PRINTED: 07/28/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315477	B. WING		C 01/20/2017	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	1 01/20/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 000	INITIAL COMMENTS		F 00	00		
	COMPLAINT # NJ 9 CENSUS: 59	95717, NJ 95718				
F 281 SS=E	PROFESSIONAL ST		F 28	11	2/16/17	
	as outlined by the comust-	d or arranged by the facility, mprehensive care plan,				
	This REQUIREMEN by:	standards of quality.  T is not met as evidenced		4 Davidanta #44 0 0 5 0 7 0 have h		
	C# NJ 95717, C# No Based on observatio	J 95718 ns, interviews, medical		1.Residents # 1,2,3,5,6,7,8 have b discharged from COAW.	een	
	facility documentatio was determined that their policy on re-ord	and review of other pertinent n on 1/9/17 and 1/20/17, it the facility failed to follow ering medications in advance		2.All Residents have the potential to affected.  Residents found in need of Schedu		
	Schedule IV (Xanax) of 9 sampled resider #8) which resulted in	of Schedule II (Dilaudid) and controlled medications for 4 ats (Resident #5, #6, #7 and the borrowing of these		control prescription or refill will be obtained by Physician to be sent to Pharmacy to fill.		
	the facility administe medications for 4 of	#1, #2 and #3). In addition, red the borrowed controlled 9 sampled residents		3.Facility educator/ designee will in licensed nurses regarding reorderir medications, obtaining of prescripti schedule 1-5 medications, non-born	ng of ons for	
	facility failed to docu Schedule II controlle (Dilaudid) on the Me	and #8). Furthermore, the ment the administration of d substance medications dication Administration of 9 sampled residents		policy, wasting procedure and documentation Medication Adminis Record (MAR) to coincide with Con Drug Administration Record (CDAR)decline control accountabili	trolled	
ABODATORY		ISLIPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>	TITLE	(X6) DATE	

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 03/24/2017

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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			A. BUILDING	i			
		315477	B. WING		01/20/2017		
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE			
				493 BLACK OAK RIDGE ROAD			
CARE ON	E AT WAYNE - SNF			WAYNE, NJ 07470			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES  EACH DEFICIENCY MUST BE PRECEDED BY FULL  EGULATORY OR LSC IDENTIFYING INFORMATION)  ID  PROVIDER'S PLAN OF CORRECTION  PREFIX  TAG  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		OULD BE COMPLETION			
F 281	Continued From pag	e 1	F 28	1			
		). This deficient practice is		record.			
	evidenced by the foll	·		Unit Manager or designee will auc current residents with an order for	-		
		sey Statutes, Annotated Title g Board The Nurse Practice		Schedule 2 (Dilaudid) and Schedu (Xanax) to ensure Individual Residual			
		lew Jersey states; "The		Prescription availability to dispens			
		s a registered professional		prescribed in accordance with Phy	ysican		
	nurse is defined as diagnosing and treating			Orders.			
		actual or potential physical		Director of Nursing obtained DEA	222		
	and emotional health problems, through such services as case finding, health teaching, health			forms for Pyxis controlled medical			
	I .	rision of care supportive to or		ordering process to maintain a su			
		I well-being, and executing a		Schedule 1-5 controlled medication			
		prescribed by a licensed or		conjunction with Medical Directors			
	otherwise legally aut	horized physician or dentist."		Inventory levels will be monitored needs.	for refill		
		sey Statutes Annotated, Title					
		sing Board. The Nurse		Unit Manager or designee will cor			
	I .	State of New Jersey states:		review residents for Medication Av	vailability		
	nurse is defined as p	ng as a licensed practical performing tasks and		for administration daily			
	responsibilities withir	n the framework of case		Director of Nursing will continue to			
		ne patient and family teaching		Pyxis inventory supply of Schedul			
	program through hea	_		controls and replenish as needed.			
		sion of supportive and					
	restorative care, und			4.505//184/5			
	authorized physician	censed or otherwise legally		4.DON/ UM/ Designees will condu audits of 2 identified residents we			
	authorized physician	or dentist.		3 months with an order for Schedu			
	According to the "Admission Record", Resident			(Dilaudid) and Schedule 4 (Xanax			
		8/8/16, and re-admitted on		prescription availability, and prope			
		oses that included but were		documentation (MAR) coinciding			
		es Mellitus, Hypertension,		Controlled Drug Administration Re			
	I .	ase, and Anxiety. Resident		(CDAR).			
	# 1 was discharged 0	11 12/20/10.		Findings will be presented at the 0	Quality		
		nt #1's Minimum Data Set		Assurance meeting held monthly			
	(MDS), an assessme	ent tool dated 10/28/16, the		further recommendations by comr	mittee		

