STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	**1417 BRACE ROAD CHERRY HILL, NJ 08034**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT # NJ158549 CENSUS: 117 SAMPLE SIZE: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. Based on interviews, medical records review, and review of other pertinent facility documents on 10/6/2022 and 10/12/2022, it was determined that the facility failed to protect a resident (Resident #2), who requires [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] for [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] according to the Physician's Order, is [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] with a known history of [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.], [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] rom physical abuse from a staff member (Certified Nursing Assistant- CNA). On 9/20/2022 at approximately 6:00 p.m., Resident #1, a [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] resident with a known history of [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] and diagnosis of [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.], and Resident #2 got into a Resident-to-Resident altercation where Resident #1 pushed the dining room table into Resident #2's chest. Resident #2 shoved the table back at Resident #1. According to the CNA, Resident #2 then swung his/her fist at Resident #1, picked up the table, and threw the table, but he/she caught the table in mid-air and swung the table around in the air. Resident #1 moved back, and he didn't know how Resident #2 ended up on the floor.	F 000		

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

Electronically Signed | 11/01/2022

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

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F 000	Continued From page 1 The CNA told Resident #2 to get his/her "ass off the floor," and the Resident started kicking. The CNA stated he told the Resident to go to his/her room. According to the Registered Nurse (RN) assigned to Resident #1 and Resident #2 at the time of the incident, she was in the bathroom and heard a plate drop to the floor around dinner time. When she came out of the bathroom, she saw the CNA kicking Resident #2 on the floor. She yelled, "Hey, hey!" The CNA stopped kicking Resident #2. She then counseled the CNA about using "excessive force; it could be considered abuse." She stated the CNA said he used that force because Resident #2 hit a woman. The RN continued to say Resident #2 was shaken up after the incident, but she assessed the Resident, and there was no complaint of pain or injury. The RN further stated she wanted to tell the Supervisor, but she didn't. According to the RN, she didn't know the facility's protocol for abuse. She told the oncoming Licensed Practice Nurse (LPN #1) about the incident, and he stated that's the way Resident #2 is with [redacted] However, LPN #1 said the RN told him the CNA may have been "rough" with Resident #2. LPN #1 stated being rough with a resident is abuse. He did not know he had to report it because he thought the RN had reported it. According to Resident #2, on 9/20/2022, the incident happened in the dining room. Resident #2 stated, "I got in a fight, and I got hurt." A CNA slammed me to the ground and began kicking me because I pushed my tray into a girl. "The Resident stated my whole [redacted] and [redacted] hurt."	F 000		

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F 000	Continued From page 2 According to the Staffing Coordinator (SC), on 9/22/2022, I was on the unit around 6:00 p.m. the RN asked the SC did the CNA get suspended. The RN then told the SC about the altercation on 9/20/2022 between Resident #2 and the CNA. According to the SC, she asked the RN why she did not report the altercation. The RN stated she did not tell anyone because she did not want to get the CNA in trouble. After the SC heard about the incident, she reported it to the Director of Nursing (DON). The DON then assessed Resident #2 on 9/22/2022, two days after the incident occurred. The DON observed NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. on the NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . The CNA who physically abused and assaulted Resident #2 was allowed to continue working the entire 3:00 p.m.-11:00 p.m. shift and the 11:00 p.m.-7:00 a.m. shift from 9/20/2022 into 9/21/2022, on the same unit as Resident #2. The CNA was also scheduled to work the 3:00 p.m. to 11:00 p.m. shift on 9/22/2022 but called out sick. According to the Physician's Order, Resident #2 needed NJAC 8:43E-2.1 and Exec Order 26, 4. due to NJAC 8:43E-2.1 and Exe, but this was not in place at the time of the incident. The facility also failed to follow the PO's and placed Resident #2 on NJAC 8:43E-2.1 and Exec Order 26, 4. after the altercation with Resident #1 occurred to ensure Resident #1 was safe and failed to follow its policies titled "Abuse Prevention," "Incidents and Accidents," "Physician's Orders" and "Mood & Behavior Monitoring." The facility's failure to protect Resident #2 from physical abuse and failure to place Resident #2	F 000		

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F 000	Continued From page 3 on [redacted] placed Resident #1, Resident #2 and all other residents placed Resident #2, and all other residents at risk for physical abuse and in an Immediate Jeopardy (IJ) situation. This IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) on 10/12/2022 at 5:06 p.m. The Administrator was presented with the IJ template that included information about the issue. The IJ began on 9/20/2022 and continued through 9/22/2022 when the physical abuse was reported, and the CNA was removed from the schedule. On 10/18/2022, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating facility staff on the Abuse Prevention Policy and Timely Reporting of Abuse. So, the noncompliance remained on 10/18/2022 as a level G for actual harm that is not an IJ based on the following: the RN and CNA no longer work at the facility, the New Jersey State Board of Nursing was notified, and the facility staff has been educated on the Abuse Prevention Policy and Timely Reporting of Abuse.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		11/7/22

