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	315085	A. BUILDING ______ B. WING ______	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL CONV CENTER	**360 CHESTNUT STREET PASSAIC, NJ 07055**

(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 CENSUS: 81 SAMPLE SIZE: 23 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 658 SS=E	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 facility failed to consistently follow medication hold parameters in accordance with physician orders and professional standards of nursing practice. This deficient practice was identified for 2 of 23 residents reviewed for medication administration (Resident #19 and #24) and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey stated,"The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching,	F 658	This Plan of Correction is submitted as required under Federal and State regulation and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the Plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited. 1) Based on the root cause analysis by the DON, it was determined that the staff administered [redacted] to Resident #19 with the order to hold for [redacted]	2/21/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/21/2020

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.

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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 stated, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; 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."

1. According to the Resident Face Sheet, Resident #19 was admitted to the facility with diagnoses which included

A review of the Physician Order Report (POR) for active orders as of 02/07/20 revealed a physician order (order), dated 12/02/19, for) daily for a diagnosis of with the scheduled administration time of 9:00 AM. The order included "Special Instructions" to " The POR revealed a second order, dated 12/02/19, for

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to Resident #19 with the order to hold for which was administered outside of the physician ordered BP parameters.

Staff administered to Resident #24 with the order to hold for which was administered outside of the physician ordered parameters.

The facility is transitioning to Electronic Health Records (EHR)effective October 2019 which may have been contributed to the deficient practice.

No negative outcomes were identified for Resident #19 and #24 for the identified concern. MD was notified immediately regarding deficient practice and no new orders received. Pharmacy consultant was also notified 1:1 re-education/re-in-service/return demonstration on proper documentation in the Electronic Medication Administration Record (eMAR) done to the licensed staff (RN#1, LPN#1 and LPN #2) involved with the deficient practice. RN#1, LPN#1 and LPN#2 were disciplined for deficient practice.

2) All residents who received medications with parameters have the potential to be affected.

3) On 2/11/2020 and 2/12/2020, 100% of residents' medication orders were reviewed by the DON/ADON to identify any other resident with any order that needed to be

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with the administration time of 9:00 AM. The order also included "Special Instructions" to

A review of the discontinued orders revealed that Resident #19 had an order for daily with the administration time of 8:00 AM that was started on 06/28/19 and discontinued on 12/02/19. The order specified to hold for . The discontinued order revealed that Resident #19 also had an order for daily with the administration time of 8:00 AM that was started on 05/09/19 and discontinued on 12/02/19. The order specified to hold for .

A review of Resident #19's November 2019 electronic Medication Administration History (eMAH) reflected the corresponding 06/28/19 order for daily, hold for , with the administration time of 8:00 AM. The November 2019 eMAH also reflected the corresponding 05/09/20 order for daily, hold for , with the administration time of 8:00 AM.

The November 2019 eMAH reflected documentation that the was administered at 8 AM and was outside of the physician ordered parameters to hold for a on the following dates:

11/04/19- ; 11/05/19-
11/06/19- 11/11/19-
11/13/19- , 11/20/19- ;
11/21/19- 11/22/19-
11/25/19- ; 11/26/19-

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held for ordered parameters. The audit concluded there were no other residents identified.

Effective 2/6/2020 the facility licensed nurses will not administer medications (and any other medications that has parameters) to any resident with outside of the physicians ordered parameters.

DON/Designee will provide 100% education for all licensed nurses to include full time and per diem staff. The emphasis of this education will be on the importance of administering medication as ordered by the physician and how to properly document information into Electronic Medication Administration Record(eMAR). Policy and procedure reviewed on 2/6/2020.

4) All licensed staff (RN/LPN) received in-service on the policy and procedure for holding parameters for and other medications with parameter order. All licensed staff (RN/LPN) will be continuously monitored and observed on proper documentation on the eMAR of medications with parameter order. DON/ADON will continue to monitor compliance for dministration by reviewing eMAR from previous 24 hour period to ensure medication is administered according to physicians' order parameter.
Findings from this monitoring will be addressed immediately by

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11/27/19- ; and 11/30/19- .

The November 2019 eMAH reflected documentation that the was administered at 8 AM and was outside of the physician ordered parameters to hold for a on the following dates:

11/04/19- ; 11/05/19- ;
11/06/19- ; 11/11/19-
11/13/19- ; 11/20/19- ;
11/21/19- ; 11/22/19-
11/25/19- ; 11/26/19- ;
11/27/19- ; and 11/30/19- .

