STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. BUILDING ______ B. WING ______	12/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & HEALTH CARE CENTER	129 MORRIS TURNPIKE NEWTON, NJ 07860

(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 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 interview and record review, it was determined that the facility failed to follow acceptable standards of clinical practice by not accurately following Physician's Orders. This deficient practice was observed for 2 of 23 residents reviewed, Resident #37 and #86. These deficient practices were evidenced by: 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 registered professional nurse is defined as diagnosing and treating human responses to actual and 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 casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of	F 658	F658-D Element 1 Specific corrective action: Resident #37 The [redacted] orders were clarified with the attending physician. The orders were confirmed, and the licensed nurse was in serviced on the importance of following physician□s orders. [redacted] levels checked daily to meet physicians order. Resident #86 The [redacted] orders were clarified with the attending physician. The orders were confirmed, and the licensed nurse was in serviced on the importance of following physician□s orders. The metoprolol orders were clarified with the attending physician. The orders were confirmed, and the licensed nurse was in serviced on the importance of following physician□s orders. [redacted] levels checked daily to meet physicians order. Resident #86 The pain medication orders were clarified with the attending physician. The orders were confirmed, and the licensed nurse	12/19/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/27/2019

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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F 658	Continued From page 1 supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 12/10/19 at 9:38 AM, the surveyor observed Resident #37 sleeping in bed. The resident was noted with a privacy covered [redacted] hanging on the left side of the bed. The surveyor reviewed Resident # 37's Face Sheet (FS) (A one-page summary of important information about a patient) that documented the resident's diagnosis, which included but was not limited to [redacted]. Resident # 37's FS reflected that the resident's first admission to the facility was on [redacted] and the last admission was on [redacted] A review of the October, November, and December 2019 Electronic Medication Administration Record (eMAR) revealed an order dated [redacted] for [redacted]. The Physician's order establishes [redacted] guidelines for the administration of [redacted] The Physician's order determines that when the [redacted] is checked three times daily, and the levels are between [redacted] should be administered to Resident #37. A review of the October 2019 EMAR revealed five documented [redacted] that were within the [redacted] level with no coverage of [redacted] administered. The [redacted] was recorded as [redacted] on 10/13, [redacted] on 10/19, [redacted] on 10/24, [redacted] on 10/27, and [redacted] on 10/31.	F 658	was in serviced on the importance of following physician□s orders. Orders will be reviewed for accurate level of [redacted] every shift when resident requests [redacted] meds and adjusted if necessary. Element 2 Identification All residents have the potential to be affected by this deficient practice. Element 3 Systemic Changes All licensed staff will be in serviced with competency evaluation with regards to [redacted] parameters and [redacted] management parameters monthly x 3 and quarterly thereafter. Element 4 Monitoring A QAPI will be done by DON/designee on all residents with orders of [redacted], [redacted] parameters and [redacted] management parameters to ensure that [redacted] parameters, [redacted] parameters on [redacted] management parameters were observed and that physicians orders were followed. Results will be submitted to the QAPI Committee monthly and to the Quality Assurance Committee quarterly.	

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Continued From page 2

A review of the November 2019 EMAR revealed five documented [redacted] that were within the [redacted] level with no coverage of [redacted] administered. The [redacted] was recorded as [redacted] on 11/2, [redacted] on 11/3, [redacted] on 11/12, [redacted] on 11/17, and [redacted] on 11/29.

A review of the December 2019 EMAR (from [redacted]) revealed one documented [redacted] that was within the [redacted] level with no coverage of [redacted] administered. The [redacted] was recorded as [redacted] on 12/1.

On 12/16/19 at 12:10 PM, the surveyor met with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing to discuss these findings. The DON could not provide any further information to explain why the facility nursing staff were not accurately following the Physician's order.

2. On 12/10/19 at 9:25 AM, the surveyor observed Resident #86 in the room, sitting on the side of the bed. Resident #86 informed the surveyor that they are treated for [redacted]. The resident also informed the surveyor that they are treated for [redacted] with [redacted] medication.