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F 600	Continued From page 4 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: C#: NJ158549 Based on interviews, medical records review, and review of other pertinent facility documents on 10/6/2022 and 10/12/2022, it was determined that the facility failed to protect a resident (Resident #2), who requires [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] for [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] according to the Physician's Order, is [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] with a known history of [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.], diagnosis of NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] om physical abuse from a staff member (Certified Nursing Assistant- CNA). On 9/20/2022 at approximately 6:00 p.m., Resident #1, a [NJSA 47 1A-1 reasonable privacy expectation] resident with a known history of [redacted] and diagnosis of [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] [NJAC 8:43E-2.1 and Exec Order] and Resident #2 got into a Resident-to-Resident altercation where Resident #1 pushed the dining room table into Resident #2's chest. Resident #2 shoved the table back at Resident #1. According to the CNA, Resident #2 then swung his/her fist at Resident #1, picked up the table, and threw the table, but he/she caught the table in mid-air and swung the table around in the air. Resident #1 moved back, and he didn't know how Resident #2 ended up on the floor. The CNA told Resident #2 to get his/her "ass off the floor," and the Resident started kicking. The CNA stated he told the Resident to go to his/her	F 600	1. At the time of the notification of the alleged incident to the Director of Nursing on 9/22/22, the following actions were taken. Resident #2 was immediately assessed by the Registered Nurse assigned to his care on 9/20/22 for pain or injury, and none were noted at that time. Resident #1 and Resident #2 were re-assessed by the Director of Nursing on 9/22/22. Upon assessment by the Director of Nursing areas of discoloration were noted on Resident #2. Resident #1 and Resident #2 were re-evaluated by Nurse Practitioner 9/23/22. Resident #1 had no sign on injury upon evaluation. Diagnostics were ordered to Resident #2 for further evaluation, resident refused the diagnostics. Resident #1 room was changed to provide additional space between the Resident #1 and Resident #2 on 9/22/22. Cherry Hill Police were contacted on 9/22/22 and initiated an investigation. Department of Health and Ombudsman notified on 9/22/22, residents' families and physicians were also notified on 9/22/22. Agency was contacted on 9/23/22 to notify them about the event. The two agency staff members involved did not return to the facility following the notification to the agency.	

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F 600	Continued From page 5 room. According to the Registered Nurse (RN) assigned to Resident #1 and Resident #2 at the time of the incident, she was in the bathroom and heard a plate drop to the floor around dinner time. When she came out of the bathroom, she saw the CNA kicking Resident #2 on the floor. She yelled, "Hey, hey!" The CNA stopped kicking Resident #2. She then counseled the CNA about using "excessive force; it could be considered abuse." She stated the CNA said he used that force because Resident #2 hit a woman. The RN continued to say Resident #2 was shaken up after the incident, but she assessed the Resident, and there was no complaint of pain or injury. The RN further stated she wanted to tell the Supervisor, but she didn't. According to the RN, she didn't know the facility's protocol for abuse. She told the oncoming Licensed Practice Nurse (LPN #1) about the incident, and he stated that's the way Resident #2 is with [redacted] However, LPN #1 said the RN told him the CNA may have been "rough" with Resident #2. LPN #1 stated being rough with a resident is abuse. He did not know he had to report it because he thought the RN had reported it. According to Resident #2, on 9/20/2022, the incident happened in the dining room. Resident #2 stated, "I got in a fight, and I got hurt." A CNA slammed me to the ground and began kicking me because I pushed my tray into a girl. "The Resident stated my whole [redacted] and [redacted] hurt." According to the Staffing Coordinator (SC), on 9/22/2022, I was on the unit around 6:00 p.m. the RN asked the SC did the CNA get suspended.	F 600	Board of Nursing will be notified on 10/13/22. Investigation was immediately initiated on 9/22/22. Reeducation on abuse initiated with staff on 9/23/22. 2. All resident are at risk to be affected by the deficient practice. 3. Staff were immediately re-educated on abuse prevention and timely reporting initiated on 9/23/22. All residents with orders and/or care plan interventions for 1-1 supervision were reevaluated for continued need and appropriateness. Signage has been hung on 10/13/22 at throughout the facility and at nurses' stations to reinforce instructions on mandatory reporting of suspected or witnessed abuse for staff to reference. Resident council meeting was held with residents about how to report suspected or witnessed abuse, and who it should be reported to. Director of Nursing will review any incidents of suspected or witnessed abuse in daily clinical meeting to ensure that there were no incidents that were not reported. Nurses were reeducated on the 1-1 supervision protocol which includes notifying nursing supervisor of any new order for 1-1, so that the Director of Nursing can ensure that the 1-1 is carried out for the appropriate amount of time necessary. 4. Director of Nursing or designee will audit 5 resident charts weekly for 30 days to ensure that 1-1 supervision orders are carried out if they are in place, and monthly thereafter for 60 days. All findings will be reviewed with the QAPI committee monthly for 3 months.	

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F 600	Continued From page 6	F 600		

The RN then told the SC about the altercation on 9/20/2022 between Resident #2 and the CNA. According to the SC, she asked the RN why she did not report the altercation. The RN stated she did not tell anyone because she did not want to get the CNA in trouble. After the SC heard about the incident, she reported it to the Director of Nursing (DON).

The DON then assessed Resident #2 on 9/22/2022, two days after the incident occurred. The DON observed multiple discolorations on the Resident's thigh, hip, and pelvic area.

The CNA who physically abused and assaulted Resident #2 was allowed to continue working the entire 3:00 p.m.-11:00 p.m. shift and the 11:00 p.m.-7:00 a.m. shift from 9/20/2022 into 9/21/2022, on the same unit as Resident #2. The CNA was also scheduled to work the 3:00 p.m. to 11:00 p.m. shift on 9/22/2022 but called out sick.

According to the Physician's Order, Resident #2 needed [redacted] due to [redacted], but this was not in place at the time of the incident. The facility also failed to follow the PO's and placed Resident #2 on [redacted] after the altercation with Resident #1 occurred to ensure Resident #1 was safe and failed to follow its policies titled "Abuse Prevention," "Incidents and Accidents," "Physician's Orders" and "Mood & Behavior Monitoring."

The facility's failure to protect Resident #2 from physical abuse and failure to place Resident #2 on [redacted] placed Resident #1, Resident #2 and all other residents placed Resident #2, and all other residents at risk for physical abuse

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F 600	Continued From page 7	F 600		

and in an Immediate Jeopardy (IJ) situation. This IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) on 10/12/2022 at 5:06 p.m. The Administrator was presented with the IJ template that included information about the issue. The IJ began on 9/20/2022 and continued through 9/22/2022 when the physical abuse was reported, and the CNA was removed from the schedule.

On 10/18/2022, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating facility staff on the Abuse Prevention Policy and Timely Reporting of Abuse. So, the noncompliance remained on 10/18/2022 as a level G for actual harm that is not an IJ based on the following: the RN and CNA no longer work at the facility, the New Jersey State Board of Nursing was notified, and the facility staff has been educated on the Abuse Prevention Policy and Timely Reporting of Abuse.

