STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

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F 000	INITIAL COMMENTS Date: 4/14/2021 Census: 47 Sample: 25 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 582		4/19/21

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

Electronically Signed | 04/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 582	Continued From page 1 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to issue the proper required Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) for 3 of 3 residents (#26, #31, #297) reviewed for facility change notifications. This deficient practice was evidenced by the following: On 4/9/21 at 9:27 AM, the surveyor reviewed	F 582	How the corrective action will be accomplished for identified affected residents. The Administrator reviewed the requirements and trained the Social Service Director on proper administration of the Advanced Beneficiary Notice (ABN). The Social Services Director completed the Advanced Beneficiary Notice for each of the identified individuals.	

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F 582	Continued From page 2 three residents (#26, #31, #297) who were discharged from their Medicare Part A stay with benefit days remaining within the past [redacted] months and should have received Beneficiary Notices. Resident #26 was admitted to the facility in [redacted]. The last documented covered day of Medicare Part A service coverage was [redacted] from a facility-initiated discharge when benefit days were not exhausted. The facility did not present the resident with the required SNFABN form to notify them of the termination of insurance. Resident #31 was admitted to the facility in [redacted] The last documented covered day of Medicare Part A service coverage was [redacted] from facility initiated discharge when benefit days were not exhausted. The facility did not present the resident with the required SNFABN form to notify them of the termination of insurance. Resident #297 was admitted to the facility in [redacted]. The last documented covered day of Medicare Part A service coverage was [redacted] from a facility-initiated discharge when benefit days were not exhausted. The facility did not present the resident with the required SNFABN form to notify them of the termination of insurance. On 4/9/21 at 9:27 AM, the surveyor interviewed the Social Worker (SW), who stated that for Medicare Part A residents discharged from Medicare Part A services, she provided those residents with the Notice of Medicare Non-Coverage (NOMNC) form only to alert residents that their coverage was ending and	F 582	How other individuals with the potential to be affected will be identified. All residents have the potential to be affected by the deficient practice. The Social Services Director completed an audit of the current resident population for Advanced Beneficiary Notices. She completed an ABN for each of our current residents that would require such. What systemic changes will ensure that the deficient practice will not recur. The Social Services Director will ensure that each resident receives the proper notifications whenever there is a change in coverage. She will complete this documentation and record it in a binder maintained in the Social Services Office. She will complete a monthly audit of all residents with a change in coverage to ensure that the ABN was complete in a timely manner. The Social Services Director will document her findings and report it at the QAPI meetings. The Social Services Director will complete this audit for a 6 month period. How the will monitor its corrective actions. The Social Services Director will complete an audit and document her findings in report that is discussed and reviewed at the monthly QAPI meetings. This practice will continue for no less than a [redacted] month	

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F 582	Continued From page 3 their right to appeal this decision. The SW stated that she provided the SNFABN form to residents that their Medicare Part B coverage was ending. The SW stated that she was unaware that she needed to provide the SNFABN form to Medicare Part A residents since residents and their representatives were aware of their financial responsibilities and potential liability of payment from the admission packet. On 4/9/21 at 12:33 PM, the Executive Director (ED), in the presence of the Registered Nurse/Infection Preventionist and survey team, stated that typically the SNFABN form was completed on admissions to inform residents and their representatives what Medicare-covered and what their financial responsibility would be. The SW has only been employed at the facility for one year. The ED stated that she was also unaware that the SNFABN form needed to be completed after the facility discharged a resident from Medicare Part A Services with benefits remaining. N.J.A.C. 8:39-5.4 (b)(c)	F 582	period.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		4/16/21

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F 656	Continued From page 4 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews, observation, record review, and review of pertinent facility documentation, it was determined that the facility failed to initiate a care plan for residents receiving [redacted] medications [redacted] This deficient practice was identified for 5 of 17 residents (Resident #6, #7, #12, #26, and #37) reviewed for	F 656	How the corrective action will be accomplished for the identified affected individual: A review of each care plan of the affected individuals (resident # 6, #7, #12, #26 and #37) was completed and a care plan for at	

