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 03/23/2021

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#: NJ143348, NJ143758 CENSUS: 140 SAMPLE SIZE: 4	F 000		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		3/31/21

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

Electronically Signed | 04/19/2021

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F 690	Continued From page 1 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: C#: NJ143348, NJ143758 Based on observations, interviews, medical record reviews, and review of other pertinent facility documentation on 3/21/2021 and 3/23/2021, it was determined that the facility failed to provide incontinence care when needed to 2 of 4 residents (Resident #1 and Resident #4), and also applied [redacted]) to 3 of 4 residents (Resident #1, #2 and #4) reviewed for incontinence care and who required staff assistance. The facility also failed to follow its policy titled "Incontinence Brief/ Incontinent Care Policy/Procedure." This deficient practice was evidenced by the following: During an incontinent tour of the ventilation unit on 3/21/2021 at 6:15 a.m., with the Registered Nurse Supervisor (RNS) and the Registered Nurse (RN), the surveyors observed Resident #1 lying in bed double diapered with [redacted] briefs which were [redacted] soiled with [redacted]. Resident #1's [redacted], and the sheet was stained with a [redacted]. The surveyors continued the incontinent tour and at 6:35 a.m., the surveyor observed Resident #4 was [redacted] diapered with [redacted] dult briefs on that were soiled with [redacted]. At 6:45 a.m., the surveyor observed Resident #2 was [redacted] diapered with [redacted] adult briefs on. A review of the Medical Records (MRs) were as	F 690	1. Resident #1 was provided with proper incontinence care. [redacted] diapering for resident #1 was removed immediately; nursing staff on the floor were in-serviced on proper incontinence care immediately.Resident #1's incontinence plan of care was modified as following: 1) check resident every 2 hours and assist with toileting as needed; 2) provide peri care after each incontinence episode; 3) provide loose sitting easy to remove clothing; 4) observe pattern of incontinence and initiate toileting schedule as tolerated. Resident # 2 was provided with proper incontinence care. [redacted] diapering for the resident #2 was removed immediately; nursing staff were in-serviced on proper incontinence care immediately. Resident #2's incontinence plan of care was modified as following: 1) check resident every 2 hours and assist with toileting as needed; 2) provide peri care after each incontinence episode; 3) provide loose sitting easy to remove clothing; 4) observe pattern of incontinence and initiate toileting schedule as tolerated. Resident #4's [redacted] diapering was removed immediately; resident #4 was provided with proper incontinence care; nursing staff were in-serviced on proper incontinence care immediately.Resident	

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F 690	Continued From page 2 follows: 1. According to the "Admission Record (AR)," Resident #1 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] A review of the Minimum Data Set (MDS), an assessment tool dated [redacted], showed that Resident #1 had [redacted] problems. The MDS also showed Resident #1 required extensive assistance with transfers and Activities of Daily Living (ADLs) and was incontinent of [redacted]. A review of the Care Plan (CP) showed Under Focus: Resident #1 "...has an ADL Self Care Performance Deficit." Under Goal: "..needs will be met through the next review date." Under "Interventions," included: "Dependent on staff for all ADLs. Anticipate and meet needs." 2. According to the AR, Resident #2 was readmitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted]. A review of the MDS, dated [redacted], showed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was [redacted]. The MDS also showed Resident #2 required extensive assistance with transfers and ADL and was incontinent of [redacted].	F 690	#4's incontinence plan of care was modified as following: 1) check resident every 2 hours and assist with toileting as needed; 2) provide peri care after each incontinence episode; 3) provide loose sitting easy to remove clothing; 4) observe pattern of incontinence and initiate toileting schedule as tolerated. 2. All residents have the potential to be affected by the same deficient practice. 3. All residents with incontinence care will be checked for [redacted] diapering if any. All incontinent residents will have incontinence plan of care with following interventions: 1) check resident every 2 hours and assist with toileting as needed; 2) provide peri care after each incontinence episode; 3) provide loose sitting easy to remove clothing; 4) observe pattern of incontinence and initiate toileting schedule as tolerated. All nursing staff will follow facility's policy and procedures on proper and timely incontinence care for residents who require such as per care plan. Nursing staff were in-serviced on proper incontinence care on 3/21/2021. All nursing staff will be in-serviced on following facility's policies and procedures regarding proper incontinence care by 3/31/2021 and quarterly/as needed. 4. Unit Managers/Designee will conduct daily random checks/ audits of the nursing incontinence care in all units to insure that nursing staff do not have [redacted] diapering while providing incontinence care.	

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F 690	Continued From page 3 A review of the Care Plan (CP) revised [redacted] showed Under Focus: Resident #2 was "incontinent of bowel." Under Goal: [redacted] Under "Interventions," included "[redacted]" Further review of the CP initiated [redacted] revealed under focus the resident "has an ADL deficit related to decrease strength, coordination and endurance..." Under "Goal" included "(Resident #2) ill improve ADLs..." Under "Interventions" included OT (Occupational Therapy) ..." 3. According to the AR, Resident #4 was readmitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted]. A review of the MDS, dated [redacted], showed that Resident #4 had [redacted] problems. The MDS also showed Resident #4 required extensive assistance with transfers and ADLs and was incontinent of [redacted]. A review of the CP showed Under Focus: "(Resident #4) is incontinent of [redacted]." Under Goal included " ...will have no complications r/t (related to) incontinence through review date." Under Interventions": included: "... Frequent incontinence checks and incontinence care through the next review date ..." During an interview on 3/21/2021 at 6:15 a.m.,	F 690	DON/Designee will conduct spot audits on proper incontinence care. Audits will be conducted weekly X 4 weeks, then bi-weekly X 4 weeks, then monthly. Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate.	

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F 690	Continued From page 4	F 690		

the RN stated Resident #1 was changed 40 minutes ago and "I never told the aide to [redacted] diaper a resident."

During an interview on 3/21/2021 at 6:20 a.m., the surveyor asked the RNS if [redacted] diapering was the facility's policy. The RNS stated, "it is not the policy to [redacted] diaper."

During an interview on 3/21/2021 at 6:22 a.m., the Certified Nursing Assistant (CNA) stated that residents are changed three times a shift. The CNA indicated, you have to know your residents, only if a resident is a [redacted], he/she is [redacted] diapered. The CNA indicated if a resident has [redacted] diapers on when he removes the diapers then performs incontinence care, then reapplied [redacted] diapers on the resident. The CNA explained Resident #1 had on [redacted] diapers when he did his rounds; he removed the [redacted] diapers and applied [redacted] more clean diapers. Also he stated Resident #1 was wearing [redacted] diapers because the resident was a [redacted]. The CNA continued to explain he changed the residents at least ever two hours but was unable to give a time for the changes.

During an interview on 3/21/2021 at 6:35 a.m., the RNS stated, "I don't know why (residents) are being [redacted] diapered."

During an interview on 3/21/2021 at 6:55 a.m., the RN stated that [redacted] diapering is not our policy.

During an interview on 3/21/2021 at 9:55 a.m., Resident # 2 stated he/she gets changed once or twice a shift and it was not his/her idea to be [redacted] diapered.

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F 690	Continued From page 5 During an interview on 3/21/2021 at 10:48 a.m., the Unit Manager (UM) stated residents are changed every 2 hours and as needed. The UM explained, "Residents should not be [redacted] diapered; it is not the policy." During an interview on 3/21/2021 at 12:47 p.m., the Director of Nursing (DON) stated that [redacted] diapering is not the facility's policy. A review of the facility's policy titled "Incontinence Brief/Incontinent Care Policy/Procedure" undated showed under "Policy: It is the policy of the Nursing Department of (facility name) to provide dignity, mobility and maintain skin integrity for the incontinent resident." Under "Procedure:" "10. Resident must be changed when wet." N.J.A.C. 8:39 27.1 (a)	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: C#: NJ143758 Based on interviews, medical record review, and review of other pertinent facility documentation on 3/21/2021 and 3/23/2021, it was determined that	F 695	1. For the resident # 2 [redacted] Flow sheets with all provided treatments, times and how the resident tolerated the treatment were completed for every four hours immediately. For resident # 2 all services provided and	3/31/21

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F 695	Continued From page 6 the facility failed to follow the resident's care plan and Physician's Order related to the administration of treatment for 1 of 4 residents (Resident #2) for [redacted]. The facility also failed to follow its policies titled "Documentation Policy/Procedure," "Charting and Documentation," and "Job Description [redacted] Staff Therapist." This deficient practice was evidenced by the following: Review of the Medical Record (MR) were as follows: According to the "Admission Record (AR)," Resident #2 was initially readmitted 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 dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident was cognitively intact. The MDS also showed Resident #2 required assistance with Activities of Daily Living (ADLs). Review of Resident #2's Care Plan (CP) dated [redacted] showed the following: Under: Focus: "(Resident #2) is [redacted]. Under Goal included: "(Resident #2) will remain free of complications [redacted], ..." Under: Interventions included: "Administer [redacted] treatment as ordered. Assess for s/sx	F 695	medications administered as per physician orders and resident's care plan were documented in the resident's clinical records, including care-specific details, the date time the procedure/treatment was provided and how the resident tolerated the procedure/treatment. [redacted] Flow sheets for the rest of the residents in vent unit completed every four hours, reflecting all procedures/treatment provided and medications administered as per physician orders and care plan, including care-specific details, the date time the procedure/treatment was provided and how the resident tolerated the procedure/treatment. 2. All vent residents have the potential to be affected by the same deficient practice. 3. DON/Lead Respiratory Therapist will conduct audit to all flow sheets to identify missing documentations if any. Respiratory therapists will complete [redacted] flow sheets and to document all prescribed treatments as per facility's policies and procedures. On 3/23/2021, Respiratory Therapists were in-serviced on following physician's order and care plan for [redacted] procedures/treatments and proper documentations of [redacted] procedures/treatment, including that all observations, medications administered, services performed, etc. must be documented in the resident's clinical records and documentation of procedures and treatments shall include care-specific details and shall include at a minimum the	

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F 695	Continued From page 7 (signs or symptoms) of [redacted] ... Monitor [redacted]. Observe/ document for use of [redacted] ... [redacted] reading ever shift or more frequently as needed ..." A review of the "Medication Orders" [redacted] revealed that Resident #2 had a Physician's Order (PO's) for [redacted] hours PRN (as needed) for [redacted]. A review of a facility "Statement" dated [redacted] and untimed from the Respiratory Therapist (RT) revealed that Resident #2 "was [redacted]. I went into the room and [redacted] (Resident #2) for a [redacted] ..." Further review of Resident #2's MR showed no evidence that the resident was assessed or given the [redacted] treatment for [redacted] as prescribed by the Physician. During an interview on /3/23/2021 at 2:20 p.m., the Lead Respiratory Therapist (LRT) indicated that the resident is assessed by the RT when a resident [redacted]. The LRT explained the resident's [redacted] and [redacted] are checked by the RT, and the medications are reviewed and given as ordered. The LRT also stated that if the resident's had an [redacted], this should be documented in the resident's MR in point click care (PCC) and what was done for the resident. During a post-survey telephone interview on 3/29/2021 at 9:05 a.m., the RT stated Resident	F 695	date time the procedure/treatment was provided and how the resident tolerated the procedure/treatment . All Respiratory therapists will be in-serviced on following physician's order and care plan for [redacted] procedures/treatments and proper documentation of [redacted] procedures/treatment, including that all observations, medications administered, services performed, etc. must be documented in the resident's clinical records and documentation of procedures and treatments shall include care-specific details and shall include at a minimum the date time the procedure/treatment was provided and how the resident tolerated the procedure/treatment by 3/31/2021, then quarterly/as needed. 4. DON/Lead Respiratory Therapist will conduct spot audits of [redacted] [redacted] sheets and [redacted] progress notes for proper documentation of the provided treatments. Audits will be conducted weekly X 4 weeks, then bi-weekly X 4 weeks, then monthly. Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate.	

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F 695	Continued From page 8	F 695		

#2 [redacted], and he assessed the resident but he did not always document what he did for the residents. The RT explained he did not give Resident #2 his/her [redacted] treatment because the resident requested his/her [redacted].

A review of the "Policy-Procedure Manual" titled "Job Description Respiratory Staff Therapist" dated August 2020 showed under "Policy: A non-exempt healthcare professional employed at the Individual [redacted] Unit per Facility responsible for the direct administration and care of residents ordered for respiratory care within the scope of respiratory care services. This responsibility includes but not limited to, the following primary duties: ... Complying with Policy and Procedure regarding medical record documentation ... Provides timely, accurate and effective resident respiratory evaluations in response to care needs ..."

A review of the facility's policy titled "Documentation Policy/Procedure" Therapist" dated 03/2019 showed under "Policy: It is the policy of this facility that all extemporaneous events, relative to a resident's condition, behavior or response to treatment(s), be documented in the Interdisciplinary Progress Notes (IPN) As such, the resident's medical record will reflect on a continuum-... Moreover, documentation in the IPN must reflect assimilation of communication amongst and between disciplines."

A review of the facility's policy titled "Charting and Documentation" dated 03/2019 showed under "Policy Statement All services provided to the resident, or changes in the resident's medical or mental condition, shall be documented in the resident's medical record." Under; 'Policy Interpretation and Implementation' included "1. All

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F 695	Continued From page 9 observations, medications administered, services performed, etc., must be documented in the resident's clinical records. 6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: a. The date and time the procedure/ treatment was provided; d. How the resident tolerated the procedure/ treatment;	F 695		
F 757 SS=D	N.J.A.C: 8:39-27.1 (a) Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: C#: NJ143758	F 757	1. Resident # 2 was re-evaluated by the	3/31/21

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F 757	Continued From page 10 Based on interviews, Medical Record review, and review of other pertinent facility documentation on 3/21/2021 and 3/23/2021, it was determined that the facility failed to obtain a Physician's Order for the administration of a PRN (as needed) [redacted] medication after the order has expired. The facility also failed to adequately monitor and document the indication for the medication administration and it's effectiveness for 1 of 4 residents (Resident #2). Also, the facility failed to follow its policies titled "Medication Administration-Policy and General Guidelines, and "Job Description Charge Nurse." This deficient practice was evidenced by the following: During an incontinent tour on 3/21/2021 at 6:45 a.m., the surveyor observed Resident #2 was [redacted] diapered with [redacted] adult briefs on. During an interview on 3/21/2021 at 9:55 a.m., Resident #2 stated [redacted] was given [redacted] by the nurse, which [redacted] did not request, and was told by the nurse it was given to calm [redacted] down. A review of the Medical Record (MR) were as follows: According to the "Admission Record (AR)," Resident #2 was readmitted 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 dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS)	F 757	psychiatrist immediately. Resident # 2's [redacted]) was re-ordered immediately. 2. All residents have the potential to be affected by the same deficient practice. 3. Unit Managers will conduct audits on timely order/re-order of medications to identify discrepancies if any. Nursing staff will continue to order/re-order medications as per facility's policy and procedures and in accordance with State and Federal regulations to ensure the safe, accurate and timely administration of medications. Nursing staff were in-serviced on facility policies and procedures on medication administration policy and general guidelines on 3/23/2021. All nursing staff will be in-services on medication administration policy and general guidelines to ensure the safe, accurate and timely administration of medications by 3/31/2021, then quarterly/as needed. 4. DON/Designee will conduct random audits on medication orders to ensure that medications ordered/re-ordered in accordance with facility's policies and procedures and State and Federal regulations. DON/Designee will conduct audits weekly X 4 weeks, then bi-weekly X 4 weeks, then monthly. Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate.	

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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
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score of [redacted] which indicated the resident was [redacted]. The MDS also showed Resident #2 required assistance with Activities of Daily Living (ADLs) and was incontinent of [redacted]

A review of the Care Plan (CP) showed under Focus: "(Resident #2) uses [redacted] medications r/t (related to) [redacted] Under Goal included: "(Resident #2) will show decreased episodes of s/sx (signs/ symptoms) of [redacted] Under Intentions included: "... Monitor/ document side effects and effectiveness. [redacted] Side Effects: [redacted]

A review of the "Medication Orders" dated [redacted] revealed a Physician's Order (PO) for [redacted] (hours) PRN for [redacted] (times) 14 days then re-eval (reevaluate) need. This PO indicated the facility staff should have given the medication from [redacted] through [redacted]

A review of two "Individual Patient Controlled Substance Administration Record" (IPCSAR) with a received date of [redacted] and [redacted] revealed Resident #2 was administered [redacted] mg Tab (tablet) a total of six times after the discontinued date without a PO as follows: On [redacted] at 1:00 a.m., [redacted] at 9:00 p.m., [redacted] at 4:00 p.m., [redacted] at 2:45 p.m., [redacted] at 12:00 p.m. and [redacted] at 6:45 a.m. A review of the MR showed the resident had no new PO for the administration of [redacted] until [redacted] on the 7:00 a.m.-3:00 p.m. shift.

Review of Resident #2's MR also showed no documentation for the indication of use and the medication administration's effectiveness on [redacted],

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F 757	Continued From page 12 [redacted] and [redacted] During an interview on 3/23/3021 at 1:15 p.m., the Charge Nurse (CN) stated Resident #2 had an [redacted] order for 14 days. The CN explained when a medication such as [redacted] is ordered for a specific timeframe; the medication is rewritten or reordered as the doctor deems appropriate. During a second interview on 3/23/2021 at 1:20 p.m., after reviewing Resident #2's chart, the CN stated it looks like the medication was not reordered. The CN explained it was the nurse's responsibility to notify the doctor of the need to reorder the medication. During an interview on 3/23/2021 at 2:06 p.m., the Director of Nursing (DON) stated she was just informed of the [redacted] given without a PO. The DON explained if a PO expired, it is d/c'd (discontinued). The DON also stated during a second interview at 4:09 p.m., when a medication is ordered and has an expired date, the date is blocked off, so the nurses are aware of the stop date. During a post-survey telephone interview on 3/24/2021 at 11:07 a.m., the Licensed Practical Nurse (LPN), who administered the [redacted] on 3/21/2021 at 6:45 a.m., stated Resident #2 was [redacted] and requested an [redacted], so she administered the medication. The LPN indicated she was not aware the PO had expired. The LPN stated she looked at the medication on the declining narcotic sheet then gave the medication but did not look to see how long the medication was ordered for or the stop date. The LPN explained that when a PRN medication is given, she documents the resident signs and symptoms before the administration	F 757		

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and the medication's effectiveness after it has been administered in the Progress Notes (PN). However, the PN review showed no LPN documentation on 3/21/2021 at 6:45 a.m. for the [redacted] administration.

During a post-survey telephone interview on 3/24/2021 at 2:35 p.m., the [redacted] Nurse Practitioner [redacted]) stated he was not aware the [redacted] was given without a PO after the discontinued date. The [redacted] stated he provides the medication's recommendations after the discontinued date, and then the physician orders the medications.

During a post-survey telephone interview on 3/29/2021 at 9:05 a.m., the Respiratory Therapist (RT) stated the LPN asked him to assess the resident for [redacted]. The RT stated he then assessed the resident's [redacted] and his/her [redacted] levels were normal. The RT stated Resident #2 said he/she was having [redacted] and requested an [redacted] so he informed the nurse.

A review of the facility's policy titled "Medication Administration-Policy and General Guidelines" reviewed/revised dated 07/18, revealed under "Policy" included "Medications are administered, as prescribed, in accordance with good nursing principles and practices, and only by persons legally authorized to do so. Medications are administered in accordance with State and Federal regulations. Under "Purpose: To ensure the safe, accurate and timely administration of medications." Under "Procedure:" includes: "Medications are administered as per the licensed prescriber... Documentation in the MAR for PRN medications includes: -complaints or symptoms for which medication was given -results achieved from giving the dose ..."

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F 757	Continued From page 14 A review of the "Job Description Charge Nurse" revised: June 2020, revealed under "Job Summary: In cooperation with Nursing Administration, the charge nurse position ensures that a consistently high-quality level of care is delivered throughout the nursing facility." Under "Main Duties ...j. Oversees residents' medications which includes seeing that refills are ordered as necessary and that all medications are handled in accordance with the written policy on medications...m. Reports all problem and incidents as soon as possible to the Director of Nursing Services (DON) ..."	F 757		
F 842 SS=E	N.J.A.C. 8:39 27.1 (a) Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		3/31/21

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F 842	Continued From page 15 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

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F 842	Continued From page 16 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: C#: NJ143758 Based on observation, interviews, medical record reviews, and review of other pertinent facility documentation on 3/21/2021 and 3/23/2021, it was determined that the facility failed to maintain accurate medical records documentation that reflected the status of the residents and adhere to the acceptable standards of nursing practice for 3 of 4 residents' (Resident #1, Resident #2 and Resident #4). The facility also failed to follow its policies titled "Charting and Documentation" and "Documentation Policy/Procedure." This deficient practice was evidenced by the following: During an incontinent tour on 3/21/2021 at 6:45 a.m., the Surveyor observed Resident #1 in bed with [redacted]. Review of the Medical Records (MRs) is as follows: 1. According to the facility Admission Record (AR), Resident #1 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] A review of the Minimum Data Set (MDS), an assessment tool dated [redacted], showed Resident #1 had [redacted]	F 842	1. - All 24 identical resident # 1's progress notes (PN) documentations dated [redacted] at 4:42am, [redacted] at 3:40am, [redacted] at 7:38am, [redacted] at 3:31am, [redacted] at 5:38am, [redacted] at 7:47am, [redacted] at 5:07am, [redacted] at 7:52am, [redacted] at 7:45am, [redacted] at 2:39am and [redacted] at 12:44am, [redacted] at 7:15pm, [redacted] at 11:15pm, [redacted] at 7:24pm, [redacted] at 11:21pm, [redacted] at 6:33pm, [redacted] at 6:26pm, [redacted] at 6:12pm, [redacted] at 8:17pm, [redacted] at 6:22pm, [redacted] at 3:29pm, [redacted] at 3:28pm, [redacted] at 2:45pm, [redacted] at 3:09pm were corrected with in PCC immediately. All corrected notes reflected all provided care/treatment, eliminating identical writing pattern and that resident #1 no longer had a [redacted]. - For resident # 2 identified 2 identical PNs documentation dated [redacted] at 8:42pm and [redacted] at 10:59pm were corrected in PCC immediately to reflect provided care/treatment, eliminating identical writing pattern. - For resident # 4 identified 3 identical PNs documentation dated [redacted] at 3:23pm, [redacted] at 11:24am and [redacted] at 12:03pm were corrected in PCC immediately to reflect provided care/treatment, eliminating identical writing pattern.	

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F 842	Continued From page 17 [redacted] problems. The MDS also showed Resident #1 needed extensive assistance with Activities of Daily Living (ADLs). Review of Resident #1 Progress Notes (PNs) for [redacted] revealed the documentations were exactly the same as follows: The Surveyor identified a total of 11 identical PNs documentations dated [redacted] at 4:42 a.m., [redacted] at 3:40 a.m., [redacted] at 7:38 a.m., [redacted] at 3:31 a.m., [redacted] at 5:38 a.m., [redacted] at 7:47 a.m., [redacted] at 5:07 a.m., [redacted] at 7:52 a.m., [redacted] at 7:45 a.m., [redacted] at 2:39 a.m. and [redacted] at 12:44 a.m. The PNs documentation showed "Note text: Skilled Needs include: [redacted], VSS (vital signs stable), afebrile (no fever), resting calmly, [redacted] Not able to participate. [redacted] tolerated well, incontinent of bowel and bladder, provided incontinent care and comfort measures. [redacted] The Surveyor identified a total of 9 identical PNs documentations dated [redacted] at 7:15 p.m., [redacted] at 11:15 p.m., [redacted] at 7:24 p.m., [redacted] at 11:21 p.m., [redacted] at 6:33 p.m., [redacted] at 6:26 p.m., [redacted] at 6:12 p.m., [redacted] at 8:17 p.m., and [redacted] at 6:22 p.m. The PNs documentation showed "Note Text: Skilled Needs include: [redacted]	F 842	2. All residents have the potential to be affected by the same deficient practice. 3. Unit Managers will conduct documentation audit to identify and correct cut and pasted PNs if any. Nursing staff were in-serviced on facility policies and procedures on proper documentation in PCC and not having any PN cut and pasted at any time on [redacted]. All nursing staff will be in-serviced on facility's policies and procedures on proper documentation and not having any PN cut and pasted in PCC at any time by [redacted] and then quarterly/as needed. Nursing staff will follow documentation policy/procedures and not having cut and paste any PN in PCC. 4. DON/Designee will conduct random audits of the PNs in PCC to ensure proper PN documentation in PCC. Audits will be conducted weekly X 4 weeks, then bi-weekly X 4 weeks, then monthly. Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate.	

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[redacted]. Complete to care. HOB (head of bed) elevated. Turned to sides q (every) 2 hours. Kept clean and dry. Maintained on [redacted]. Still with [redacted]. Daily dressing done. [redacted] maintain by RT (Respiratory Therapy). No coughing heard. No resp (respiratory) distress noted. [redacted]. Resident incontinent of [redacted])."

The Surveyor identified a total of 4 identical PNs documentation dated [redacted] at 3:29 p.m., [redacted] at 3:28 p.m., [redacted] at 2:45 p.m., and [redacted] at 3:09 p.m. The PNs documentation showed "Note Text: Skilled Needs include: Physical Therapy, Occupational Therapy, Speech Therapy, Respiratory Therapy, Resident is in [redacted] Resident is incontinent of [redacted]. [redacted] cleanse, apply [redacted], cover with gauze and bordered gauze, change daily and PRN (as needed) soiling or [redacted] rendered by [redacted]. Resident incontinent of [redacted]

The MR for revealed Resident #1 was admitted on [redacted] with a [redacted] The PN also revealed the [redacted] was healed on [redacted], indicating the resident was not

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assessed. The documentation of the [redacted] treatments being done was inaccurate for all of the PNs mentioned above. The exact repetition of the PNs also indicated that the PNs were copied and paste.