This deficient practice was identified for 2 of 4 residents (Resident #1 and #2) and was evidenced by the following:

According to the Facility's Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by the healthcare facilities to report incidents dated 9/22/2022, with an event date of 9/20/2022 and a "time of event" of 6:00 p.m., revealed the following: On 9/20/2022, at approximately 6:00 p.m., there was a Resident-to-Resident altercation between Resident #1 and Resident #2, and it was related to the Staff-to-Resident altercation between the

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F 600	Continued From page 8 CNA and Resident #2. These two events were reported at 6:20 p.m. on 9/22/2022. Upon notification of the Resident-to-Resident altercation on 9/22/2022, Resident #1 was moved to the opposite side of the unit from Resident #2. The Police was also notified of the Staff-to-Resident altercation. A review of the Medical Records (MR) for Resident #1 revealed the following: 1. According to the Admission Record (AR), Resident #1 was admitted to the facility on [NJAC 8:43E-2.1 and Exec Ord] with diagnoses which included but were not limited to [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] [redacted] According to the Minimum Data Set (MDS), an assessment tool dated 08/18/2022, Resident # 1 had no Brief Interview of Mental Status (BIMS) score, which indicated the Resident had a [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1] [redacted]. The MDS also showed Resident #1 needed [NJAC 8:43E-2.1 and Exec Ord] and [NJSA 47:1A-1 reasonable] [redacted] A review of Resident #1's Care Plan (CP) initiated on 5/24/2022 revealed under "Focus": Resident #1 is at risk for and/or has [NJAC 8:43E-2.1 and Exec Ord] [redacted] evidenced by the potential to be [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] Under "Goal," indicated: "The Resident will demonstrate effective coping skills through the review date.	F 600		

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F 600	Continued From page 9 The Resident will verbalize understanding of the need to contro NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. and noncompliance with care through the review date." Under "Interventions" included: "Administer medications as ordered. Monitor/document for side effects and effectiveness with a date initiated 05/24/2022. Analyze times of day, places, circumstances, triggers, and what de-escalates NJAC 8:43E-2.1 and E and document with a date initiated 05/24/2022, Assess and address for contributing sensory deficits, date initiated 05/24/2022, Assess and anticipate Resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc., date initiated 08/27/2022. Attempt redirecting Resident #1 when he/she becomes NJSA 47 1A-1 reasonable privacy expectation . If there is no success, remove other residents away for safety, date initiated 09/22/2022, Communication: Provide physical and verbal cues to alleviate NJSA 47 1A-1 rea . Give positive feedback, assist in verbalizing the source of agitation, and assist in setting goals for more NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . Encourage seeking out staff member when agitated; date initiated 05/24/2022, Monitor Resident #1 for NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. and attempted intervention in Behavior log; date initiated 05/24/2022. Psychiatric/ Psychogeriatric consult as indicated; date initiated 08/27/2022. A review of Resident #1's Progress Notes (PNs) revealed the following: On 9/23/2022 at 1:14 p.m., the Nurse Practitioner Progress Notes (NPPNs) written by the NP revealed Resident #1 was seen at the request of nursing. "Provider met with (the) patient [Resident], he/she is non-cooperative during the encounter, ...no visible injury noted on (the)	F 600		

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F 600	Continued From page 10 exposed area. Nursing denies any acute events." A review of Resident #1's PNs dated 9/23/2022 at 4:59 p.m. written by the Director of Nursing (DON) revealed a "Telephone call was placed to [the] resident's daughter to inform her of the resident-to-resident and room change." A review of Resident #1's PNs dated 9/23/2022 at 9:39 p.m., written by LPN #2, revealed Resident #1 was moved to another room. A review of the MR for Resident #2 revealed the following: 2. According to the AR, Resident #2 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses which included but were not limited to [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] According to the MDS, dated 9/8/2022, Resident # 2 had a BIMS score of [redacted], which indicated the Resident was [redacted]. The MDS also showed Resident #2 needed [redacted] NJSA 47:1A-1 reasonable privacy expectation. A review of Resident #2's CP initiated on 03/30/2022 revealed under "Focus": Resident #2 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] 9/20/2022 [Resident #2] was verbally	F 600		

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F 600	Continued From page 11 abusive/shoved a table toward another resident." Under "Goal": Resident #2 "will have a noted decrease in [NJAC 8 43E-2.1 and Exe] by the review date. Resident #2 will have fewer episodes of physical and verbal aggression towards other residents by the review date." Under "Interventions": "[NJAC 8 NJAC 8 43E-2.1 and Exec Ord] for safety/behavior PRN (as needed), date initiated 06/17/2022, Administer medications as ordered. Monitor/document for side effects and effectiveness, date initiated 09/27/2022. Anticipate and meet the Resident's needs, dated initiated 03/30/2022. Attempt to minimize episodes of target [NJAC 8 43E-2.1 and Ex] by anticipating Resident #2's needs, i.e. [for example] offer beverage of choice as appropriate, invite and assist to out-of-room activities of interest, offer assistance with ADLs as indicated, etc.; date initiated 07/04/2022. Caregivers should consider supportive interventions such as redirection, support/reassurance, reduced stimulation, allow Resident #2 to express his/her feelings, family involvement, etc ...; date initiated 06/17/2022. Caregivers to provide opportunity for positive interaction and attention. Stop and talk with Resident #2 as passing by; date initiated 06/17/2022; Encourage Resident #2 to approach staff with concerns about other residents and staff. Praise efforts, date initiated 09/22/2022. Explain all procedures to the Resident before starting and allow the resident time to adjust to changes; date initiated 03/30/2022. If reasonable, discuss the Resident's [NJAC 8 43E-2.1 and Exe] Explain/reinforce why [NJAC 8 43E-2.1 and E] is inappropriate and/or unacceptable to the Resident, date initiated 03/30/2022. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert	F 600		

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attention. Remove from situation and take to (an) alternate location as needed, date initiated 03/30/2022. Monitor [redacted] episodes and Attempt to determine (the) underlying cause. Consider location, time of day, persons involved, and situations. Document [redacted] and potential causes, date initiated 09/27/2022, Monitor target [redacted] date initiated 03/30/2022, pain assessment q (every) shift administer analgesic PRN (as needed), date initiated 09/27/2022, Praise any indication of the Resident's progress/improvement in [redacted] date initiated 03/30/2022, Provide a program of activities that is of interest and accommodates residents status. (easy listening music, sports/football, TV), date initiated 03/30/2022, S-COPE (Statewide-Clinical Outreach Program for the Elderly) eval [evaluation] and psych [psychiatrist] consult as needed, date initiated 06/17/2022, Resident #2 can be offered a cup of ice or small snack if he/she is becoming agitated, date initiated 08/08/2022."

