STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A008	A. BUILDING: _____ B. WING _____	C 01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA BY MONARCH	2 KATHLEEN DRIVE JACKSON, NJ 08527

(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) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint CENSUS: 67 SAMPLE SIZE: 7 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 779	8:36-7.5(c) Resident Assessments and Care Plans (c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care intervention or medical care. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00150844	A 779		

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A 779	Continued From page 1 Based on interview and record review it was determined that the facility failed to notify a Registered Professional Nurse (RN) when a resident [redacted] in order to assess the resident's nursing care needs for 1 of 7 residents reviewed, Residents [redacted]. This deficient practice was evidenced by the following: On 1/19/22 at 10:20 a.m., the surveyor reviewed Resident [redacted]s medical record. According to the "Resident Face Sheet" the resident was admitted to the facility [redacted] with diagnoses which included [redacted] The Nurses' Progress Note (PN) dated 1/12/22 at 9:30 a.m., documented by a Licensed Practical Nurse (LPN); revealed that the resident was [redacted]. The resident was hospitalized and was not available for interview during the survey. The PN "Incident Note" dated [redacted] at 12:34 [a.m./p.m., not indicated] written by LPN #1 revealed that at 10:30 a.m., the resident had an [redacted] in the apartment kitchen. The LPN documented that the resident stated that he/she hit his/her [redacted] but there was no injury noted and that [redacted] was within normal limit. The PN "Fall Note" dated [redacted] at 1630 [4:30 p.m.,] written by LPN #2 indicated that the resident stated that he/she [redacted] and slid to the floor. The LPN documented that the resident denied hitting his/her [redacted] and was not in any [redacted]. The surveyor interviewed LPN #1 and LPN #2 regarding the aforementioned [redacted] incident that occurred on [redacted] and [redacted], and inquired if a	A 779		

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A 779	Continued From page 2 Registered Nurse (RN) was notified of the incidents. Both LPNs confirmed that they did not notify an RN. LPN #1 explained that she was used to calling the Executive Director (ED) when there was no RN. LPN #2 stated that she notified another LPN of the incident and she was told that there was no RN and to only notify the physician.	A 779		
A 793	8:36-8.2 Nursing Services A facility shall have at least one registered professional nurse available at all times. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00150844 Based on interview and record review it was determined that the facility failed to ensure a Registered Professional Nurse (RN) was available to the facility at all times. The facility failed to have an RN available from [redacted] through [redacted] as evidenced by the by the following: On 1/19/22 at 9:30 a.m., the surveyor interviewed the Executive Director (ED) and inquired as to the whereabouts of the Director of Nursing (DON). The ED stated that the facility had a new DON who would be starting employment on [redacted] The ED explained that the former DON resigned, and that her last date of employment was on [redacted]. The surveyor then asked the ED about RN coverage from [redacted] through [redacted], date of survey. The ED informed the surveyor that the facility had 3 on-call RNs from [redacted] through [redacted] when the DON will resume the position. The ED provided the surveyor a list of RN	A 793		

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A 793	Continued From page 3 coverage from [redacted] to [redacted] The surveyor conducted an interview with Licensed Practical Nurse (LPN) #1, LPN #2, LPN #3 and LPN #4 from 9:45 a.m., to 10:40 a.m., and asked the LPNs who would they notify in the event of an incident or accident at the facility. LPN #1 stated that she just found out yesterday [1/18/22] of the on-coming DON and today [1/19/22] of the on-call RN. LPN #1 explained that she was instructed by the ED to call her [ED] with nursing related issues since the facility did not have an RN at the time. LPN #2 stated that she was new to the facility and was told by LPN #1 that the facility did not have an RN. LPN #2 added that she was instructed by LPN #1 to call the ED with any nursing issues and that the ED would then look for an RN to notify. LPN #3 stated that she returned to work today after being out of work for a while. LPN #3 explained that she was informed by the staffing coordinator today [1/19/21] that there is a new DON effective [redacted] and that there was an on-call RN available. LPN #4 told the surveyor that the ED sent out a memo via email dated [redacted] that there was an RN on-call for all nursing issues. She confirmed that prior to [redacted], the facility did not have an RN after the former DON resigned on [redacted] and that all nursing issues went to the ED. Surveyor review of the "Registered Nursing Coverage Timeline" provided by the ED indicated that the former DON's last date of employment was [redacted]. RN #1's last date on-call was [redacted] and RN #2 began taking calls from [redacted] to present. The current DON [RN #3] began taking calls on [redacted] and will resume the	A 793		