Facility ID: NJ61619

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315477	B. WING		C 01/20/2017	
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	1 01/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 281	Continued From paresident had impair memory, and had in ability.  According to the Ph 10/23/16, Resident 0.25 milligram (mg. day. In addition, on tablet by mouth everanxiety was ordered. According to Reside Medication Administ Xanax was docume administered as ord 12/26/16, and was Controlled Drug Ad. On 1/9/17 at 10:05 Narcotic box inside Cart (MC#3) was contained to the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controlled drugs with ability and the surveyor obsert (pop-out medication controll	ge 2 ed short and long-term mpaired decision making  nysician's Orders dated #1 was prescribed Xanax ) 1 tablet by mouth once a 10/24/16, Xanax 0.25 mg 1 ery 6 hours as needed for	F 28			
	there were 13 table administered). A re #1's Xanax reveale RN #2 as wasted (of for Resident #1 rev been 18 tablets of a tablets. The docum revealed that five o	Resident #1 revealed that its of Xanax 0.25 mg. left (not view of the CDAR for Resident d four tablets were signed by disposed of). This same CDAR ealed that there should have Kanax left instead of 13 ent attached to the CDAR f Resident #1's remaining ere used for two other t #5 and #8).				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		315477	B. WING			C
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF	1 00		STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470		01/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 281	Continued From pag	ge 3 m., the Director of Nursing	F 2	81		
	(DON) stated that R Nurse (LPN #1) wer Assistant Director of The DON stated that the ADON that Resi Xanax were not was Resident #8 by RN #2 and LPN #1 were provided with an In- which included: "No medications, the ph notified for all contro need prescriptions, Medication Unavaila what to do, and all of wasted would need An interview with RI	IN #2 and Licensed Practical re interviewed by the the f Nursing (ADON) on 1/9/17. It RN #2 and LPN #1 informed dent #1's four tablets of sted but were given to #2. The DON stated that RN re given verbal warnings and service Education on 1/9/17, borrowing" of any kind of sysician would need to be solled medications that would the nurse should follow the " able Flow Chart" to determine controlled medications that get a witness.  N #2 and LPN #1 was				
	that Resident #1's X was borrowed and a RN #2 stated that sl Resident #1's Xana: Resident #8 had no time and there was (an automated med for emergency). RN documented Reside because she knew to borrowing of medical During this interview present when RN #2 Xanax for Resident RN #2 documented	ent #1's Xanax as wasted that the facility would not allow ations.  V, LPN #1 stated that she was 2 borrowed Resident #1's #8. LPN #1 also stated that the 4 doses of 0.25 mg ecause the nurses were not				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, , ,	LE CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED		
		315477	B. WING			C 01/20/2017	
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470		01/20/2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 281	Continued From pa	ge 4	F 28	1			
	#2 was admitted on included but were n Diabetes Mellitus, a was discharged on						
		mission Assessment dated #2 was alert and oriented to ime.					
	11/14/16, Resident	ysician's Orders dated #2 was on Dilaudid 2 mg. 1 ry 6 hours as needed for					
	revealed that the res 1 tablet by mouth ex moderate pain and of was administered the	t #2's November 2016 MAR sident was on Dilaudid 2 mg. very 6 hours as needed for documented that Resident #2 is medication as ordered until n., as well as recorded on R.					
	Narcotic box inside	a.m., an inspection of the the South Unit's MC#3 was irveyor in the presence of RN					
	there was zero table pain) for Resident # Resident #2's Dilaud have been 26 tablet The document attact that all of Resident?	Resident #2 revealed that ets left of Dilaudid 2 mg. (for 2. A review of the CDAR for did revealed that there should s left instead of zero tablets. hed to the CDAR revealed #2's remaining tablets of for three other residents d #8).					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		315477	B. WING			C <b>01/20/2017</b>
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470		01/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	#3 was admitted on included but were in Obstructive Pulmon Fibromyalgia, and A discharged on 12/2:  According to Reside the resident scored for Mental Status (E resident was cognit According to the Ph 12/12/16, Resident tablet by mouth every Anxiety.  A review of Resider revealed document administered this in 12/23/16 at 1:19 a.r. Resident #'3's CDA On 1/9/17 at 10:05 Narcotic box inside conducted by the standard RN #2.  The Bingo card for there were 3 tablets Resident #3. The C revealed that there left instead of 3 tablets to the CDAR reveal #3's remaining tablet two other residents	"Admission Record" Resident 12/12/16, with diagnoses that of limited to; Chronic lary Disease, Hypertension, Anxiety. Resident #3 was 3/16.  Bent #3's MDS dated 12/18/16, 15/15 on the Brief Interview BIMS), which indicated the ively intact.  Bysician's Orders dated #3 was on Xanax 0.25 mg. 1 Bry 4 hours as needed for  At #3's December 2016 MAR ation that Resident #3 was edication as ordered until m. and was recorded on	F 2	81		
	conducted by the st RN #1 and RN #2.  The Bingo card for there were 3 tablets Resident #3. The C revealed that there left instead of 3 tablets to the CDAR reveal #3's remaining tablet two other residents #8).	Resident #3 revealed that seleft of Xanax 0.25 mg. for DAR for Resident #3's Xanax should have been 16 tablets lets. The document attached led that thirteen of Resident lets of Xanax were used for				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  E AT WAYNE - SNF	·		STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	01/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 281	included but were r Replacement, Hype Resident #5 was di Resident #5's MDS the resident had im long-term memory, making ability.  According to the Pt 12/18/16, Resident tablet by mouth eve A review of Resident January 2017 MAR was administered t 1/15/17 at 5:17 p.m documentation of the from Resident #1 of from Resident #3 of 5. According to the 12/22/16, Resident diagnoses that incluvaginal and Cervic Compression. Resi 1/14/17.  According to Resident the resident scored indicated the resident According to the Pt 12/23/16, Resident tablet by mouth eve breakthrough pain.	n 12/13/16, with diagnoses that not limited to; Right Hip ertension, and Dementia. Ischarged on 1/19/17.  Is dated 12/19/16, revealed that apaired short term and and had impaired decision  Inysician's Orders dated #5 was on Xanax 0.25 mg. 1 ery 6 hours as needed.  Int #5's December 2016 and Redocumented that Resident #5 he Xanax as ordered until n., which included he Xanax that was borrowed in 1/2/17 at 12:00 a.m. and in 12/25/16 at 7:11 p.m.  "Admission Record" dated #6 was admitted with uded but were not limited to; all Cancer and Spinal Cord ident #6 was discharged on  ent #6's MDS dated 12/29/16, in 15/15 on the BIMS which ent was cognitively intact.  In ysician's Orders dated #6 was on Dilaudid 2 mg. 1 ery 4 hours as needed for In addition, on 12/27/16, blet by mouth every 3 hours as	F 28	31	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315477	B. WING				20/2017
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF		1	4	STREET ADDRESS, CITY, STATE, ZIP CODE 193 BLACK OAK RIDGE ROAD NAYNE, NJ 07470	1 0117	20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	revealed that the Dila having been administ would account for the Resident #2 on 12/22 recorded on Resident MAR also revealed the signed as having been which would account from Resident #2 on recorded on Resident A review of the Nurse at 11:17 p.m., signed Currently receives me management."  A review of the NN dasigned by RN #2, review of the NN dasigned and Dila Resident #2 on not signed as having in Resident #6's MAR During the same post on 1/25/17 at 2:00 p.1 LPN #2 documented	#6's December 2016 MAR udid was not signed as ered by LPN #2, which is Dilaudid borrowed from 1/16 at 10:00 p.m., as it #2's CDAR. Resident #6's not the Dilaudid was not in administered by RN #2, for the Dilaudid borrowed 12/23/16 at 9:00 a.m., as it #2's CDAR.  It's Note (NN) dated 12/22/16 by LPN #2 revealed: "Pain: edication related to pain ated 12/23/16 at 10:19 a.m., realed that Resident #6 pain on the left side of udid was given with relief.  In the interview was conducted 25/17 at 2:00 p.m., with the rimed that the Dilaudid ent #2 on 12/22/16 at 10:00 as having been #2 in Resident #6's MAR. In the the Dilaudid borrowed 12/23/16 at 9:00 a.m., was been administered by RN #2 in the DON explained that on his/her NN dated	F	281			
	LPN #2 documented 12/22/16 at 11:17 p.n	•					

	AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING			OATE SURVEY COMPLETED		
		315477	B. WING_			C 01/20/2017
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	·	01/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 281	facility. The DON furth documented in his/f 10:19 a.m. that the Resident #6.  6. According to the #7 was admitted on included but were in Discitis with lower brown and discharged on The Physician's Ordan order for the resitablet every 4 hours and Dilaudid 2 mg. hours as needed for A review of Resider revealed that the Di as administered by for the Dilaudid born 11/24/16 at 4:00 a.m. The MAR also reverdocumented as administered as administered as administered by for the Dilaudid born 11/24/16 at 4:00 a.m. The MAR also reverdocumented as administered as administered by the Bilaudid born the Don Comborrowed from Resident #2 on 11/29/16 as having been administered as having been administered by the surveyor on Don. The Don comborrowed from Resident #7's MAR the Dilaudid borrow 11/24/16 at 9:55 a.m.	"Admission Record" Resident 11/23/16, with diagnoses that ot limited to; Status Post ack pain, Diabetes Mellitus, Hypertension. Resident #7 11/29/16.  ders dated 11/28/16, revealed dent for Dilaudid 2 mg. 1 as needed for moderate pain 2 tablets by mouth every 4 r severe pain.  at #7's November 2016 MAR laudid was not documented RN #3, which would account rowed from Resident #2 on n. and 11/29/16 at 7:30 a.m. aled that the Dilaudid was not ninistered by LPN #3, which ne Dilaudid borrowed from	F 2	81		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 281	1/26/17, written by L administered Dilaud 11/24/16 at 9:55 a.m.  A review of the facility 2/9/17, written by RI administered Dilaud 11/24/16 at 4:00 a.m. but forgot to sign the 12/14/16, Resident diagnoses that inclu Replacement of Infe Anxiety, and Hypert discharged on 12/29.  According to Resident diagnoses that inclu Replacement of Infe Anxiety, and Hypert discharged on 12/29.  According to Resident scored indicated the	ty's witness statement dated LPN #3, revealed that LPN #3 id 2 mg. to Resident #7 on h., but forgot to sign the MAR.  Ity's witness statement dated N #3, revealed that RN #3 id 2 mg. to Resident #7 on h. and 11/29/16 at 7:30 a.m., when MAR.  I'Admission Record" dated #8 was admitted with ded but were not limited to; where the content was a man and the co	F 28	81			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		315477	B. WING _			C 01/20/2017	
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF	1 2777		STREET ADDRESS, CITY, STATE, ZIP COD 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470		11/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 281	resident was on Dilatevery 3 hours as new Dilaudid 4 mg. 1 tab severe pain. This Marks was administered which included the Efrom Resident #2 on 12/14/16 at 7:40 p.m a.m.  When interviewed on stated that the medications as soor (eight pills left) indicated that the nurse medications.  The surveyor condumated that the nurse medications.  The surveyor condumated that the nurse medications.  The surveyor condumated that the first was not aware to cards of controlled do residents inside the the day of the surveyor that she was also not borrowing these contadministered the contesting that the contesting t		F 2	81			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315477	B. WING				C <b>20/2017</b>
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			4	TREET ADDRESS, CITY, STATE, ZIP CODE  93 BLACK OAK RIDGE ROAD  VAYNE, NJ 07470	1 0 11.	20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	the medication, should provider for a stat del Pharmacy or in case Pyxis. The DON state Doctor (AMD) was represcriptions for continued whenever the AMD of able to issue the Presedrug in a timely mannal a Physiatrist available. The DON stated that an emergency.  When interviewed by 1:00 p.m., the Physiathe AMD would not be for a controlled drug facility would ask him he would issue the provider and delivery was early in of 11:00 p.m 7:00 a second delivery was the end of the 3:00 p.  When further intervied DON stated that the form the Consultant (PC) not a provider. The DON scome to the facility expression of 1/19/17.	uld call the doctor to change ld request the Pharmacy livery, should call another of emergency, use the ed that the Attending Medical	F	281			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER  E AT WAYNE - SNF	1		STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	1	01/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 281	The PC stated that the every month and wo Review, would ensure were in place for proposed administration, disposition of the things required law. The PC further medications ordered should call the facilities stated elivery, or call the order change.  A review of the "Nurst 12/30/16, revealed at the medication avails completed every ship to hotified for any more medications where reals of directed that all compliance with the count every shift.  A review of the In-service education kind of medications also included the foll to be notified on time medications that woon nurse should follow the Unavailable Flow Charter and the court every of the caution of the caution that woon nurse should follow that all compliance with the court every shift.	ility's Pharmacy Provider. hey would go to the facility uld conduct Drug Regimen re that systems/processes per storage, labeling, position of medication amongst if by local, state and federal stated that if and when were not available, the staff y's Pharmacy provider for a the facility's alternate a AMD for possible medication  sing News Letter" dated a reminder for all nurses that ability form should be fit and the supervisor should issing medications. This ated that nurses should on Unavailable Flow Chart" iff on what to do when not available. The News letter staff must observe controlled drugs inventory  ervice Education Record (17, the facility provided an about "No borrowing" of any This In-service education owing: the AMD would need	F 28			

	A. BUILDING		SURVEY LETED				
		315477	B. WING				20/2017
	ROVIDER OR SUPPLIER			4	TREET ADDRESS, CITY, STATE, ZIP CODE 93 BLACK OAK RIDGE ROAD VAYNE, NJ 07470	1 017	20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	drug to any person of whom it was prescrib  A review of the undat "Documentation on M Record" revealed tha the medication admin all medications administ Medications administ Medication Administrate explained that the docas a minimum: (f.) signerson administering  A review of the undat Medication orders and that the Director of Not designate individuals completing medication medications should be	ed facility's Policy titled ledication record to document histered. The policy res should document histered. The policy res should document all ered to each resident's ation Record (MAR). It also cumentation must include, mature and title of the the medication.	F:	281			
F 431 SS=E	drugs and biologicals them under an agree §483.70(g) of this par	ide routine and emergency to its residents, or obtain ment described in t. The facility may permit to administer drugs if State	F	431			2/16/17

