STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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 #: NJ149361, NJ150335, NJ152254, NJ152699 and NJ154513 Census: 282 Sample Size: 13 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure care was provided in accordance with accepted standards of nursing practice, as evidenced by failure to ensure physician's medication orders were accurately transcribed and followed for 1 (Resident #1) of 4 sampled residents reviewed for accuracy of medication administration. Findings included: A review of an "Admission Record" revealed the	F 684	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE. Resident #1 was assessed by Nursing and by Attending Physician, The physician discontinued the [redacted] and decreased the dose of [redacted]. No harm to the resident. The resident continued to be closely monitored with no ill effects observed. The responsible party was	8/22/22

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

Electronically Signed | 07/21/2022

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F 684	Continued From page 1 facility admitted Resident #1 with diagnoses that included [redacted]. The significant change Minimum Data Set (MDS), dated [redacted] revealed Resident #1 scored [redacted] on a Brief Interview for Mental Status (BIMS), which indicated [redacted]. Per the MDS, the resident was able to make his/her needs known and was able to understand others. The resident required extensive assistance with activities of daily living (ADLs). A review of Resident #1's care plan, dated [redacted], revealed Resident #1 had a potential for [redacted] with interventions to offer/administer as needed (PRN) analgesics as ordered. Resident #1 had a focus of [redacted] and [redacted], had a recent hospitalization, and had a history of refusing [redacted]. Review of a hospital discharge medication list dated [redacted] revealed orders including [redacted] It is also used to treat other conditions such as [redacted] and [redacted]). The directions were to	F 684	notified. Nursing Staff education was immediately initiated and completed on [redacted]. The nurse responsible for the transcription error of the medication [redacted] received 1:1 education on January 7, 2022 and was monitored for the three months following the error [redacted]. Additionally, the nurse responsible for the transcription error was to complete only one admission a month for three months following the error. The admissions were audited by the Quality Assurance Director and no further errors were discovered. Education was completed on [redacted] for all licensed nurses regarding transcribing physician orders. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. Any resident that was assigned to the nurse who made the transcription error had the potential to be affected. The facility Quality Assurance Director completed an audit for the three months following the error ([redacted], [redacted] and [redacted]) on the admissions that the nurse was completing. No other residents were identified as affected by this practice.	

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F 684	Continued From page 2 administer [redacted] milligrams (mg) by mouth every four hours as needed (PRN) for [redacted] A review of the [redacted] "Medication Administration Record (MAR)" revealed the order was transcribed as follows: [redacted] tablet [redacted] mg [redacted]), give one tablet by mouth every four hours for [redacted], with a start date of [redacted], and a discontinued (D/C) date of [redacted]. Nurses indicated on the MAR that the medication was administered every four hours, for a total of nine doses on [redacted] and [redacted]. A review of "Progress/Physician Progress Notes," dated [redacted] revealed the chief complaint/nature of the presenting problem was a [redacted] status change. The notes indicated the patient's family member reported the resident did not recognize him/her today. The patient had been [redacted] and had a [redacted]. When the physician spoke to the resident, the resident was awake and recognized the physician. The physician reviewed the resident's medications and noted the [redacted] dose was increased in [redacted]. The physician also noted there was an order in the chart for [redacted] mg every 4 hours routine (instead of PRN). The physician discontinued the [redacted] order and decreased the dose of [redacted]. A review of an "Error Report," dated [redacted], indicated Registered Nurse (RN) #1 had erroneously transcribed the frequency of the [redacted] order as a routine medication (every four hours) as opposed to an as-needed medication (every four hours as needed for [redacted]). The report indicated the error had been discovered by Physician (MD) #1. The report	F 684	WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR. The Facility Educator or Designee will provide re-education to the licensed nursing staff on the policy for transcribing medication orders and Physician orders by 8/22/2022. The Unit Managers and ADON or Designee will conduct an audit on the transcription of orders for all new and re admission on a weekly basis for the next two quarters to ensure compliance. Any discrepancies will be rectified immediately to assure compliance. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE The Director of Nursing will report the findings to the Quality Assurance Committee on a quarterly basis for the next two quarters to assure compliance.	

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F 684	Continued From page 3 indicated the hospital admission/discharge medication list included [redacted] MG by mouth every four hours PRN for [redacted]. RN #1 transcribed the order as [redacted] MG by mouth every four hours. The report indicated there was no harm to the resident, and the medication was discontinued. The action the facility implemented to reduce the potential for transcription errors was to add a requirement for the nurse to review and have another nurse review and crosscheck the physician's orders. During an interview with Certified Nursing Assistant (CNA) #1 on 06/28/2022 at 2:56 PM, the CNA indicated she was familiar with the care for Resident #1 and worked with the resident very often. She indicated there was a change in the resident's [redacted]; the resident seemed tired and was seen by the physician. A telephone interview was conducted with Licensed Practical Nurse (LPN) #1 on 06/28/2022 at 3:17 PM. The nurse indicated she was no longer employed by the facility but remembered Resident #1. She stated the resident was being treated for [redacted]. She recalled the resident was given a wrong medication but could not remember the name or dose of the medication that was administered incorrectly. The nurse stated the resident was [redacted] on [redacted] but was seen by the physician and there were no adverse side effects. The nurse also stated the facility provided education for nurses concerning transcribing verbal/written orders accurately. During a telephone interview on 06/28/2022 at 4:06 PM, LPN #4, a 7:00 AM to 7:00 PM shift nurse, indicated Resident #1 was in the facility dealing with serious medical issues, including [redacted]. She indicated the facility	F 684	TIME FRAME 08/22/2022	

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F 684	Continued From page 4 administered medications according to the MAR. During a telephone interview on 06/28/2022 at 4:13 PM, Physician Assistant (PA) #1 stated she was covering for Resident #1's primary physician and received a report concerning the medication transcription error. The medication was ordered as a four-hour PRN medication and was incorrectly transcribed to be administered routinely every four hours. The resident was given the medication for a day and a half and was found to be [redacted]. The medication was stopped by the physician, and the resident returned to his/her baseline status. During an interview on 06/28/2022 at 5:28 PM, the Director of Nursing (DON) indicated the nurse erroneously transcribed the order to direct the staff to administer a medication routinely instead of PRN. The resident received doses of the medication every four hours, for a total of nine doses. The resident was assessed by the physician, and the medication was discontinued. RN #1 was very remorseful when it was discovered. The RN was educated and put on one admission a month for three months, and there had not been another mistake. The DON also stated all medications were expected to be transcribed as written for all residents in the facility. An interview was conducted with the Administrator on 06/28/2022 at 5:32 PM. The Administrator indicated Resident #1 did have a transcription error concerning a PRN medication that was administered routinely. The error was discovered by the physician's assessment and corrected. RN #1 received education and was monitored for the next three months without any	F 684		

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F 684	Continued From page 5	F 684		

issues. The Administrator also stated it was expected that all medications were transcribed as ordered.

During the survey, RN #1 was out of the country and was not available for an interview.

During the survey, MD #1 was out on sick leave and was not available for interview.

A review of the facility's policy titled, "Physician Orders Policy," updated 12/2021, revealed, "It is the policy of [the facility] to follow physician orders to provide continue [sic] medical care to each resident after transition to the facility." The policy also indicated, "The licensed nurse will update the Attending Physician/NP [Nurse Practitioner]/PA regarding any Medications/Treatments resident was receiving prior to discharge. The licensed nurse will update all orders in [electronic medical record software] as prescribed by the attending Physician/NP/PA including diagnosis for each medication."

New Jersey Administrative Code § 8:39-27.1(a)