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A 793	Continued From page 4 DON position on [redacted]. The surveyor interviewed RN #1, RN #2, and RN #3 at 1:15 p.m., 1:30 p.m., and 1:50 p.m., respectively. RN #1 told the surveyor that she was never on call for the facility and that her last date of employment at the facility was [redacted]. RN #2 stated that she is currently on-call for the facility which began around the end of [redacted]. RN #3 confirmed that she will be the current DON effective [redacted] and began taking calls for the facility on [redacted]. The Timeline indicated that the facility had RN coverage from [redacted] through [redacted], however, RN interviews revealed that there was no RN coverage from [redacted] through [redacted]. At 3:30 p.m., the surveyor informed the ED of the aforementioned concerns and she was not able to provide the surveyor evidence to show that the facility had an on-call RN from [redacted] to [redacted].	A 793		
A 963	8:36-11.5(f) Pharmaceutical Services (f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00150844 Based on interview and record review it was	A 963		

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A 963	Continued From page 5	A 963		

determined that the facility staff authorized to administer medications failed to ensure medications were administered to residents and documented in accordance with prescriber's orders for [redacted] residents reviewed, Residents [redacted], Resident [redacted], Resident [redacted] Resident [redacted], and Resident [redacted] This deficient practice was evidenced by the following:

On 1/19/22 at 10:20 a.m., the surveyor reviewed Resident [redacted]s medical record and the "Resident Face Sheet" revealed that the resident was admitted to the facility [redacted] with diagnoses which included [redacted]. According to the "Nurses' Progress Note" (PN) dated [redacted] at 9:30 a.m., the Licensed Practical Nurse (LPN),documented that the resident was [redacted]. The resident was not available for interview due to the resident's hospitalization.

Further, the surveyor reviewed Resident [redacted]s Physician's Order Sheet (POS) dated [redacted] and observed that the resident had an order for [redacted] milligram (mg) tablet by mouth every eight hours. [redacted] is a medication used to treat adults with [redacted]. The surveyor reviewed the Medication Administration Record (MAR) dated [redacted] and observed that the [redacted] mg tablet was not signed as administered to the resident on the following dates and times: On 12/20, 12/21, 12/25 and 12/26/21 at 6 a.m.. On 12/11 and 12/24/21 at 2 p.m., and on 12/20 and 12/26/21 at 10 p.m.

Surveyor review of the MAR dated [redacted], indicated that [redacted] mg tablet was not signed as administered on 1/1 and 1/9/22 at 6

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A 963	Continued From page 6 a.m. The [redacted] order included to hold the medication if [redacted], however, the surveyor observed that the resident's [redacted] was not obtained and documented as ordered by the physician. The MARs revealed that the resident missed a total of 8 doses of [redacted] mg on the aforementioned dates. The surveyor interviewed a Registered Nurse (RN) via telephone, Licensed Practical Nurse (LPN) LPN #1, LPN #2, and LPN #3 between 11:40 a.m., and 1:50 p.m. regarding the [redacted] omission on the MAR. They all stated that the resident would refuse the [redacted] if not administered at a specific time or if the [redacted] was [redacted]. The four licensed staff agreed that rational for not administering the medication to Resident [redacted] should have been documented at the back of the MAR. At 3:30 p.m., the surveyor interviewed the Executive Director (ED) regarding Resident [redacted] Adempas not administered to the resident on the aforementioned dates. The ED stated that the resident once told her [ED] that if the [redacted] was not brought to him/her [Resident [redacted]] at a specific time that the resident would refuse the medication. The ED acknowledged that the medication was omitted on the aforementioned dates and times and the reason for the omissions should have been documented. The ED added that she was not aware of the missing signatures on the MAR. Review of the "Medication Administration" policy and procedures dated 01/01/2021 revealed, "The eMAR will be accurate and include the following	A 963		

