/20/16 at 10 a.m. and 9 p.m.; 5/21/16; 5/22/16; 5/24/16 at 10 a.m. and 9 p.m.; and 5/25/16. The directions for the pain medication notes on the MAR stated, "The medication nurse must assess and document the pain intensity each time pain medication is administered and evaluated." There was no pain medication note documented for the Percocet medication that was administered to the resident on 5/10/16; 5/19/16; 5/20/16 at 10 a.m. and 9 p.m.; 5/21/16; 5/22/16; 5/24/16 at 10 a.m. and 9 p.m.; and 5/25/16. On 5/25/16 at 12:35 a.m. The first floor medication LPN confirmed that there was no pain assessment documentation for those dates. The LPN stated that there was no more space to write the pain notes and that he/she was "going to make one (an additional pain medication notes form) and transfer all the information over."	H1200		

POC accepted 9/9/16 JJ

Voorhees Senior Living Plan of Correction

A310 - 8:36-3.4(a)(1) Administration

Facility failed to follow the following policies and procedures - Blood Glucose Calibration Quality Control Testing, Medication Incident Reporting Process, Oxygen Utilization and Storage and Resident Self-Administration of Medications.

1. Resident #2 – LPN's and certified med-techs administering insulin to this resident will adhere to medication administration practices to check medication 3 times prior to administration. Facility implemented "Blood Glucose Calibration Log". All glucometers in community were checked for proper function, test strips, and testing solutions. Items unavailable at survey were ordered and put in place by 5/27/16. LPN on overnight shift to complete logs, ensuring glucometers are functioning properly and each resident has supplies needed. Medication Incident Reporting processes reviewed. LPN's and Med-tech's in-serviced on reporting of medication errors and policy and procedure regarding medication errors. RSD will communicate all medication errors immediately to Executive Director to ensure procedures are being followed according to policy. RN to oversee process.

   Resident #5 – Physician contacted and correct order was obtained. LPN and certified med-techs will follow MD order for oxygen administration. New tubing was put in place. Community review of oxygen utilization and storage policy resulted in immediate follow up by RN to ensure all residents on oxygen have written orders according to policy. Oxygen utilization log (residents on oxygen, type of concentrator, company name and contact info) implemented August 1st, 2016. LPN to complete weekly and keep up to date. All residents on oxygen services had service plans updated by RN to reflect oxygen management. New policy and procedure implemented where LPN's will change all oxygen tubing on a bi-weekly basis, at a minimum. All residents on oxygen had doors checked by maintenance staff and signage put up.

   Resident #3 - no longer resides on the community.

   Resident #6 – had a self-administration of medication assessment completed on 6/8/16 and is not able to administer the medications. Resident was educated on why she was not able to administer her own medications and fully agreed with outcome of assessment. Residents who express desire to administer own medications will be assessed by RN, including upon move in and minimally every 90-days once approved. RN to oversee and assess all residents who wish to self-administer medications..

2. All current and future residents that receive blood glucose monitoring, oxygen services, and medication services by community have the potential to be affected by these deficient practices. Any resident requesting self-administration of medications have potential to be affected by deficient practice.
3. Blood glucose calibration quality control testing, medication incident reporting process, oxygen utilization and storage and resident self-administration of medications policies have been reviewed and adjustments made to ensure residents safety where applicable.

   All residents who have insulin orders will have orders checked by RSD/designee on admission, re-admission and with order changes.

   All residents who have oxygen orders will have orders checked by RSD/designee on admission, re-admission and with order changes.

Residents who will be moving into the community and express a desire to self-administer their own medications will have a self-administration of medication assessment completed prior to move-in to determine capabilities and will be re-assessed by RN every 90days.
All licensed nurses and certified med-techs will be re-educated on blood glucose calibration quality control testing, medication incident reporting process, oxygen utilization and storage and resident self-administration of medications policies by RSD/designee
Blood glucose calibration will be completed once weekly on the night shift (10p – 6A) and documented on the log.

4. RSD/designee will conduct reviews every 2 weeks to ensure accuracy of orders and documentation. RSD/designee to check all logs every 2 weeks for accuracy and signature of LPN's, including but not limited to oxygen log, blood glucose calibration log. Binder set up for monitoring of residents who self-medicate.

