| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315387 | A. BUILDING _____ B. WING _____ | C 09/05/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLAIRE REHAB & NURSING | 115 DUTCH LANE ROAD FREEHOLD, NJ 07728 |

| (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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| F 000 | INITIAL COMMENTS<br><br>COMPLAINT# NJ 127840, 127842<br><br>CENSUS: 174<br><br>SAMPLE SIZE: 8 | F 000 | | |
| F 658 SS=E | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Complaint# NJ 127840, 127842<br><br>Based on interviews, record review, and review of pertinent facility documents on 9/4/19 and 9/5/19, it was determined that facility staff failed to document physician's ordered medications, as well as failed to follow facility's policy titled "Administering Medications" for 3 of 8 sampled Residents (Resident #1, #3, and #7). This deficient practice was evidenced by the following:<br><br>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]<br><br>According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the Resident's cognition was | F 658 | 1. For residents #1, #3, and #7,Nurses that were identified as not following the facility policy titled Administering Medication received 1:1 education on 9-6-19.<br>2. All residents have the potential to be affected by this deficient practice.<br>3. All licensed nurses have been re-educated regarding the facility policy titled Administering Medications completed by 9-11-19.<br>4. DON/designee will complete daily audits of the EMAR/ETAR for signatures daily for 4 days, weekly for 4 weeks, and then monthly for 3 months until compliance is achieved.<br><br>Audits will be submitted to the QA committee (Director of Nursing, Administrator, and Medical Director) for 6 months who will determine the necessity of further audits. The Director of Nursing | 10/18/19 |

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

Electronically Signed | 10/10/2019

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| F 658 | Continued From page 1<br>[redacted] impaired. The MDS further indicated the Resident required extensive assistance with Activities of Daily Living (ADLs).<br><br>Review of Resident #1's Order Summary Report (OSR) dated September 2019, were as follows:<br>Pain assessment every (q) shift for [redacted] management, [redacted] = [redacted], [redacted] = [redacted], [redacted] = [redacted], [redacted] = [redacted], dated [redacted].<br>[redacted] and [redacted] every day shift, every Monday for [redacted], and [redacted] every Monday 7-3 shift, dated [redacted].<br>[redacted] tablet [redacted] (mg), give 1 tablet by mouth one time a day for [redacted], dated [redacted].<br>[redacted] tablet [redacted] (mcg) [redacted] Give 1 tablet by mouth one time a day for [redacted], dated [redacted]<br>[redacted] tablet delayed release [redacted] mg, give [redacted] mg by mouth every 8 hours for [redacted], give [redacted] caps (capsules) [redacted] mg tablets-[redacted] mg, dated [redacted].<br><br>Review of Resident #1's August and September 2019, "Medication Administration Record (MAR)" indicated that the above were not documented as having been administered as ordered:<br>[redacted] assessment q shift for pain management [redacted] = [redacted], [redacted] = [redacted], [redacted] = [redacted], [redacted] = [redacted], on 8/30/19 for the 3:00 p.m. to 11:00 p.m. shift.<br>[redacted] every day shift, every Monday for [redacted] and [redacted] every Monday 7-3 shift, on 8/19/19.<br>[redacted] tablet [redacted] mg, give 1tablet by mouth one time a day, on 8/30/19 at 9:00 p.m.<br>[redacted] tablet [redacted] give 1 tablet by mouth one | F 658 | will be responsible to review the audits at the QA meetings. | |

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| F 658 | Continued From page 2 | F 658 | | |

time a day, on 9/1/19 at 6:00 a.m. [redacted] mg, give [redacted] mg by mouth every 8 hours, give [redacted] caps (capsules) [redacted] mg tablets = [redacted] mg, on 8/29/19 at 2:00 p.m. and 8/30/19, at 10:00 p.m.

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

According to the MDS, an assessment tool dated [redacted], Resident #3 had a BIMS score of [redacted] indicating the Resident's cognition was intact. The MDS further indicated the Resident required extensive assistance with ADLs.