2. According to the AR, Resident #2 was readmitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted].

A review of the MDS, an assessment tool dated [redacted], showed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was [redacted]. The MDS also showed Resident #2 required extensive assistance with transfers and ADLs.

Review of Resident #2's PNs for [redacted] revealed the documentations were exactly the same as follows:

The Surveyor identified 2 identical PNs documentation dated [redacted] at 8:42 p.m. and [redacted] at 10:59 p.m. The PN showed "Note Text: Skilled Needs include: Physical Therapy, Occupational Therapy, Respiratory Therapy, [redacted] Therapy, [redacted], Pt (patient) is alert and oriented [redacted] as needed for PRN [redacted] Dressing to [redacted] done. No [redacted] & and intact. Medication education provided [redacted] daily and PRN soilage/dislodgement. Followed by [redacted]

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NP (Nurse Practitioner) weekly. Remains [redacted] as maintained by RT. [redacted] when laying flat. Occasional cough treated with PRN [redacted] tolerating regular/thin liquid diet with scant intake. Receiving [redacted]. Incontinent of [redacted] w (with)/ care rendered. LTC. 24-hour Nursing and respiratory care to continue to meet resident's needs."

3. According to the AR, Resident #4 was readmitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted].

A review of the MDS, an assessment tool dated [redacted], showed that Resident #4 had [redacted] problems. The MDS also showed Resident #4 required extensive assistance with transfers and ADLs.

Review of Resident #4's PNs for [redacted] revealed the documentations were exactly the same as follows:

The Surveyor identified 3 identical PNs documentation dated [redacted] at 3:23 p.m., [redacted] at 11:24 a.m., and [redacted] at 12:03 p.m. The PN showed "Note text: Skilled Needs include: Physical Therapy, Speech Therapy, Respiratory Therapy, [redacted] therapy, [redacted], [redacted], [redacted] (intravenous) medications, [redacted], [redacted]. [redacted] ([redacted]

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[redacted]. Refer to [redacted] note for details. Monitored by RT. [redacted] secondary to [redacted] Incontinent of stool, incontinent care provided. LTC [redacted]."

During a telephone interview on 3/23/2021 at 10:48 a.m., the MDS Coordinator/ Registered Nurse (RN)stated the PNs were only updated if a change in condition was noted. The MDS Coordinator also stated that the nurse could copy the same note if the resident had no changes.

During an interview on 3/23/2021 at 4:00 p.m., the Director of Nursing (DON) stated, "I do not tell staff to copy and paste notes when there are no changes. There is no reason to do it."

During a post-survey telephone interview on 3/24/2021 at 9:00 a.m., the RN stated, she "did copy and pasted the (progress) notes." The RN stated coping and pasting PNs are not part of the facility's policy. The RN indicated Resident #1 had a [redacted] but no longer had a [redacted]; therefore, the documentation in the PNs of the resident having a [redacted] was incorrect.

Review of the facility policy titled "Charting and Documentation" dated 3/2019 revealed under "Policy Statement" "All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record." Under "Policy Interpretation and Implementation" "1. All observations, medications administered, services performed etc., must be documented in the resident's clinical records ...6. Documentation of procedures and treatments shall include

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care-specific details and shall include at a minimum: ...c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment;"

Review of the facility policy titled "Documentation Policy/Procedure" dated 3/2019 revealed under "Policy: It is the policy of this facility that all extemporaneous events, relative to a resident's condition, behavior or response to treatment(s), be documented the Interdisciplinary Progress Notes ....Moreover, documentation in the IPN must reflect assimilation of communication amongst and between disciplines." Under "Procedure: 1. Pursuant to the Policy and Procedure for the IPN, all professional disciplines are to document accordingly. 2. It is recommended that IDT noting be utilized as a means for recording in the medical record. 3. Documentation must address both new positive or negative events, e.g. resident's favorable response to a medication and/or negative response ..."

N.J.A.C.: 8:39-35.2(k)