The surveyor reviewed Resident # 86's FS. Resident # 86 was admitted to the facility on [redacted] with diagnoses that included but is not limited to [redacted]

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F 658	Continued From page 3 The surveyor reviewed Resident # 86's December 2019 eMAR which revealed that the resident received [redacted] four times daily with a protocol to administer [redacted]. If the [redacted] result is [redacted], then administer [redacted] and if the [redacted] result is [redacted] administer [redacted] units. On 12/5/19 at 8:30 AM, the nurse administered [redacted] of [redacted] to the resident for a [redacted] of [redacted] and on 12/12/19 at 8:30 AM, the nurse administered [redacted] of [redacted] of [redacted] The surveyor reviewed Resident # 86's December 2019 eMAR which revealed that the resident received [redacted] mg by oral route two times daily for [redacted] with a protocol to hold the medication if the [redacted]) measures less than [redacted] or if the [redacted] is less than [redacted]. On 12/1/19 the [redacted] measured [redacted] and the nurse administered the medication, on 12/9/19 the [redacted] measured [redacted] and the nurse administered the medication and on 12/13/19 the [redacted] measured [redacted] and the nurse administered the medication. There were no documented adverse effects identified from receiving the medications on those dates listed above. On 12/16/19 at 11:40 AM, the surveyor interviewed the nurse who administered the [redacted] to Resident # 86, who stated that the [redacted] recording in the eMAR must have been an error because nursing practice is to follow the protocol for the	F 658		

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[REDACTED]. The surveyor was unable to get in contact with the nurse who administered the [REDACTED] medication.

On 12/16/19 at 12:10 PM the surveyor brought these findings to the attention of the Administrator, Director of Nursing and Assistant Director of Nursing who stated that the medications should have been administered according to the protocols.

The surveyor reviewed the undated "Proper Documentation and Hold Parameters Policy and Procedure" which showed that "If the order contains parameters for [REDACTED] or [REDACTED] both values must be acceptable for the medication to be administered."

3. On 12/10/19 at 9:33 AM, during the medication administration observation, Resident #86 was observed sitting in bed and watching TV. The Licensed Practical Nurse (LPN) assigned to the resident assessed the resident for [REDACTED]. Resident #86 stated that the [REDACTED] level that they were experiencing was at a [REDACTED]). The LPN treated the resident's [REDACTED] by administering two tablets of [REDACTED] mg).

The surveyor reviewed Resident #86's FS that documented the resident's diagnosis, which included but was not limited to [REDACTED] and [REDACTED].

Resident #86's FS indicated that the resident was

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F 658	Continued From page 5 first admitted to the facility on [redacted] Review of the resident's MDS dated [redacted] revealed that Resident #86 had a Brief Interview for Mental Status (BIMS) with a score of [redacted] Resident's BIMS scores between [redacted] and [redacted], are interpreted as having moderate cognition impairment. Review of the Physician's orders (PO) revealed an order for [redacted] 2 tablets ([redacted] mg) every 6 hours as needed for [redacted], dated 1[redacted] and a PO for [redacted] mg by oral route every 6 hours as needed for [redacted] Level ([redacted], dated [redacted] On 12/10/19 at 11:10 AM, the surveyor interviewed the LPN who could not explain why she administered [redacted] rather than the [redacted]. On 12/10/19 at 12:25 PM, the surveyor interviewed Resident #86, who stated that the [redacted] ordered by the Physician and received that day was effective for the [redacted]. Resident #86 did not express any further concerns regarding the [redacted] A review of the facility's form titled, [redacted] Assessment and Management Protocol" section [redacted] Scale, which documented guidelines that designated [redacted] as levels [redacted] [redacted] as levels [redacted], and worst possible [redacted] as [redacted] On 12/11/19 at 1:30 PM, the surveyor informed the Administrator and the Director of Nursing, who both acknowledged agreed, that the medication was not administered according to the Physician's	F 658		