A review of Resident #19's December 2019 eMAH reflected the corresponding 06/28/19 order for daily and to hold for , with the administration time of 8:00 AM and a discontinued date of 12/02/19. The December 2019 eMAH also reflected the corresponding order 12/02/19 for and to hold for , with the administration time of 9:00 AM. The December 2019 eMAH reflected the corresponding 05/09/20 order for daily, hold for , with the administration time of 8:00 AM and a discontinued date of 12/02/19. The December 2019 eMAH also reflected the corresponding 12/02/19 order for , hold for , with the administration time of 9:00 AM.

The December 2019 eMAH reflected documentation that the was administered outside of the physician ordered parameters to hold for a on the following dates and times:

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DON/ADON/Designee. This monitoring process will take place daily for 2 weeks, then weekly for 2 weeks and then monthly x 3 months.
The facility QAPI committee was notified of this plan of action on 2/11/2020.
Effective 2/11/2020, the DON/ADON will report findings of this monitoring process to the QAPI committee during quarterly meeting.
THE QAPI committee can modify this plan to ensure the facility remains in substantial compliance.

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F 658	Continued From page 4 12/01/19 at 8:00 AM- ; 12/02/19 at 8:00 AM- 12/03/19 at 9:00 AM- ; 12/04/19 at 9:00 AM- ; 12/05/19 at 9:00 AM- ; 12/06/19 at 9:00 AM- ; 12/14/19 at 9:00 AM- ; 12/15/19 at 9:00 AM- ; 12/20/19 at 9:00 AM- ; 12/22/19 at 9:00 AM- ; and 12/26/19 at 9:00 AM- . The December 2019 eMAH reflected reflected documentation that the was administered outside of the physician ordered parameters to hold for a on the following dates and times: 12/01/19 at 8:00 AM- ; 12/3/19 at 9:00 AM- ; 12/04/19 at 9:00 AM- ; 12/05/19 at 9:00 AM- ; 12/06/19 at 9:00 AM- ; 12/14/19 at 9:00 AM- ; 12/15/19 at 9:00 AM- ; and 12/20/19 at 9:00 AM- . The January 2020 eMAH also reflected the corresponding order 12/02/19 for hold for , with the administration time of 9:00 AM. The January 2020 eMAH also reflected the corresponding 12/02/19 order for daily, hold for , with the administration time of 9:00 AM. The January 2020 eMAH reflected documentation that the was administered at 9 AM and outside of the physician ordered parameters to hold for a on the following dates: 01/01/20- ; 01/2/20- ; 01/07/20- ; 01/08/20- ;	F 658		

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01/16/20- ; 01/17/20- ; and
01/19/20-

The January 2020 eMAH reflected documentation that the was administered at 9 AM and outside of the physician ordered parameters to hold for a on the following dates:

01/01/20- ; 01/02/20-
01/07/20- ; 01/08/20- ; and
01/16/20- .

The February 2020 eMAH also reflected the corresponding order 12/02/19 for , hold for , with the administration time of 9:00 AM. The February 2020 eMAH also reflected the corresponding 12/02/19 order for daily, hold for , with the administration time of 9:00 AM.

The February 2020 eMAH reflected documentation that the was administered outside of the physician ordered parameters to hold for a on 02/01/20 at 9:00 AM-

The February 2020 eMAH reflected documentation that the was administered outside of the physician ordered parameters to hold for a on 02/01/20 at 9:00 AM- .

On 02/07/20 at 12:15 PM, the surveyor interviewed Licensed Practical Nurse #5 (LPN), who was responsible for caring for Resident #19. LPN #5 stated she would take the resident's and input the results into the

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electronic Medication Administration Record (eMAR). LPN #5 further stated if the resident's [redacted] was outside the physician ordered parameters, she would select "Not Given" and another screen would come up for her to document the reason the medication was not administered. LPN #5 further stated that if Resident #19's [redacted], she would hold the medication in accordance with the physician's order.

The surveyor conducted a telephone interview with the Registered Nurse (RN) on 02/10/20 at 11:23 AM. The RN administered the [redacted] 26 times outside of the physician ordered parameters from 11/04/19 to 02/01/20. The RN also administered the [redacted] 26 times outside of the physician ordered parameters from 11/04/19 to 02/01/20. The RN stated she would take the resident's [redacted] and document the results into the eMAR. The RN further stated that if the resident's [redacted] was outside the physician ordered parameters, she would not administer the medication. When questioned about administering the medications outside the physician ordered parameters, the RN stated that she did not know why she administered the medications. The RN then stated that she should hold the medication and not administer it to the resident if the [redacted] was outside of the parameters.