Review of Resident #3's OSR September 2019, were as follows:
[redacted] mg, give 1 capsule orally every 8 hours for [redacted], dated [redacted] mg, give 1 capsule orally every 8 hours for [redacted], dated [redacted].
[redacted] tablet [redacted] mg, give 1 tablet orally every 12 hours for [redacted], dated [redacted].
[redacted] tablet [redacted] mg, give 1 tablet orally every 4 hours for [redacted], dated [redacted]
[redacted] tablet [redacted] mg, give 1 tablet orally every 12 hours, related to [redacted] and [redacted], dated [redacted]
[redacted] tablet [redacted] mg, give 1 tablet orally at bedtime for [redacted], dated [redacted].
[redacted] capsule 1 mg, give 1 capsule orally at bedtime for [redacted], dated [redacted]

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| F 658 | Continued From page 3<br>[redacted] assessment q shift for [redacted] management = [redacted] = [redacted] = [redacted] = [redacted], dated [redacted].<br>[redacted] Capsule [redacted] mg, give 1 capsule by mouth in the afternoon for [redacted], dated [redacted]<br>[redacted] Tablet [redacted] give 1 tablet by mouth in the afternoon for [redacted], dated [redacted]<br>[redacted] Q 8 hours, dated [redacted].<br>[redacted] tablet [redacted] mg, give 1 tablet by mouth twice a day related to [redacted] dated [redacted].<br>[redacted] Tablet [redacted] mg, give [redacted] tablets orally every 8 hours related to [redacted], dated [redacted]<br><br>Review of Resident #3's August and September 2019, MARs indicated that the above were not documented as having been administered as ordered:<br>[redacted] capsule [redacted] mg, give 1 capsule orally every 8 hours, on 8/25/19 at 10:00 p.m. and 9/1/19 at 6:00 a.m.<br>[redacted] capsule [redacted] mg, give 1 capsule orally every 8 hours, on 8/25/19 at 10:00 p.m., and 9/1/19 at 6:00 a.m.<br>[redacted] tablet [redacted] mg, give 1 tablet orally every 12 hours, on 8/25/19 at 6:00 p.m., and 9/1/19 at 6:00 a.m.<br>[redacted] tablet [redacted] mg, give 1 tablet orally every 4 hours, on 8/25/19 at 6:00 p.m., 10:00 p.m., and 9/1/19, at 6:00 a.m.<br>[redacted] tablet [redacted] mg, give 1 tablet orally every 12 hours, on 8/25/19 at 9:00 p.m.<br>[redacted] tablet [redacted] mg, give 1 tablet orally, on 8/25/19 at 9:00 p.m.<br>[redacted] capsule [redacted] mg, give 1 capsule orally, on 8/25/19 at 9:00 p.m.<br>[redacted] assessment q shift [redacted] = [redacted], [redacted] = [redacted], [redacted] = [redacted], = [redacted], | F 658 | | |

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| F 658 | Continued From page 4 | F 658 | | |

on 8/25/19 for the 3:00 p.m. to 11:00 p.m. shift. [redacted] Capsule [redacted] mg, give 1 capsule by mouth in the afternoon, on 8/25/19 at 5:00 p.m. [redacted] Tablet [redacted], give 1 tablet by mouth in the afternoon, on 8/25/19 at 4:00 p.m. [redacted] Q 8 hours, on 8/6/19 at 6:00a.m., and 8/25/19 at 10:00 p.m. [redacted] tablet [redacted] mg, give 1 tablet by mouth twice a day, on 8/25/19 at 5:00 p.m. [redacted] Tablet [redacted] mg, give [redacted] tablets orally every 8 hours, on 8/25/19 at 10:00 p.m., and 9/1/19 at 6:00 a.m.

3. According to the AR, Resident #7 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted].

According to the MDS, an assessment tool dated [redacted], Resident #7 had a BIMS score of [redacted] indicating the Resident's cognition was [redacted] The MDS further indicated the Resident required minimum assistance with ADLs.

Review of Resident #7's OSR dated July and August 2019, were as follows:
[redacted] tablet [redacted] mg, give 1 tablet orally every 8 hours for [redacted], dated [redacted] [redacted] capsule [redacted] mg, give 2 capsules orally 1 time a day every other day for [redacted], dated [redacted] [redacted] capsule [redacted] mg, give 1 capsule orally every 8 hours for [redacted] dated [redacted] mg tablet, give 1 tablet every 6 hours for [redacted] dated [redacted] [redacted] Assessment (q) shift, every shift for [redacted]

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| F 658 | Continued From page 5 | F 658 | | |

Management, dated [redacted].
[redacted] tablet [redacted] mg, give 1 tablet by mouth for [redacted], dated [redacted].
[redacted] capsule [redacted] mg [redacted]), give 1 capsule by mouth 3 times a day for [redacted], dated [redacted]