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F 658	Continued From page 6 order. NJAC 8:39- 29.2 (d), NJAC 8:39-27.1 (a)	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 accurately set [redacted] levels for 2 of 4 residents (Resident #23 and #25) reviewed for [redacted] use. This deficient practice was evidenced by the following: 1. On 12/9/19 at 10:30 AM, the surveyor observed Resident #23 lying in bed, [redacted], and [redacted] with a [redacted] in place. Resident #23 had a privacy covering the resident's [redacted] hanging on the left bedside. Resident #23 was attached to an [redacted] set at [redacted] via a [redacted]. The resident's breathing appeared normal. Resident #23 did not engage in conversation nor respond to any other stimulation. On 12/10/19 at 8:50 AM, the surveyor observed	F 695	F695-D Element 1 Resident #23 The [redacted] order was clarified with the attending physician. The [redacted] order was changed to administer [redacted] continuously. [redacted] saturation check will be done every shift. Resident #25 The [redacted] order was clarified with the attending physician. The order was confirmed to administer [redacted] as needed for [redacted] checks every shift. All nurses were in serviced to check the order for the [redacted] administration from the physician□s order before administering the [redacted] and ensure that the [redacted]	12/19/19

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F 695	Continued From page 7 Resident #23 attached to an [redacted] at [redacted]. The resident's breathing appeared normal. The surveyor reviewed Resident #23's Face Sheet (A one-page summary of important information about a patient) that documented the resident's diagnosis, which included but was not limited to [redacted]. Resident #23 was first admitted to the facility on [redacted] and had a documented last admission to the facility as [redacted] on the resident's Face Sheet. A review of the resident's Minimum Data Set (MDS) (a health status screening and assessment tool used for all residents of long-term care nursing facilities), dated [redacted] revealed that Resident #23 was [redacted] and never [redacted] as noted in the Cognition / Brief Interview for Mental Status (a test that is used to get a quick snapshot of cognitive function) section of the MDS. The surveyor reviewed Resident #23's November and December 2019 Physician's Orders and Electronic Medication Administration Record (EMAR). The Physician's order, dated [redacted], documented [redacted] at [redacted]." The November and December 2019 EMAR documented the order [redacted]" which was signed daily as administered by nursing from 11/1/19 to 12/12/19.	F 695	[redacted] displayed on the [redacted] matches the physician□s order. [redacted] check will be done every shift. Element 2 Identification All residents have the potential to be affected by this deficient practice. Element 3 Systemic changes Licensed staff will check the [redacted] flow rate on all residents using [redacted] therapy during rounds and compare it against the physician□s order at the start and end of each shift. Element 4 Monitoring A QAPI will be done by DON/Designee to ensure that residents receiving [redacted] therapy have a physician□s order before [redacted] administration and that the flow rate displayed in the gauge matches the physician□s order monthly, for three months, and quarterly thereafter. Results will be submitted to the QAPI Committee monthly and discussed during the Quality Assurance meeting quarterly with the QAPI team.	

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A review of the November and December 2019 EMAR documented the "Monthly Vital Signs," which included "Respiration." A person's respiratory rate is the number of breaths they take per minute. The average respiration rate for an adult at rest is 12 to 20 breaths per minute (RPM), as per the Cleveland Clinic. The November and December 2019 EMAR documented 16 RPM on 11/5/19 and 12/3/19, within normal respiration limits.

A review of the Care Plan (CP) with an effective date of [redacted] belonging to Resident #23 documented "[redacted]"

On 12/12/19 at 1:04 PM, the surveyor once again observed Resident #23 lying in bed, receiving [redacted]. The surveyor interviewed Resident #23's nurse, who stated that they could not set the [redacted]. She further noted that the [redacted] had a maximum setting [redacted]. The resident's nurse added that the resident's breathing was normal.

On 12/12/19 at 1:13 PM, the surveyor informed the Director of Nursing (DON) of the discrepancy between the Physician's order, the EMAR, the CP. The DON stated, "We do have [redacted] go up [redacted]." The DON could not explain why the discrepancies were present.

2. On 12/09/19 at 9:36 AM, the surveyor observed Resident #25 seated in a wheelchair wearing eyeglasses. The resident was receiving [redacted]

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F 695	Continued From page 9 via a that was set at . When interviewed, the resident informed the surveyor that the is used only as needed. On 12/10/19 at 1:13 PM, the surveyor observed Resident #25 seated in a wheelchair in the resident's room. The resident was receiving that was set at . On 12/12/19 at 10:30 AM, the surveyor observed Resident #25 seated in a wheelchair in the resident's room. The resident was receiving that was set at . The surveyor reviewed Resident #25's Face sheet that documented the resident's diagnosis, which included but was not limited to . Resident #25 was first admitted to the facility on and had a Face Sheet documented last admission to the facility on . Review of the resident's MDS dated revealed that Resident #25 had a Brief Interview for Mental Status (BIMS) with a score of Resident's BIMS scores between and , are interpreted as having moderate cognition impairment. The surveyor reviewed the Patient Safety Notes (PSN) from dated that detailed in the Skilled Nursing Evaluation,	F 695		

