New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12039	A. BUILDING: ______ B. WING ______	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER AT MONROE	**395 SCHOOL HOUSE ROAD MONROE, NJ 08831**

(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
S 000	Initial Comments Standard Survey: 11/3/21 Census: 96 Sample: 10 THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. 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 THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and facility document review, the facility failed to ensure staffing ratios were met for 2 of 14 day shifts checked out of 42 total shifts reviewed. There was no substantial increase in the resident census for a period of forty-two consecutive shifts. This deficient practice had the potential to affect all residents.	S 560		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/22/21

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S 560	Continued From page 1 Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. On 10/4/21, the day shift staffing ratio was 1 CNA to 8.09 residents. The minimum staffing ratio for day shift is 1 CNA to 8 residents. On 10/16/21, the day shift staffing ratio was 1 CNA to 8.27 residents. On 10/29/21 at 12:25 PM, the surveyor discussed the staffing ratios concerns with the Administrator and Director of Nursing, who stated the facility is attempting to hire new CNAs. NJAC 8:39-5.1(a)	S 560		

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S1935	8:39-29.2(d) Mandatory Pharmacy (d) Medications shall be accurately administered and documented by properly authorized individuals, as per prescribed orders and stop order policies. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure accurate accountability and administration records for a Controlled Substance. This deficient practice was identified for Resident #1, 1 of 4 residents reviewed, receiving a controlled substance medication. The deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."	S1935		

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S1935	Continued From page 3	S1935		

Reference: New Jersey Administrative Code, Title 13, Law and Public Safety, Chapter 37, New Jersey Board of Nursing, under 13:37-6.5 Non-Delegable Nursing Tasks, includes: "A registered professional nurse shall not delegate the physical, psychological, and social assessment of the patient, which requires professional nursing judgment, intervention, referral, or modification of care."

Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case-finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.

1. On 10/21/21 at 1:15 PM, the surveyor inspected the NJAC 8:43E-2.1 and Exec Order unit Medication Cart and Narcotic log in the presence of the Registered Nurse (RN).

The surveyor reviewed the "Controlled Drug Administration Record" (CDAR), an accountability record associated with NJAC 8:43E-2.1 and Exec O NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. for Resident #1. The surveyor noted that the CDAR had cross outs on the recorded quantity from 10/3/21 to 10/7/21. The cross outs had "error" documented next to the updated quantities with no initials, time or dates associated with the corrections. In addition, an entry dated October 3, 2021 located on the narcotic log for the NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.

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S1935	Continued From page 4 documented that 0.75 milliliters (ml) were destroyed. The surveyor reviewed Resident #1's Face Sheet (a document that gives a patient's information at a quick glance). The Face Sheet documented that Resident #1 was admitted to the facility on NJAC 8:43E-2.1 and with diagnoses that included but not limited to NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. A review of the October 2021 Electronic Physician Order Sheet documented an order for NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. with an order date, NJAC 8:43E-2.1 and On 10/22/2021 at 10:15 AM, the surveyor interviewed the Registered Nurse Neighborhood Guide (NG) on the NJAC 8:43E-2.1 and Exec Order unit, regarding the discrepancies found on Resident #1's CDAR for NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NG informed the surveyor that the Consultant Pharmacist (CP) conducted a monthly review on 10/7/21 which identified accountability discrepancies. NG confirmed that she made the corrections, cross outs, and documented "error" in response to the CP's recommendation from 10/7/21. The NG could not explain why she did not document her initials, time, or date when the changes were made to the CDAR. The surveyor reviewed the CP report dated 10/7/2021 that identified, "quantity in CDS book does not reconcile with 10/3/21 NJAC 8:43E-2.1 and Exec Order 10/3/21 start quantity 25.75 ml, 10/3/21 quantity wasted 0.75 ml, remaining quantity written 24.0 ml should be 25.0 ml."	S1935		

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S1935	Continued From page 5 On 10/25/21 at 9:57 AM, the DON provided a statement from the Licensed Practical Nurse (LPN) who documented discarding 0.75 ml of NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. l on the CDAR. The LPN's statement explained that she documented discarding 0.75 ml to adjust the level of medication to the visual amount that she saw in the bottle, 24 ml. The DON added that the LPN confessed that in reality only 0.25 ml of NJAC 8:43E-2.1 and Exec O was wasted due to a spillage caused by Resident #1. The DON explained that there was also a subtraction error documented when calculating 0.75 ml removed from the documented CDAR total of 25.75 ml. The total amount of NJAC 8:43E-2.1 and Exec O NJAC 8:43E-2.1 an after the subtraction was incorrectly documented by the LPN as 24 ml. The correct amount left on the CDAR after the subtraction of 0.75 ml should have been 25 ml. 2. The surveyor reviewed the CP report, dated 10/7/21. The Report identified, "CDS (Control Declining Sheet) declining book: does not reconcile with the eMAR (Electronic Medication Administration Record) on 10/1/21. NJAC 8:43E-2.1 and Exec Order NJAC 8:43E-2.1 eMAR 10/1/21 is documented one time and CDS declining book is documented two times." The surveyor reviewed and compared the CDS accountability documentation with that on the October 2021 eMAR for Resident #1 receiving NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. The surveyor noted that on 10/10/21, two doses were documented as removed from the CDS accountability record, yet only one dose was documented as administered to Resident #1 on the October 2021 eMAR.	S1935		

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S1935	Continued From page 6 The surveyor also noted that on 10/21/21, one dose was documented as removed from the CDS accountability record, while no doses were documented as administered to Resident #1 on the October 2021 eMAR. On 10/25/21 at 9:57 AM, the surveyor interviewed the Director of Nursing (DON) and the Administrator, regarding the timeline and the accountability discrepancies. The DON stated "NG made calculation errors in an attempt to correct the discrepancies found by the CP." The DON admitted there was "poor documentation" on the CDAR and the eMAR for [NJAC 8:43E-2.1 and Exec Order 2] [NJAC 8:43E-2.1] On 10/27/21 at 12:11 PM, the surveyor conducted an interview with the CP, via telephone. The CP explained that she communicated the calculation and documentation errors that occurred from 10/1/2021 to 10/7/2021 to the NG. The CP explained that she was able to identify the mathematics error by subtracting the quantity administered and destroyed of [NJAC 8:43E-2.1 and Exec Order] from the total amount documented on the CDAR accountability sheet. The CP also stated that she compared the CDS with the eMAR documentation. The CP found that nursing signatures documenting the administration of [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] were missing on the eMAR that related to the 10/1/2021 documentation of the removal of the [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] on the CDAR accountability sheet for Resident #1. Review of the facility Controlled Substance Policy	S1935		

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S1935	Continued From page 7 section titled Controlled Substance Declining Inventory Accountability revealed, "Any discrepancies found must be documented and reported to the Director of Nursing/designee. The Director of Nursing/designee shall investigate discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties and shall give the Administrator a written report of such findings. Review of the facility Controlled Substance Policy section titled Controlled Substance Medication Administration revealed, "The inventory on hand must be checked against the declining inventory at the time of taking a controlled substance medication from the locked storage to administer to a resident." The surveyor further discussed the discrepancies with the DON and Administrator. No further information was provided. NJAC 8:39- 29.2 (d)	S1935		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
12039		12/22/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER AT MONROE	395 SCHOOL HOUSE ROAD MONROE, NJ 08831

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/16/2021	ID Prefix S1935 Reg. # 8:39-29.2(d) LSC	Correction Completed 11/04/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
11/3/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO