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	315201	A. BUILDING _____ B. WING _____	10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER	255 EAST MAIN ST MOORESTOWN, NJ 08057

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F 000	INITIAL COMMENTS STANDARD SURVEY: 10/30/19 CENSUS: 69 SAMPLE SIZE: 20 + 8 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		11/30/19

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

Electronically Signed | 11/22/2019

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F 609	Continued From page 1 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to report to the New Jersey Department of Health an incident pertaining to a.) an incident of resident-to-resident verbal altercation and alleged physical abuse on [redacted], and b.) a resident allegation of physical abuse on [redacted]. This deficient practice was identified for 2 of 4 residents reviewed for abuse (Residents #53 and #63) and was evidenced by the following: 1. On 10/28/19 at 10:30 AM, the surveyor observed Resident #53 sitting up in bed, with the head of bed elevated. The resident was pleasant and agreed to be interviewed. The surveyor asked the resident if he/she had experienced any instances of abuse. The resident could not recall any such incidents. The surveyor reviewed the medical record for Resident #53. A review of quarterly MDS dated [redacted] reflected the resident was admitted to the facility on [redacted] and had diagnoses which included but were not limited to [redacted] ng. A review of Resident #53's Incident/Accident Report document titled, "Safety/Security/Conduct Event" revealed on [redacted] at 9:15 AM, staff	F 609	1. Reports were made to the NJDOH on [redacted] about the abuse of Resident #53 by another resident. The allegation of abuse by Resident #63 was reported to the NJDOH on [redacted]. Facility will assure that all alleged violations will be reported per requirements. 2. An audit of facility□s Grievance Log was conducted to assure that all allegations of abuse were reported per NJDOH requirements. All other grievances except for those cited in the SOD (2567) were properly reported. Residents who are unable to express grievances or allegations will be monitored for changes in behavior such as guarding, crying or other signs of distress. Investigations and reporting will be done as required. 3. Daily Leadership Meetings will include discussion of any resident/family grievances and/or allegations. LNHA reviewed the regulation and facility policy to assure a clear understanding of reporting requirements involving allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property. The Leadership Team and Co-workers were re-educated about the importance of adherence to the requirements for reporting allegations of abuse, neglect, etc. Final review of all completed investigations will be done by	

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F 609	Continued From page 2 overheard Resident #53 and another resident arguing. Staff entered the room and observed Resident #53 holding his/her face and crying. The Incident/Accident Report revealed that the resident had wandered into another resident's room and rubbed that resident on the shoulders, which prompted the verbal altercation and an alleged physical abuse. The Incident/Accident Report further reflected that the residents were separated and relocated to safe areas. Resident #53 was assessed by the nurse and no no facial injuries, red marks or swelling were noted. A review of the the Incident/Accident Report statement by a Physical Therapy (PT) staff dated [redacted] documented that the PT staff member heard the residents arguing and went to mediate to ensure the residents' safety. The PT staff member observed Resident #53 was holding his/her face and crying due to an alleged hit. The staff member did not see Resident #53 being struck. The Incident/Accident Report statement by the DON dated [redacted] reflected that the resident was startled when Resident #53 entered the room and touched his/her shoulder, but the other resident did not strike Resident #53. A review of Resident #53's undated ICCP included a problem area that the resident wandered in and out of other resident's rooms and was not easily redirected. On 10/28/19 at 10:15 AM, the surveyor interviewed the CNA who stated Resident #53 had behaviors of wandering and the resident wore a [redacted]	F 609	the LNHA to ensure that all allegations of abuse/neglect have been appropriately reported. 4. A weekly review of the Grievance Log will be conducted by the SW and LNHA to assure that grievances and allegations are addressed per NJDOH and government agency guidelines. SW will conduct interviews on 10% of the resident population on a monthly basis to assure grievances are appropriately reported. Quarterly audits of grievances will be done by an IDT member other than SW to assure objectivity and compliance. Findings from audits and resident interviews will be reported and discussed at the monthly Quality Assurance / Performance Improvement Committee meeting. Remedial actions will be implemented when needed.	

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F 609	Continued From page 3 [redacted]	F 609		

On 10/28/19 at 10:35 AM, the surveyor interviewed an LPN who stated that Resident #53 had become much calmer, but still wandered into other residents' rooms.

On 10/28/19 at 3:10 PM, during the exit conference, the DON stated abuse and neglect were "usually" reported within 24 hours to the NJDOH. The DON further stated that the resident-to-resident altercation between Resident #53 and another resident on [redacted] was not reported to NJDOH because the alleged physical altercation was unwitnessed and Resident #53 had no evidence of "marks" when a body assessment was performed on the resident.

On 10/28/19 at 3:12 PM, during the exit conference, the LNHA stated allegations of abuse or neglect should be reported and investigated regardless of the intent, and the facility's investigation would substantiate or unsubstantiated the allegation of abuse or neglect based on the investigation. The LNHA further stated the resident-to-resident altercation on [redacted] should have been reported to the NJDOH.

10/30/19 at 11:13 AM, the surveyor conducted a follow up interview with the LNHA who stated allegations of abuse with serious injury should be reported to the NJDOH within 2 hours, and all others should be reported within 24 hrs.

2. On 10/23/19 at 10:26 AM, the surveyor observed Resident #63 seated upright in bed in

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F 609	Continued From page 4	F 609		

their room. The resident stated that he/she had spoken to the LNHA about a specific staff member who was, "nasty" to him/her. The resident further stated that since he/she spoke to the LNHA, the staff member had not taken care of him/her. The resident was unable to recall specific dates when the incident had occurred.

The surveyor reviewed the medical records for Resident #63.

A review of the resident's Face Sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included but were not limited to [redacted]

A review of the resident's most recent quarterly, MDS (an assessment tool used to facilitate the management of care) dated [redacted] reflected that the resident had a BIMS score of [redacted] which indicated the resident was [redacted] intact.

A review of a Grievance Form provided by the LNHA dated [redacted] reflected the resident made an accusation that on either [redacted] or [redacted] he/she was, "thrown" in the shower by an aide. The resident further reported on the Grievance Form that the specific staff member he/she mentioned to the surveyor was, "rough" when providing care.

A review of Resident #63's undated ICCP included a problem area that the resident had

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conflict with staff due to ineffective coping skills, an anger management problem, manipulative behavior, adjustment disorder, and a knowledge deficit. As evidenced by verbalizing dissatisfaction with staff performance, being verbally and physically abusive to staff members, and having unrealistic expectations of staff.

On 10/28/19 at 12:51 PM, the surveyor conducted an interview with the SW in the presence of another surveyor who stated that the LNHA and the DON were the facility staff members ultimately responsible for investigating and reporting abuse.

On 10/28/19 at 3:19 PM, the surveyor interviewed the LNHA in the presence of the survey team who stated that all allegations of abuse would be investigated as abuse and would be reported to the NJDOH. The LNHA did not specify time frames for reporting to the New Jersey NJDOH. T he LNHA did not speak as to why Resident #63's [redacted] allegation of abuse was not reported to the NJDOH.

On 10/29/19 at 12:52 PM, the surveyor conducted a follow up interview with the LNHA in the presence of the survey team. The LNHA stated the facility reported the allegation of abuse made by Resident #63 to the NJDOH last night after surveyor inquiry and the resident's perception was their reality so all allegations of abuse and neglect would be investigated and reported.

A review of the facility's Resident/Participant

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F 609	Continued From page 6 Abuse Protection Policy and Procedure revised on 6/30/17 included, "Reporting/response- The reporting and filing of accurate documents relative to incidents of abuse; reporting to the State agencies as required, analyze and implement necessary changes to prevent future occurrences of abuse." The facility's Resident/Participant Abuse Protection Policy and Procedure did not specify time frames for the reporting of abuse to the New Jersey Department of Health. A review of the facility's Abuse Policy provided by the LNHA dated 4/1/19 included, "A seven-step approach to abuse and neglect detection and prevention will be utilized which includes Screening, training, prevention, identification, investigation, protection and reporting and response." The facility's Abuse Policy further included, "7. REPORTING AND RESPONSE: 1. Initial reporting and allegations: If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the State Agency." Refer to F610	F 609		
F 610 SS=D	NJAC 8:43-10.6(b); 8:39-9.4(e)(3)(i) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		11/30/19

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F 610	Continued From page 7 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was identified that the facility failed to thoroughly investigate, a resident allegation of physical abuse on [redacted]. This deficient practice was identified for 1 of 4 resident's reviewed for abuse, (Resident #63) and was evidenced by the following: 1. On 10/23/19 at 10:26 AM, the surveyor observed Resident #63 seated upright in bed in their room. The resident stated that he/she had spoken to the LNHA about a specific staff member who was, "nasty" to him/her. The resident further stated that since he/she spoke to the LNHA, the staff member had not taken care of him/her. The resident was unable to tell the surveyor specific dates when the incident had occurred. The surveyor reviewed the medical records for Resident #63. A review of the resident's Face Sheet (an	F 610	1. The allegation forwarded by Resident #63 was reported to the NJDOH on [redacted]. Facility will thoroughly investigate allegations by Resident #63 per requirements. Resident #63□'s Care Plan was updated to assure preference of caregivers is honored. 2. An audit of facility□s Grievance Log was conducted to assure that all allegations of abuse were investigated per NJDOH requirements. All other grievances except for those cited in the SOD (2567) were properly investigated. 3. The Leadership Team and Co-workers were re-educated about the importance of adherence to the requirements for investigating allegations of abuse, neglect, etc. Daily Leadership Meetings will include discussion of any resident/family grievances and/or allegations to assure that an investigation is initiated and thoroughly completed. A weekly review of the Grievance Log will be conducted by the SW and LNHA to assure that grievances and allegations are	

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F 610	Continued From page 8 admission summary) reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included but were not limited to [redacted] A review of the resident's most recent quarterly Minimum Data Set, MDS (an assessment tool used to facilitate the management of care) dated [redacted] reflected that the resident had a BIMS score of [redacted] which indicated the resident was [redacted] intact. A review of the resident's undated CP included a problem area that the resident had conflict with staff due to ineffective coping skills, an anger management problem, manipulative behavior, adjustment disorder, and a knowledge deficit. As evidenced by verbalizing dissatisfaction with staff performance, being verbally and physically abusive to staff members, and having unrealistic expectations of staff. A review of the Grievance Form provided by the LNHA dated [redacted] reflected the resident made an accusation that on either [redacted] he/she was "thrown" in the shower by an aide. The resident further reported on the Grievance Form that the specific staff member he/she mentioned to the surveyor was "rough" when providing care to the resident. A further review of the Grievance Form indicated that Resident #63 had not made an allegation of abuse or neglect. The Grievance Form indicated that if the resident had made an allegation of abuse or neglect to initiate the abuse protocol.	F 610	investigated per NJDOH and government agency guidelines. A list was developed to assure that residents preference of caregivers is honored. This list will be placed in the C.N.A. Assignment Book to assure that Nurses/Aides know/honor resident preferences. A checklist of important elements recommended for a thorough investigation was developed and implemented. Final review of all completed investigations will be done by the LNHA to ensure that all allegations of abuse/neglect have been fully investigated and appropriately reported. 4. A weekly review of the “Grievance Log” will be conducted by the SW and LNHA to assure that grievances and allegations are addressed/investigated per NJDOH and government agency guidelines. Quarterly audits of grievances will be done by an IDT member other than SW to assure objectivity and compliance. Findings from audits will be reported and discussed at the monthly Quality Assurance / Performance Improvement Committee meeting. Remedial actions will be implemented when needed.	

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A review of the Grievance Form steps taken to investigate the grievance indicated, "Spoke with resident. Resident was unhappy about taking a shower. [He/She] said 'OK' when asked about taking a shower. Then stated [he/she] was unhappy afterwards.

A review of a typed statement dated [redacted] completed by the DON indicated that the CNA who was accused of being rough during care by the resident stated that he was not rough when providing care to the resident and the resident had not complained to him regarding the type of care he/she had received.

A review of the Grievance Form Summary of Findings indicated that the resident was verbally abusive to staff and had [redacted] cognition. The Summary of Findings further indicated that the resident's perception on what occurred was "skewed" due to his/her declining condition and the staff reported that the resident was very accusatory.

A complete review of the Grievance Form did not indicate additional statements obtained from staff or alert and oriented residents on [redacted] and [redacted]

On 10/24/19 at 10:45 AM, the surveyor interviewed the resident's 7:00 AM - 3:00 PM CNA who stated that the resident was alert to person, place, and time, but had behaviors where he/she would accuse people of doing things that were not true. For example, the resident would say that a male staff member was going to kidnap him/her and take the resident to Camden. The CNA further stated that the resident would be

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perfectly normal and then accuse someone of stealing something from him/her. The CNA stated that she would spend time talking with the resident to calm him/her down when the resident had behaviors.

On 10/28/19 at 9:25 AM, the surveyor interviewed Resident #63's LPN who stated that the resident was, [redacted] and had, '[redacted] The LPN stated that if the resident had a nurse he/she wasn't familiar with the resident would be reluctant to take his/her medications. The LPN told the surveyor that she would take her time during care with the resident and would sit and talk with the resident and offer him/her snacks to calm him/her down. The surveyor asked the LPN what she would do if the resident told her someone did something to him/her. The LPN stated she would go directly to the unit manager working and report it so we could investigate it.

On 10/28/19 at 10:50 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that the resident was very [redacted] and would ask staff members repetitive questions while providing care for reassurance. The RN/UM stated that she had met with the resident several times and the resident had asked her what her name and position was on multiple occasions. The RN/UM stated that she believed the resident had confabulated stories at times and had altercations with staff. The RN/UM further stated that if a resident made an allegation of abuse directed toward a staff member, that staff member would be removed from providing care and an investigation would ensue. The RN/UM stated, " Any allegation of abuse regardless of the mentation of the resident or resident's behaviors needs to be investigated as

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an abuse investigation and taken seriously."

On 10/28/19 at 12:51 PM, the surveyor interviewed the SW in the presence of another surveyor who stated that abuse could be physical, mental, financial, or sexual in nature. The SW further stated that any concerns a resident had would need to be investigated and the nature of the concern would depend if the facility would investigate it as a grievance or an abuse. The surveyor asked the SW what the difference between a grievance and an abuse investigation was. The SW stated that she did not make that determination and that would be determined by the LNHA or the DON. The SW stated that if an allegation of abuse was made by a resident the facility would conduct an abuse investigation and statements would be obtained from all potential witnesses and the statements would be reviewed by her and the LNHA. The SW further stated that the facility would also interview residents on the unit who were alert and oriented in relation to the care the alleged staff member provided. The SW told the surveyors that she was responsible for teaching the staff on orientation to report any and all allegations of abuse to a nurse or supervisor.

On 10/29/19 at 9:39 AM, the surveyor interviewed the CNA who was accused of being "rough" during care. The CNA stated that the resident was alert with confusion and had stated in the past that the resident had told other staff members that he was going to take him/her out of the facility to Route 38. The CNA further stated that he didn't know why the resident thought that because sometimes when he walked by the resident's room the resident would say hello to him. The CNA told the surveyor that he had never provided the resident with one on one intimate

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care because the resident preferred female staff members. This statement contradicted the statement provided in the Grievance Form completed by the DON. The CNA stated that at times he would bring the resident his/her breakfast tray or answer the resident's call bell, but was told not to go into the resident's room a few months back because of the resident's accusations and behaviors. The CNA further stated that if a resident made an allegation of abuse he would follow the chain of command and tell the nurse and also the unit manager.

On 10/29/19 at 12:52 PM, the surveyor conducted an interview with the LNHA in the presence of the survey team. The LNHA stated that a resident's perception was their reality so all allegations of abuse and neglect would be investigated and reported.

On 10/30/19 at 10:47 AM, the surveyor conducted a follow up interview with the LNHA in the presence of the survey team. The LNHA stated that if a resident alleged that a staff member was abusive, they would send the staff member home until the allegation of abuse was thoroughly investigated.

A review of the facility's Resident/Participant Abuse Protection Policy and Procedure revised on 6/30/17 included, "All residents/participants have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, misappropriation of property and exploitation." The facility's Resident/Participant Abuse Protection Policy and Procedure further included, "Investigating- timely and thorough investigations of all reports and allegations of abuse to include injuries of

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F 610	Continued From page 13 unknown origin. Reporting/response- The reporting and filing of accurate documents relative to incidents of abuse; reporting to the State agencies as required, analyze and implement necessary changes to prevent future occurrences of abuse." Refer to F609 NJAC 8:39-4.1(a)5	F 610		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) carry out a physician's order for a [redacted] consultation in a timely manner and b.) take vital signs prior to the administration of [redacted] medication with hold parameters in accordance with professional standards of nursing practices. This deficient practice was identified for 2 of 20 residents reviewed for professional standards of practice, (Resident #10 and #57). Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential	F 658	1. Resident #10 was seen by the [redacted] Nurse Practitioner on [redacted]. Nurse responsible for medication administration to Resident #57 was re-educated regarding medication administration and the need to take vital signs as per physician orders. Nurse was also re-assessed for medication administration competency. Vital signs for Resident # 57 have been taken per physician orders since observation by the Survey Team on 10/23/2019. 2. An audit of all charts with orders for Psychiatric consults was done and no other orders for consults went unaddressed. A review of residents who require that vital signs be taken prior to	11/30/19

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F 658	Continued From page 14 physical and emotional health problems, through such services as casefinding, 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." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; 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." The evidence was as follows: 1. On 10/23/19 at 11:01 AM, the surveyor observed Resident #10 laying in bed listening to music. The resident stated that he/she was [redacted]) and preferred to stay in bed. The surveyor reviewed the medical record for Resident #10. A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included [redacted] and	F 658	the administration of medications was compiled for auditing purposes. 3. Medication Administration competency testing will be performed on staff Nurses to assure that protocols are correctly followed. [redacted] consult requests will be arranged in a binder so that the [redacted] Practitioner and facility staff can compare notes to assure all consults are completed according to physician orders. 4. Medication competency testing will be performed for each staff nurse at least an annual basis. At least one medication pass audit will be completed monthly by Pharmacy Consultant or designee. Daily review of new physician orders will be done by Unit Managers/designee to assure that [redacted] consultations are completed as ordered. Monthly audits x 3 months and then quarterly, will be done of all physician orders for [redacted] consults to assure ongoing compliance. Findings from audits will be reported and discussed at the monthly Quality Assurance / Performance Improvement meeting. Remedial actions will be implemented when needed.	

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A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating a fully intact cognition.

A review of the resident's individualized, comprehensive care plan (ICCP) dated effective [redacted] to present, included that the resident had a potential for [redacted] to the history of [redacted]. Interventions included were to give positive feedback for participation in social activities, give resident as many choices as possible, and encourage to express feelings.

A further review of the ICCP included a problem area that the resident had behavioral symptoms not directed towards others with interventions that included to encourage the resident to contact appropriate staff with concerns, provide medication as ordered, and remove resident from the situation.

A review of the [redacted] dated [redacted] indicated that the resident was referred for a consult for reason which included calling the police, accusing staff, and yelling at staff. Based on the clinical

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assessment, the resident's behaviors appear related to [redacted]. Although past [redacted] history is unclear and underlying [redacted] history is unclear, [redacted] cannot be ruled out. Recommendations made by [redacted] included to consider [redacted] and/or counseling support to assist and manage coping skills and decrease behaviors.

A review of a follow-up [redacted] dated [redacted] included resident's behaviors remained the same and recommended to consider on-going [redacted] support for the resident.