A review of Resident #2's Physician's Order Form (POF) dated 09/2022 revealed a Physician's Orders (PO's) for [redacted] every shift r/t (related to) [redacted]

A review of Resident #2's Medication Administration Record (MAR) for 9/2022, revealed there were blank spaces for the entire month for [redacted] every shift, indicating the PO's order for [redacted] was not implemented.

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A review of Resident #2's PNs for July and September 2022 revealed the following:

On 9/15/2022 at 9:44 p.m., the Physician Progress Notes (PPNs) written by the Physician revealed Resident #2 "is intrusive and can escalate without warning. Staff are able to re-direct him/her ...cont. (continue) to monitor [NJAC 8:43E-2.1 and E]."

On 9/20/2022 at 8:24 p.m., the PNs, [NJAC 8:43E-2.1 and E]r Note" written by the RN, revealed Resident #2, "post-dinner became involved in hitting match with female Resident. Medicated and advised to go to his/her room, refused, stating, "I need (a) snack." Assessed for c/o (complaint of) pain and signs of injury none noted."

On 9/25/2022 at 5:20 p.m., the PNs, [NJAC 8:43E-2.1 and Exe] Note" written by LPN #3, revealed, "at 2:30 p.m. technician from came to do an [NJAC 8:43E-2.1 and Exec Or] for the pt.[patient] (resident). Pt refused to go to his/her room to get the Ultrasound done .. [NJAC 8:43E-2.1 and Exec Or] not done after several attempts."

On 10/6/2022 at 10:14 a.m., the Advanced Nurse Practitioner (ANP) 's Acute/Follow-up Visit revealed she had a DOS (Date of Service) on 9/23/2022 with Resident #2 "at the request of the facility DON for [NJAC 8:43E-2.1 an] on [NJAC] ([NJAC 8:43E-2.1 and Exec Order 26] h, [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.]). Resident #2 denies any pain or discomfort; nursing denies any [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.]), CP [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.], (and) [NJAC 8:43E-2.1 and E] [NJAC 8:43E-2.1 and] noted."

During an interview on 10/6/2022 at 9:02 a.m., Resident #2 stated, "I got in a fight. The CNA

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slammed me to the floor, and I didn't have a concussion; it happened in the dining room while I was waiting for my medication then I went to my room. When the CNA threw me to the ground, I hurt my whole [redacted] and my [redacted] I think it was my [redacted], and I had [redacted] on my [redacted]. He hit me because I put my tray into a girl. The CNA said, "Don't put your hands on a girl" (Resident #1). He just picked me up and threw me on the ground."

During an interview on 10/6/2022 at 9:02 a.m., Resident #4, who has a BIMS of 10 indicating he/she has moderate cognitive impairment and was present at the time of the incident, stated Resident #2 and the staff was fighting. Resident #4 hit the staff, and the staff put him down. The staff "put (Resident #2) face down on the floor and then beat him up."

During an interview on 10/6/2022 at 11:33 a.m., the Staffing Coordinator (SC) stated, "on the next day, the RN told her what happened. The RN stated she was in the ladies' room and heard something break. Then she saw Resident #2 on the floor, and the CNA was kicking him/her, so the RN told him to stop. The SC stated the RN said she didn't tell anyone because she did not want to get the CNA in trouble, so she verbally counseled him. The SC stated she asked the RN why she did not tell her Supervisor. The RN repeated she did not want to get the CNA into trouble. After the RN said this, I called the DON immediately, and she came down to the unit; it was the 3:00 p.m. - 11:00 p.m. shift, around 6:00 p.m."

During an interview on 10/6/2022 at 1:25 p.m.,

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F 600	Continued From page 15 the DON stated, "the SC was collecting assignment sheets when the RN told her between 6:00 p.m.-7:00 p.m. on 9/22/2022 the story of what happened." The DON explained that the SC then told her that the RN went to the bathroom on Pod B, on the opposite side of the unit, heard a plate [fall] on the floor, and heard a scuffle. She opened the bathroom door and saw the CNA kicking Resident #2. The RN yelled, "hey, hey," and the CNA stopped kicking the Resident mid-kick, and he stopped. The RN told the CNA that it could be considered abuse, and excessive force, so she counseled the CNA. In the same interview, the DON stated I asked the RN if she knew the nursing Supervisor, and she replied "yes," but she did not report to her because she was trying to protect the CNA." The DON continued to say the SC was there, and I called the Corporate Nurse to report it and the Police Department. The Police arrived between 9:00 p.m.-10:00 p.m., and I assessed Resident #2 and saw a [redacted] on his/her [redacted]. The DON asked the Resident what had happened, and he/she replied that he/she was sitting at the table. Resident #1 sat down and pushed the table into him/her, so he/she shoved the table back; then the CNA came across the room shouting at Resident #2, pushed the Resident to the floor, and began kicking him/her. The RN broke it up, and he/she retreated to his/her room. Resident #2 continued, "I don't know if I got anything for pain." The DON further stated, on 9/22/2022, Resident #2 could walk and had no pain. The RN was almost done with her shift, gave the report, and left. Both the RN and CNA are agency [staff] and have been placed on a "Do not return" list as of 9/23/2022.	F 600		

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During a telephone interview on 10/6/2022 at 1:48 p.m., the CNA stated that on 9/20/2022 at approximately 6:00 p.m., Resident #1 was aggravating Resident #2 and pushed the dining room table into Resident #2's chest. Resident #2 shoved the table back at Resident #1. Resident #2 then swung his/her fist at Resident #1, picked up the table, and threw the table, he (the CNA) caught the table in mid-air and swung the table around in the air. Resident #1 moved back, and he didn't know how Resident #2 ended up on the floor. The CNA explained Resident #4 (a third resident that was present at the time of the incident) was going after Resident #2 trying to protect Resident #1. The CNA continued to say I was in between Resident #4 and Resident #2. Then, I told Resident #2 to get his/her "ass off the floor," and the Resident started kicking. The CNA told him/her to go to his/her room. No other staff was present. The CNA continued to say, "I was yelling and screaming, the nurse (RN) was behind the nurse's station on the computer, and the nurse said to me, "you look like you had everything under control." He further stated, "I was in a panic. Resident #4 can punch [you] out. If he/she started punching me, I yelled out for help." The Nurse waited three days later to tell someone. If it was abuse, I would've been removed from the facility. On Friday, the Nurse complained about me with a resident to the staffing agency; I had never met her before. Why didn't the Nurse call the Supervisor? There was no report. She thinks I mentioned it to someone else. There was no incident report ... If you saw all this, why wasn't it written down? When I come in, I huddle with the residents; Resident #2 likes ginger ale. "I asked the Nurse why you didn't help me, and I told other aides later on - where were

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you at? The only visible [person] was the Nurse (RN), agency, like me." In the same telephone interview, when the Surveyor asked the CNA did he kick Resident #2, the CNA replied, "No, I did not kick the Resident. I had to stop the table from coming down on me. Resident #2 was 10 feet from me, and Resident #4 was 15 feet from me. Resident #4 hits and Resident #2 was on the floor, I had to tend to Resident #4 first, and I told Resident #2 to go to his/her room. I can take Resident #4 to his/her room. The table was swinging. The Nurse (RN) gave Resident #2 his/her medication. Resident #2 wanted his/her medication, but it was not time for it. Resident #2 gets rowdy with someone new. The CNA continued to say Resident #2 was at one table, and Resident #4 was sitting separately at another table. Then Resident #1 came up and aggravated Resident #2 ... even if the Nurse (RN) could not see it, she could still hear. I had no assistance; the only time I saw her was when everything was over. You had it under control, she said. I said I did not have it under control." The CNA continued, "I worked a double shift that night, 11:00 p.m. - 7:00 a.m. [shift] was calm. On Friday, I was called by the Staffing Agency for a complaint by the Nurse, and the facility called and asked me to email a statement about the incident. On 9/20/2022, the 11:00 p.m.- 7:00 a.m. shift nurse was LPN #1, a regular there, and nothing was mentioned to him about what happened. He got a report from the RN, I was sitting there, and she left." The facility gave us information on Abuse training in-service about three months ago with Resident to Resident, handle problems together; you never handle a situation by yourself."

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F 600	Continued From page 18 During a telephone interview on 10/11/2022 at 8:37 a.m., when the Surveyor asked the RN what happened on 9/20/2022, she stated the following: "I was in the bathroom, and I heard a plate fall on the floor around dinner time; I saw the CNA kicking Resident #2, who was already on the floor. I yelled, "hey, hey." The CNA is a 7-foot-tall guy, and no other staff was there. They were at lunch; it happened in the common area. I talked to the CNA and told him that is excessive force. The CNA replied that Resident #2 hit a woman, no name given to her, so that is why he used that force, and Resident #2 has a history of striking [a] nurse in the face, and he/she tends to be violent. Resident #2 was on the ground, and the CNA was kicking the Resident, but the CNA stopped when I yelled, "hey," and Resident #2 was shaken up after. The RN continued to say, "I wanted to tell the Supervisor, but I didn't. I told the night shift nurse (LPN #1) that Resident #2 was beaten up by the CNA. LPN #1 said that's the way Resident #2 is with [redacted]. I didn't know the facility protocol or that facility had a [redacted] unit, and I didn't know LPN #1's name. I thought that the CNA would be OK with my in-service on abuse. My training him was enough. She continued to say, "I thought the patient [Resident] was OK. Resident #2 did not complain of pain; I assessed him/her and wrote a note on the assessment." During the same telephone interview, the Surveyor asked the RN if she was protecting the CNA. The RN replied, "No, I wasn't protecting the CNA; this was the first time I worked with him, and the CNA stated this is how Resident #2 is with [redacted]" The RN explained the next day; she asked the SC if the CNA was here or did he	F 600		

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get suspended. The SC didn't know why the RN asked that question, so "I told her about the altercation with Resident #2 and the CNA." According to the RN, the SC said she had to call the DON. Then she asked me why didn't I call the DON or a Supervisor; "I told her that I didn't know the protocol or the facility's procedure. I wasn't trained in behavior or dealing with those people [residents]. I never knew the facility had a behavior unit; I'm an agency nurse and refuse to answer any more questions."

During a telephone interview on 10/12/2022 at 9:16 a.m., LPN #1 stated, "I was not present; I came into work, the Nurse [RN] told me something happened with the CNA and Resident #2, the CNA might have hit Resident #2 was reported to me by the Nurse (RN), she thought he [CNA] might have been rough with him/her. I don't remember the agency nurse's name, and I believe the CNA was on the assignment; I didn't check the previous [shift] assignment." LPN #1 further stated he thought the RN's exact words were the CNA was a little "rough" with Resident #2. When the Surveyor asked if being rough was abuse? LPN #1 replied "rough with a resident is abusive. But I didn't witness it...." When asked by the Surveyor if he told anyone else about the incident, LPN #1 stated, "No, I didn't tell anyone else; I didn't know I had to report it; I thought she [RN] reported it to the Supervisor. He further explained the RN did not tell him that she reported the incident to the Supervisor. But, he knew NJSA 47 1A-1 reasonable privacy expectation checks were initiated, and the RN was doing paperwork. "I assumed that she did an incident report, did it on the computer, and called a supervisor. I didn't report it because I assumed the 3:00 p.m. - 11:00 p.m.

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shift nurse [RN] did it ..." After it happened, Resident #2 said nothing to me; he/she did not complain of pain, and I did not see the CNA that night."

During a second interview on 10/12/2022 at 9:31 a.m., the DON stated, "the protocol for Abuse, [redacted], and [redacted] education is the same for the facility and agency staff." She continued, "when she assessed Resident #2, it was only documented in the FRE; there is no separate assessment." She stated there were "bluish discolorations to the calf, thigh, and pelvic area, followed up by the Nurse Practitioner (NP). As noted in the Abuse Policy, we don't have an Abuse Investigative Report. The CNA should never have done it, the CNA should have reported it to the Nurse, the Nurse should have said the resident-to-resident to the Supervisor, and it should never have escalated to a staff-to-resident.

During an interview on 10/12/2022 at 10:35 a.m., the NP stated, "I was asked to assess Resident #2 on 9/23/2022. Resident #2 did not complain of pain, and he/she did not tell me what happened. Because of his/her mental state, he/she was all over the place. Resident #2 asked me if the staff got fired, and I said, "yes," I saw his/her [redacted] on the [redacted] and [redacted]. She stated the [redacted] did [redacted]. They looked 24-48 hours old, with purple [color] around the surrounding tissue. I didn't measure the [redacted]; I just looked at them. I ordered a [redacted] near the [redacted] to check the [redacted]

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During an interview on 10/12/2022 at 2:08 p.m., the RN Supervisor (RNS) stated, "I wasn't aware until the next day. The Supervisor has to make sure the Resident is safe. The Nurse (RN) should have told me, and I would report it to the DON or Administrator. The investigation would come from me, and the Nurse (RN) writes the incident." She continued, "I was not aware of either incident, resident-to Resident or staff-to-resident, until 9/23/2022. It is a serious staff-to-resident. I was asked to write a statement."

During a second interview on 10/12/2022 at 3:50 p.m., the DON stated she could not find a "one-to-one for (Resident #2) done in September. She further stated the Resident stayed in his/her room after the incident and was not socializing. Resident #2 was not on one-to-one on the assignment sheet."

On 10/18/2022, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating facility staff on the Abuse Prevention Policy and Timely Reporting of Abuse. So, the noncompliance remained on 10/18/2022 as a level G for actual harm that is not immediate based on the following: the RN and CNA no longer work at the facility, and the facility staff has been educated on the Abuse Prevention Policy and Timely Reporting of Abuse.

A review of the facility policy titled "Abuse Prevention" with a reviewed/revised date 05/22 revealed the following: Under "Policy": included "It is the policy of the facility not [to] tolerate any form of Resident abuse, neglect, or exploitation by staff members, volunteers, visitors or family

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members, or by another resident. The facility will have an abuse prevention program that protects residents from physical and mental abuse, neglect, exploitation, misappropriation of property, and injuries of unknown origin in compliance with State and Federal regulations and the mission and philosophy of this facility. All employees are expected to immediately report any sign of injury sustained by a resident whether or not the nature of the injury is known. An employee witnessing any form of abuse is required to promptly report the incident to the Nurse or Supervisor. Any staff member failing to report an incident will be subject to disciplinary action which may include termination." " ...The following Definitions are acknowledged: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm or pain or mental anguish or deprivation by an individual of goods or services that are necessary for the Resident to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being. This presumes that instances of abuse of any reside, even those in a coma, cause physical harm, pain, or mental anguish. Physical Abuse: Any inappropriate physical contact with a resident, such as hitting, slapping, striking with an open or closed hand, pinching, biting, kicking, rough handling, pulling of hair, twisting of limbs, or punching. This also includes controlling behaviors through the infliction of corporal punishment. Verbal Abuse: Any use of oral, written, or gestured language which is threatening, profane, degrading, loud, and/or using nicknames when the Resident does not approve of them. This includes the willful use of disparaging or derogatory terms toward residents

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F 600	Continued From page 23 or their families, or within the hearing distance, regardless of their age, ability to comprehend, or disability. Verbal abuse includes, but is not limited to, threats of hard or comments to frighten a resident." Under "Reporting and Investigation Protocols" indicated: "Any employee of this facility who has knowledge of, or reasonable cause to believe or suspect that a resident is being, or has been a victim of mistreatment, abuse, neglect, exploitation or any other criminal offense shall report or ensure that a report is made of the alleged mistreatment or offense to the Administrator, the Director of Nurses or the charge nurse or Supervisor of the facility ...Suspected abuse or incidents of abuse are to be reported promptly to the Nurse in charge ...The charge nurse will document all pertinent information on the "Abuse Investigation Report, including the names of the individuals interviewed, description of the allegation, and assessment finding ..." A review of the updated facility policy titled "Accidents and Incidents" revealed the following: Under "Definition": included "Incidents and Accidents - any event or unusual occurrences that occur that may cause potential harm or injury to a resident which includes but not limited to falls, skin tears, bruises, etc." Under "Policy": included "All incidents and accidents will be recorded, investigated, and reported accordingly. Necessary interventions will be put in place to prevent reoccurrence." Under "Procedure":" 1. The facility staff will document all incidents and accidents, or unusual incidents experienced by the Resident on an Incident/Accident Report. 2. Any employee who witnessed any incidents/accidents or assigned to a resident with	F 600		

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potential or actual injuries must report their findings to the Nurse on the unit or the Nursing Supervisor. 3. The form must be completed immediately or no later than the shift that the incident occurred or when the event has been discovered." Under Procedure/Responsibility": "Unit Manager/Unit Nurse: He/she will be responsible for completing the incident or accident report and investigative report. The Unit Manager/Unit Nurse will be responsible for notifying the attending Physician and appropriate family member or contact person regarding the incident/accident. It is also the responsibility of the Unit Manager/Unit Nurse to determine any alleged mishandling and neglect. Any suspicions must be reported immediately to the DON or Administrator ...Certified Nursing Assistant: Any CNA who witnessed an incident/accident or found a reportable possible injury on a resident (i.e., falls, skin tears, hematomas (bruises), ecchymotic (skin discoloration) areas), must immediately notify the Nurse on the unit or the Nursing Supervisor. All nursing assistants that have contact or have provided direct or indirect care to the Resident must provide a written statement. All sections must be properly filled out. No section must be left blank. CNA statement must be submitted to the unit nurse or manager on the floor no later than the end of the shift when the incident/accident occurred or discovered."