A447 - 8:36-5.1(a) General Requirements

Facility Registered Nurse failed to consistently complete an assessment for residents

POC accepted 9/9/16

1. Initial admission assessments will be reviewed and signed by RN within 72 hours of admission. All new charts to be left on cart for RSD to review upon arrival to community.
Resident #1-initial assessment missing RN signature. Resident has been assessed since admission by RN with service plans and level of care signed off by RN.
Resident #5 was readmitted from hospital and RN failed to make note 4/1/16. RN will make notes and assess all residents upon return from hospitalization.
Resident #6 – At time of admission, RN did not document assessment of resident. Resident has been evaluated and service plans and level of care has been updated by RN.
All residents indicated above have had an updated service plan and level of care by the RN.
2. All current and future residents have the potential to be affected by not having the RN complete/sign off on initial assessments.
3. Residents who are admitted to the community will have a nursing review of systems completed by the licensed nurse with a review note completed the RSD/RN within 24-72 hours after admission. New admission/readmissions will be reviewed at daily stand up meeting.
4. ED/designee will conduct audits monthly on newly admitted residents to ensure compliance with evaluation process. Any non-compliance will be addressed immediately and resident will receive assessment as needed.

A547 - 8:36:5.7(a)(6) General Requirements

Facility failed to develop and implement a specific and comprehensive policy requiring employees' physical examinations and TB test upon hire.

POC accepted 9/9/16

1. All policy and procedure manuals were reviewed and signed. Policies and procedures updated to include requirement of pre-employment physicals. Employee files reviewed for physicals and 2 step TB testing. All employees prior to 8/1/2016 have been asked to complete physicals. All new hires, effective 8/3/16 will need to provide documentation of physical exam/fit for duty from physician or go to local clinic for physical prior to 1st day of employment. PPD records will be reviewed. Tickler file developed and LPN(scheduler) with coordination of BOM will ensure all employees have 2 step PPD on file and single step PPD annually in medical record.
2. All current and future residents have the potential to be affected by this deficient practice.
3. TB test was provided to the one employee identified to be non-compliant.
All future employees will have physical examinations and 1st-step PPD completed prior to first day of work and the 2nd step or appropriate follow up completed within 2 weeks of first day of employment. All managers in-serviced on hiring practices to include pre-employment testing that is required, in addition to informing managers that staff that do not comply will be removed

from schedule. PPD tickler file has been set up to track annual compliance for current team members.

4. BOM/RSD to coordinate together to ensure compliance. ED/designee will conduct monthly audits of new employees to ensure all testing was completed. Any staff member found not in compliance will be removed from schedule until PPD is complete.

A565 - 8:36-5.10(a)(3) General Requirements

Facility failed to notify DOH of a resident to resident altercation that led to a resident's physical abuse

PoC accepted 9/9/16 SD

1. Resident #4 resident on resident abuse was not reported to ED. Staff being re- educated regarding what is considered a reportable event and when to contact the ED and/or designee.
2. All current and future residents have the potential to be affected by this deficient practice.
3. ED to educate all managers on internal investigation policy/procedure
   ED to educate all staff regarding what is to be immediately reported to ED/RSD/any department manager in order to appropriately notify DOH and/or Ombudsman within the applicable time period as required by State Law.
   ED/designee will educate all team members during new hire orientation and annually on reportable events effective 8/1/16 and going forward.
   Executive Director/designee will immediately notify DOH and/or Ombudsman of reportable events as required by State Guidelines effective immediately.
4. ED monitoring incidents and conducts mini-educations at monthly department meetings regarding resident rights and reportable events. All employees have been trained to report anything they feel should be brought to ED's attention. ED signing off on all incident reports monthly, at a minimum, allowing opportunity to review potential reportable events.

A753 - 8:36-7.3(c) Resident Assessments and Care Plans

Facility staff failed to provide documentation to confirm the health service plan was developed and/or updated to reflect specific interventions.