A review of the physician's progress note dated [redacted] an assessment plan for a [redacted] consultation.

A review of the Medication Management Assessment completed by the psychiatric Nurse Practitioner (NP) on [redacted] included that the resident was seen for [redacted] issues; that the resident was calmer than previous visit but does again discuss his/her frustration with facility issues.

On 10/28/19 at 9:26 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was alert but confused at times. The resident refuses to get out of bed and sometimes could be "fussy" if he/she did not get things when he/she wanted them.

At 11:50 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN), who stated that the resident was alert, able to makes needs known, and had [redacted] The resident was encouraged to get out of bed and sit in his/her chair, but he/she refused. The

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resident had a history of [redacted] and felt that if he/she got out of bed, they would have a [redacted] The LPN denied the resident having a [redacted] at the facility since admission.

At 2:46 PM, the Licensed Nursing Home Administrator (LNHA) informed the surveyor that the Social Worker initiated the [redacted] in response to the resident calling the police. The matter was investigated, and found to be unsubstantiated.

On 10/29/19 at 12:52 PM, the LNHA informed the surveyor that the Medication Management Assessment dated [redacted] was the only assessment the facility could locate.

At 1:28 PM the LNHA in the presence of the administration team and survey team stated that the Social Worker, who was not present that day, reviewed the [redacted]. The LNHA could not speak to why the recommendations made on the [redacted] for [redacted] support on [redacted] and [redacted] were not followed until 10/22/19.

At that time, the Director of Nursing (DON) stated that a psychiatric recommendation could have been made sooner, but it sometimes takes a while for [redacted] consultation. The DON stated that it could take up to three weeks, but would follow-up on that. The DON added that the previous Unit Manager (UM) was no longer here, and the recommendation could have been missed during the transition.

On 10/30/19 at 10:41 AM, the LNHA in the presence of the Vice President of Clinical Services (VPCS) and the survey team, stated that the original request for Resident #10 to receive a

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psychiatric consultation was made on [redacted]. An additional request was made in October for a [redacted] consultation, and the resident was first seen on [redacted]. The LNHA could not speak to why the resident was not seen in [redacted], and was not seen until an additional request in [redacted] was made.

At 12:30 PM, the VPCS informed the surveyor that she could not locate a policy concerning carrying out a physician's order for a [redacted] consultations.

A review of the facility's Medication & Treatment Orders policy dated 10/2/17 did not include a procedure for following physician's orders written for [redacted] consultations.

2. On 10/24/19 at 9:23 AM, the surveyor, in the presence of another surveyor, observed the LPN3 preparing to administer 11 medications to Resident #57 which included a [redacted] used to [redacted] and a [redacted] MG tablet of [redacted]. The LPN3 referred to a paper that she stated she had recorded the resident's [redacted] of [redacted] and a [redacted]) of 1[redacted]. The LPN2 stated that she needed the AP for the [redacted] and the [redacted] for the [redacted] because the physician's orders required the vital signs to be obtained before administering the medication because if the vital signs were too low she would have to hold the medications.

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On 10/24/19 at 9:30 AM, the surveyor in the presence of another surveyor observed the resident lying in bed with eyes closed.

At that time, the resident awakened and was agreeable to take his/her medications.

On 10/24/19 at 9:31 AM, the surveyor in the presence of another surveyor, observed the nurse administer the [redacted] and [redacted].

On 10/24/19 at 9:48 AM, the surveyor in the presence of another surveyor, interviewed the LPN2 who stated that her routine was to come in for her 7:00 AM to 3:00 PM shift and get report from the 11:00 PM to 7:00 AM shift and then make her rounds. The LPN2 added that she would then review which residents required vital signs for the medication pass and obtain the vital signs. The LPN2 then stated that she thought she had taken the resident's [redacted] approximately 30 minutes or so before administering the medications. The LPN2 stated that her routine helped for an easier medication pass.

On 10/24/19 at 10:27 AM, the surveyor reviewed the eMR for Resident #57.

A review of the Face Sheet (an admission summary) included that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted] and [redacted].

A review of the quarterly MDS, an assessment tool used to facilitate the management of care, dated [redacted] reflected the resident had a BIMS score of [redacted], indicating that the resident

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F 658	Continued From page 20 had a [redacted] cognition. A review of the October 2019 POS revealed a PO dated [redacted] for [redacted] tablet, one tablet once a day five times a week. A review of the October 2019 POS revealed a PO dated [redacted] for [redacted] MG, one tablet, by mouth twice a day, hold for [redacted] less than [redacted] and/or [redacted] than [redacted] On 10/28/19 at 2:48 PM, the survey team met with the LNHA, the DON and the VPCS. The DON acknowledged that vitals signs such as [redacted] and [redacted] were required to be obtained just prior to the administration of the medication as a nursing standard of practice. A review of the facility policy dated 10/2/2017 for "Administering Medications" included that vitals signs must be checked prior to administering medications.	F 658		
F 693 SS=D	NJAC 8:39-11.2(b) Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical	F 693		11/30/19

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F 693	Continued From page 21 condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record, it was determined that the facility failed to a.) monitor an [redacted] administration pump to assure the [redacted] administered was in accordance with physician's orders, and b.) maintain a resident's weight which resulted in both a significant weight loss and a significant weight gain. This deficient practice was identified for 1 of 1 residents reviewed for enteral tube feeding, (Resident #266), and was evidenced by the following: On 10/23/19 at 10:32 AM, the surveyor observed Resident #266 asleep in bed with an [redacted] pump [redacted] administering [redacted] at a rate of [redacted] (mL) an hour with a total volume infused thus far of [redacted] On 10/24/19 at 8:59 AM, the surveyor observed the resident in bed awake, but non-responsive to surveyor questioning. The surveyor observed [redacted] 2 being administered at a rate of [redacted] per hour with a total volume infused thus far of	F 693	1. The physician order for Resident #266 was changed to reflect the [redacted] infused. The [redacted] order was rewritten to clearly indicate the documentation of the total volume infused. Staff Nurses were re-educated on the proper programming of the [redacted] and documentation of the [redacted] infused. 2. Only residents with [redacted] may be affected. 3. Re-education was provided to nursing staff about the operation of the [redacted] pump and physician orders in preparation of any new resident on [redacted]. All [redacted] residents' weights will be reviewed by the IDT weekly. Discrepancies with documented weights will be addressed by Nursing and the Dietician. An audit of [redacted] total volume infusion (TVI) will be completed weekly by the DON/designee for one month to assure sufficient/proper resident nutrition and compliance with physician	