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  IG	` '	TE SURVEY MPLETED
		315477	B. WING _			C 1/ <b>20/2017</b>
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	1	11/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 431	that assure the accudispensing, and admibiologicals) to meet to the service Consultate mploy or obtain the pharmacist who  (2) Establishes a systimation of all conditions of all conditions that of that an account of all maintained and period (g) Labeling of Drugs and biological labeled in accordance professional principle appropriate accesso instructions, and the applicable.  (h) Storage of Drugs (1) In accordance with the facility must store locked compartment controls, and permit have access to the king of the service of	cility must provide ces (including procedures rate acquiring, receiving, inistering of all drugs and the needs of each resident.  tion. The facility must services of a licensed  tem of records of receipt and trolled drugs in sufficient ccurate reconciliation; and  drug records are in order and controlled drugs is odically reconciled.  s and Biologicals. s used in the facility must be ewith currently accepted es, and include the ry and cautionary expiration date when  and Biologicals. th State and Federal laws, evall drugs and biologicals in sunder proper temperature only authorized personnel to	F 4	31		

PRINTED: 07/28/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		315477	B. WING		01/20/2017
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF	1		STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	1 01/20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 431	Control Act of 1976	e 15 g Abuse Prevention and and other drugs subject to the facility uses single unit	F 4	31	
	package drug distrib quantity stored is min be readily detected. This REQUIREMEN by:	ution systems in which the nimal and a missing dose can  T is not met as evidenced			
	C# NJ 95717, C# N			1.Residents noted in survey sample been discharged from COAW.	le have
	(MR) review, and revided documentation on 1/	n, interviews, medical record view of other pertinent facility 9/17 and 1/20/17, it was facility failed to ensure that all		2.All Residents have the potential to affected.	o be
	and accounting of So and Schedule IV (Xa for 2 of 9 sampled re #9). In addition, the final policy to remove con- timely manner (Dilaudithat were discharged sampled residents (Failed to follow facility borrowed Dilaudid at residents (Residents administered these of 9 sampled residents #8). Furthermore, the to document proper controlled medication residents (Residents evidenced by the followed)	controlled medications to 4 of (Resident #5, #6, #7 and e facility Nursing staff failed witnessed disposal of ns for 1 of 9 sampled #1). This deficient practice is owing:		3.The Facility educator (FE) or deswill inservice licensed nurses regar wasting procedure for controlled medication including the need for a witness and documentation on Con Administration Declining Record (C The FE/ ADON or designee will audication carts weekly for removadischarged medications and contromedication following the destruction procedure.  The Director of Nursing (DON) or designee conducted an audit 1/9/13 ongoing of current residents to eval Control Administration Declining.  4.The Unit Managers (UM) or designed administration Records (CDAR) for the service will audit current Control Declining Administration Records (CDAR)	ding a a antrol CDAR) dit al of olled n 7 and luate
	#1 was admitted on 10/22/16, with diagnostic	Admission Record", Resident 8/8/16, and re-admitted on oses that included but were es Mellitus, Hypertension,		residents weekly for 3 months for compliance.  The FE/ADON, UM or designee will	

Facility ID: NJ61619

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315477	B. WING			C 01/20/2017	
NAME OF PI	ROVIDER OR SUPPLIER	0.0		STREET ADDRESS, CITY, STATE, ZIP COI		01/20/2017	
CARE ON	E AT WAYNE - SNF			493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 431	Continued From pag	e 16	F 43	31			
	#1 was discharged of According to Reside (MDS), an assessme	nt #1's Minimum Data Set ent tool dated 10/28/16, the		medication carts for timely redischarged medications daily then weekly for 3 months.  Findings will be presented at	x 3 weeks		
		d short and long-term paired decision making		Assurance meeting held mor further recommendations by will be made as needed.	•		
	10/23/16, Resident # milligram (mg.) 1 tab addition, on 10/24/16	vsician's Orders dated \$1 was on Xanax 0.25 Het by mouth once a day. In 5, Xanax 0.25 mg 1 tablet by as needed for anxiety was					
	Medication Administr Xanax was documer administered as orde 12/26/16, and was re	nt #1's December 2016 ration Record (MAR), the nted as having been ered until 9:00 a.m. on ecorded on Resident #1's ninistration Record (CDAR).					
	Narcotic box inside t Cart (MC#3) was con Manager/Registered The surveyor observ (pop-out medication controlled medication	i.m., an inspection of the he South Unit's Medication inducted with the Unit Nurse (RN #1) and RN #2. The detection of the dispensing packages) of the ns, with a CDAR for each discharged Residents at #3).					
	there were 13 tablets review of the CDAR revealed four tablets and signed by one n	Resident #1 revealed that s of Xanax 0.25 mg. left. A for Resident #1's Xanax were wasted (disposed of) urse (RN #2). This same #1 revealed that there should					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315477	B. WING				20/2017	
	OVIDER OR SUPPLIER  AT WAYNE - SNF			4	STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	1 0111	20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	tablets. The documer revealed that five of F tablets of Xanax were residents (Resident # The surveyor conduction 1/9/17 at 10:30 a.r Resident #1 was disctablets of Xanax were resident refused their that the controlled druwere kept in the narcomedication cart until twith another nurse.  On 1/9/17 at 1:45 p.m (DON) stated that RN Nurse (LPN #1) were Assistant Director of I The DON stated that the ADON that Resident #8 by RN #2 #2 and LPN #1 were provided with an In-secution included: "No be medications, the physical notified on time for all would need prescription the "Medication Unavidetermine what to do medications that get witness.  An interview with RN conducted on 1/9/17 that Resident #1's Xanax were not yet witness.	of Xanax instead of 13 at attached to the CDAR Resident #1's remaining a used for two other 5 and #8).  Ited an interview with RN #2 m. RN #2 stated that harged and that the four a wasted because the medications. RN #2 stated ags for discharged residents of the because the he supervisor destroyed it  In., the Director of Nursing #2 and Licensed Practical interviewed by the the Nursing (ADON) on 1/9/17. RN #2 and LPN #1 informed ent #1's four tablets of ed but were given to 2. The DON stated that RN given verbal warnings and ervice Education on 1/9/17, corrowing" of any kind of scician would need to be controlled medications that ons, the nurse should follow ailable Flow Chart" to and all controlled wasted would need a	F	431				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
		315477	B. WING_			C 01/20/2017
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	ı	01/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 431	Resident #1's Xana Resident #8 had no time and there was (an automated med for emergency). RN documented Reside because he/she kne allow borrowing of r During this interview present when RN # Xanax for Resident documented the 4 c wasted because the borrow any medicat that it was the facilit document disposal nurses.  2. According to the #2 was admitted on included but were n Diabetes Mellitus, a was discharged on  According to Reside Assessment dated alert and oriented to According to the Ph #2 dated 11/14/16, mg. 1 tablet by mout for moderate pain.  A review of Resider revealed that the re 1 tablet by mouth even to the ph was the pain.	hould not have borrowed x for Resident #8 however, available medication at that none available in the Pyxis ication delivery cabinet used #2 stated that she ent #1's Xanax was wasted ew that the facility would not nedications.  If LPN #1 stated that she was 2 borrowed Resident #1's #8. LPN #1 stated that RN #2 loses of 0.25 mg Xanax as a nurses were not supposed to ions. LPN #1 further stated y's policy to witness and of narcotics by two licensed  "Admission Record", Resident 11/14/16, with diagnoses that ot limited to; Hernia Repair, nd Hypertension. Resident #2 11/19/16.	F 4	31		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		315477	B. WING			C 01/20/2017
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	'	0172072017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	Continued From pag	ge 19	F 43	31		
		d this medication as ordered 3 p.m., and it was recorded DAR.				
	Narcotic box inside	a.m., an inspection of the the South Unit's MC#3 was urveyor in the presence of RN				
	there were zero tab pain) for Resident # Resident #2's Dilaud have been 26 tablet document attached of Resident #2's ren	Resident #2 revealed that lets left of Dilaudid 2 mg. (for 2. A review of the CDAR for did revealed that there should to left instead of zero. The to the CDAR revealed that all naining tablets of Dilaudid other residents (Resident #6,				
	#3 was admitted on included but were n Obstructive Pulmon	"Admission Record", Resident 12/12/16, with diagnoses that ot limited to; Chronic ary Disease, Hypertension, waxiety. Resident #3 was 3/16.				
	the resident scored	ent #3's MDS dated 12/18/16, 15/15 on the Brief Interview BIMS), which indicated the ively intact.				
	#3 dated 12/12/16,	ysician's Orders for Resident the resident was on Xanax mouth every 4 hours as				
	revealed that the re-	nt #3's December 2016 MAR sident was on Xanax 0.25 mg. very 4 hours as needed for				