PoC accepted 9/9/16 SD

1. Resident #4-Resident service plan was not updated to reflect specific interventions related to fall prevention 4/1/16. Resident chart has been reviewed by RN to reflect updated care needs, including resident needs assistance with transfer and is utilizing wheelchair at this time.
   Resident #3-ISP and GSP for resident did not reflect resident's oxygen needs, nor was GSP updated bi-annually. Resident is no longer in community, but all resident charts have been checked to ensure bi-annual GSP's are up to date and residents requiring health service plans are documented with a plan in place effective 8/1/16.
   Resident #5-GSP updated to reflect continuous oxygen use. ISP has been updated to reflect level of assistance required by staff. HSP put in place by RN.
   Resident #1-Resident's ISP/GSP did not include pain treatment plan. Resident does have pain management specialist at this time and ISP has been updated to reflect pain management needs.
   Resident #6-HSP not developed to manage resident's need for oxygen. ISP, GSP updated to reflect need. HSP in place for oxygen management as of 8/1/16.
2. All current and future residents have the potential to be affected by not developing and/or updated the health service plan to reflect specific interventions.
3. RSD/RN will ensure that each resident that is a new admission has a completed ISP within 14 days of admission to reflect current care needs, including specific health care needs.
   RSD/RN will complete ISP addendum as needed with the changes in residents care needs.
   RSD/RN will review each resident bi-annually or upon change in condition and update the ISP as needed to reflect current care needs.

4. ED will conduct random audits monthly, utilizing auditing tool, to ensure compliance with completion of ISP/HSP/GSP for the residents. Any observations will be brought to RN immediately to update health service plan.

A779 - 8:36-7.5(c) Resident Assessments and Care Plans

Facility failed to provide documented evidence that the RN was consistently notified of changes in residents' condition

POC accepted 9/9/16 SJ

1. Resident #1-Resident had fall, LPN made note in chart, but did not document that RN was notified. Additionally, RN did not document post-fall assessment. Resident has updated assessments in chart based on other incidents. Notification procedures have been updated regarding RN. Resident #3-LPN noted change in resident condition (SOB) but did not document notification of RN. RN assessment not completed for this resident on 3 occasions. Resident no longer resides in building.
   Resident #5-Resident stated during PT that they were going to kill self, as noted by LPN in chart. RN notification and/or physician notification not documented. RN assessment for change in mental condition not documented.
   Resident #6-Resident complaint of change in condition noted by LPN without documented evident that RN was notified of change in condition. No documented evidence of RN assessment to follow. Resident has updated assessments in chart based on other incidents. Notification of RN procedures have been updated.
2. All current and future residents have the potential to be affected by failure to notify RN of changes in resident's condition.
3. All LPN's have been educated regarding notification procedures to the RN for any residents' change in condition to include appropriate documentation in resident's medical record of RN notification. RN to conduct assessment of resident within 24, but not more than 72 hours after being reported and document in the medical record.
   Resident changes in condition will be discussed/reviewed during daily stand-up meeting and at weekly resident review meeting. LPN's have been educated to leave any charts that require RN review on cart, and not return to shelf, to ensure RN is able to assess and note changes in all residents with change in condition.
4. ED/designee will conduct random audits monthly, utilizing audit tool, to ensure compliance with RN notification process. Additionally, ED to review Incident Reports monthly, and cross-check that RN notification has been documented in chart.

A783 8:36-7.5{e} Resident assessments and care plans

Facility failed to ensure that each resident had an annual examination and certification that their needs did not exceed the care that the AL was capable of providing.

POC accepted 9/9/16 SJ

1. All physicians related to #1, 2, 6 contacted. Resident #1-Medical H&P and physical exam was not completed at time of move in. Updated H&P on file effective 7/7/2016. #2 H&P updated 6/8/16. Resident #6 updated H&P dated 7/14/16. Each resident will have an examination by the MD with certification completed.
2. All current and future residents have the potential of being adversely affected by not having annual exam and certification.
3. All charts to be reviewed by RN to ensure all resident annual physicals and certifications are up to date. Any residents missing an annual examination with certification will have one completed by their MD no later than 8/31/2016.
   Upon annual level of care review, RSD/RN will ensure that annual examination with certification has been completed.