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F 693	Continued From page 22 [redacted]. The [redacted] bottle was labeled as hung on [redacted] at 12:50 AM. At 10:17 AM, the surveyor observed the resident in bed with the [redacted] administering [redacted] at a rate of [redacted] per hour with a total volume infused thus far of [redacted]. On 10/25/19 at 8:44 AM, the surveyor observed the resident in bed with the [redacted] administering [redacted] a rate of [redacted] hour with a total volume infused thus far of [redacted]. The [redacted] bottle was labeled as hung on [redacted] at 6:30 AM. The surveyor reviewed the medical record for Resident #266. A review of the Face Sheet (an admission record) reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included [redacted] A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had both a [redacted] with [redacted] impaired cognition. A review of the MDS [redacted], reflected that the resident received more than [redacted] of his/her [redacted] and more than [redacted] per day through a [redacted]	F 693	orders. TVI audits will then be completed monthly x 2 months then quarterly thereafter. The DON/designee will immediately review audit findings with the IDT to address potential discrepancies. 4. The Dietician monitors weights of all tube fed residents. The Dietician will review all tube fed residents□ weight fluctuations at the bi-monthly Wound & Weight meetings and address issues as needed. Outcomes from audits will be reported at the monthly Quality Assurance / Performance Improvement meeting. Remedial actions will be completed as needed.	

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F 693	Continued From page 23 A review of the resident's individualized, comprehensive care plan (ICCP) dated effective [redacted] to present, included that the resident required a [redacted] for nutritional support related to a history of [redacted] with a weight decline of 5% over the last two weeks since admission. On 10/7/19 weight increase was noted with a return to usual body weight range. Interventions included to monitor labs when available, monitor tolerance of [redacted], provide [redacted] as ordered, and monitor weight monthly. A review of the October 2019 Physician Order Sheet (POS) indicated a physician's order (PO) dated [redacted] administered at a rate of [redacted] an hour for [redacted]; from [redacted] An additional order indicated to record total volume infused for all shifts three times a day at 6:30 AM, 2:30 PM, and 10:30 PM. A review of the corresponding October 2019 electronic Medication Administration Record (eMAR) indicated the following: The total volume for the [redacted] formula documented on the eMAR on 10/5, 10/6, 10/7, 10/8, 10/9, 10/12, 10/13, 10/14/ 10/15, 10/16, 10/19, 10/20, 10/21, 10/22, and 10/23 indicated an excess of [redacted] The total volume for the TF formula documented on the eMAR on 10/10, 10/11, 10/17, and 10/18 indicated a deficit of [redacted] A review of the October 2019 POS indicated a	F 693		

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F 693	Continued From page 24 PO dated [redacted] to flush the [redacted] with [redacted] of water before and after medication administration each shift. A review of the corresponding October 2019 eMAR reflected the following for first shift: 10/1 [redacted]; 10/3 [redacted]; 10/7 [redacted]; 10/8 [redacted]; 10/9 [redacted]; 10/10 [redacted] 10/13 [redacted]; 10/17 [redacted]; 10/18 [redacted]; 10/22 [redacted]; and 10/23 [redacted] A review of the corresponding October 2019 eMAR reflected the following for second shift: 10/1 [redacted]; 10/3 [redacted]; 10/4 [redacted] 10/5 [redacted]; 10/6 [redacted]; 10/7 [redacted] 10/8 [redacted]; 10/9 [redacted]; 10/10 [redacted]; 10/15 [redacted]; 10/16 [redacted] 10/17 [redacted]; 10/20 [redacted]; 10/21 [redacted] 10/22 [redacted] and 10/23 [redacted] A review of the corresponding October eMAR reflected the following for third shift: 10/1 [redacted] 10/2 [redacted] 10/3 [redacted] 10/5 [redacted] 10/6 [redacted]; 10/7 [redacted] 10/8 [redacted] 10/9 150 [redacted] 10/10 [redacted] 10/11 [redacted]; 10/12 [redacted]; 10/13 [redacted] 10/14 [redacted]; 10/15 [redacted]; 10/16 [redacted]; 10/17 [redacted] 10/18 [redacted]; 10/19 [redacted]; 10/20 [redacted] 10/21 [redacted] 10/22 [redacted] and 10/23 [redacted]. A further review of the October POS indicated a PO dated 10/3/19 for weekly weights three times a week during 7:00 AM to 3:00 PM medication pass starting on 10/4/19. A review of the electronic Vital Signs indicated the following weights: 9/18 [redacted]) 9/26 [redacted] 10/2 [redacted]; reweigh [redacted]	F 693		

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F 693	Continued From page 25 10/7 [redacted] 10/11 [redacted] 10/16 [redacted] 10/24 [redacted] The weight from [redacted] through [redacted] indicated a significant weight loss of [redacted]. The weights had not corresponded with the PO dated [redacted] for weights three times a week. A review of the most recent labs on [redacted] indicated a [redacted] and a [redacted] level of [redacted] which were both below normal levels. On 10/25/19 at 10:26 AM, the surveyor interviewed the resident's Certified Nursing Aide #1 (CNA) who stated that the resident received [redacted], had a [redacted], and received incontinence care every two hours for a heavy bladder. The CNA stated that she went to the nurse every two hours to have the [redacted] turned off when it was running to perform incontinence care, then the nurse turned the [redacted] back on afterwards. The resident also had a [redacted] on the top of his/her [redacted]s that was healing. At 10:30 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident had [redacted], was complete care, and received [redacted] at a rate of [redacted] per hour for a total volume of [redacted]. The resident also received 30 mL of water before and after each medication pass for a total volume of [redacted]. The LPN continued that she turned off the pump when the total volume read [redacted] The resident's head of the bed was positioned at a forty-five degrees before, during,	F 693		

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F 693	Continued From page 26 and after the [redacted] The resident wore [redacted]) that were only taken off during care and treatments to that area. At 10:41 AM, the LPN accompanied the surveyor to Resident #266's room. The resident was observed in bed with the [redacted] running at a rate of [redacted] per hour with a total volume of [redacted] infused. The surveyor observed the resident was wearing [redacted]s. The LPN stated that the CNA took the weights with another CNA utilizing a hoyer lift (an assistive device used to transfer residents) scale. The LPN stated that the CNA told the nurse the weight, and the nurse entered the weight directly into the the computer system. At 10:52 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that she was new to the facility, and just started on this unit in the middle of [redacted]. The RN/UM stated that Resident #266 had a [redacted] received nothing by mouth, and was admitted to the facility with [redacted] that were healing. The RN/UM confirmed that all the resident's weights were in the computer. The RN/UM stated that the nurses stopped the [redacted] each day when the pump reflected a total volume of [redacted]; the pump was not cleared after each shift. At that time, the RN/UM accompanied the surveyor into Resident #266's room. They observed the [redacted] running with a total volume of [redacted] infused. The RN/UM reviewed the October eMAR with the surveyor. The RN/UM stated that the totals for each shift were incorrect. She stated that maybe	F 693		

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nurses included water flushes in the total. The surveyor asked the RN/UM how the eMAR would be read if the pump had not reflected a total volume of [redacted] when turned off. The RN/UM stated that she could not speak to that. The RN/UM reviewed the water flushes during each medication pass, and confirmed that the total volume should have been [redacted] each medication pass.