STATEMENT OF DEF AND PLAN OF CORF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		PLETED
		315477	B. WING		1	C / <b>20/2017</b>
NAME OF PROVIDI				STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470		20/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
anxi adm 12/2 Res On Nard cond RN:  The there Res reveleft it to the #3's two 4. A #5 v inclu Rep Res the long mak Accumak Acc	sinistered this metalogical at 1:19 a.r. ident #'3's CDA 1/9/17 at 10:05 cotic box inside ducted by the signal and RN #2.  Bingo card for e were 3 tablets ident #3. The Cotaled that there instead of 3 tablets other residents other residents occording to the was admitted on ided but were in lacement, Hyperident #5 was disident #5's MDS resident had imperent memory, ing ability.  Ording to the Property of Resider wary 2017 MAR ident was ident was admitted by the property in the property in the property in the property in the property and the property and the property in the property in the property in the property and the property in the property i	revealed that Resident #3 was edication as ordered until m., and it was recorded on	F 43	31		

			(X3) DATE COMP	SURVEY LETED			
				-			
		315477	B. WING		<del></del>	01/:	20/2017
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAREON	E AT WAYNE - SNF			4	93 BLACK OAK RIDGE ROAD		
CARE ON	EAI WATNE - SNF			١	WAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	ordered until 1/15/17 the Xanax that was be on 1/2/17 at 12:00 a.r 12/25/16 at 7:11 p.m.  5. According to the "A #6 was admitted on 1 included but were not Cervical Cancer, and Resident #6 was disconding to Resident the resident scored 1 indicated the resident According to the Phys #6, dated 12/23/16, tf 2 mg. 1 tablet by moufor breakthrough pain Dilaudid 2 mg. 1 tablet needed for cancer part A review of Resident revealed that the Dilaudid account for the Resident #2 on 12/22 recorded on Resident MAR also revealed the signed as having been which would account from Resident #2 on recorded on Resident #2 on recorded on Resident A review of the Nurse at 11:17 p.m., signed	administered the Xanax as at 5:17 p.m., which included browed from Resident #1 m., and from Resident #3 on admission Record", Resident 2/22/16, with diagnoses that limited to; Vaginal and Spinal Cord Compression. harged on 1/14/17.  It #6's MDS dated 12/29/16, 5/15 on the BIMS, which was cognitively intact.  Sician's Orders for Resident he resident was on Dilaudid with every 4 hours as needed. In addition, on 12/27/16, but by mouth every 3 hours as in was ordered.  #6's December 2016 MAR udid was not signed as ered by LPN #2, which Dilaudid borrowed from 1/16 at 10:00 p.m., as at #2's CDAR. Resident #6's that the Dilaudid was not n administered by RN #2, for the Dilaudid borrowed 12/23/16 at 9:00 a.m., as	F	431			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	COMPLETED
		315477	B. WING		01/20/2017
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	01/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 431	signed by RN #2, reverbalized moderal his/her body and D  A post survey telep by the surveyor on DON. The DON coborrowed from Resp.m., was not signed administered by LF The DON also verifications.	dated 12/23/16 at 10:19 a.m., evealed that Resident #6 e pain on the left side of ilaudid was given with relief.  hone interview was conducted 1/25/17 at 2:00 p.m., with the infirmed that the Dilaudid ident #2 on 12/22/16 at 10:00 ed as having been PN #2 in Resident #6's MAR. ified that the Dilaudid borrowed	F 43	31	
	not signed as havir in Resident #6's M/During the same poon 1/25/17 at 2:00 LPN #2 documented 12/22/16 at 11:17 padministered to Rethat LPN #2 was not facility. The DON for documented in his/10:19 a.m., that the Resident #6.	n 12/23/16 at 9:00 a.m., was ag been administered by RN #2 AR.  Dest survey telephone interview p.m., the DON explained that ad on his/her NN dated b.m., that the Dilaudid was sident #6. The DON stated b. Inger employed in the jurther explained that RN #2 her NN dated 12/23/16 at a Dilaudid was administered to "Admission Record", Resident			
	#7 was admitted or included but were r Discitis with lower to Radiculopathy, and was discharged on The Physician's Or 11/28/16, revealed tablet every 4 hours	n 11/23/16, with diagnoses that not limited to; Status Post pack pain, Diabetes Mellitus, I Hypertension. Resident #7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315477	B. WING				20/2017	
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			49	TREET ADDRESS, CITY, STATE, ZIP CODE 93 BLACK OAK RIDGE ROAD VAYNE, NJ 07470	1 011	20/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 431	revealed that the Dila as administered by R for the Dilaudid borro 11/24/16 at 4:00 a.m. The MAR also reveal documented as admi would account for the Resident #2 on 11/24 A post survey telephoto by the surveyor on 1/DON. The DON confiborrowed from Resida.m. and 11/29/16 at as having been admin Resident #7's MAR. The Dilaudid borrowed 11/24/16 at 9:55 a.m. administered by LPN A review of the facility 1/26/17, written by LP administered Dilaudid 11/24/16 at 9:55 a.m. A review of the facility 2/9/17, written by RN administered Dilaudid 11/24/16 at 4:00 a.m. but forgot to sign the 7. According to the "A#8 was admitted on 1 included but were not Infected Right Hip President and the president as administered Right Hip President and the president and the president as administered Right Hip President and the president	#7's November 2016 MAR udid was not documented N #3, which would account wed from Resident #2 on , and 11/29/16 at 7:30 a.m. ed that the Dilaudid was not nistered by LPN #3, which Dilaudid borrowed from /16 at 9:55 a.m.  In interview was conducted 25/17 at 2:00 p.m. with the rmed that the Dilaudid ent #2 on 11/24/16 at 4:00 7:30 a.m., was not signed nistered by RN #3 in The DON also verified that d from Resident #2 on was not signed as #3 in Resident #7's MAR.  It's witness statement dated PN #3, revealed that LPN #3, if 2 mg. to Resident #7 on , but forgot to sign the MAR.  It's witness statement dated #3, revealed that RN #3 if 2 mg. to Resident #7 on , and 11/29/16 at 7:30 a.m.,	F	431				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION (X		(X3) DATE SURVEY COMPLETED	
		315477	B. WING			C <b>01/20/2017</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	<u> </u>	01/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 431	12/29/16.  According to Resid the resident scored indicated the resident According to the Pt #8 dated 12/14/16, mg. 1 tablet by more for moderate pain a mouth every 3 hours on 12/24/16, Resid 0.5 mg. tablet 2 tab for Anxiety.  Resident #8's Decethe resident was or tablets by mouth every 3 hours as new many many many many many many many many	ent #8's MDS dated 12/21/16, 14/15 on the BIMS, which ent was cognitively intact.  Inysician's Orders for Resident the resident was on Dilaudid 2 ath every 3 hours as needed and Dilaudid 4 mg. 1 tablet by rs for severe pain. In addition, ent #8 had an order for Xanax elets by mouth every 12 hours  In Xanax 0.5 mg. tablet 2 very 12 hours for Anxiety. This Resident #8 was administered and the Xanax 1 mg. borrowed in 12/28/16 at 9:00 p.m., and and from Resident #3 at 9:00 p.m., and and 12/28/16.  It is MAR revealed that the audid 2 mg. 1 tablet by mouth eveded for moderate pain and blet by mouth every 3 hours for MAR revealed that Resident #8 his medication as ordered, Dilaudid that was borrowed in 12/14/16 at 4:13 p.m., on m., and on 12/15/16 at 4:56 cautionary warning written on the CDAR revealed:	F 4:	31			