A review of the facility policy titled "Physician Orders" with a last date reviewed 05/2022 revealed the following: Under "Policy": included "It is the policy of this facility to secure physician orders for care and services for residents as required by state and federal law. Physician

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F 600	Continued From page 25 orders will be dated and signed according to state and federal guidelines." A review of the facility policy titled "Mood & Behavior Monitoring" with a revised date of 05/2022 revealed the following: Under "Policy & Procedure" included "a. Mood and Behavior tracking documentation will be completed by the licensed nurse every shift, based upon comprehensive assessment outcomes, to identify any mood and behavior patterns, interventions attempted, outcome of approaches and side effects of medication ...d. Psychoactive Monitoring Form with behavior chart will be initiated for every resident who receives psychoactive, anti-anxiety, sedative or antidepressant medications as well as any patient without medical regiment but with new onset of behaviors."	F 600		
F 755 SS=D	N.J.A.C.: 8.39-27.1 (a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		11/7/22

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F 755	Continued From page 26 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: C#: NJ158549 Based on observations, interviews, medical record review, and review of other pertinent facility documents on 10/6/2022 and 10/12/2022, it was determined that the facility failed to follow the professional standards for nursing practice and administer a controlled drug and routine medications according to the Physician's Orders (PO's). The facility also failed to follow its policies titled "Physician Order" and "Documentation of Medication Administration." This deficient practice was identified for 2 of 4 residents (Resident #1 and Resident #2) reviewed and was evidenced by the following:	F 755	1. A. Resident #1 had no negative outcome relating to the deficient practice. Physician and family were notified about the discrepancy in the Medication Administration Record, unit manager ensured that the resident is getting the correct dose of medication as of 9/15/22. B. Resident #2 had no negative outcome relating to the deficient practice. 2. A. Any resident with an order for a change in dosage of medication is at risk to be affected by the deficient practice. An audit was done by the unit manager to ensure all residents are receiving the correct dosage. B. All residents receiving medications are at risk to be affected by the deficient	

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F 755	Continued From page 27 A review of the Medical Record was as follows: 1. According to the "Admission Record," Resident #1 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] According to the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 8/18/2022, Resident #1 had a Brief Interview of Mental Status (BIMS) score of [redacted], which indicated Resident #1 was [redacted]. The MDS also showed Resident #1 required [redacted] and NJSA 47:1A-1 reasonable privacy expectation A review of the "Physician's Order Form (POF)" for Resident #1 with a "Review Date" of 9/2022 included the following POs: [redacted] A review of a second "Physician Orders" for Resident #1 dated 8/21/2022 included the following PO's indicating the [redacted] was decreased as follows: [redacted] A review of Resident #1's "Medication Administration Record (MAR)" dated September	F 755	practice of blanks on the Medication Administration Record. An audit was done on resident charts to check for blanks on the Medication Administration Record. 3. A. Nurses were re-educated on medication dose changes. B. Nurses were re-educated on medication administration documentation. 4. A. Director of Nursing or designee will audit 3 residents' charts weekly for 30 days, and monthly for 60 days. All findings will be reviewed with the QAPI committee monthly for 3 months. B. Director of Nursing or designee will audit 3 residents' charts weekly for 30 days to check fro blanks on the Medication Administration Record, and monthly for 60 days. All findings will be reviewed with the QAPI committee monthly for 3 months.	

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F 755	Continued From page 28 2022 revealed under "Medications," [NJAC 8:43E-2.1 and Exec] [redacted] Under the spaces for the administering nurse's initials, the initials were filled in for 9/2/2022 through 9/14/2022 for 9:00 a.m. and 5:00 p.m., indicating the medication was administered as ordered. However, a review of the "Individual Patient Controlled Substance Administration Record (IPCSAR) - 90 doses" (a Narcotic Declining Sheet) with a "date received" of 8/16/2022 for [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] showed Resident #1 did not receive [NJAC 8:43E-2.1 and Exec O] [NJAC 8:43E-2.1 and Exec Or] [redacted] But, instead, he/she received [NJAC 8:43E-2.1 and Exec O] on the following dates and times: on 9/2/2022 and 9/7/2022 at 9:00 a.m., on 9/3/2022 at 9:00 a.m. and 1:00 p.m., on 9/5/2022 at 9:00 a.m. and 5:00 p.m., and on 9/6/2022 at 5 p.m. A review of the facility document titled "IPCSAR - 60 dose" with a "date received" of 8/16/2022 for [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] [redacted]. reveals the first dose of one tablet was taken on 9/15/2022 at 9:00 a.m. At the time of the survey, the Surveyor requested the Medication Declining Sheet for the [NJAC 8:43E-2.1 and Exec Ord] [NJAC 8:43E-2.1 an] [redacted] for 9/2/2022 through 9/14/2022. However, the facility was unable to provide the IPCSAR for these dates. A review of the facility document titled "Item Transaction Log by Department/Item" with a print date of 10/12/2022, under "Item: [NJAC 8:43E-2.1 and Exec O] [NJAC 8:43E-2.1 and Exec Order 26] [redacted]." revealed that the backup medication system "Medrex" had no [NJAC 8:43E-2.1 and Exec Ord] [NJAC 8:43E-2.1 and Exec Order 26, 4] [redacted] for the date range of 9/1/2022 through 10/12/2022 available in the "Medrex." A review of the facility document titled "Packing Slip Proof of Delivery" with a "Delivery Time:	F 755		