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A 963	Continued From page 7 information: Documentation of any omission of medications or treatments, and the reason for the omission, including refusal." 1. On 1/19/22 at 10:30 a.m., the surveyor reviewed Resident [redacted]'s Medication Administration Records (MAR) dated [redacted], 1[redacted], and [redacted] which showed that there were four medications not signed as being administered to Resident [redacted] on the following dates and times: a) On 11/19/21 [redacted] mg tablet ([redacted]) 9:00 p.m. dose was unsigned. b) On 11/30/21 [redacted] microgram (mcg) tablet [redacted]) 7:30 a.m. dose was unsigned c) On 11/5/21, 11/12/21, 11/16/21, 11/19/21 [redacted]) 7a.m. to 3:00 p.m. shift doses were unsigned. d) On 12/14/21 [redacted] mcg tablet 7:30 a.m. dose was unsigned. [redacted] mg tablet (supplement) 9:00 a.m. dose was unsigned. e) On 12/11/21 to 12/30/21 [redacted] paste 16 doses were unsigned between the 7:00 a.m. to 3:00 p.m. shifts, the 3:00 p.m. to 11:00 p.m. shifts, and the 11:00 p.m. to 7:00 a.m. shifts. f) On 1/10/22 and 1/14/22 [redacted] mg tablet 5:00 p.m. doses were unsigned. g) On 1/1/22 to 1/18/22 [redacted] paste 19 doses were unsigned between the 7:00 a.m. to 3:00 p.m. shifts, the 3:00 p.m. to 11:00 p.m. shifts, and the 11:00 p.m. to 7:00 a.m. shifts. 2. On 1/19/22 at 11:00 a.m., the surveyor reviewed Resident [redacted]'s MAR dated [redacted] which showed that there were five medications not signed out as being administered to Resident [redacted] on the following dates and times: a) On 1/7/22 and 1/9/22 [redacted] mg tablet	A 963		

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A 963	Continued From page 8	A 963		

[redacted]) 9:00 p.m. doses were unsigned.
b) On 1/10/22 and 1/15/22 [redacted] mg tablet [redacted] 2:00 p.m. doses were unsigned, and on 1/7/22, 1/8/22, and 1/9/22 9:00 p.m. doses were unsigned.
c) On 1/9/22 [redacted] tablet 5:00 p.m. dose was unsigned.
d) On 1/7/22, 1/8/22, 1/9/22 [redacted] mg tablet [redacted]) 9:00 p.m. doses were unsigned.
e) On 1/10/22 [redacted] gram (gm) packet [redacted] 9:00 a.m. dose was unsigned.

3. On 1/19/22 at 11:45 a.m., the surveyor reviewed Resident [redacted]'s MAR dated [redacted] which showed that there was one medication not signed out as being administered to Resident [redacted] on the following dates and times:

a) On 1/5/22, 1/9/22, 1/10/22, and 1/11/22 Soothe and [redacted] Cream ([redacted]) for the 7:00 a.m. to 3:00 p.m. shift, and the 3:00 p.m. to 11:00 p.m. shifts doses were unsigned. In addition, Resident [redacted] may self-apply medication, but the medication still has to be signed out as identified on Resident [redacted]'s MAR.

4. On 1/19/22 at 12:15 p.m., the surveyor reviewed Resident [redacted]'s MAR dated for [redacted], and [redacted] which showed that there were six medications not signed out as being administered to Resident [redacted] on the following dates and times:

a) On 12/16/21 and 12/20/21 [redacted] mg tablet [redacted]), [redacted] mg tablet ([redacted]), [redacted] mg tablet ([redacted] mg tablet [redacted]), and [redacted] mg tablet doses were unsigned.

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A 963	Continued From page 9 b) On 1/1/22 and 1/12/22 [redacted] mg [redacted] tablet ([redacted]), [redacted] mg tablet ([redacted] mg tablet ([redacted] mg tablet [redacted], and [redacted] mg tablet [redacted] doses were not signed out. Further review of Resident [redacted]'s, Resident [redacted]'s, Resident [redacted]'s and Resident [redacted]'s MARs, displayed on the back side of the MAR's an area titled "PRN, STAT AND MEDICATION NOT ADMINISTERED" which included a space for documentation of the date, the hour, the medication, the reason, and the result. In addition, there was a key for recording omissions of medications and spaces for signatures and initials. The surveyor did not identify any documentation for the unsigned medications or reasons for omission of medication on any of the sampled residents MARs. The surveyor interviewed LPN #1, LPN #2, and LPN #3 between 2:00 p.m. and 2:30 p.m., regarding the procedure for omitted medications and they all stated if a medication was not given or not available the medication would be initialed and circled on the date and time the medication was due to be administered. Additionally, the reason for the omitted medication would be documented on the back of the resident's MAR. At 2:45 p.m., the surveyor reviewed the facility policy and procedure titled "Medication Administration" and listed under " ...Procedures: ...2. The associate administering medications will document on the resident's electronic medication administration record (eMAR) immediately following administration of the medication to the resident ....3. The eMAR will be accurate and include the following information: ...g.	A 963		

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A 963	Continued From page 10 Documentation of any omission of medications or treatments, and reason for the omission ...." At 3:30 p.m., the surveyor interviewed the Executive Director (ED) regarding the unsigned medications on the residents MARs and the ED informed the surveyor that she was not aware of the missing signatures on the MARs or why the staff did not document the reasons for the omitted medications.	A 963		