During an interview with the surveyor on 02/10/20 at 11:27 AM, the Director of Nursing (DON) stated that the RN had previously been disciplined for administering medications outside the physician ordered parameters.

2. A review of Resident #24's POR for the period

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F 658	Continued From page 7 11/01/19 to 02/07/20, revealed an order with a start date of 10/24/19 and an end date of 11/30/19 for [redacted] [redacted] twice daily. The order specified to hold the [redacted] for a [redacted]. A review of the November 2019 eMAH revealed documentation that the [redacted] was administered daily at 8:00 AM and 4:00 PM and had been administered on 11/08/19 at 4:00 PM-[redacted] by LPN #1. A review of the POR for the period 11/01/19 to 02/07/20 revealed an order with a start date of 11/30/19 and an end date of 01/12/20 for [redacted] twice daily. The order specified to hold the [redacted] for a [redacted]. A review of the December 2019 eMAH revealed documentation that the [redacted] was administered daily at 8:30 AM and 4:30 PM and had been administered on 12/15/19 at 4:30 PM-[redacted] by LPN #2. A review of the POR for the period 11/01/19 to 02/07/20 revealed an order dated 01/12/20 for [redacted] twice daily. The order specified to hold the [redacted] for a [redacted] A review of the February 2020 eMAH for the period 02/01/20 to 02/07/20 revealed that [redacted] had been scheduled to be administered daily at 9:00 AM and 5:00 PM and had been administered on 2/01/20 at 9:00 AM-[redacted] by LPN #3; on 02/01/20 at 5:00 PM-[redacted] by LPN #2; and on 2/3/20 at 5:00 PM-[redacted] by LPN #2. During an interview with the surveyor on 02/06/20	F 658		

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at 12:12 PM, LPN #4, the nurse assigned to Resident #24, stated that she assessed the resident's [redacted] because [redacted] had a parameter. LPN #4 stated that she would not administer the medication if the resident's [redacted] was over [redacted] and she documented the [redacted] in the eMAR.

During an interview with the surveyor on 02/07/20 at 12:05 PM, the UM stated that if a medication had a [redacted] parameter, the nurses assessed the [redacted], reviewed the parameters and determined whether the medication should be given. The UM further stated that if a medication was within parameters, the nurse clicked "Given" in the eMAR and administered the medication. The UM stated that if the medication was held, the nurse clicked "Not Given" in the eMAR and documented the reason why the medication was held.

On 02/10/20 at 11:10 AM, the surveyor attempted to telephone LPN #3. LPN #3 was unavailable to be interviewed.

During a telephone interview with the surveyor on 02/10/20 at 11:18 AM, LPN #2 stated that he reviewed the medication parameters, assessed the [redacted], and based on the [redacted] reading, he either gave the medication or held the medication. LPN #2 further stated that if the medication was held, he documented the reason why in the eMAR.

During a telephone interview with the surveyor on 02/10/20 at 11:25 AM, LPN #1 stated that he assessed the resident's [redacted] to see if it was within parameters, and if the [redacted] was outside of parameters, he held the medication and documented the reason why it was not given.

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F 658	Continued From page 9 During an interview with the surveyor on 02/10/20 at 11:32 AM, the DON stated that she expected the nurses to assess the [redacted], and if the [redacted] was out of parameters, the nurse would hold the medication. The surveyor reviewed the facility's Medication Parameter policy, dated 12/2019, provided by the DON. The policy revealed that prior to administering Midodrine, the nurse will monitor the patient's BP. The policy further revealed that the medication would be withheld if the [redacted] was not within the physician ordered parameter range. NJAC 8:39-11.2(b)	F 658		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756		2/21/20

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F 756	Continued From page 10 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to act upon a recommendation made by the Pharmacy Consultant (PC) in a timely manner for medications that were administered outside of the physician ordered parameters. This deficient practice was identified for 1 of 6 residents reviewed for unnecessary medications (Residents #19) and was evidenced by the following: According to the Resident Face Sheet, Resident #19 was admitted to the facility with a diagnoses which included	F 756	1) Based on the root cause analysis by the DON, it was determined that the facility failed to act upon a recommendation made by the Pharmacy Consultant in a timely manner for medications that were administered outside of the physician ordered parameters as evidenced by Resident #19. The staff administered to Resident #19 with the order to hold for and to Resident#19 with the order to hold fro , which was administered outside of the physician ordered BP parameters. MD was notified regarding this deficient practice and no new orders were received. 2) No negative outcomes were identified	