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F 656	Continued From page 5 comprehensive care plans, and was evidenced by the following: 1. On 4/8/21 at 12:33 PM, the surveyor, observed Resident #12 sitting in their room eating lunch. The surveyor attempted to interview the resident but was unable to. The surveyor reviewed the medical record for Resident #12. A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] indicated in section [redacted] for Medications, noted that the resident was administered an [redacted] medication [redacted]) for seven of seven days. A review of the [redacted] Physician Order Sheet reflected a physician's order (PO) for [redacted] mg) tablet twice a day for a diagnosis of [redacted] A review of the resident's individualized person-centered Care Plan (CP) dated effective [redacted] did not include the use of [redacted] medications.	F 656	risk for [redacted] and [redacted] use implemented. How will other individuals with the potential to be affected be identified and protected: A complete audit was done to identify all residents residing at the Crestwood Manor Health Care Center that are on an [redacted] medication. Each resident identified was assessed and a [redacted] care plan was put into place. What systemic changes will ensure that the deficient practice will not recur: The Interdisciplinary team was educated on correctly identifying residents on [redacted] drugs for care planning purposes. The Unit Manager will review all new admissions and physician orders and identify any resident receiving an [redacted] medication. The Unit Manager will ensure that a care plan is initiated and in place. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur: The MDS Coordinator will complete an audit of all residents receiving anticoagulant medications to ensure they have an [redacted] care plan in place. The audit will be conducted monthly for a period of [redacted] months to ensure proper care planning for residents on [redacted]	

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F 656	Continued From page 6 On 4/13/21 at 10:42 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1), who stated that the CP was completed and updated by the Registered Nurses (RN). On 4/13/21 at 11:58 AM, the surveyor observed the resident sitting in their room receiving lunch from the Certified Nursing Aide (CNA). On 4/13/21 at 12:00 PM, the surveyor interviewed LPN #2, who stated that the resident was very [redacted]. The resident received several medications for his/her heart condition but could not recall if the resident received an [redacted] medication; The LPN confirmed that she was not involved in the CP process. On 4/13/21 at 2:46 PM, the DON, in the presence of the Executive Director, Infection Preventionist, UM, Regional Nurse Consultant, and survey team, stated that the CP's for [redacted] have already been addressed and that all resident on [redacted] medications now have a CP for that medication. The DON confirmed that the residents should have had a CP for [redacted] medications prior to the surveyor inquiry. 2. On 4/8/21 at 12:30 PM, the surveyor, observed Resident #37 being propelled in their wheelchair by staff to the restroom. The resident was dressed with no observed bruising. The surveyor reviewed the medical record for Resident #37. A review of the Face Sheet reflected that the	F 656	medications. These audits will be reviewed by the Director of Nursing and Administrator and reported at the monthly QAPI meeting.	

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F 656	Continued From page 7	F 656		

resident was admitted to the facility in [redacted] with diagnoses that included [redacted] weakness, and presence of a cardiac pacemaker).

A review of the admission MDS reflected in section [redacted]. Medications that the resident received [redacted] medication [redacted]) for four of seven days.

A review of the [redacted] Physician Order Sheet indicated a physician's order dated [redacted] for [redacted] mg one time per day for [redacted].

A review of the resident's individualized person-centered CP dated effective [redacted] did not include the use of [redacted] medications.

On 4/13/21 at 10:42 AM, the surveyor interviewed LPN #1, who stated that the CP was completed and updated by the RN.

On 4/13/21 at 11:14 AM, the surveyor interviewed the DON, who stated that initial CP was completed within twenty-four hours of a resident's admission by the admitting nurse of the UM. The MDS Coordinator then completed the CP based on the comprehensive MDS assessment. The DON stated that the CP, in general, contained plan for any wounds, treatments, certain medications like psychotropic (mental health), antidepressant, antianxiety, and anticoagulant use for each individualized resident.

On 4/13/21 at 11:24 AM, the surveyor interviewed

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F 656	Continued From page 8	F 656		

the MDS Coordinator, who stated that anyone could create or update the CP, and not just her. The baseline CP was completed upon admission by the admitting nurse, which included activities of daily living, cognition, skin condition, dietary, rehabilitation, and medications; anything that was known about the resident upon admission. The comprehensive CP was completed after the MDS was completed. The MDS Coordinator stated that the nurses would need to monitor a resident on an [redacted] because of the risk factors associated with that medication. The MDS Coordinator confirmed that she does initiate a CP for that.