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F 695	Continued From page 10 Review of the Physician's Order dated documented ' as needed for or) below " Review of the December 2019 EMAR documented the as on 12/9/19, 12/10/19, and 12/12/19. There were recorded levels of on the 12/10/19 3:00-11:00 shift, on the 12/12/19 3:00-11:00 shift, and on the 12/12/19 11:00-7:00 shift when was administered to Resident #25. On 12/12/19 at 1:36 PM, the surveyor met with the DON and informed him that the Physician's order was yet on three occasions, the was found set at On 12/16/19 at 10:30 AM, the DON informed the surveyor that he observed the at and could not explain why Resident #25's was not set to the appropriate Physician's order level of NJAC 8:39-15.1(a)	F 695		
F 756 SS=D	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.	F 756		12/19/19

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F 756	Continued From page 11 §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 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 observation, interview, and record review, it was determined that the Consultant Pharmacist (CP) failed to identify the dosing irregularities documented on a [redacted] physician's order. This irregularity was identified for 1 of 23 residents reviewed by the CP, Resident #37.	F 756	F756-D Element 1 Resident #37 The [redacted] orders for the [redacted] were clarified with the attending physician. All nurses that took care of resident #37 were	

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(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 756	Continued From page 12 The deficient practice was evidenced by the following: On 12/10/19 at 9:38 AM, the surveyor observed Resident #37 sleeping in bed. The resident was noted with a privacy covered [redacted] hanging on the left side of the bed. The surveyor reviewed Resident # 37's Face Sheet (A one-page summary of important information about a patient) that documented the resident's diagnosis, which included but was not limited to [redacted]. Resident # 37's Face Sheet indicated that the resident was first admitted to the Facility on [redacted] and last admitted on [redacted]. Review of the October, November, and December 2019 Electronic Medication Administration Record (EMAR) reveals an order dated [redacted] for [redacted]. The physician's order establishes [redacted] guidelines for the administration of [redacted] The physician's order determines that when the [redacted] is checked three times daily, and the levels are between [redacted] then [redacted] of [redacted] should be administered to Resident #37. A review of the October 2019 EMAR revealed five documented [redacted] that were within the [redacted] level with no coverage of [redacted] administered. The [redacted] was documented as [redacted] on 10/13, [redacted] on 10/19, [redacted] on 10/24, [redacted] on 10/27, and [redacted] on 10/31. A review of the November 2019 EMAR revealed five documented [redacted] that were within the [redacted]	F 756	in serviced with regards to [redacted] [redacted] coverage and [redacted] parameters. The pharmacy consultant reviewed all residents' charts with [redacted] and [redacted] parameters to ensure that accurate [redacted] coverage is administered. Element 2 Identification All residents have the potential to be affected by this deficient practice. Element 3 Systemic changes The pharmacy consultant will review all residents on a monthly basis, and not spot check the administration records. Element 4 Monitoring A QAPI will be done by DON/designee on all residents with [redacted] to ensure that [redacted] parameters are observed, and [redacted] coverage are administered accurately monthly x3 and quarterly thereafter. Reports will be submitted to the QAPI Committee monthly and discussed during the Quality Assurance meeting quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. BUILDING ______ B. WING ______	12/16/2019

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F 756	Continued From page 13 with no coverage of administered. The was documented as on 11/2, on 11/3, on 11/12, on 11/17, and on 11/29. A review of the December 2019 EMAR (from 12/1-12/11) revealed one documented that was within the level with no coverage of administered. The BS was documented as on A review of the Consultant Pharmacist Evaluation sheet revealed that the CP visited the Facility on and , with no comments identifying the lack of administration when Resident # 37's levels were documented to be within the dosing guidelines. On 12/16/19 at 1:01 PM, the surveyor interviewed the CP, who stated that she spot checks parameters. The CP said, "I must have missed it, and if I had noticed it, I would have identified it." The surveyor reviewed the CP agreement with the Facility that identified the "Duties of Consultants." Under section 2. a. the agreement describes, "The Consultant shall be responsible for consultation on all aspects of the provision of pharmacy services in the Facility. More Specifically, Consultant shall provide the following services: iii. Performing a monthly onsite review of the drug regimen of each patient on the Facility's unit census on date(s) of the visit. Reports of any irregularities shall be provided to the nurse in charge and/or the attending physician, and the administrator." On 12/16/19 at 10:23 AM, the surveyor met with	F 756		

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F 756	Continued From page 14 the Director of Nursing, Assistant Director of Nursing and Administrator, who could not provide any further information. NJAC 8:39 - 29.3 (a 1, 6)	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain a medication rate error below 5%. The surveyor observed three nurses administer 28 doses of medication to 3 residents, and there were 3 errors, which resulted in a medication error rate of 10.71%. The deficient practice was evidenced by the following: 1. On 12/10/19 at 9:09 AM, during the medication administration observation (med pass), the surveyor observed the Licensed Practical Nurse (LPN) preparing to administer medications to Resident #89 which included a Physician ' s order (PO) for [redacted] mg 1 tablet by mouth every 12 hours with parameters to hold the medication for [redacted] or for [redacted]) below [redacted]. The LPN did not take the [redacted] or [redacted] immediately before administering the [redacted] mg. The LPN stated that she checked the [redacted] and [redacted]	F 759	F759-D Element 1 Specific Corrective action Resident #89 a) MD was made aware that resident was given the [redacted] mg 1 tab based on [redacted] that was taken in earlier timeframe instead of taking the [redacted] immediately before administering the [redacted] 1 tab. The licensed staff who took care of resident #89 was in service to take the [redacted] immediately before administering [redacted] mg I tab. b) MD was made ware that resident #89 was given [redacted] mg I tab at 9:15 am during [redacted] days. The physician□s order is to administer [redacted] mg I tab at 7:30am during [redacted] days [redacted], [redacted] and [redacted] Physician order was changed, Give [redacted] mg I tab	12/19/19

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F 759	Continued From page 15	F 759		

F 759 — Summary Statement of Deficiencies:

before 9 AM.

2. On 12/10/19 at 9:09 AM, during the med pass, the surveyor observed the LPN preparing to administer medications to Resident #89, which included a PO for mg 1 tablet by mouth once a day with a protocol to give at 7:30 AM to allow for absorption before A review of the most current PO indicated that Resident #89 went to , and . The LPN administered the medication at 9:15 AM on the resident ' s day,

3. On 12/10/19 at 10:00 AM, during the med pass, the surveyor observed the LPN preparing to administer medications to Resident #86, which included a PO for mg 1 tablet by mouth twice a day with parameters to hold the medication for below or . The LPN did not take the or immediately before administering the medication. The LPN stated that she checked the and at about 9:00 AM.

On 12/11/19 at 1:30 PM, the surveyor brought these findings to the Administrator and the Director of Nursing (DON). The DON stated that and HR should be checked immediately prior to the administration of medication with parameters.

NJAC 8:39-29.2 (d)

F 759 — Provider's Plan of Correction:

p.o. once daily at 7:30 am on days - Med Pass observation was done on the licensed staff that was assigned to resident #89 by Pharmacy consultant.

Resident #86
MD was made aware that resident was given the mg 1 tab based on that was taken in earlier time frame instead of taking the immediately before administering the mg 1 tab. The licensed staff who took care of resident #86 was in serviced to take the immediately before administering mg I tab.
Med Pass observation was done on the licensed staff that was assigned to resident #86 by Pharmacy consultant.

Element 2
Identification
All residents have the potential to be affected by this deficient practice.

Element 3
Systemic changes
Licensed nurses to be med passed randomly on a monthly basis by the pharmacy consultant.

Element 4
Monitoring
Monthly Med pass audits to ensure proper procedures are sustained to be reviewed by the DON/designee.

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F 759	Continued From page 16	F 759	A QAPI will be done by DON/Designee. Results will be submitted to QAPI Committee monthly and to the Quality Assurance Committee meeting quarterly.	