At 11:18 AM, the LPN informed the surveyor that the nurses used a manual irrigation system to flush the [redacted] with the appropriate amount of water administered according to the PO.

At 11:24 AM, the surveyor interviewed the Registered Dietitian (RD) who stated that the resident was new to the facility and had a new [redacted]. Prior to admission to the facility, the resident received [redacted] in the hospital, but the facility only had [redacted] in stock. The facility had not received many [redacted] residents, so the formula usually expired before being used. The physician wrote an order for the [redacted] until the facility received the [redacted] The original PO when the resident was here, was for [redacted] administered at [redacted] per hour continuously for twenty-four hours with a total volume of [redacted]. The resident tolerated that [redacted]. The RD stated that the [redacted]g provided a total of [redacted] and [redacted] which met his/her calculated [redacted] needs of [redacted] a day based on the admission weight of [redacted].

At 12:18 PM, the LPN, CNA #1, and CNA #2 accompanied the surveyor into Resident #266's room for a weight check. CNA #1 confirmed she

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was the CNA who always weighed the resident, and the last time the resident was weighed was probably last week. CNA #1 stated that the resident always had on his/her [redacted] when weighed. CNA #2 stated that she usually did not assist CNA #1 with Resident #266's weight, but she took the resident's weight upon entrance. CNA #2 stated that the resident wore [redacted] from the hospital during that weight. As per the LPN, the resident came in from the hospital with [redacted] that were black and cushiony, but she was unable to recall the name of the [redacted]s. The LPN stated that she thought the current [redacted] were heavier than his/her origina[redacted].

At 12:38 PM, the surveyor observed CNA #1 and CNA #2 in the presence of the LPN weigh the resident after incontinence care with the [redacted] on. The weight observed was [redacted]. The surveyor than observed a weight of [redacted].

At that time, the LPN stated that she was verbally told that morning by the 11:00 PM to 7:00 AM shift nurse that the resident received [redacted] thus far. The LPN stated that the pump must have somehow reset itself, but she usually stopped the pump when it reflected the total volume of [redacted] infused. The LPN stated that maybe the nurse wrote the total volume on the twenty-four hour nursing report.

The surveyor reviewed the twenty-four hour nursing report with the LPN. The report had not reflected the total volume of [redacted] infused per shift. The surveyor reviewed with the LPN all the twenty-four hour nursing reports for the resident from admission; the reports had not reflected the

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total volumes infused by shifts.

At 12:45 PM, the LPN informed the surveyor that the resident received incontinence care every two hours, which was performed around the clock through all shifts. The LPN stated that the [redacted] was turned off prior to incontinence care, and then the CNA alerted the nurse to turn the pump back on after care was completed.

At 1:04 PM, the RN/UM stated that she went through the resident's physician's orders, and there was no PO to explain how the documentation was to be completed each shift. The order only indicated to record the total volume of each shift. The RN/UM continued that the nurses possibly included the flushes in the total volume. The RN/UM stated that the order was confusing so the nurses were probably confused with how to document. The RN/UM stated that the plan was to have the physician discontinue that order. The RN/UM confirmed that the nurse should have clarified with the physician the order prior to surveyor inquiry. The RN/UM stated that they were clarifying with the nurses that the pump would not get cleared or stopped until the total volume infused was [redacted]. The RN/UM stated that there was no policy that she could locate for [redacted] The RN/UM stated that there had not been another resident on [redacted] since she started at the facility, and believed it had been a while since the facility had a resident on a [redacted] The UM/RN was unsure the last time staff was educated on [redacted] and that the Assistant Director of Nursing (ADON) was in charge of staff education.

At 1:21 PM, the surveyor interviewed the ADON who stated she started at the facility four months

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ago, and had not completed staff education on the administration of the [redacted]. The ADON further stated that she could not locate any prior [redacted] education. The ADON stated that there was no policy regarding [redacted].

The surveyor continued reviewing the medical record for Resident #266.

A review of the September 2019 eMAR reflected a PO dated [redacted] for [redacted] administered at [redacted] per hour continuously. An additional PO dated [redacted] reflected to record the total volume of [redacted] one time per day. The eMAR reflected this corresponding order as followed:

On 9/19 a total volume of [redacted] was infused.
On 9/20 a total volume of [redacted]L was infused.
On 9/21 a total volume of [redacted]L was infused.
On 9/22 a total volume of [redacted] was infused.
On 9/23 a total volume of [redacted] was infused.
On 9/24 a total volume of [redacted] was infused.
On 9/25 a total volume of [redacted] was infused.
On 9/26 a total volume of [redacted] was infused.
On 9/27 a total volume of [redacted] was infused.
On 9/28 a total volume of [redacted] was infused.
On 9/29 a total volume of [redacted] was infused.
On 9/30 a total volume of [redacted] was infused.

The surveyor reviewed the weights for the resident. From the weight on 10/16/19 of [redacted] (which was the weight the resident was upon admission) to the weight observed on 10/25/19 of [redacted], reflected a significant weight gain of [redacted].

On 10/28/19 at 11:09 AM, the surveyor re-interviewed the RD who stated you would generally expect to see weight loss from a

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resident admitted from the hospital due to edema or fluid losses. Other factors that could contribute to weight fluctuations was how staff was weighing the resident; if the heel boots were on or off. The RD stated she had not observed the resident being weighed, so could not speak to how staff was weighing the resident. The RD reviewed the resident's weights with the surveyor. The RD acknowledged that the continued weight loss reflected between [redacted] and [redacted] was most likely not from hospital [redacted]. The RD stated weight loss could occur from [redacted] such as [redacted], but she was unaware that had occurred with the resident. The RD stated that when the resident was first admitted, he/she received [redacted] in twenty-four hours based on a rate of [redacted] per hour. The RD acknowledged that the pump had not run continuously for twenty-four hours, that the pump was turned off for care throughout each shift. The RD was unsure how many times in twenty-four hours the pump was turned off for care, but stated it was not for a long period of time. The RD stated that the nurses documented the total volume infused on the eMAR. The RD stated that she had reviewed the eMAR, and was aware there was some confusion with nurse documentation after surveyor inquiry.

The RD reviewed the September 2019 eMAR with the surveyor. The RD confirmed that a total volume of [redacted] that was documented on [redacted] would not be feasible if the resident was administered [redacted] at a rate of [redacted] per hour for twenty-four hours because the maximum total volume at that rate would be [redacted]. The RD stated that the resident needed at least [redacted] to [redacted] per day for adequate nutrition. The RD acknowledged that all the total volume's

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recorded on the eMAR besides the total volume on [redacted] of [redacted] 0 mL, were all less than the resident's required daily caloric intake. The RD acknowledged that the calories the resident received based on the total volume of [redacted] documented on the September eMAR as received could, correlate with the weight loss documented in the electronic Health Record (eHR). The RD stated that she had reviewed the September 2019 eMAR, but the documentation was written in several different places. The RD stated that she had not conducted inservices on [redacted] in the past, but had inserviced staff on weights because the facility did not have many residents on [redacted]

The RD informed the surveyor that [redacted] was a marker used for [redacted] in the body, which was found to not be the most reliable marker because different stressors could effect the level. The various stressors included [redacted] The RD also stated that protein stores were also affected by similar stressors. The RD and surveyor reviewed the lab results from the hospital dated [redacted] which indicated the [redacted] and [redacted] which were both below normal values. The RD and surveyor compared the hospital lab values with the lab values on [redacted] which showed that the [redacted] and [redacted] were still low but had improved. The RD also confirmed that the resident had two healing [redacted] which would have also affected the [redacted] and [redacted].

On 10/29/19, the surveyor interviewed the Consultant Pharmacist (CP) who stated that she did not review the eMAR for the administration of

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F 693	Continued From page 33 enteral formula; that would be something the RD reviewed. On 10/30/19 at 11:00 AM, the Vice President of Clinical Services (VPCS) in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team indicated that the facility did have an [redacted] policy. The VPCS stated that the nurses needed to work on their documentation; that they misunderstood the PO and included flushes in the total volumes. The order was confusing and it had to be clarified. The VPCS continued that the RD was adjusting the [redacted] based on the weights, and the ICCP was updated to reflect to weigh the resident with the [redacted] on. The VPCS could not speak to how staff was ensuring that the resident was receiving the total amount of [redacted] per PO if the pump was not shut off at [redacted] as observed by the surveyor on three consecutive days, and there was no documentation that reflected the actual amount of [redacted] the resident received during each shift to equal the total volume of [redacted] A review of the facility's Weight Assessment and Intervention policy dated 3/23/17 included that the threshold for significant unplanned and undesirable weight loss and/or gain in one month of 5% is significant and greater than 5% is severe. A review of the facility's [redacted] policy dated 6/10/13 included that the total rate for [redacted] will be calculated over a twenty-two hour time period, allowing for feedings to be turned off for care and activities. The policy also included that [redacted] are administered using a [redacted]; pump accuracy is	F 693		

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F 693	Continued From page 34 assessed by the nurse. The policy further included that the volume infused is assessed at the end of each shift. At the end of each shift, the nurse documents the total volume infused for that shift. The nurse documents the volume of water flushes. The policy also included to assure that "volume infused" has been cleared when total volume to be infused is reached. Set rate and total volume to be infused based on the [redacted] schedule. If the feeding is intermittent, set the volume to be infused for that interim. If the [redacted] is continuous, set the total volume for each twenty-four hours. Start pump.	F 693		
F 759 SS=D	NJAC 8:39-27.1(a) Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication pass on 10/24/19 and 10/25/19, the surveyor observed three (3) nurses administering medications to six (6) residents. There were 32 opportunities and five (5) errors observed which calculated to a medication administration error rate of 15.6 %. The deficient practice was identified for 2 of 3 nurses for 2 of 6 residents, (Resident #57 and #59) as evidenced by the	F 759	1. Nurse(s) responsible were re-educated regarding medication administration and were assessed for medication administration competency. The packaging of [redacted] with minerals for Resident #59 was marked to differentiate it from [redacted]s. Medication administration times were updated for Resident #57 to be in accordance with manufacturer's recommendations relating to food consumption with medications.	12/6/19

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F 759	Continued From page 35 following: 1. On 10/24/19 at 08:47 AM, the surveyor in the presence of another surveyor, observed the Licensed Practical Nurse (LPN1) preparing to administer medications to Resident #59. The LPN1 stated that according to the electronic medication administration record (eMAR) the resident was to receive two medications which included one [redacted]. The LPN1 then explained that the [redacted] was supplied by the facility house stock and was labeled [redacted]Daily" and removed one red tablet from the bottle. On 10/24/19 at 8:51 AM, the surveyor in the presence of another surveyor, observed the LPN1 administer the two (2) medications which included the "[redacted] Daily" red tablet. On 10/24/19 at 10:45 AM, the surveyor reviewed the medical record for Resident #59. A review of the October 2019 physician order (PO) sheet revealed an order dated [redacted] for [redacted], one tablet by mouth daily." On 01/04/19 at 11:37 AM, the surveyor, in the presence of another surveyor, interviewed the LPN1 at the medication cart. The LPN1 acknowledged that she had administered the red tablet from the facility house stock labeled [redacted]Daily" to Resident #59. At that time, the surveyor read the ingredients of the [redacted] Daily" which revealed that the product had not contained [redacted]. The LPN1 explained that the PO was for the product labeled	F 759	2. Physician orders for [redacted] with [redacted] will be reviewed. Medication administration times for all residents will be reviewed and updated to be in accordance with manufacturer's specifications relating to food consumption with medications. 3. Nurses will be re-educated on proper medication administration practices and Nurses will be will be assessed for medication administration competency. Packaging of [redacted] will be differentiated from [redacted] with [redacted]. A list of medications with significant manufacturer specifications will be placed at each Nurse's Station, Unit Manager Office and R.N. Supervisor's Office for reference when placing medication orders. Education will be provided to all nursing staff regarding this change. 4. Medication competency testing will be performed for each staff nurse on an annual basis. At least one medication pass audit will be completed monthly. The Pharmacy Consultant will continue to conduct medication pass competency testing in collaboration with Nurse Administration. Any deficient practices will be immediately addressed. Pharmacy Consultant will continue to review new orders to monitor that medication manufacturer's recommendations relating to food consumption is noted and followed. Competency test results and new medication order audit findings will be	