On 4/13/21 at 11:53 AM, the surveyor observed the resident ambulating with a walker in the hallway with therapy. The resident's skin did not appear visibly [redacted]

On 4/13/21 at 11:54 AM, the surveyor re-interviewed LPN #1, who stated that the resident was on an [redacted] for [redacted]. The resident's skin was monitored for [redacted], and they denied any current concerns. The LPN stated that she was not involved in the updating or initiating of a CP.

On 4/13/21 at 2:46 PM, the DON, in the presence of the Executive Director, Infection Preventionist, UM, Regional Nurse Consultant, and survey team, stated that the CP's for anticoagulants had already been addressed and that all resident on [redacted] medications now have a CP for that medication. The DON confirmed that the residents should have had a CP for [redacted] medications prior to the surveyor inquiry.

3. On 4/13/21 at 11:42 AM, the surveyor reviewed

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F 656	Continued From page 9	F 656		

Resident #6's Admission Record, which indicated that the resident was admitted in [redacted] with diagnoses that included but were not limited to [redacted]

A review of the Quarterly MDS dated [redacted] revealed that Resident #6's cognition was [redacted] The MDS also indicated that the resident received an [redacted]

A review of the Physician Order Sheet (POS) revealed a physician's order dated [redacted] for [redacted] mg one tablet oral two times daily. The POS had a start date of [redacted] and no end date. The POS also indicated that the medication was ordered for the diagnosis of [redacted]

On the same day, during a review of the Resident's medical record, the surveyor reviewed a Care Plan that did not reveal Resident #6 being on an [redacted] and at risk [redacted].

At 1:16 PM, the surveyor interviewed LPN #2, who stated that Resident #6 takes [redacted] mg two times daily. LPN #2 mentioned that the medication was an [redacted], and the medication side effects were as follows: [redacted]. LPN #2 looked in the computer located on top of the medication cart to review Resident #6's Care Plan. LPN #2 confirmed that the Resident did not have a care plan initiated for [redacted] medication. LPN #2 continued to mention that care plans are created by the Registered Nurse, Supervisor, or

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F 656	Continued From page 10	F 656		

Unit Manager. LPN #2 stated the reason for a care plan was to have short-term goals and long-term goals; and that the Resident was non-ambulatory, therefore staff was to observe for [redacted]

At 1:27 PM, the surveyor interviewed the Unit Manager (UM), who stated that care plans are discussed during the morning meetings and quarterly and consisted of the following staff members: MDS Coordinator, Social Service, Therapy, DON, and Unit Manager. The UM mentioned that Resident #6 did not have a care plan because "We don't have a policy for residents on [redacted] The UM confirmed that [redacted] was an [redacted], "a high-risk medication," and the resident received it for atrial fibrillation. The UM mentioned that staff observed the Resident for medication side effects such as [redacted]. The UM continued to state that the purpose of the care plan was to give direction on the flow of care planned for the resident.

On 4/14/21 at 12:26 PM, the UM provided an [redacted] Care Plan created on [redacted], that reflected Resident #6 was at risk for [redacted] secondary to the use of an [redacted].

4. On 04/07/21 at 10:27 AM, the surveyor, observed Resident #7 sitting in a chair and combing their hair. The resident stated they just had a shower, was not experiencing any pain, and confirmed that they took a [redacted] as part of their daily medication regimen. The top of the resident's [redacted] had minor [redacted].

On 04/14/21, the surveyor obtained and reviewed

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F 656	Continued From page 11 medical records for the resident consisting of a Face Sheet, MDS, PO Sheet, and CP. According to the Face Sheet, the resident was admitted to the facility in [redacted] with various diagnoses, including [redacted] The resident's Quarterly MDS Assessment, dated [redacted] revealed that the resident received and an [redacted] during the previous seven out of seven days, during the review period. Further review of the MDS revealed a BIMS score of 9, which was indicative of [redacted] as it related to the resident's [redacted] The PO Sheet for [redacted] confirmed that the resident had a current order for a [redacted] as [redacted] mg, one tablet orally twice per day for [redacted]. The interdisciplinary CP through the period of [redacted] revealed that there was no plan of care related to the use of the [redacted] 5. On 4/8/21 at 7:56 AM, the surveyor observed Resident #26 in bed with the head of the bed elevated. The resident was feeding themselves breakfast without difficulty. At 11:59 AM, Resident #26 was sitting up in a recliner in their room and stated, "I'm doing ok." On 4/13/21 at 9:32 AM, the surveyor reviewed the Admission MDS dated [redacted], which indicated in section [redacted] Medications that the resident was administered an [redacted] medication for one of seven days.	F 656		

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F 656	Continued From page 12	F 656		

At 10:54 AM, Resident #26 was in bed with the head of the bed elevated, and their eyes were closed.