4. ED/designee will conduct random audits quarterly, utilizing audit tool, to ensure compliance with annual examination. Any further non-compliance will be bought to QAPI committee for further review

A925 - 8:36-11.2 Pharmaceutical Services

Facility nursing staff failed to ensure that medication was available and to ensure that blood glucose monitoring supplies were available

POC accepted 9/9/16 SS

1. Residents #2 did not have medication available. Resident's medications were reviewed, and all items are in place. RN checked with LPN's to ensure medications had been ordered appropriately.
   Resident #4 did not have test strips available and CMA utilized another resident's items. Upon notification of issue, test strips were ordered for resident #4.
2. All current and future residents that require blood glucose monitoring have the potential to be affected by not having blood glucose monitoring supplies available.
3. All LPN and CMA's will be re-educated on the refilling of medications.
   All LPN and CMA's will be re-educated on the process for ensuring the blood glucose monitoring supplies are ordered and available for those residents needing these supplies.
   LPN will check in medications received with the refill order form to ensure all medications ordered were delivered. If medications not received, RSD/RN will be notified immediately for follow-up. Extra glucometers and test strips available in RN's office, in event test strips do not arrive at community timely. In-services completed by 8/1/16 and on-going.
4. RSD/designee will conduct weekly audits to ensure all medications ordered have been received and all medications required are in house. Non-compliance will result in staff re-education and/or appropriate actions as per company policy.

A935- 8:36-11.4(b) Pharmaceutical Services

Facility failed to administer medications in accordance with MD orders

POC accepted 9/9/16 SS

1. Resident #1 was not given Fentanyl patch, as prescribed. Resident #2 was given incorrect medication and was not given specific medication at another time. LPN's and Med-techs to be re-educated around notification to RN when medications are not administered according to policy and physician's order.
   (please note on pg. 28 of 45-should state resident #2, not resident #3, as resident #3 did not reside in community 5/27/16)
2. All residents that receive medication administration have the potential to be affected by this practice.
3. All LPN and CMA's re-educated on the refilling of medications by 8/1/2016 and on-going.
   LPN will check in medications received with the refill order form to ensure all medications ordered were delivered. If medications not received, RSD/RN will be notified for follow-up.
   All residents who have narcotic medications will have a review of dates during shift-to-shift narcotic count to ensure that medications have been properly administered.
   All residents who have insulin orders will have orders checked by RSD/designee on admission, re-admission and with order changes. Staff education to include reporting to RN when medication errors/omissions occur immediately.
4. RSD/designee will conduct random audits weekly to ensure compliance with medication administration. Any non-compliance will be bought to the QAPI committee for further review

A963 – 8:36-11.5(f) Pharmaceutical Services

POC accepted 9/9/16 SS

Facility nursing staff failed to document the administration of medications in accordance with facility policy and MD orders

1. Resident #2 was found to have multiple medication omissions on MAR. There was no explanation for the omissions provided. Effective 7/1/16 all medications for resident #2 were available. Medication refill process reviewed with all LPN/med-tech's.
2. All residents receiving medication administration by facility staff have the potential to be affected by failure to document the administration of medications.
3. All LPN's and CMA's have been re-educated on the medication administration process, for completing an entry for medications not given and/or refused and RN notification. Medication administration observations will be completed for LPN annually and CMA's every 90 days to ensure appropriate administration of medications. Non-compliance will be addressed through education and/or appropriate action as per company policy. All education conducted 8/1/2016 and on-going.
4. RSD/RN will conduct weekly audits of MAR's/TAR's, utilizing audit tool, to ensure proper medication administration is being conducted according to policy and MD orders. Any non-compliance will be addressed with individual employees.

A981 – 8:36-11.7(a)(4) Pharmaceutical Services

Facility nursing staff failed to store ointments and creams separately for each resident

PoC accepted 9/9/16 by

1. Med carts were re-organized to ensure ointments, creams, drops, and medications are stored separately. Individually labeled bags with resident names have been put in place to keep items separate. Treatments/creams are now stored separately.
2. All residents have the potential to be effected by not storing creams, ointments, and powders separately on medication carts.
3. Medication cart for treatments will be cleaned, organized and each residents' treatments supplies will be separated using baggies or small storage containers. Education will be provided to the LPN's on the night shift to check treatment cart nightly to maintain cleanliness, organization and ensure medications are separated by resident by 8/1/2016.
4. RSD/designee will conduct random audits weekly to ensure compliance with treatment cart organization. Any non-compliance will be bought to the QAPI committee for further review

A983 – 8:36-11.7(a)(5) Pharmaceutical Services

Facility failed to store medication per manufacturer's specifications

PoC accepted 9/9/16 by

1. Community did not have eye drops dated and/or discarded according to manufacturer's instructions. Additionally refrigerator did not have thermometer or temperature log in place. Refrigerator was defrosted and cleaned upon observation. Thermometer and logs updated.
2. All current and future residents' have the potential to be affected by not storing medications according to manufacturer's specifications.
3. LPN and CMA's have been re-educated on dating and discarding medications according to specific manufacturer guidelines. LPN and CMA's re-educated on procedure for ensuring thermometer is present and functioning, checking refrigerator temps daily. Malfunction or concerns are to be reported to maintenance with a work order through the concierge.
4. Maintenance Director or designee will ensure availability of thermometers and check refrigerators monthly to ensure cleaning has been completed. Maintenance to defrost/clean refrigerator's on monthly basis, or more often if necessary. RSD/RN or designee will conduct checks weekly to ensure temperature logs are being completed Any non-compliance will be bought to the QAPI committee for further review

A985 – 8:36-11.7(b)(1) Pharmaceutical Services

Facility nursing staff failed to ensure the prescription medications had a permanently affixed label that contained the residents' full name, prescription number and date of issue and directions for use

POC accepted 9/9/16 SS

1. Resident #2 had insulin pen with label removed. Pen was discarded by RN upon notification. New pen was received and no doses missed.
2. All current and future residents that require prescription medications have the potential to be effected by medications missing label information and/or torn labels.
3. All LPN and CMA's re-educated on the importance of proper labeling of all medications. Any item found not properly labeled to be brought to the RN for review.
4. RSD/RN or designee will conduct weekly audits to ensure medications are properly labeled. Any non-compliance will be bought to the QAPI committee for further review

A999 – 8:36-11.7(e) Pharmaceutical Services

Facility nursing staff failed to remove expired medication from cart

POC accepted 9/9/16 SS

1. Expired Humalog pen found on cart was discarded by RN. Additionally, med cart audit completed to ensure no additional expired medications were on medication carts.
2. All current and future residents that receive medications have the potential to be affected by this deficient practice
3. All LPN and CMA's educated on process to remove expired medications from the med carts and destroy within 30 days following appropriate protocols.
4. RSD/RN will conduct monthly audits of medications carts to ensure expired medications are removed and destroyed. Any non-compliance will be bought to the QAPI committee for further review

A1047 – 8:36-14.3(d) Emergency Service and Procedures

Facility maintenance staff failed to consistently document the monthly inspection of all fire extinguishers.

POC accepted 9/9/16 SS

1. No residents were adversely affected by this deficient practice
2. All current and future residents have the potential to be affected by this deficient practice
3. Maintenance Director and Maintenance Assistant educated on completion of monthly checks and documentation for all fire extinguishers. Maintenance Director/designee will complete all tag checks and sign off on monthly checklist. New Fire Extinguisher Monthly Log tracking sheet implemented 8/1/16 to ensure all tags are checked off monthly.
4. ED to conduct random audits of fire extinguisher tags and monthly checklists to ensure compliance.

A1073 – 8:36-15.6(b) Resident Records

Facility nursing staff failed to consistently document the coordination of oxygen services to ensure functionality and maintenance of oxygen equipment

POC accepted 9/9/16 SS

1. Resident #3 is no longer in the community.
   Resident #5 did not show consistent documentation regarding coordination of oxygen services. Physician contacted and correct order was obtained. LPN and certified med-techs will follow MD order for oxygen administration. New tubing was put in place. Community review of oxygen utilization and storage policy resulted in immediate follow up by RN to ensure all residents on oxygen have written orders according to policy. Oxygen utilization log (residents on oxygen, type of concentrator, company name and contact info) implemented August 1st, 2016. LPN to complete weekly and keep up to date. All residents on oxygen services had service plans

updated by RN to reflect oxygen management. New policy and procedure implemented where LPN's will change all oxygen tubing on a bi-weekly basis, at a minimum. All residents on oxygen had doors checked by maintenance staff and signage put up.