Review of Resident #7's July 2019 and August 2019, MARs indicated that the above were not administered as ordered as follows:
[redacted] tablet [redacted] mg, give 1 tablet orally every 8 hours on 7/3/19 at 5:00 a.m., 7/17/19 at 9:00 p.m., and 8/25/19 at 9:00 p.m.
[redacted] capsule [redacted] mg, give [redacted] capsules orally 1 time a day on 7/17/19 at 9:00 p.m.
[redacted] capsule [redacted] mg, give 1 capsule orally every 6 hours on 7/3/19 at 6:00 a.m., 7/17/19 at 10:00 p.m., and 8/25/19 at 10:00 p.m.
[redacted] mg tablet, give 1 tablet every 6 hours on 7/17/19 at 10:00 p.m., and 7/19/19 at 8:00 a.m.
[redacted] Assessment q shift, on 7/2/19 at night and 8/25/19 at evening.
[redacted] tablet [redacted] mg, give 1 tablet by mouth at bedtime on 7/17/19 at 9:00 p.m., and 8/25/19 at 9:00 p.m.
[redacted] mg [redacted] give 1 capsule by mouth 3 times a day on 7/17/19 at 9:00 p.m., and 7/27/19 at 9:00 p.m.

During an interview on 9/4/19 at 11:30 a.m., the Registered Nurse (RN #1) stated, "when I administer medications, I first look at the MAR, check the Resident's photo for identification, pull the medications from the medication cart, administer the medication to the Resident, I would then come back and sign the MAR indicating the medication was given. A blank on

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| F 658 | Continued From page 6<br>the MAR means that the medications were not given."<br><br>Review of facility's policy titled "Administering Medications" dated 12/2008, indicated the following:<br>Under "Policy Statement": Medications shall be administered in a safe and timely manner, and as prescribed.<br>Under "Policy Interpretation and Implementation": #19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving the medication and before administering the next ones.<br>Under #20. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record.<br>Under #20 a. The date and the time the medication was administered.<br>Under #20 g. The signature and title of the person administering the drug.<br><br>N.J.A.C 8:39-29.2(d) | F 658 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals | F 761 | | 10/18/19 |

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| F 761 | Continued From page 7<br>§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.<br><br>§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 and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>COMPLAINT# NJ 127840<br><br>Based on observations, interviews, record review and review of pertinent facility documents on 9/4/19 and 9/5/19, it was determined that facility staff failed to appropriately secure a medication cart as well as failed to follow facility's policy titled "Security of Medication Cart". This deficient practice was evidenced by the following:<br><br>Review of the facility's "Incident Investigative Form" dated [redacted] revealed the following:<br>On 8/30/19 at 6:47 a.m., the nurse left the medication cart outside the shower room while assisting the Certified Nurse's Assistant (CNA). The nurse left the keys in the drawer.<br>The "Incident Investigative Form" further revealed, nurses were in-serviced on locking the medication cart. The Staffing Agency was notified of incident and agency nurse will not be returning to the facility. | F 761 | 1. The nurse that failed to secure the medication cart and failed to follow the facilities policy titled Security of Medication Cart was an agency nurse and the Staffing Agency was notified of the incident and told that he/she is unable to return to the facility. A complaint was filed with the State Board of Nursing on 9-6-19.<br><br>2. All residents could have been affected by this deficient practice.<br>3. All licensed nurses were in-serviced by 9-11-19 in regards to securing the medication cart during the medication pass to prevent unauthorized entry, the storage of medication carts behind the nurse□s station when not in use on the [redacted], and medication carts to be turned around when not in use at the nurse□s station on the [redacted], and medication carts must be locked at all times when out of the nurse□s view. | |

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| F 761 | Continued From page 8<br>On 9/4/19 at 11:25 a.m., an observation of 2 of 2 medication carts were observed appropriately secured.<br><br>During an interview on 9/4/19 at 11:30 a.m., a Registered Nurse (RN) stated "responsibilities of the medication cart include, always locking the medication cart, the narcotic box is doubled locked and when not in use the medication cart must be stored behind the nurses' station. The policy is if the medication cart is not in use it should be locked or should be within eyeshot, close as possible." The RN further stated, 'the nurse is the only one with keys to the medication cart."<br><br>Review of the facility's policy titled "Security of Medication Cart" dated 12/2018, indicated the following:<br>Under "Policy Statement": The medication cart shall be secured during medication passes.<br>Under 'Policy Interpretation and Implementation":<br>#1 The nurse must secure the medication cart during the medication pass to prevent unauthorized entry.<br>#4 Medication carts must be securely locked at all times when out of the nurse's view.<br>#5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.<br><br>N.J.A.C 29.4(h) | F 761 | 4. DON/designee with complete an audit every shift for 4 days to assure medication carts are secured to prevent unauthorized entry during medication pass and stored correctly, weekly for 4 weeks, and then monthly for 3 months until compliance is achieved.<br>Audits will be submitted to the QA committee (Director of Nursing, Administrator, and Medical Director) for 6 months who will determine the necessity of further audits. The Director of Nursing will be responsible to review the audits at the QA meetings. | |