A review of Resident #26's medical record revealed an order dated [redacted] that read: Hold [redacted] hours. Diagnosis, [redacted] from the [redacted]

The PO sheet for [redacted] confirmed the resident had a current order for a [redacted] as [redacted] mg, one tablet orally two times daily starting on [redacted] for [redacted] Prevention (prevention of [redacted]).

On 4/13/21 at 11:27 AM, the surveyor reviewed the facility policy titled Resident Care Plan (RCP) with a revised date of [redacted], under Procedure it read:

1. Resident Care Plan will be developed for all care planning issues, including but not limited to:

a. Resident Problem
b. Resident's goals, incorporate personal and cultural preferences
c. Resident's risk factors associated with identified problems
d. Resident's needs
e. Resident's strengths
f. Resident's Functional Status
g. Maintenance levels
h. Improvement possibilities
i. Rehabilitation/Restorative Nursing
j. Discharge Potential
k. Daily Care Needs

2. The Resident Care Plan will include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 656	Continued From page 13 a. Problems b. Goals c. Interventions d. Evaluation e. Discharge Plan (when appropriate) On 4/13/21 at 11:14 AM, the surveyor interviewed the Director of Nursing (DON), who stated that initial CP's were completed within twenty-four hours of a resident's admission by the admitting nurse of the Unit Manager (UM). Then the MDS Coordinator completed the CP based on the comprehensive MDS assessment. The DON stated that the CP, in general, contained any wounds, treatments, certain medications like psychotropic (mental health), antidepressant, antianxiety, and medications (such as anticoagulant therapy) for each individualized resident. At 11:24 AM, the surveyor interviewed the MDS Coordinator, who stated that anyone could create or update the CP, and not just her. The baseline CP was completed upon admission by the admitting nurse, which included activities of daily living, cognition, skin condition, dietary, rehabilitation, medications; anything that was known about the resident upon admission. The comprehensive CP was completed after the MDS was completed. The MDS Coordinator stated that the nurses would need to monitor a resident on an [redacted] because of the risk factors associated with that medication. The MDS Coordinator confirmed that she does initiate a CP for that. At 1:32 PM, the surveyor interviewed LPN #1, who stated that Resident #26 was on the [redacted] mg two times a day and had a	F 656		

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F 656	Continued From page 14 history of [redacted]. LPN #1 said they would monitor the resident for signs of [redacted] and notify the physician if [redacted] was identified. On 4/14/21 at 12:27 PM, the UM stated that Resident #26's CP for the Problem: Risk for [redacted] secondary to [redacted] therapy had been created on [redacted] after surveyor inquiry. A review of Resident #26's Care Plan Report revealed a CP with the Problem identified: Risk for [redacted] secondary to [redacted] with an effective date: [redacted]. N.J.A.C. 8:39 - 27.1(a)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the nurse failed to a.) properly administer the correct dose of medication; and, b.) obtain an order to crush and open medication from the physician. This deficient practice was identified for 1 of 1 nurse observed during the medication pass observation task and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse	F 658	How the corrective action will be accomplished for those residents affected by the deficient practice: The physician was notified of the failure to administer the proper dosage of [redacted] to resident #16. A physician's order was obtained to crush and open [redacted] when administering medication to resident #16. A physician order was also obtained to	5/4/21