2. All current and future residents on oxygen have the potential to be affected by the deficient practice
3. Oxygen Utilization policy reviewed and adjusted to ensure appropriate procedures are maintained for residents utilizing oxygen. All residents who have oxygen orders will have orders checked by RSD/designee on admission, re-admission and with order changes.
   All nursing staff educated on appropriate oxygen utilization including functionality and maintenance and documentation that is required. New log sheet implemented to ensure all residents on oxygen have properly cleaned, functioning equipment with weekly checks in place effective 8/1/2016 and on-going.
4. RSD/designee will conduct weekly checks to ensure oxygen equipment in properly maintained and functioning and ensure LPN's are completing assigned log. Non-compliance will result in staff re-education and/or appropriate actions as per company policy.
5. Any non-compliance will be bought to the QAPI committee for further review

A1089 – 8:36-16.3(b) Physical Plant

Facility maintenance staff failed to ensure all bathrooms had means of ventilation.

POC accepted 9/9/16 DS

1. Resident #7 's bathroom fan immediately replaced.
2. All current and future residents have the potential to be affected by failure of bathroom ventilation fans.
3. Maintenance Director/designee to implement monthly checklist for all bathrooms. Monthly checklist implemented 8/1/16 to ensure all fans are checked monthly.
4. ED to conduct random audits, quarterly, of resident apartments to ensure compliance. Monthly review of maintenance log to be completed as well. Any non-compliance will be brought to QAPI committee for further review.

A1299 – 8:36-18.3(a)(5) Infection Control and Control Services

Facility LPN failed to wash her hands or use other effective hand sanitation techniques

POC accepted 9/9/16 DS

1. Resident #2 did not exhibit any adverse effects from deficient practice.
2. All current and future residents have the potential to be affected by poor hand sanitation techniques.
3. All staff re-educated on proper hand washing technique that included a return demonstration, how to wash and when to wash hands. Education occurs at new hire orientation, annual orientation, and at additional staff meetings throughout the year.
   Medication carts will have a sanitizer available at all times.
4. RN/Department Directors will conduct random competencies for employees on hand washing procedure during observation of normal work procedures.

H1180 – 8:43E-6.4{c} Pain Management Procedures

Facility failed to develop and implement a pain treatment plan

POC accepted 9/9/16 DS

1. Resident #1 -LPN and CMA will check daily to ensure that residents Fentanyl patch is in place as per MD order. LPN and CMA will evaluate resident on level of pain and medicate as needed per MD order. LPN will notify RSD/RN of consistent PRN pain medication for follow-up with MD and any changes will be updated to the ISP

2. All current and future residents have the potential to be affected by this deficient practice
3. Pain management policy and procedure will be developed and implemented by 8/1/16. All LPN and certified med-techs will be re-educated on pain management policy/procedure by 8/1/16.
4. RSD/RN or designee will conduct random review monthly to ensure compliance with pain management protocols. Any non-compliance will be bought to the QAPI committee for further review

H1200 – 8:43E-6.4{e} Pain Management Procedures

Facility failed to document pain assessment findings in resident's medical record

POC accepted 9/9/16 DJ

1. Resident #1 did not have documentation related to pain assessment for PRN medication. LPN and certified med-tech will check daily to ensure that residents Fentanyl patch is in place as per MD order. LPN and certified med-tech will evaluate resident on level of pain and medicate as needed per MD order. LPN/CMA to complete proper pain assessment and document in resident chart. LPN will notify RSD/RN of consistent PRN pain medication for follow-up with MD and any changes will be updated to the ISP
2. All current and future residents requiring pain management have the potential to be affected by this practice.
3. Pain management policy and procedure developed and implemented effective 8/1/16. All LPN and certified med-techs educated on pain management policy/procedure effective 8/1/2016.
4. RSD/RN will conduct random review of MAR's monthly to ensure compliance with pain management protocols. Any non-compliance will be bought to the QAPI committee for further review