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F 756	Continued From page 11 On 02/10/20 at 9:30 AM, the surveyor reviewed the PC Summary Report (SR) for Resident #19, provided by the Administrator. The SR reflected a 11/14/19 PC recommendation assigned to nursing that "MAR [Medication Administration Record] [redacted] reading show that a dose of [redacted] is to be held per hold parameter. Documentation on the MAR does not show that the dose is being held on several days." The SR reflected a second PC recommendation assigned to nursing, dated 01/08/20, that "MAR BP reading show that the dose of [redacted] and [redacted] is to be held per hold parameter. Documentation on the MAR does not show that the dose is being held on several days." A review of the Physician Order Report (POR) for active orders as of 02/07/20 revealed a physician order (order) dated 12/02/19 for [redacted] daily with the scheduled administration time of 9:00 AM. The order included "Special Instructions" to "Hold for [redacted]." The POR revealed a second order dated 12/02/19 for [redacted] daily with the administration time of 9:00 AM. The order also included "Special Instructions" to "Hold for [redacted] A review of the discontinued orders revealed that Resident #19 had an order for [redacted] daily with the administration time of 8:00 AM with a start date of 06/28/19 and a	F 756	for Resident #19 for the identified concern. All residents have the potential to be affected. 3) The facility DON/ADON/Designee will complete 100% education for all licensed nurses to include full time and per diem staff. The emphasis of the education will be on the importance of Pharmacy recommendations that need to be followed up in a timely manner by the nurse and physician. The education was completed by 2/20/2020. This education will be added to the new hire orientation process for all new nurses and will also be provided annually effective 2/11/2020. All licensed staff (RN/LNP) received in-service on the policy and procedure for Drug Regimen Review. Policy and procedure reviewed on 2//10/2020. 4)Effective 2/11/2020, the DON/ADON/Designee will monitor compliance. Facility QAPI committee was notified of this plan of action on 2/11/2020. DON/ADON/Designee will conduct monthly audit of the Drug Regimen Review to ensure policy and procedure compliance. Pharmacy Consultant will conduct monthly audit, review and compare previous recommendations with the DON/ADON/Designee. Pharmacy Consultant will notify DON/ADON/Designee of any non-completion of previous recommendations.	

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	315085	A. BUILDING ______ B. WING ______	02/11/2020

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F 756	Continued From page 12 discontinue date of 12/02/19. The order specified to hold the medication for [redacted]. The discontinued order revealed that Resident #19 also had an order for [redacted] daily with the administration time of 8:00 AM with a start date of 05/09/19 and a discontinue date of 12/02/19. The order specified to hold the medication for [redacted]. A review of Resident #19's electronic Medication Administration History (eMAH) revealed Fludrocortisone was documented as administered outside of the physician ordered [redacted] parameters on the following dates: 11/04/19 at 8:00 AM-[redacted]; 11/05/19 at 8:00 AM-[redacted]; 11/06/19 at 8:00 AM-[redacted]; 11/11/19 at 8:00 AM-[redacted]; 11/13/19 at 8:00 AM-[redacted]; 11/20/19 at 8:00 AM-[redacted]; 11/21/19 at 8:00 AM-[redacted]; 11/22/19 at 8:00 AM-[redacted]; 11/25/19 at 8:00 AM-[redacted]; 11/26/19 at 8:00 AM-[redacted]; 11/27/19 at 8:00 AM-[redacted]; 11/30/19 at 8:00 AM-[redacted] 12/01/19 at 8:00 AM-[redacted]; 12/02/19 at 8:00 AM-[redacted]; 12/03/19 at 9:00 AM-[redacted] 12/04/19 at 9:00 AM-[redacted]; 12/05/19 at 9:00 AM-[redacted]; 12/06/19 at 9:00 AM-[redacted]; 12/14/19 at 9:00 AM-[redacted]; 12/15/19 at 9:00 AM-[redacted]; 12/20/19 at 9:00 AM-[redacted]; 12/22/19 at 9:00 AM-[redacted]; 12/26/19 at 9:00 AM-[redacted]; 01/01/20 at 9:00 AM-[redacted]; 01/02/20 at 9:00 AM-[redacted]; 01/07/20 at 9:00 AM-[redacted]; 01/08/20 at 9:00 AM-[redacted]; 01/16/20 at 9:00 AM-[redacted]; 01/17/20 at 9:00 AM-[redacted]; 01/19/20 at 9:00 AM-[redacted]; and 02/01/20 at 9:00 AM-[redacted] A review of Resident #19 eMAH revealed that Midodrine was administered outside of the	F 756	The findings of the monthly audit will be reported to the DON/ADON/Designee. The DON/ADON/Designee will take corrective action, as necessary, based upon the pharmacy consultant reports, DON/ADON/Designee will review for trends and use findings for performance improvement and report to the quarterly QAPI Committee for 4 quarters. Pharmacy Consultant will conduct QAPI for any findings regarding non-completion of recommendation on quarterly basis. Effective 2/11/2020, the DON/ADON/Designee will report findings of this monitoring process to the QAPI committee during quarterly meetings for 4 quarters. The QAPI committee will modify this plan to ensure the facility remains in substantial compliance.	

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F 756	Continued From page 13 physician ordered BP parameters on the following dates: 11/04/19 at 8:00 AM-[redacted]; 11/05/19 at 8:00 AM-[redacted]; 11/06/19 at 8:00 AM-[redacted]; 11/11/19 at 8:00 AM-[redacted]; 11/13/19 at 8:00 AM-[redacted]; 11/20/19 at 8:00 AM-[redacted]; 11/21/19 at 8:00 AM-[redacted]; 11/22/19 at 8:00 AM-[redacted]; 11/25/19 at 8:00 AM-[redacted]; 11/26/19 at 8:00 AM-[redacted]; 11/27/19 at 8:00 AM-[redacted]; 11/30/19 at 8:00 AM-[redacted]; 12/01/19 at 8:00 AM-[redacted]; 12/03/19 at 9:00 AM-[redacted]; 12/04/19 at 9:00 AM-[redacted]; 12/05/19 at 9:00 AM-[redacted]; 12/06/19 at 9:00 AM-[redacted]; 12/14/19 at 9:00 AM-[redacted]; 12/15/19 at 9:00 AM-[redacted]; 12/20/19 at 9:00 AM-[redacted]; 01/01/20 at 9:00 AM-[redacted]; 01/02/20 at 9:00 AM-[redacted]; 01/07/20 at 9:00 AM-[redacted]; 01/08/20 at 9:00 AM-[redacted]; 01/16/20 at 9:00 AM-[redacted]; and 02/01/20 at 9:00 AM-[redacted]. During an interview with the surveyor on 02/10/20 at 11:01 AM, the Unit Manager (UM) stated the PC sends the pharmacy recommendations to the Director of Nursing (DON) and Assistant Director of Nursing (ADON). The UM further stated the DON would give him the PC recommendations to address and he would return the completed recommendations to the DON within three days. During an interview with the surveyor on 02/10/20 at 11:38 AM, the DON stated she may have overlooked the 11/14/19 PC recommendation for Resident #19. The DON further stated that the PC informed her in January 2020 and she initiated an investigation of the medication parameters at that time.	F 756		

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F 756	Continued From page 14 During an interview with the surveyor on 02/11/20 at 10:25 AM, the PC stated that she comes to the facility monthly to complete the residents' medication regimen review (MRR). The PC stated she typed up any recommendations and generated a summary report that was sent to the Administrator, DON, and ADON. The PC further stated the recommendations on the summary report were broken down into two sections: nursing and physicians. The PC stated recommendations that had a clinical approach (nursing) such as medications errors or transcription errors should be followed up as soon as possible. The PC further stated recommendations that were not followed-up would be repeated on the next month's summary report. If the recommendation was of serious concern, she would conduct a face-to-face with administration to inform them about the recommendation. The PC stated during the December 2019 MRR, she noted that the medications were still being given outside of the parameters and felt that it needed to be addressed right away. The PC further stated she conducted a face-to-face with the ADON because the DON was not available at that time. The PC stated the ADON informed her that she would take care of it. The PC stated that during the January 2020 MRR, she noted that the medications were still being given outside of the parameters, so she documented it on the summary report and conducted a face-to-face with the DON. During a follow-up interview with the surveyor on 02/11/20 at 11:29 AM, the ADON confirmed she was informed that the medications were being administered outside of the physician ordered parameters in December 2019. The ADON	F 756		

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F 756	Continued From page 15 further stated she could not recall if anything was done at that time. The surveyor reviewed the facility's Pharmacy Consultant Services Policy, dated 12/2019, provided by the Administrator. The policy reflected the PC would fax/email recommendations after conducting monthly unit reviews and the Charge Nurses/designee were responsible for following up with physicians. NJAC 8:39 - 29.3(a)(1)	F 756		