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F 658	Continued From page 15 Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 04/09/21 at 8:18 AM, the surveyor observed the Licensed Practical Nurse (LPN) administer medication to Resident #16. The LPN poured a total of seven medications into two different medication cups. The medications poured into the first medication cup consisted of one tablet of [redacted], one tablet of [redacted] milligrams (mg) (a medication used to treat high [redacted], one tablet of [redacted] mg (a [redacted]), and one tablet of [redacted] mg (a medication used to treat [redacted] is considered a controlled substance (a medication with a potential for abuse that must be counted and logged when administered). The medications	F 658	Crush all medications for resident #16. The Director of Nursing provided an in-service with the LPN for proper administration technique. How the facility will identify other residents having the potential to be affected by the same deficient practice: The DON completed a medication audit to identify residents that require their medications crushed. All orders were verified for proper documentation. All staff were in-serviced on proper procedures for administration and crushing medications. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: The Director of Nursing conducted an in-service to all nursing staff on 4/29/21 regarding appropriate medication administration. Medication administration will continue to be addressed at each monthly nursing meeting for 1 year. The Consulting Pharmacist will provide an additional in-service to all nursing personnel regarding proper medication administration and adhering to the documented medication precautions as recommended by the manufacturer on 5/04/21. Random weekly medication administration audits will be completed by the Director of Nursing or designee for one month and	

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F 658	Continued From page 16 poured into the second cup consisted of two [redacted] mg capsules ([redacted]) and one tablet of [redacted] ([redacted]). The LPN crushed all the medication in the first cup together, explained this was done for ease of swallowing for the resident and mixed the crushed medication with applesauce. The LPN then took out a capsule of [redacted] (a supplemental medication used to maintain [redacted] levels within normal range). [redacted] levels must remain within the normal range for the [redacted] to function properly. The surveyor observed the LPN open the capsule of [redacted] over the first cup of crushed medications mixed with applesauce. Part of the [redacted] capsule contents fell outside and around the cup of crushed medications onto the medication cart. The LPN cleaned the spilled [redacted] contents off of the medication cart with a disposable wipe. The LPN stated that they did not know how much of the [redacted] Resident #16 was getting due to the spilled contents, but this would be noted in the record, and the physician would be notified of the occurrence. The LPN further stated that [redacted] contents were mixed with the other medications, including a controlled substance medication, and the [redacted] could not be taken out to start the process all over as a result. During an interview with the LPN on 04/09/21 at 11:52 AM, the LPN again acknowledged that [redacted] capsule contents fell out during the medication pass, and the Nurse Practitioner (NP) was not advised of this yet. The LPN expressed concern that the resident did not receive the total dose of [redacted] and did not know how much of the dosage the resident received. When the surveyor asked about the spilled [redacted] contents, the LPN stated	F 658	periodically thereafter to ensure all nurses are following proper procedures and adhering to the documented medication precautions as recommended by the manufacturer. The Consulting Pharmacist will provide monthly medication administration reviews to ensure proper medication administration and adherence to the documented medication precautions as recommended by the manufacturer. All audits will be reviewed by the Director of Nursing and the Administrator. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur: The Director of Nursing and the Administrator will review each weekly/monthly audit completed to ensure proper procedures are being followed. The results of all audits will be assessed and reviewed at the monthly QAPI meetings.	

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F 658	Continued From page 17	F 658		

that they could have destroyed all medications, gotten a witness to observe the disposal of the mixed medications, and started the medication pouring process from the beginning. The LPN further stated that they should have gotten a witness for the described purposes but did not do so due to concerns of asking someone else to verify the wasting of [redacted] (a controlled substance) that that individual did not witness. The LPN could not provide details of the facility policy related to crushing, opening, and mixing medications when asked to do so.

The surveyor obtained and reviewed the physician's order (PO) sheet and Medication Administration Record (MAR) for Resident #16. A MAR is a document on which a nurse records all medications administered to a resident. The [redacted] PO Sheet revealed an order for [redacted], one capsule by mouth two times a day for [redacted] a condition in which [redacted] is low). There was a note attached to the [redacted] indicating that the capsule was opened to empty the contents due to the resident's inability to swallow the capsule, that the resident did not receive the entire contents of the capsule, and the physician would be made aware in order to possibly change the medication to another dosage form. The administration of the [redacted] itself was recorded on the MAR.

The surveyor interviewed members of the facility staff in the presence of the survey team on 04/13/21 at 2:39 PM. The Executive Director (ED), who was acting as the Licensed Nursing Home Administrator (ED/Acting-LNHA), stated that the [redacted] capsule should have been opened and administered separately from the other medication and the Registered

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F 658	Continued From page 18	F 658		

Nurse/Unit Manager (RN/UM) agreed. The ED/Acting-LNHA stated that it would have been easier for the LPN to start the medication process from the beginning if the [redacted] had been opened separately from the other medication. The RN/Regional Representative (RN/RR) stated a different dosage form might be a better option in the future.