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CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER	255 EAST MAIN ST MOORESTOWN, NJ 08057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 36 [redacted]Daily." The LPN1 further explained that she had another facility house stock [redacted] in the medication cart labeled "Daily [redacted]" but did not think that was what the physician ordered. The surveyor, in the presence of another surveyor, observed that the [redacted]" were orange tablets. The LPN1 stated that she thought she was following the PO. On 10/24/19 at 11:46 AM, the surveyor, in the presence of another surveyor, interviewed the Unit Manager, in the presence of the Assistant Director of Nursing (ADON) and LPN1 with regard to the two (2) house stock [redacted] in the medication cart. The UM stated that the [redacted]" contained [redacted] and the [redacted]" did not contain [redacted] At that time, the PO was reviewed and the UM and ADON acknowledged that the PO indicated to administer a [redacted] that contained [redacted] The UM and ADON stated that the PO was not specific to the label of the house stock [redacted] product and that the PO indicated to administer a [redacted] contained [redacted] The UM stated that the resident should have received the "[redacted]" (ERROR#1) On 10/29/19 at 1:50 PM, the surveyor, in the presence of the survey team, interviewed the Consultant Pharmacist (CP) who stated that she instructs the nurses to administer the correct house stock medications according to what the physician ordered. The CP added that she recalled having done a couple of med passes with LPN1 and stated that after each med pass	F 759	reported at the monthly Quality Assurance / Performance Improvement meetings. Remedial actions will be discussed and implemented as needed.	

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she would review a medication pass in-service.

A review of the facility policy dated 10/2/17 included that medications must be administered in accordance with orders and the nurse administering must check to verify the right medication.

2. On 10/24/19 at 9:23 AM, the surveyor, in the presence of another surveyor, observed the LPN2 preparing to administer 11 medications to Resident #57 which included a [redacted] (MG) tablet of [redacted] (a medication to [redacted]), an [redacted] tablet of [redacted] (a medication used for [redacted]) and a [redacted] MG tablet of [redacted]).

On 10/24/19 at 9:30 AM, the surveyor in the presence of another surveyor observed the resident lying in bed with eyes closed. At that time, the resident awakened and was agreeable to take his/her medications. At 9:31 AM, the surveyor in the presence of another surveyor observed the nurse administer 9 of the 11 medications which included the [redacted]

On 10/24/19 at 9:48 AM, the surveyor in the presence of another surveyor interviewed the LPN2 who stated that during morning report from the night shift she was told that the resident was up late and added that was the reason that he/she was still in bed and not dressed which was unusual for the resident. The LPN2 also stated that the resident had eaten breakfast between 8 AM and 8:30 AM. Neither surveyor observed food

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trucks or meal trays on the unit.

On 10/24/19 at 10:27 AM, the surveyor reviewed the eMR for Resident #57.

A review of the October 2019 "Physician Order Sheet (POS)" revealed a PO dated [redacted] for "[redacted] one tablet by mouth twice a day" scheduled for 7 AM and 4 PM administration times.

Further review of the POS revealed the following PO with dates and scheduled administration times:

[redacted], one tablet by mouth two times a day" dated [redacted] and scheduled for 9 AM and 5 PM.

[redacted], one tablet by mouth two times a day" dated [redacted] and scheduled for 9 AM and 5 PM.

[redacted], one tablet by mouth twice a day" dated [redacted] and scheduled for 9 AM and 5 PM.

In addition, the POS indicated for each PO a "physical monitors" section with "Precautions acknowledged as dispensing label."

On 10/24/19 at 11:41 AM, the surveyor, in the presence of another surveyor, interviewed LPN2. The LPN2 stated that she was not sure where to find the cautionary warnings for medications. The LPN2 explained that she had access to drug information for each medication in the eMAR. The LNP2 then stated that she knew [redacted] should be administered with food. The LPN2 then

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stated that the [redacted] was timed for 7:00 AM and should have been administered by the 11: 00 PM to 7:00 AM shift but the resident was sleepy that morning because he/she was up all night so she administered the medication on her shift. The LPN2 could not speak to why she administered the [redacted] at 9:31 AM after the resident had already eaten breakfast.

At that time, the surveyor, in the presence of another surveyor, observed with the LPN2 the labels of the medications for Resident #57 in the medication cart which revealed the following:

1. [redacted] tablets with a cautionary warning on the label, "Take half-hour before meals." (ERROR #2)

2. [redacted] tablets with a cautionary warning on the label, "Take this med with a meal." (ERROR #3)

3. [redacted] tablets with a cautionary warning on the label, "Take this med with a meal." (ERROR #4)

4. [redacted] MG tablets with a cautionary warning on the label, "Take with or immediately after meal." (ERROR #5)

The LPN2 then stated that she thought she had an hour after a resident finished eating to administer medications with food and the resident had eaten breakfast around 8:30 AM. The LPN2 added that if a resident had not eaten a meal then she would offer a snack with the medications.

On 10/25/19 at 8:13 AM, during a medication pass, the LPN3 stated that she was waiting to

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administer medications until the breakfast trays were delivered. The LPN3 stated that she had several medications that required the resident to have food or a meal. The LPN3 explained that the cautionary warnings for medications were on the label of the medications and the nurses were responsible for reading and following the cautionary warnings. The LPN3 also stated that the eMAR had a "Notes" section for each medication and sometimes the cautionary warnings were typed into that section. The LPN3 also added that the nurses would have to manually input the cautionary information into the electronic "Notes" section and that was not always done.

A review of the facility policy dated 10/2/17 for "Administering Medications" included that medications must be administered in accordance with orders, including any required time. In addition, the policy included that the nurse administering the medications must check the label and verify the right time for the medication prior to administering the medication.

On 10/28/19 at 2:48 PM, the survey team met with Licensed Nursing Home Administrator, the Director of Nursing and the Vice President of Clinical Services (VPCS). The VPCS stated that the current "Administering Medications" policy was to be followed but had not been updated to include the electronic process.

On 10/29/19 at 1:50 PM, the surveyor, in the presence of the survey team, interviewed the Consultant Pharmacist (CP) who stated that she instructs the nurses to read and follow cautionary warnings before administering a medication and also instructs the nurses to find the cautionary

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warnings printed on the medication label. The CP added that she was aware that the nurses could enter the cautionary into the electronic system but was unsure if that was always done. The CP stated that she had done a medication pass every month but was unsure if she had ever done a medication pass with LPN2.

A review of the manufacturer's specifications for [redacted] reflected that the medication was to be administered 30 minutes before a meal.

A review of the manufacturer's specifications for [redacted] reflected that the medication was to be administered with the first bite of a meal.

A review of the manufacturer's specifications for [redacted] reflected that the medication was to be administered with food.

A review of the manufacturer's specifications for [redacted] reflected that the medication was to be administered with or immediately following a meal.

NJAC 8:39-11.2(b), 29.2(d)