STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING _____ B. WING _____	08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE LIVINGSTON, NJ 07039**

(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 Standard Survey: 8/6/21 Census: 91 Sample Size: 22 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal	F 761		8/18/21

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

Electronically Signed | 08/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING _____ B. WING _____	08/06/2021

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INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE LIVINGSTON, NJ 07039**

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F 761	Continued From page 1 and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in 2 of 9 medication carts inspected. This deficient practice was evidenced by the following: On 8/4/21 at 9:15 AM, the surveyor inspected the Heritage West medication cart #2 in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed an opened Novolog Insulin that did not contained a label with a resident's name. At that time, the surveyor interviewed LPN #1 who stated that the Novolog insulin pen should have contained a label with the resident's name. On 8/4/21 at 10:15 AM, the surveyor inspected the Heritage East medication cart #2 in the presence of LPN #2. The surveyor observed an opened vial of Humalog insulin that did not contained a label with a resident's name. At that time, the surveyor interviewed LPN #2 who stated that the Humalog insulin vial should have contained a label with the resident's name. On 8/4/21 at 1:15 PM, the surveyor met with the Administrator and the Director of Nursing (DON) and no further information was provided by the facility. A review of the facility's policy for Medication Labels dated 12/17/20 that was provided by the DON indicated the following: 1. "Labels are	F 761	ELEMENT I The resident name was put on the medication that was identified with no resident name. ELEMENT II Inglemoor identifies that all residents that have orders for medication have the potential to be affected. ELEMENT III The DON and or ADON will ensure nursing staff is educated/in-serviced that upon receipt of medications, whether pharmacy delivered or medications from home, the nurse will verify correct labeling of medication with patient's name. Education/in-service will be completed by 08/18/2021 ELEMENT IV The DON/ADON will utilize a medication audit tool to do unit inspections of medication labeling on a weekly basis for 3 months. The findings of these weekly audits will be reported to the following quarterly PI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING _____ B. WING _____	08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE LIVINGSTON, NJ 07039**

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F 761	Continued From page 2 permanently affixed to the outside of the prescription container. No mediation is accepted with the label inserted into a vial. If a label does not fit directly onto the product, e.g eye drops, the label may be affixed to an outside container or carton, but the resident's name must be maintained directly on the actual product container." and 2. "Each prescription medication label includes: a). Resident's name." A review of the facility's policy for Medications from Home dated 9/7/20 that was provided by the DON indicated the following: b). "Verify that the medication is in the original manufacturer/outside pharmacy packaging; and d). For home medications from an outside pharmacy, verify that the medication is properly labeled by an outside pharmacy as per current state/federal labeling regulations for prescription medication." NJAC: 8:39-29.4 (a) (h) (d)	F 761		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315322 Y1	A. Building B. Wing Y2	9/8/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	311 S LIVINGSTON AVE LIVINGSTON, NJ 07039

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 F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 08/18/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
8/6/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315322	A. BUILDING **01** B. WING _____	**08/06/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLEMOOR REHABILITATION AND CARE CENTER OF LIVING	**311 S LIVINGSTON AVE** **LIVINGSTON, NJ 07039**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/04/21 and Inglemoor R&CC was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Inglemoor R&CC is a 1-story building that was built in 60's. It is composed of Type II unprotected construction. The facility is divided into 6 smoke zones.	K 000		

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

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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.