On 04/13/21 at 2:41 PM, the surveyor asked the facility staff if there should have been a physician's orders to crush and open medications. The Director of Nursing (DON) nodded up and down and stated there should have been a physician's order to crush or open medication for administration to residents requiring this practice, where applicable and safe to do so.

On 04/14/21 at 10:31 AM, the surveyor further interviewed facility staff in the presence of the survey team. The Registered Nurse/Infection Preventionist (RN/IP) confirmed that there was no order to open/crush medications for Resident #16.

The surveyor then reviewed the facility's policy titled, Administering Medications, with a revised date of 2/6/20, which read under Procedure:
9. The individual administering the medication must ensure that the right medication, the right dosage, the right time, and the right method of administration are verified before the medication is administered.

The surveyor then provider the pharmacy's policy, titled PCU018 - Medication Administration and General Guidelines 2020 edition, which read that a physician's order is obtained to crush

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F 658	Continued From page 19 medications and administer them in an appropriate medium, such as applesauce. It is also necessary to ensure that the correct dose of medication is administered. N.J.A.C. 8:39-29.2(d)	F 658		
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: Based on observation, interview, and record review, it was determined that the facility failed to: a.) obtain a physician's order (PO) for the administration of [redacted]; b.) document the administration of [redacted] in the electronic Treatment Administration Record (eTAR); c.) document the changing of [redacted] and [redacted] in the eTAR, and d.) Care Plan for the administration of [redacted]. This deficient practice was identified for 1 of 2 residents reviewed for [redacted] care (Resident #97) and was evidenced by the following. On 4/8/21 at 9:09 AM, the surveyor observed Resident #97 laying in bed eating breakfast, which they stated was good. The resident was observed being administered [redacted] at [redacted]	F 695	How the corrective action will be accomplished for those residents affected by the deficient practice: The physician was notified and an order was obtained for the administration of PRN [redacted] for resident #97. A care plan was developed to reflect the oxygen order. An in-service was completed with all nursing staff for proper procedures for [redacted] orders. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. An	5/4/21

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F 695	Continued From page 20 [redacted]). On 4/8/21 at 12:40 PM, the surveyor observed the resident sitting in a wheelchair in their room with their eyes closed. The resident was not receiving [redacted] at this time. The surveyor reviewed the medical record for Resident #97. A review of the Face Sheet (an admission record) reflected that the resident was admitted to the facility in [redacted] with diagnoses that included [redacted] with [redacted]. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that it was still in progress. A review of the [redacted] Physician Order Sheet did not reflect a Physician Order (PO) for [redacted]. A review of the [redacted] electronic Medication Administration Record (eMAR) did not reflect [redacted] administration for [redacted] A review of the [redacted] eTAR did not reflect oxygen administration for [redacted]. A review of the individualized person-centered Care Plan (CP) had not reflected the use of [redacted]. A review of the [redacted] Vital Signs reflected that on [redacted] Resident #97 had a [redacted]	F 695	audit was completed to ensure all residents on [redacted] have appropriate orders and proper procedures are being followed. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: The Director of Nursing provided an in-service to all nursing staff on 4/29/21 regarding following proper procedure and adhering to the proper administration and recording of physician orders for [redacted], and changing [redacted]. This topic will continue to be addressed at each monthly nursing meeting for a period of 1 year. The consulting Pharmacist will provide an additional in-service to all nursing personnel regarding proper [redacted] administration and order documentation. [redacted] Random weekly audits will be completed by the Unit Manager or Director of Nursing for a period of one month and periodically thereafter to ensure all nurses are following proper procedures and adhering to the proper documentation of [redacted] administration. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Nursing and the	

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F 695	Continued From page 21 measurement device on (used to measure the [redacted] levels) while receiving [redacted] administered at [redacted]. On 4/12/21 at 12:44 PM, the surveyor observed the resident sitting in their wheelchair in their room being administered [redacted]. The resident was unable to be interviewed. On 4/13/21 at 8:56 AM, the surveyor observed the resident sitting in the wheelchair in their room. The resident was wearing [redacted] The surveyor continued to review the resident's medical record. A review of the [redacted] Therapy Progress Note dated [redacted] indicated no observed signs or symptoms of distress; apply [redacted] as needed to maintain an [redacted] level) greater than [redacted] On 4/13/21 at 10:23 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA), who stated that the resident was pleasant but had [redacted]. The CNA said that he thought the resident received [redacted] as needed. On 4/13/21 at 10:42 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN), who stated that the resident had [redacted]) and received [redacted]. The LPN stated that the resident had an average [redacted] and improved [redacted] therapy. The LPN said that to administer [redacted], the resident would have a PO	F 695	Administrator will review each weekly/monthly audit completed to ensure proper procedures are being followed. The results of all audits will be assessed and reviewed at the monthly QAPI meetings.	

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F 695	Continued From page 22	F 695		

and be signed as administered on the eTAR. If the order were for continuous [redacted], then the [redacted] would not be signed for on the eTAR. The LPN stated that the [redacted] and [redacted] were changed weekly on [redacted] nights and that the Registered Nurse (RN) completed the Care Plan.

At this time, the surveyor asked the LPN to see the PO for [redacted]; The LPN confirmed that there was no PO.

On 4/13/21 at 10:51 AM, the night Supervisor/LPN reviewed the resident's medical chart. The night Supervisor/LPN stated that according to the [redacted] Therapy Note on [redacted], the resident was supposed to be on [redacted] as needed. The night Supervisor/LPN said that she did not see a PO for [redacted], but she needed to check the hospital discharge paperwork. She stated that residents were discharged from the hospital with a list of medications; the receiving nurse entered the medications into the computer and confirmed them with the resident's physician. After that, the PO would be sent to the pharmacy to review for any discrepancies. Then, the nurse would reconcile the medications to ensure all the medications were listed at the correct time and dosage. The night Supervisor/LPN stated that nurses signed every shift on the eTAR for [redacted] [redacted] and when administered for an as-needed order. The [redacted] and [redacted] were changed every week on [redacted] night. The night Supervisor/LPN stated that the admitting nurse usually started a baseline Care Plan which would include [redacted], and she confirmed the resident did not have it.

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F 695	Continued From page 23 On 4/13/21 at 11:11 AM, the LPN accompanied by the surveyor took the resident's [redacted] of [redacted] on [redacted]. The LPN confirmed the resident's [redacted] was being administered at [redacted] The LPN stated that the [redacted] Therapist was just here earlier working with the resident. They must have changed the administration rate from [redacted] to [redacted]; she had not reviewed the notes yet. The resident was unable to be interviewed at this time. On 4/13/21 at 11:14 AM, the surveyor interviewed the Director of Nursing (DON), who stated that a PO was needed to administer [redacted] and that the nurses signed for the administration of [redacted] in the eTAR. The DON said that the Care Plan was started upon admission by the admitting nurse and that [redacted] should be included. The DON confirmed that there would need to be accountability and monitoring for [redacted] including an [redacted], the [redacted] being administered, and [redacted] and [redacted] changing. On 4/13/21 at 2:34 PM, the DON, in the presence of the Executive Director, Unit Manager, Infection Preventionist/RN, Regional Nursing Consultant, and survey team, stated that she reviewed the resident's hospital discharge record and spoke with the resident's physician. The record indicated that the resident was experiencing some shortness of breath at the hospital. The resident now has a PO for [redacted] as needed. The DON confirmed that the resident should have had a PO for the [redacted] the entire time at the facility. A review of the facility's [redacted] Therapy policy dated 6/1/01 and revised date 5/18/12 included	F 695		

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F 695	Continued From page 24	F 695		

that [redacted] therapy is provided upon the physician's written order. The policy also included documenting maintenance of [redacted] for [redacted] on the eTAR, including tubing changes and changing the [redacted] in the [redacted]

On 4/13/21 at 11:27 AM, the surveyor reviewed the facility policy titled Resident Care Plan (RCP) with an effective date of [redacted] and revised [redacted] under Procedure it read:

1. Resident Care Plan will be developed for all care planning issues, including but not limited to:

a. Resident Problem
b. Resident's goals, incorporate personal and cultural preferences
c. Resident's risk factors associated with identified problems
d. Resident's needs
e. Resident's strengths
f. Resident's Functional Status
g. Maintenance levels
h. Improvement possibilities
i. Rehabilitation/Restorative Nursing
j. Discharge Potential
k. Daily Care Needs

2. The Resident Care Plan will include:

a. Problems
b. Goals
c. Interventions
d. Evaluation
e. Discharge Plan (when appropriate)

N.J.A.C. 8:39-27.1(a)

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F 755	Continued From page 25	F 755		
F 755 SS=D	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, 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: Based on observation, interview, and record review, it was determined the facility failed to ensure an accurate ordering and receiving of	F 755	How the corrective action will be accomplished for those residents affected by the deficient practice:	5/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

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F 755	Continued From page 26 narcotic medications. The required Federal narcotic acquisition forms (DEA 222 form) were not completed with sufficient detail to enable accurate reconciliation for 6 of 7 forms provided as was evidenced by the following: On 4/14/21 at 12:00 PM, a review of the facility's DEA 222 forms revealed the facility did not record the number of packages of controlled substances received or date the medication was received as instructed to on the reverse of the DEA 222 form. The inaccuracies were as follows: Order Form: #203396572, No date and No quantity received Further review of the forms provided revealed there was an inconsistent pattern in regards to ordering the medication package size versus the number of packages being ordered. This inconsistency was identified on the following order forms: Order Form: #203396570, #203396568, #193942045, #193942048, #193942049, On 04/14/21 at 1:28 PM, the surveyor interviewed the interim Director of Nursing (DON), who stated one of the responsibilities of the DON was to complete the DEA 222 forms. The interim DON acknowledged she had not completed the form as required when receiving narcotic medications and should have filled in the quantity received as well as the date the medication was received.	F 755	There were no residents affected by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice: No residents are affected by the deficient practice. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: The Administrator, Director of Nursing and Medical Director met to review how to properly complete the 222 form when controlled substances are received. A sample page was completed and entered into the 222 binder for future review when completing the form. An in-service was complete with the Director of Nursing, Medical Director and Administrator on the proper way to complete the form. The provider Pharmacy will complete an advisory guideline for the Medical Director and Director of Nursing with the accurate directions for completion of the 222 form by May 04, 2021. The format was reviewed with the Pharmacy for accuracy. The Medical Director, Administrator and the Director of Nursing will conduct intermittent reviews to ensure the 222	

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F 755	Continued From page 27 She further stated she was unfamiliar with how to complete the new form, and this was the first time she was completing the form since it had been changed. The interim DON additionally stated when she first started at the facility, and she questioned how the previous DEA Form 222 forms were being completed. She questioned if the facility had reversed the number of packages with the package size on previous forms. She stated on 3/16/21, she called the provider pharmacy and clarified under Part One, column one was the number of Bingo cards, and column two was the number of tablets contained in the Bingo card per the narcotic division of pharmacy. A review of the instructions for submission of the DEA 222 form located on the reverse of the form reveals " Part 1. Purchaser Information, 2. Only one item may be entered on a single line. Enter the number of packages, the size of the package, and the name of the item. Part 5. Controlled Substance Receipt 1. The purchaser fills out this section on its copy of the original form. 2. Enter the number of packages received and the date received for each line item. On 4/14/21 at 1:44 PM, the surveyor interviewed the Pharmacist from the facility's provider pharmacy, who confirmed the number of packages is the bingo card. The package size is the number of tablets in the bingo card. On 4/14/21 at 2:34 PM, the Licensed Nursing Home Administrator (LNHA) stated there is no consistency. Both the LNHA and the interim DON acknowledged the facility, the provider pharmacy, and the Medical Director need to come together and formulate a plan going forward to fix the process of ordering narcotic medications on the	F 755	form is complete and accurate. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Medical Director, Administrator and the Director of Nursing will conduct monthly reviews to ensure the 222 form is complete and accurate. A report will be made and reviewed at the monthly QAPI meeting.	

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F 755	Continued From page 28 DEA Form 222. A review of the facility's policy provided titled "Nursing policies and procedures [Name redacted] Medication Reconciliation, Receipt of Medications at Facility, with a revised date of 4/20/12 read: A. Match all medications with corresponding records. The policy did not speak to the completion of the DEA 222 form once the medication was received by the pharmacy. N.J.A.C. 8:39-29.7	F 755		