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	COMPLETED	
		315477	B. WING		C 04/20/2047	7
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF		STREET ADDRESS, CITY, STATE, ZIP CODE  493 BLACK OAK RIDGE ROAD  WAYNE, NJ 07470		01/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLE	ETION
F 431	whom it was presco When interviewed stated that all control discharged resider narcotic box inside supervisor destroy stated that the con discharged resider away, and that two when controlled me destroyed. RN #1 s nurses should re-o reached the blue li the Bingo card to e medications. RN # were not allowed to  The surveyor cond 11:35 a.m., with the she was not aware cards of controlled discharged resider MC #3 until the day DON stated that sh nurses were borrow medications and ha residents.  The DON further sh have a policy for be the Nursing staff w	on 1/9/17 at 10:45 a.m., RN #1 rolled medications for ats were kept locked in the the medication cart until the ed it with another nurse. RN #1 trolled medications for ats should be destroyed right anurses were required to sign edications were wasted and/or stated that the medication reder medications as soon as it ne (eight pills left) indicated on ensure availability of 1 further stated that the nurses to borrow medications.  ucted an interview on 1/9/17 at the DON. The DON stated that there were three bingo medications from three ats inside the narcotic box of y of the survey (1/9/17). The ne was also not aware that the wing these controlled and administered them to other tated that the facility did not corrowing medication because ere not allowed to borrow any	F 43	,		
	residents.  The DON further so have a policy for bethe Nursing staff with medications from a another resident. Tresident had an ordination available or wo	tated that the facility did not orrowing medication because				

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		` ′	COMPLETED		
		315477	B. WING			C 01/20/2017		
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	1	1 01120/2011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 431	Pharmacy or in case The DON stated tha Doctor (AMD) was r prescriptions for cor whenever the AMD able to issue the Pre drug in a timely mar a Physiatrist availab The DON stated tha an emergency.  When interviewed b 1:00 p.m., the Physi the AMD would not of for a controlled drug facility would ask hir he would issue the precessary.  When interviewed b 12:45 p.m., the DON no time frame as to drugs for discharged that it should remain double lock until ren Supervisor for destr The DON stated tha drugs destruction de controlled drugs we  During this interview stated that the facilit delivered twice a da early in the morning - 7:00 a.m. (11-7) sh	elivery, should call another e of emergency use the Pyxis. It the Attending Medical esponsible for issuing introlled drugs and that of a resident would not be escription for the controlled inner for any reason, there was ile to issue the Prescription. It the Pyxis was only used for  y the surveyor on 1/9/17 at atrist stated that if and when be able to write a prescription for a resident promptly, the into assess the resident and prescription if medically  y the surveyor on 1/20/17 at a stated that the facility had when to destroy controlled deresidents. The DON stated in in the medication cart under moved by the Nursing function by two Nursing staff. It the frequency of controlled expends on how many free needed to be destroyed.  It with the surveyor, the DON ty's Pharmacy Provider y, the first delivery would be before the end of 11:00 p.m. fift, and the second delivery expending before the end of	F 4	31				

				ATE SURVEY DMPLETED			
		315477	B. WING _			C <b>01/20/2017</b>	
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	'	1 0112012011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 431	Continued From page	ge 27	F 4	31			
	8. According to the #9 was admitted on included but were in Accident, Hypertens Stage 3 Pressure S  According to Reside the resident scored indicated that the resident score indicated that the score indicated that Resident score in the s	"Admission Record", Resident 11/19/16, with diagnoses that of limited to; Cardiovascular sion, Anxiety, and Left Buttock ore.  ent #9's MDS dated 11/26/16, 13/15 on the BIMS, which isident was cognitively intact.  ysician's Orders for Resident ent was on Duragesic Patch g) per hour (hr), changed					
	the usage of one Du 1/19/17 at 5:00 p.m A review of the indiv by LPN #4 dated 1/2	uragesic Patch 12 mcg/hr. on					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		315477	B. WING		<b>I</b>	C /20/2017	
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF	1		STREET ADDRESS, CITY, STATE, ZIP CO 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470		01/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 431	Continued From pag	ge 28	F 43	31			
	Duragesic patch. The this was not the LPN  When interviewed by 10:45 a.m., LPN #4: was conducted their the outgoing 11:00 pland the incoming 7:0 LPN #4 stated that he Duragesic patches be box was not opened  When interviewed by 11:35 a.m., RN #4 stated that he/she CDAR but was called	y the surveyor on 1/20/17 at stated that a Narcotic count morning of 1/20/17, between b.m 7:00 a.m. (11-7) shift 00 a.m 3:00 p.m. (7-3) shift. ne/she did not count the because he/she thought the					
	3:00 p.m11:00 p.m incoming 11:00 p.m. count the Duragesic	t was conducted between n. (3-11) shift and the - 7:00 p.m. shift, but forgot to patches. RN#4 stated that e she missed signing the					
	12:45 p.m., the DON should conduct narc incoming and outgoi would be a turn-over nurses. The DON staincluded the controll.  When further intervied DON stated that the	y the surveyor on 1/20/17 at I stated that the nurses otic count between the ng shifts and whenever there is between the medication ated the narcotic count also ed substances in the Pyxis.  Hewed by the surveyor, the facility has a Pharmacy affiliated with their Pharmacy					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED		
	315477	B. WING		C 01/20/2017		
			STREET ADDRESS, CITY, STATE, ZIP CODE  493 BLACK OAK RIDGE ROAD  WAYNE, NJ 07470	1 01/20/2017		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
come to the facility of facility on 1/19/17.  When interviewed b 2:00 p.m., the PC ve affiliated with the facility every month and wo Review, would ensure were in place for proadministration, disponsive things required law.  During this interview informed the survey discharged resident South Unit Medication December 2016. The to identify whose an removed but it should inspection report. To document their findicand would give it to stated that she would DON about their findicand would give it to stated that she would DON about their findicand would give it to stated that she would DON about their findicand would give it to stated that she would DON about their findicand would give it to stated that she would pool was very in concerns and recomply further stated the ordered were not as the facility's Pharma or call the facility's a AMD for possible mending the facility should improve the facility should in the same for disposite the facility should in the possible mending the facility should in the province of the province of the facility should in the province of th	y the surveyor on 1/20/17 at erified that they were not cility's Pharmacy Provider. They would go to the facility buld conduct Drug Regimen are that systems/processes oper storage, labeling, position of medication amongst diby local, state and federal with the surveyor, the PC or that medications for swere not removed from the on Cart for November and the PC stated she was not able did what medications were not lid be written in the PC's the PC stated that they would the pool. The PC further did also talk to the nurses and dings. The PC explained that they local and addressed their mendations promptly. The lattif and when medications arillable, the staff should call they provider for a stat delivery, alternate Pharmacy or call the edication order change. The although the facility had no sal of controlled medications, mediately remove all	F 43				
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIEN REGULATORY OF SUPPLIER)  Continued From page come to the facility of facility on 1/19/17.  When interviewed be 2:00 p.m., the PC verificated with the facility of stated that the every month and work Review, would ensure were in place for produministration, disposition of the survey discharged residents.  During this interview informed the survey discharged residents.  The possible may be a survey of the stated that she would provide the poon about their finding and would give it to stated that she would poon about their finding and would give it to stated that she would poon about their finding and would give it to stated that she would poon about their finding and would give it to stated that she would poon about their finding and would give it to stated that she would poon about their finding and would give it to stated that she would poon about their finding and would give it to stated that she would poon about their finding and would give it to stated that she would poon about their finding and would give it to stated that she would poon about their finding and would give it to stated that she would give it to stated that she would poon and their finding and would give it to stated that she would give it to st	CORRECTION  315477  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 29 come to the facility every month and was in the facility on 1/19/17.  When interviewed by the surveyor on 1/20/17 at 2:00 p.m., the PC verified that they were not affiliated with the facility's Pharmacy Provider. The PC stated that they would go to the facility every month and would conduct Drug Regimen Review, would ensure that systems/processes were in place for proper storage, labeling, administration, disposition of medication amongst other things required by local, state and federal	CONTIDENT CONTINENT CONTIDENT CONTINENT CONTIN	IDENTIFICATION NUMBER:  315477  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470  SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 29  Come to the facility every month and was in the facility on 1/19/17.  When interviewed by the surveyor on 1/20/17 at 2:00 p.m., the PC verified that they were not affiliated with the facility's Pharmacy Provider. The PC stated that they would go to the facility every month and would conduct Drug Regimen Review, would ensure that systems/processes were in place for proper storage, labeling, administration, disposition of medication amongst other things required by local, state and federal law.  During this interview with the surveyor, the PC informed the surveyor that medications were not removed but it should be written in the PC's inspection report. The PC stated she was not able to identify whose and what medications were not removed but it should be written in the PC's inspection report. The PC stated that they would document their findings during their monthly visit and would give it to the DON. The PC further stated that the would aload lake to the nurses and DON about their findings. The PC explained that the DON was very involved and addressed their concerns and recommendations promptly. The PC further stated that if and when medications ordered were not available, the staff should call the facility's Pharmacy provider for a stat delivery, or call the facility's Pharmacy or call the AMD for possible medication order change. The PC also stated that although the facility had no time frame for disposal of controlled medications of discharged residents to prevent medication		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		315477	B. WING			1	20/2017
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			4	TREET ADDRESS, CITY, STATE, ZIP CODE  93 BLACK OAK RIDGE ROAD  VAYNE, NJ 07470	<u> </u>	20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	medications more that was discharged.  A review of the Pharm Inspection Report from January 2017 revealed Inspection Report for revealed that the discontinued residents (not in the signed and the Pyxis was missing. 2. The Inspection Carts, confeach shift was not do units, there were missiboth unit's narcotic shift was not do units, there were missiboth unit's narcotic shift was not do units, there were missiboth unit's narcotic shift was not do units, there were missiboth unit's narcotic shift nar The report dated 1/19 discontinued medication A review of "Nursing revealed a reminder from pliance with continued revery shift.  A review of the "Nurs 12/30/16, revealed a the medication availa completed every shift be notified for any missing and the medication availa completed for any missin	I practice to keep controlled in a month after a resident in a resident in a month after a resident in a month after a resident in a resident	F	431			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315477	B. WING		C 01/20/2017
	ROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 193 BLACK OAK RIDGE ROAD NAYNE, NJ 07470	01720/2017
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION
F 431	which guide the star medications where also directed that a compliance with convery shift.  A review of the Inservealed that on 1/9 Inservice Education borrowing" of any knowled need to be medications that we nurse should follow Flow Chart" to detecontrolled medication need a witness.  A review of the Inservice a witness.  A review of the Inservice a witness.  A review of the Inservice a witness.  A review of the Factorial that the facility provabout signing out a nurcotic between a change of shift and narcotic keys are serves ponsible party, that both responsible that both responsible cand document the condition of the spaces. It also indications are sufficiently as the start of the spaces. It also indications are sufficiently as the start of the s	ion Unavailable Flow Chart"  iff on what to do when not available. The News letter Il staff must observe introlled drugs inventory count  service Education Record 19/17, the facility provided an on which included: "No cind of medications, the AMD otified on time for all controlled ould need prescription, the or the "Medication Unavailable ermine what to do, and all ons that get wasted would  Service Education Record day of the survey, revealed orided an In-Service Education arcotics and accounting of incoming and outgoing shifts.  Selitity's Policy titled "Controlled 1 (CDCR) and Controlled Drug 18/1/10, revealed that at the of a tany time in which the urrendered to another the outgoing responsible party introlled drugs with the ole party. The Policy indicated ole parties would count the ards, packs/boxes, and bottles, count on the designated cated that all discontinued ould be included in the count	F 431		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315477	B. WING _			C 1/20/2017	
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CO 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470		01/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 431	Continued From pag	e 32	F 4	31			
		a reconciliation of all drugs in will be completed and a new would be initiated.					
	Non Hazardous Med Medications" revised the policy of the facil discontinued medical active medication sureturned to the provice policy, were disposed and standards, and we documented complete policy revealed that the would remain in the lock until removed by appropriate storage of This Policy indicated substances would be individuals and in account and local regulations the destroying professional should standing and standing should standing and should standing should sho	on 6/4/14, revealed that it is ity to assure that tions were removed from the pply in a timely fashion, were der if allowed by law and d of in compliance with laws were accounted for and tely and accurately. The the controlled medications medication cart under double of the DON or designee for the properties of the destruction of controlled the completed by two cordance with state, federal, and the witnessing sign the upon time that destruction on the					
	Medication orders ar that the Director of N designate individuals completing medication medications should be	ted facility's Policy titled " and Receipt Record" revealed lursing Services would at to be responsible for on order/receipt forms and one ordered in advance, based larmacy's required lead time.					
	"Documentation on N Record" revealed that	ted facility's Policy titled Medication Administration at the facility should maintain nistration record to document					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		315477	B. WING			C <b>01/20/2017</b>	
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470		01/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 431	medications administ Medication Administr explained that the do	nistered. The policy urse should document all tered to each resident's ration Record (MAR). It also ocumentation must include, gnature and title of the	F 43	31			
F 492 SS=E		DCAL LAWS/PROF STD Federal, State, and Local	F 49	02		2/16/17	
	The facility must ope compliance with all a local laws, regulation accepted professiona	rate and provide services in pplicable Federal, State, and is, and codes, and with al standards and principles conals providing services in					
	In addition to complia forth in this subpart, the applicable provis regulations, including pertaining to nondisc race, color, or nation	ther HHS Regulations.  ance with the regulations set facilities are obliged to meet ions of other HHS g but not limited to those rimination on the basis of al origin (45 CFR part 80); the basis of disability (45					

PRINTED: 07/28/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315477	B. WING		C 01/20/2017	
	ROVIDER OR SUPPLIER  E AT WAYNE - SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470	1 01/20/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 492	CFR part 84); nondis age (45 CFR part 91) basis of race, color, r disability (45 CFR pa subjects of research and abuse (42 CFR pindividually identifiable CFR parts 160 and 1 provisions may result non-compliance with This REQUIREMENT by:  C# NJ 95717, C# NJ Cross Reference F-2  Based on observation (MR) review, and review, and review, and review documentation on 1/2 the facility failed to focontrolled substances controlled medication IV medications (Xanaresidents (Resident # administering these controlled residents 9 sampled residents	crimination on the basis of a proposition on the pational origin, sex, age, or rt 92); protection of human (45 CFR part 46); and fraud part 455) and protection of e health information (45 64). Violations of such other in a finding of this paragraph.  The is not met as evidenced  195718  181  195718  1967  1977  1987	F 49.	1.Residents noted in survey sample he been discharged from COAW.  2.All Residents have the potential to be affected.  Residents found in need of Schedule control prescription or refill will be obtained by Physician to be. sent to the Pharmacy to fill.  Control Accountability Declining Recorfor current residents audited for evider of borrowing.  3.Facility educator/ designee will inser licensed nurses that the facility has a report borrowing policy and the process for Medication Availability.  Unit Manager or designee will audit current residents with an order for Schedule 2 (Dilauded) and Schedule 2 (Xanax) to ensure Individual Resident Prescription availability to dispense as prescribed in accordance with the Physician Orders.	e 1-5 e rds nce vice no	

Facility ID: NJ61619

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY
		315477	B. WING				C
		319477	B. WING_			01/	20/2017
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
CARE ON	E AT WAYNE - SNF			493	3 BLACK OAK RIDGE ROAD		
OAILE OIL	LAI WAINE - ONI			WA	AYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 492			F 4	492		ory 1-5. Ty r	DATE

#### POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION  A. Building		DATE OF REVISIT	
	B. Wing		4/4/2017	
315477 <sub>Y1</sub>	B. Willig	Y2	4/4/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
CARE ONE AT WAYNE - SNF		493 BLACK OAK RIDGE ROAD		
		WAYNE, NJ 07470		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM DATE		ITEM		DATE	ITEM			DATE	
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	F0281	Correction	ID Prefix	F0431	Correction	ID Prefix	F0492		Correction
Reg. #	483.21(b)(3)(i)	Completed	Reg. #	483.45(b)(2)(3)(g)(h)	Completed	Reg.#	483.70(b)(c)		Completed
LSC		02/16/2017	LSC		02/16/2017	LSC			02/16/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #		Completed	Reg.#			Completed
LSC			LSC		_	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #		Completed	Reg.#			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #		Completed	Reg.#			Completed
LSC			LSC			LSC			
REVIEWEI		REVIEWED BY (INITIALS)	DATE	SIGNATURE O	F SURVEYOR			DATE	
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 1/20/2017		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					☐ YE	s 🔲 no	