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F 755	Continued From page 29 9/15/2022" for Resident #1 revealed the [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] were not delivered to the facility until 9/15/2022. Further review of the "POF" for Resident #1 with a "Review Date" of 9/2022 included the following PO's: [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] dated 5/18/2022. [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] dated 5/18/2022. Pain assessment every shift (scale 0-10), 0 = no pain, 1-3 = mild pain, 4-6 = moderate pain, 7-10 = severe pain. A review of Resident #1's Medication Administration Record (MAR) dated September 2022, revealed that medications were not administered according to the PO's, as evidenced by the following: [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] on 9/6/2022 at 9:00 a.m. was blank. [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] 9/6/2022 at 9:00 a.m. was blank. Pain Assessment every shift for pain evaluation on a 0-10 scale, 9/19/2022 on the 3:00 p.m.-11:00 p.m. shift was blank.	F 755		

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F 755	Continued From page 30 2. According to the Admission Record (AR), Resident #2 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses which included but were not limited to [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated 9/8/2022, Resident # 2 had a BIMS score of [redacted], which indicated the Resident was [redacted]. The MDS also showed Resident #2 needed [redacted] and [redacted] A review of Resident #2's POF dated 10/2022 revealed the following PO's: [redacted] [redacted] A review of Resident #2's Medication Administration Record (MAR) for 10/2022 revealed the following blank spaces indicating the following medications were not administered as follows: [redacted] [redacted]	F 755		

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[redacted].

During an interview on 10/12/2022 at 11:15 a.m., a Licensed Practical Nurse (LPN #1) stated that the medication was not given if there is a blank space on MAR.

During an interview on 10/12/2022 at 11:20 a.m., the Unit Manager (UM) stated that the Physician ordered [redacted] to be [redacted] on 9/1/2022. She further stated that the new order should start right away when the medication is ordered. The UM explained that when the medication order was obtained, the prescription from the Doctor also needed to be faxed to the pharmacy by the nurse so the priscription could be filled. The UM further stated that the "MAR for [redacted]" and "the countdown sheet for Resident #1 [redacted] The UM continued by reading from the "IPCSAR - 90 doses" as follows: '[redacted]

NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.

During an interview on 10/12/2022 at 12:00 p.m., the Assistant Director of Nursing (ADON) stated in the presence of the Director of Nursing (DON) that the [redacted]. was signed out. But according to Resident #1's PO's, he/she should have received [redacted] The ADON further stated that this was a medication error. The DON indicated no Medication Declining Sheet for Resident #1's [redacted].

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F 755	Continued From page 32 During an interview on 10/12/2022 at 1:20 p.m., the Pharmacist stated the fax was received from the facility on 9/1/2022 but did not include an official doctor's prescription form with the Physician's signature, which is required because NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] The facility eventually faxed an approved form to the pharmacy on 9/12/2022. The pharmacy filled the prescription on 9/14/2022 and delivered the medication to the facility on 9/15/2022. During a second interview on 10/12/2022 at 2:05 p.m., the DON stated that the backup medication storage does not have any [redacted] Tablets are available, and we have not had any during September 2022. During an interview on 10/12/2022 at 2:30 p.m., the Pharmacy Consultant (PC) stated she had just started being the Pharmacy Consultant and visited the facility once on September 15, 2022, and was looking at records for the end of August and September of 2022. She further stated that during a visit, she reviewed MARs and POs for all the residents and said that for the next visit scheduled on 10/18/2022, she would bring two additional Pharmacists because "I need help." Since some of the records are electronic and others are on paper. The Surveyor asked if she should have noticed the discrepancy between the MAR and the Medication Declining Sheet. The PC stated that "there was a lot to look at" because she had just started and "it was my first time seeing all the residents" and "yes, I probably should have picked it up."	F 755		

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F 755	Continued From page 33 During an interview on 10/12/2022 at 3 p.m., LPN #2 stated that she did not give Resident #1 the [redacted] as ordered and should have "done the 5 rights before I do" and document if the Resident refused to take a medication, reported it to the Unit Manager, and contacted the Doctor. During the survey, the Surveyor attempted to contact the other nurses assigned to the residents, but they were unavailable for an interview. A review of the facility policy titled "Medication Administration Policy," created 4/2018 and the last date reviewed 8/5/2022, revealed under "Policy: All medications will be prepared (blister card, vials, etc.) and administered in a manner consistent with the general requirements outlined in this policy. [...] D: Medication Inspection: 1. Confirm that medication name and dose are correct" and "G: Prior to Medication Administration: 1. Verify each medication preparation that the medication is the RIGHT DRUG and the RIGHT DOSE [...] for the RIGHT CUSTOMER. 2. Verify that the MAR reflects the most recent medication order" and "J. Medication Administration: 4. As specified by federal and state regulations, controlled substances are documented as given at the time of administration.... K. After Medication Administration: 1. Document necessary medication administration/treatment information (e.g. when medications are administered, medication injection site, refused medications and reason, prn (as needed) medications, etc.) on appropriate forms."" A review of the facility policy created 12/ 2012	F 755		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 34 and last date reviewed on 5/2022 and titled "Physician Orders" reveals under "Policy: It is the policy of this facility to secure physician orders for care and services for residents as required by state and federal law. Physician orders will be dated and signed according to state and federal guidelines." Under "Procedure: [...] 2. Medication orders will include [...] c. dosage, d. frequency, [...] 9. Communicate orders to the pharmacy." A review of the facility document titled "Scriptwise Consultants, LLC Agreement" signed and dated by the Pharmacy President and Facility Administrator on 7/18/2022, revealed "Scriptwise Consultants, LLC shall be responsible for rendering the following consulting services to Home: a. Review the drug regimen of each resident in Home at least once each month and report in writing any irregularity to Home's Administrator, Director of Nursing Services, Medical Director and, where appropriate, the individual resident's physician." N.J.A.C:8:39-29.1(e)	F 755		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315280	A. Building B. Wing	11/18/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0600 Reg. # 483.12(a)(1) LSC	Correction Completed 11/07/2022	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 11/07/2022	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	
10/18/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO