STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315425	A. BUILDING _____ B. WING _____	08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILL ACRES REHABILITATION & NURSING CENTER	39 EAST MOUNTAIN ROAD HILLSBOROUGH, NJ 08844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 8/28/19 CENSUS: 161 SAMPLE SIZE: 32 + 2 closed records The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. The facility failed to ensure nurses administered medications in accordance with physicians orders and failed to identify drug irregularities were identified and acted upon for errors made for the administration of [redacted] and [redacted] medication(F658), (F756).	F 000		
F 658 SS=K	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and review of other facility documentation, it was determined that the facility had a multi-system failure resulting in an immediate jeopardy situation; when multiple nurses failed to follow professional standards of nursing clinical practice by disregarding physician's orders. This deficient practice was evidenced by the following: Part A.	F 658	F658 A. 1. Report generated for all residents with [redacted] order and [redacted] Medication with parameters. 2. All [redacted] Medication orders were replotted to reflect dose, site and [redacted] [redacted] level. 3. All [redacted] medication orders were replotted to reflect [redacted] parameters and monitoring as needed.	10/25/19

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

Electronically Signed | 10/02/2019

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F 658	Continued From page 1 Forty nurses on two units disregarded physician ordered parameters for [redacted] administration for a period of seven months from February 2019 to August 2019 for four of six residents reviewed, Residents #39, #85, #100, and #155. In addition, ten nurses on one unit disregarded physician ordered parameters for administration of [redacted] medication for a period of six months from March 2019 to August 2019 for one of six residents reviewed, Resident #71. The facility's failure to administer medications according to physician ordered [redacted] parameters, [redacted] parameters and clinical standards of nursing practice had the likelihood to affect all residents receiving medications with physician ordered parameters. On at 8/23/19 at 11:13 AM, the facility Administrator was notified that an Immediate Jeopardy situation (IJ) had been identified. The IJ removal plan was put into place and accepted on 8/23/19 at: 2:46 PM for Resident's #39, #85, #100 and #155. The Administrator ensured that immediate nursing education was provided regarding [redacted] orders with parameters and administration of [redacted] medication with parameters. The survey team continued to monitor throughout the survey that the facility instituted the plan of correction submitted. Reference: New Jersey Statutes, 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	F 658	4. Nurses In-serviced provided and competency evaluation ongoing regarding transcription of medication orders with parameters; accurate chart check; proper documentation of medication administration. B. Any resident who has an [redacted] order and [redacted] medication with parameter order is potentially affected by this deficient practice. C. 1. Nurses In-serviced provided and competency evaluation ongoing regarding transcription of medication orders with parameters; accurate chart check; proper documentation of medication administration. 2. Facility will provide pathway on how to plot medication with parameters, pathway for proper medication administration documentation and checklist for items that needs to be reviewed when inputing an order and completing a chart check. D. DON/Designee will print and review all NEW [redacted] orders and [redacted] medication with parameters to ensure medications are plotted accurately daily for 7 days; weekly for 2 weeks, then monthly thereafter. DON/Designee will print all [redacted] order and [redacted] medication with parameters administered the day prior for accurate documentation of medication administration in the MAR daily for 7 days; weekly for 2 weeks, then monthly thereafter.	

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F 658	Continued From page 2 human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist:" Reference New Jersey Statutes, 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 task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist." INSULIN ADMINISTRATION 1.) RESIDENT #39 According to the Admission Record (AR) Resident # 39 was admitted to the facility on [redacted] with the medical diagnoses of [redacted]. The Annual Minimum Data Set (MDS), an assessment tool used to assess a resident's functional capabilities and identify health problems dated [redacted] documented that Resident #39 was [redacted] The MDS also reflected that the resident had a diagnosis of [redacted] The surveyor reviewed the Care Plan dated 5/28/19 with the focus of [redacted]. An	F 658	Result of these audits will be reported to the QA Committee quarterly.	

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intervention implemented in Resident #39's care plan was to administer medications according to the physician's orders.

The Physician Order Report (POR) dated 1/26/19, documented an order for [redacted] were ordered to be conducted 3 times a day before meals with extra [redacted] coverage to be administered according to a [redacted] measurements. Additional [redacted], was ordered to be administered with the dosage based on the following parameters:
[redacted]
If the [redacted] is greater than [redacted] the physician was to be notified.

According to the Medication Administration Record (MAR) for the period of 7/1/19 to 7/30/19, Resident #39 was administered the medication [redacted] outside of the physician ordered parameters 12 times out of 90 opportunities by 8 nurses. (LPN #29, RN #5, LPN #30, LPN #8, LPN #28, LPN #31, LPN #2, LPN #38)

On 7/4/19, 7/11/19, 7/14/19, 7/21/19, and 7/25/19 at 7:30 AM, there were nurses' signatures documented on the MAR that [redacted] was administered. There was no documentation of the [redacted] on the MAR. (LPN #29, LPN #30, LPN #8)

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F 658	Continued From page 4 On 7/14, 7/16, 7/21, and 7/29/19 at 11:30 AM, there were nurses' signatures documented on the MAR that [redacted] was administered. There was no documentation of [redacted] on the MAR. (LPN #30, LPN #8, LPN #28) On 7/5/19 at 5:00 PM, there were a nurse's signatures documented on the MAR that [redacted] was administered There was no documentation of [redacted] on the MAR. (LPN #31) On 7/6/19 at 7:30 AM the nurse documented that Resident #39's [redacted] and [redacted] of [redacted] was administered. At 11:30 AM, the [redacted] was documented on the MAR as [redacted] was administered. According to the physician ordered [redacted], Resident #39 should not have received any [redacted] (RN #5) The surveyor revived the Consultant Pharmacist (CP) Evaluation (a hand-written resident specific pharmacy report located on the resident's chart) dated 7/15/19. This Evaluation contained no documentation that there were concerns with [redacted] being was administered outside the physician ordered parameters. On 8/22/19 at 9:30 AM, the surveyor interviewed the [redacted] Unit Licensed Practical Nurse Unit Manager (LPN/UM #1) who stated that when the nurses received an [redacted] order, "it's a matter of putting the order in the computer correctly to include the dose of the [redacted] and [redacted] as to where the [redacted] was [redacted]" LPN/UM # 1 further stated that even if the nurse did not put the [redacted] in the electronic MAR, the nurse could take the	F 658		

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"initiative" to enter this information on the MAR. "Some nurses are doing it and some nurses are not." LPN/UM #1 did confirm that the nurses should be documenting if they are holding [redacted] or giving the [redacted] according to the physician's orders.

On 08/23/19 at 12:53 PM, the surveyor interviewed Resident # 39 who stated that he/she has not had any concerns associated with [redacted] while in the facility.

On 08/23/19 at 1:00 PM, the surveyor attempted to conduct a telephone interview with LPN #5. The LPN was unavailable.

On 08/26/19 at 10:23 AM, the surveyor interviewed LPN #30 by telephone, who stated that when a resident is on a [redacted] with parameters for [redacted] administration related to the [redacted], she checked the residents [redacted] by [redacted] and then documented the [redacted] on the MAR. She then would look at the physician orders to see how much [redacted] was to be administered according to the [redacted]. If the [redacted] was in the range in which [redacted] was to be administered, she would then give the [redacted] and document the dose of [redacted] and the [redacted]. She also added, "I really don't know what happened and why I documented that I administered [redacted] outside of the ordered [redacted] parameters, that must be a mistake."

2.) RESIDENT #85
According to the administration record, Resident

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F 658	Continued From page 6 #85 was admitted on [redacted], with medical diagnoses including [redacted] The quarterly MDS, dated [redacted], indicated that the resident had [redacted] The surveyor reviewed the [redacted] focus in Resident # 85's care plan. On 1/28/19 the facility initiated an intervention to administer medication according to the physician's order. The surveyor reviewed an untitled report for Resident # 85 which revealed an original physician's order dated 02/10/19, for the medication [redacted] to be administered daily at 7:30 AM and 4:30 PM. According to Resident #85's individualized [redacted] was ordered to be administered with the dosage based on the following parameters. These parameters were listed on the Medication Administration Record (MAR). If [redacted] = administer [redacted] If greater than [redacted] call MD (medical doctor). The surveyor reviewed Resident # 85's Physicians Order Report which revealed a revised physician's order dated 02/22/19 for the medication [redacted] to be administered daily at 9:00 PM with the dosage based on the following parameters:	F 658		

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F 658	Continued From page 7 If [redacted] is between [redacted] This 2/22/19 physician's order also contained the order for the medication [redacted] to be administered daily at 7:30 AM, 11:30 PM and 4:30 PM based on the following parameters, which were listed on the MAR. If [redacted] is between [redacted] The surveyor reviewed Resident # 85's Physicians order report which revealed a revised physician's order dated 6/18/19 for the medication [redacted] to be administered daily at 7:30 AM, 11:30 AM and 4:30 PM based on the following parameters: If [redacted] is between [redacted] The surveyor reviewed Resident # 85's Physicians order report which revealed a revised physician's order dated 06/18/19, for the medication [redacted] to be administered daily at 9:00 PM based on the following parameters:	F 658		

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F 658	Continued From page 8 If [redacted] is between [redacted] The surveyor reviewed the electronic MARs for the period 2/1/19 to 8/21/19, and noted the following: -2/1/19 until 2/28/19 documented that the medication was administered outside the physician ordered parameters 1 time out of 24 opportunities by 1 nurse, as indicated on the MAR. (RN #26) In addition, on 2/19/19, medication was documented as not administered when medication should have been given according to physician parameters. (RN #39) -3/1/19 until 3/31/19 documented that the medication was administered outside the physician ordered parameters 26 times out of 124 opportunities by 3 nurses, as indicated on the MAR. On 3/6/19 and 3/7/19, at 7:30 AM, there were nurse's signatures documented on the MAR that [redacted] was administered however, there was no documentation of dose or site on the MAR. On 3/2/19, 3/3/19, 3/4/19, 3/5/19, 3/6/19, 3/7/19, 3/8/19, 3/9/19, 3/10/19, 3/11/19, 3/12/19, 3/13/19, 3/14/19, 3/18/19, 3/19/19, 3/22/19, 3/23/19, 3/24/19, 3/26/19, 3/27/19, 3/28/19, 3/29/19, 3/30/19 and 3/31/19 at 11:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of dose or site. On 3/4/19, 3/12/19, 3/16/19, 3/18/19, 3/22/19 and 3/25/19 at 4:30 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of dose or site. (LPN #19, RN #21, and RN #24)	F 658		

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-4/1/19 until 4/30/19, revealed that the medication was administered outside the physician ordered parameters 24 times out of 120 opportunities by 9 nurses, as indicated on the MAR.
On 4/24/19, at 7:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of dose or site on the MAR. On 4/1/19, 4/5/19, 4/7/19, 4/14/19, 4/16/19, 4/17/19, 4/18/19, 4/19/19 and 4/24/19 at 11:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of dose or site on the MAR. On 4/5/19, 4/6/19, 4/12/19, 4/15/19, 4/28/19 and 4/29/19 at 4:30 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of dose or site on the MAR. (LPN #19, LPN #3, LPN #22, LPN #25, LPN #40, LPN #23, LPN #38, RN #21, and LPN #41)

-5/1/19 until 5/31/19, revealed that the medication was administered outside the physician ordered parameters 32 times out of 124 opportunities by 10 nurses, as indicated on the MAR. On 5/16/19, at 7:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of dose or site on the MAR. On 5/1/19, 5/2/19, 5/4/19, 5/5/19, 5/6/19, 5/9/19, 5/11/19, 5/12/19, 5/15/19, 5/16/19, 5/20/19, 5/22/19, 5/23/19, 5/24/19, 5/26/19, 5/28/19 and 5/30/19 at 11:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 5/5/19, 5/7/19, 5/8/19, 5/19/19 and

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5/27/19 at 4:30 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. (LPN #3, LPN #19, LPN #12, RN #20, RN #15, LPN #23, LPN #1, LPN #6, LPN #41, and LPN #42)

-6/1/19 until 6/30/19, revealed that the medication was administered outside the physician ordered parameter 20 times out of 120 opportunities by 9 nurses, as indicated on the MAR. On 6/1/19, 6/2/19, 6/3/19, 6/6/19, 6/11/19, 6/12/19, 6/14/19, 6/16/19, 6/17/19, 6/25/19, 6/26/19, 6/27/19, 6/28/19, 6/29/19 and 6/30/19 at 11:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 6/1/19, 6/2/19, 6/7/19, 6/15/19, 6/21/19, 6/29/19 and 6/30/19 at 4:30 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. (LPN #3, LPN #11, LPN #12, LPN #25, LPN #13, RN #15, and LPN #41)

-7/1/19 until 7/31/19, revealed that the medication was administered outside the physician ordered parameter 26 times out of 120 opportunities by 11 nurses, as indicated on the MAR. On 7/5/19, 7/6/19 and 7/9/19 at 7:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 7/1/19, 7/3/19, 7/6/19, 7/7/19, 7/9/19, 7/10/19, 7/11/19, 7/14/19, 7/15/19, 7/16/19, 7/17/19, 7/20/19, 7/21/19, 7/22/19, 7/23/19, 7/24/19, 7/35/19, 7/26/19, 7/27/19, 7/30/19 and 7/31/19 at 11:30 AM, there were nurse's signatures documented on the MAR that

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indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 7/2/19, 7/9/19, 7/11/19, 7/14/19, 7/16/19, 7/19/19 and 7/26/19 at 4:30 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 7/16/19, at 9:00 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. (LPN #25, LPN #2, RN #20, LPN #3, LPN #4, LPN #43, RN #5, LPN #44, RN #34, RN #24, and LPN #6)

-8/1/19 until 8/21/19, revealed that the medication was administered outside the physician ordered parameter 10 times out of 80 opportunities by 9 nurses, as indicated on the MAR. On 8/1/19, 8/2/19, 8/3/19, 8/5/19, 8/6/19, 8/7/19, 8/8/19, 8/9/19, 8/10/19, 8/11/19, 8/12/19, 8/14/19, 8/16/19, 8/17/19, 8/19/19, and 8/20/19 at 11:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 8/2/19, 8/5/19, 8/6/19, 8/9/19, 8/19/19 and 8/20/19 at 4:30 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 8/10/19, at 9:00 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. (LPN #16, LPN #3, LPN #17, LPN #8, RN #15, LPN #1, LPN #43, LPN #45, and LPN #18)

The surveyor reviewed the Consultant

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Pharmacist Evaluations and noted there was no documentation of medication errors documented for the period 2/1/19 through 8/8/19 for Resident #85.

3.) RESIDENT #100
According to the admission record, Resident # 100 was readmitted to the facility on [redacted] with medical diagnoses including [redacted].

The quarterly MDS, dated [redacted] indicated that the resident had [redacted]

The surveyor reviewed the diabetes focus in Resident # 100's care plan. On 4/16/15 the facility initiated an intervention to administer medication according to the physician's order.

The surveyor reviewed Resident # 100's Physicians order report which revealed an original physician's order dated 08/19/19, for the medication [redacted] to be administered daily at 4:30 PM and 9:00 PM based on the following parameters:
If [redacted]
If greater than [redacted] or below [redacted] call MD.

The surveyor reviewed Resident #100's electronic

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F 658	Continued From page 13 MAR's for the period 8/1/19 until 8/22/19 and noted the following: -8/1/19 until 8/22/19, revealed that the medication was administered outside the physician ordered parameter 2 times out of 6 opportunities by 2 nurses, as indicated on the MAR, for Resident #100. (LPN #18 and LPN #1) 4.) RESIDENT #155 According to the AR with an admission date of [redacted], Resident #155 was admitted to the facility with the medical diagnoses of [redacted]. The admission MDS, dated [redacted], indicated that the resident was [redacted]. The surveyor reviewed the [redacted] focus in Resident #155's care plan. On 7/23/19 the facility initiated an intervention to administer [redacted] according to the physician's order. The surveyor reviewed Resident #155's Physicians Order Report which revealed an original physician's order dated 07/23/19 for the medication [redacted] to be administered daily at 7:30 AM and 4:30 PM with the dosage based on the following parameters: If [redacted] The surveyor reviewed Resident #155's electronic	F 658		

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MAR's for the period 8/1/19 to 8/21/19, and noted the following:

-8/1/19 until 8/21/19 documented that the medication was administered outside the physician ordered parameter 1 time out of 41 opportunities by 1 nurse, as indicated on the MAR. (RN #15)

The surveyor reviewed Resident #155's Consultant Pharmacist Evaluation dated 8/7/19. There were no indications of medication errors documented by the PC.

INTERVIEWS OF STAFF

On 08/21/19 at 12:30 PM, the surveyor interviewed LPN #3 who worked on 8/12/19 on the 7:00 AM to 3:00 PM shift. LPN #5 confirmed the initials on the 8/12/19 eMAR for Resident #85's at 7:30 AM were hers and confirmed the medication [redacted] was signed as given. LPN #5 stated the electronic signature was signed in error. LPN stated the computer program permits a nurse to sign off a medication regardless of the physician ordered parameters. LPN #5 stated she may have signed multiple items together and signed them all at one time. She stated her normal process was to leave the outliers off, such as medications held, and sign them off individually.

During a follow up interview on 08/28/19 at 10:36 AM, LPN #3 told the surveyor the computer program would not allow her to enter the dose or the site. The surveyor showed the LPN the printout of the MAR and asked why other nurses

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could enter in the dose and site? LPN #5 stated she only documented on what was flagged in the system. She also stated that each dose and site should be indicated as mandatory with a red flag and if there was no spot to enter the information, she should have informed the supervisor. LPN #5 stated other nurses probably entered the dose and site information in the comment section.

On 08/23/19 at 10:28 AM, the surveyor attempted to contact LPN #19 by telephone but was unsuccessful. LPN #19 did not return the call or stop in to speak with the surveyor.

On 08/23/19 at 10:52 AM, the surveyor interviewed LPN #8 who had worked on 8/18/19 on the 7:00 AM to 3:00 PM shift by telephone. The surveyor read the LPN the order and the [redacted] results. LPN #5 confirmed that [redacted] should have been held based on the physician ordered parameters. LPN #5 also confirmed if a medication was not given, it was necessary to click, "Not administered," in the computer program.

On 08/28/19 at 12:40 PM, LPN #5 was in the facility and reviewed the paper printout of the eMAR with the surveyor. After this review, LPN #5 told the surveyor if the medication was held, a nurse must manually unclick the box indicating a medication was not administered. LPN #8 also said they may have been sidetracked and forgot to unclick the box.

On 08/23/19 at 11:40 AM, the surveyor interviewed LPN #14 who had worked on 6/9/19 on the 3:00 PM to 11:00 PM shift. LPN #14 confirmed the initials on the 6/9/19 eMAR for Resident #85's at 9:00 PM were hers and

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confirmed the medication [redacted] was signed as given and it should have been held. LPN #14 indicated when a medication was not administered, the clinical rationale for holding the medication should be documented in the computer system drop down box. LPN #14 stated it was possible she was orienting a new nurse who may have signed under her name.

On 08/22/19 at 11:34 AM the RN UM #1 told the surveyor medication order parameters were manually entered by charge nurses or the supervisor into the computer system for the parameters to populate. The RN UM #1 further revealed if a parameter did not populate in the computer system correctly, the nurse must inform her so she can make the correction. The RN UM #1 stated it was the responsibility of the pharmacy consultant to review the eMAR and find errors. The RN UM #1 indicated she didn't do a chart check.

On 08/23/19 at 09:44 AM, the surveyor interviewed the Pharmacy Consultant (PC) by telephone. The PC revealed the facility nurses received an in-service on medication parameters in July and additional education on parameters was further provided to the facility in the pharmacy's third quarter report, "The Quarterly Connection." The PC told the surveyor if she found a medication documented as administered and it was outside of parameters, she would immediately bring it to the, nurses' attention as well as the UM or supervisor and the Director of Nursing (DON). The pharmacist revealed she did not identify medication being signed as administered outside of physician ordered parameters as a repetitive issue in this building. The PC indicated that the dose and

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administration site should be documented in the eMAR. The PC further stated there were too many steps in the computer system to identify a pattern of medications being administered outside of parameters. The pharmacist was unable to provide documentation of education regarding [redacted] education and [redacted] parameters or documentation demonstrating corrective actions provided to the nurses, UM/supervisor and DON when parameter related medication errors occurred.

On 08/26/19 at 10:06 AM, the surveyor interviewed the attending physician (MD#1) for Resident #85 and Resident # 155 by telephone. MD #1 indicated he was not made aware of any medication errors for Resident #85 or Resident #155 but described both residents as clinically fine regarding the residents' [redacted].

On 08/26/19 at 10:20 AM, the surveyor interviewed Resident's #100's physician (MD #2) by telephone. MD #2 revealed she was not aware Resident #100 was given medications outside parameters but would assume it was given according to the standard coverage and Resident #100 would not have been given more than [redacted]. MD #2 stated medications should have been given according to ordered parameters. MD #2 indicated Resident #100 should not have been affected and remarked the medication error was not a terrible mistake. MD #2 further stated it was good practice to write down the dose on the MAR when administering the medication.

On 08/21/19 at 09:34 AM, the DON revealed that physicians and the consultant pharmacist were responsible for reviewing the [redacted]

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administration documentation. The DON revealed the consultant pharmacist comes to the facility monthly and should review the eMAR's back to their previous visit.

During a follow up interview with the DON on 08/28/19 at 09:00 AM, the DON told the surveyor the nursing staff believed when they were signing off in the computer, they were documenting the task of taking the [redacted] was completed instead of medication was administered for [redacted] outside of parameters. The DON further revealed the facility reached out to the computer program vendor regarding the parameters. The DON stated the vendor stated the system could not be changed and informed the facility to instruct the nurses to enter the information uniformly.

The surveyor reviewed the undated job description of the Unit Manager. One of the main duties included monitoring programming and completing all documentation as necessary for the unit.

HYPOTENSIVE MEDICATION

1.) RESIDENT #71
According to the Admission Record (AR) Resident # 71 was admitted to the facility on [redacted], with the medical diagnoses of [redacted]).
The quarterly MDS, dated [redacted] indicated that Resident #71 had [redacted] The MDS also reflected that the resident had a

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F 658	Continued From page 19 diagnosis of [redacted] The POR revealed that there was an original order dated 3/12/2019, for the medication [redacted] to give 1 tablet 3 times a day and to hold the medication for [redacted] The parameters for holding the [redacted] were listed on the MAR. The surveyor reviewed Resident #71's MAR's for the period of 3/12/19 to 8/20/19 and noted the following: - 3/1/19 to 3/31/19, the medication [redacted] was administered outside the physician ordered [redacted] parameter 2 times out of 52 opportunities by 2 nurses, as indicated on the MAR. (LPN #11 and LPN #41) - 4/1/19 to 4/30/19, the medication [redacted] was administered outside the physician ordered [redacted] parameter 3 times out of 90 opportunities by 3 nurses, as indicated on the MAR. (LPN #32, LPN #22, and RN #21) - 5/1/19 to 5/31/19, the medication [redacted] was administered outside the physician ordered [redacted] parameter 5 times out of 93 opportunities by 2 nurses, as indicated on the MAR. (RN #33 and RN #34). - 6/1/19 to 6/30/16, the medication [redacted] was administered outside the physician ordered [redacted] parameter 6 times out of 90 opportunities by 2 nurses, as indicated on the MAR. (LPN #25 and RN #33).	F 658		

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- 7/1/19 to 7/31/19, the medication [redacted] was administered outside the physician ordered [redacted] parameter 11 times out of 93 opportunities by 4 nurses, as indicated on the MAR. (RN #33, LPN #32, RN #35, RN #21.)

- 8/1/19 to 8/20/19, the medication [redacted] was administered outside the physician ordered [redacted] parameter 8 time out of 58 opportunities by 2 nurses, as indicated on the MAR. (RN #33 and RN #24.)

The surveyor reviewed the Consultant Pharmacist Evaluations dated 3/18/19, 4/15/19, 5/13/19, 6/17/19, 7/15/19 and 8/20/19. There was no documentation on the Pharmacist monthly evaluations that reflected that the medication [redacted] was being administered by nurses outside of the physician ordered [redacted] parameters.

On 08/20/19 at 11:35 AM, the surveyor interviewed the Director of Nursing (DON) who reviewed Resident #71's MAR from March 2019 to August 2019 and confirmed that some of the nurses gave Resident #71 [redacted] outside of the physician ordered parameters.

The DON stated that, "The order clearly reads that the medication should be held if the [redacted] I don't know how the nurses could read the order and hold it one day and then give it the next day when the order did not change."

On 8/20/19 12:24 PM, the surveyor interviewed the Consultant Pharmacist who stated that she comes in monthly to review residents' medications and when she finds concerns, she would write recommendations and give them to

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the DON and administrator. The PC revealed that she did not find the medication error that the nurses were giving Resident #71's [redacted] outside of the physician ordered parameters. The consultant Pharmacist also stated, "There are two ways to review medication administration on the computer program and the one way that I look to see if the medications were given as ordered by the physician must give me a false indicator. I should have looked at it a different way and then I could have seen that there was an error."

On 8/21/19 at 9:33 AM, the surveyor interviewed the DON who stated that there was not a facility protocol to review the residents MAR every day. The DON added the PC was responsible to come to the facility every month to review the MAR and physician orders. She also added that if there was a medication error the PC would notify the DON right away.

On 8/21/19 at 1:53 PM, the surveyor interviewed the Primary Care Physician (PCP) who stated that Resident # 71 was prescribed the medication [redacted]. He further added that [redacted] parameters were ordered because if the medication [redacted] was given when the [redacted], it could make the [redacted] which may have a negative impact on the resident if the [redacted] went [redacted] He stated that he was not aware that the nurses were administering [redacted] medication out of the physician ordered parameters.

On 8/21/19 at 2:21 PM, the surveyor interviewed the MDS Coordinator Licensed Practical Nurse (LPN #11) by telephone who stated that he administered medications occasionally, however

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he was familiar with Resident #71. The LPN stated that he knew that the medication [redacted] was for [redacted] and that when he administered medications to residents with ordered [redacted] parameters, he would take the blood pressure and document the results on the electronic MAR. He added that if the [redacted] was out of the physician ordered parameters, he would document the [redacted] on the computer system and hold the medication. The LPN could not explain why the documentation on Resident #71 MAR indicated that he gave the resident [redacted] medications outside of the ordered parameters when he knew that the medication should not have been given.

On 8/21/19 at 2:29 PM, the surveyor interviewed LPN #32 by telephone who stated that based on the resident's [redacted] and physician ordered parameters, he would hold or give the [redacted] medications. He added that the process of holding medications in the computer system is an "extra step" and if the nurse missed the extra step it would look like the medication was administered when it was not. If the extra step is missed, it could be a case of human error or it could happen if the nurse was behind or rushing.

The facility policy titled, "Medication Administration" dated 3/20/15 indicated that when nurses are administering medications the nurses will ensure the resident are receiving the right medication with the resident's name, the right time the right dose and the right route.

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Part B.

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F 658	Continued From page 23 Based on interview and record review, it was determined that the facility failed to document physician ordered [redacted] parameters for 2 of 6 resident reviewed, Residents #85 and #147. This deficient practice is evidenced by: 1. RESIDENT #85 According to the admission record, Resident #85 was admitted to the facility on [redacted], with the medical diagnoses including [redacted] The quarterly MDS, dated [redacted], indicated that the resident had [redacted] The surveyor reviewed the [redacted] focus in Resident #85's care plan. On 1/28/19 the facility initiated an intervention to monitor vital signs and blood pressure according to the physician's order and to administer [redacted] medications as prescribed by the MD (medical doctor). There was a note at the bottom of this focus section created by an RN on 4/11/19 which documented that Resident #85 had some elevated blood pressure levels and interventions should be continued. The surveyor reviewed the [redacted]: [redacted] focus in Resident #85's care plan. On 1/28/19 the facility initiated an intervention to monitor vital signs and blood pressure according to the physician's order.	F 658		

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The surveyor reviewed the [redacted] focus in Resident #85's care plan. On 1/28/19 the facility initiated an intervention to monitor vital signs according to the physician's order.

The surveyor reviewed Resident # 85's Physicians order report which contained an original physician's order dated 01/28/19 for the medication [redacted] tablet by mouth once daily at 9:00 AM. The protocol was to [redacted].

The surveyor reviewed Resident #85's Physicians Order Report which revealed an original physician's order dated 01/28/19 for the medication [redacted] 24 hr, give 1 tablet ([redacted]) by mouth daily at 8:00 AM for the diagnosis of [redacted]. The protocol for this medication was to [redacted].

The surveyor reviewed the electronic MAR which documented Resident #85's last recorded [redacted] was documented on 3/28/2019 and the last recorded [redacted] in a skilled nursing note was dated 4/13/19.

On 08/22/19 at 11:05 AM LPN #30 told the surveyor that routine vital signs (vital signs include blood pressure) were completed monthly and entered into the electronic charting system. This should then automatically enter the monthly vital signs as an order when a resident was admitted. LPN #30 stated the facility was paperless and that monthly vital signs would not be stored on paper documents and that physicians had access to the electronic vital

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signs. LPN #30 stated that everyone should have monthly vitals and monthly weights.

On 08/22/19 at 11:21 AM LPN #3 told the surveyor that nurses were responsible for obtaining a resident's vital signs and documenting them into the computer system as ordered by the physician or UM.

On 08/22/19 at 11:34 AM, RN UM #1 told the surveyor the facility's protocol for vital signs were that vital signs were to be taken a minimum of once a month, unless otherwise indicated by a physician. RN UM #1 stated vital signs were electronically submitted into the computer system and the facility didn't keep paper documents. The RN UM stated that when sometimes things didn't populate in the computer system, the floor nurse would have to identify the missing information and inform her to make a correction. The RN UM #1 stated that she was not responsible for reviewing the eMARs for errors or omissions, that was the responsibility of the pharmacist. The RN UM #1 reviewed Resident #85's January [redacted] order. She described the order as vague and indicated that the facility should have added clinical monitoring for the [redacted] to show up on the eMAR. The RN UM #1 was unable to locate the order for monthly vitals or an order to discontinue vitals. The RN UM #1 stated after Resident #85 transferred into long-term care, the blood pressures monitoring continued for another month. The RN UM #1 stated, she was not not sure why the monthly vitals weren't put in.

On 08/21/19 at 11:44 AM, the DON told the surveyor vital signs were to be completed monthly on Long term care units and as ordered by the

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F 658	Continued From page 26 physician. 2.) RESIDENT #147 According to the AR, Resident #147 was admitted to the facility on [redacted] with the medical diagnoses of [redacted] The MDS indicated that Resident #147 had [redacted] Resident #147 was unable to be interviewed [redacted] The Care Plan dated 11/4/18, reflected a focus on the diagnoses of [redacted]. On 8/21/19 at 10:30 AM, the surveyor reviewed Resident #147's POR which reflected an original order dated 10/25/18, for [redacted] to administer one tablet daily and to hold the medication for [redacted] for the diagnoses of [redacted] The surveyor reviewed the MAR's for the period of 10/26/18 to 8/20/19. There were no documented [redacted] documented on the electronic MAR related to the use of the medication [redacted] as prescribed by the physician.	F 658		

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F 658	Continued From page 27 On 8/21/19 at 11:30 AM, the surveyor interviewed the primary care LPN #37 on the [redacted], who stated that she takes Resident #147's [redacted] but did not document it on the MAR. She revealed she did not document the resident's [redacted] on the MAR because she worked on a [redacted] and that she would sometimes get distracted "It was my mistake and it's an act of human error." On 8/21/19 at 11:35 AM the surveyor interviewed the Registered Nurse Unit Manager (RN/UM#2) on the [redacted] and he confirmed that Resident #147's [redacted] should be documented according to the physician ordered parameters. He added that someone should have caught this mistake and changed the MAR to reflect documentation for [redacted]. On 8/21/19 at 2:35 PM, the surveyor interviewed the Resident #147's Primary Care Physician (PCP) by telephone who stated that he was not aware that there were no [redacted] or [redacted] documented on the MAR because he did not look at the MAR. He added that he looked at the Clinical Monitoring Report (CMR) section of the computer program to see what the resident's [redacted]' were. The PCP stated that he was not aware that on the CMR there was only one [redacted] that had been documented for the period of 12/2018 to 8/20/19. The Consultant Pharmacist Evaluations for Resident #147 dated 11/26/18, 12/21/18, 1/25/19, 2/25/19, 3/19/19, 4/11/19, 5/16/19, 6/18/19 and 7/12/19, did not note that there were omissions of [redacted] documented on the MAR for the use of the medication [redacted], when the	F 658		

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F 658	Continued From page 28 physician had ordered specific [redacted] parameters. On 8/26/19 at 9:25 AM, the surveyor interviewed the Medical Director (MD) who has held that position since 2007. The Medical Director stated that during the quarterly quality meeting held approximately 2 weeks ago the PC discussed the issue that blood pressure medications with parameters needed to be looked at closer for trends, but that the PC was not resident specific. The Medical Director was not made aware about this until the DOH found the issue. Going forward the facility is contacting the computer program vendor to see if there is a better way to put the orders in and further training of staff. In discussing Resident #147, the Medical Director said, "I'm not too sure how the resident slipped through the cracks and did not have [redacted] taken. Monthly vital signs are standard. If a resident is on a [redacted] medication or an [redacted] order with parameters, the nurse should be documenting the [redacted], the [redacted], the medication dose and the [redacted] administration. "Of course they should be documenting it." The surveyor reviewed the "Resident Vital Signs" policy dated 8/21/17. Under the procedure portion the policy revealed that residents should have their vital signs taken according to physician's orders. NJAC 8:39- 11.2 (b), 27.1 (a), 29.2 (d)	F 658		
F 756 SS=K	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		10/25/19

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§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical 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.

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F 756	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the Pharmacy Consultant (PC): a.) consistently reviewed resident's medical records for drug irregularities and b.) consistently report and identify the irregularities in accordance with the PC agreement, during a 10 month period (October 2018 to July 2019). The deficient practice was identified for 4 of 32 residents, (Resident #39, #71, #147 and #85) reviewed for drug regimen review. This resulted in an immediate jeopardy situation when the pharmacy consultant failed to identy and report the irregularies and multiple nurses continued administer medications out of physician ordered parameters that resulted in the likelihood of serious injury or harm to all residents. The deficient practice was evidenced by the following: On 8/23/19 at 11:13 PM, the facility's Administrator was notified that an Immediate Jeopardy (IJ) situation had been identified related to the failure to ensure drug irregularities were discovered and acted upon. Errors were made by nurses who; A. disregarded physician ordered parameters for the administration of [redacted], a medication that regulates[redacted], for the period of February 2019 to August 2019 (7 months) according to the physician ordered parameters B. disregarded physician ordered [redacted] parameters for the administration of	F 756	F756 A. Pharmacy Consultant will audit all residents with [redacted] order and [redacted] medication with parameters to ensure medications are plotted accurately and medication administration documentation is accurate and complete. B. Any resident who has an [redacted] order and [redacted] medication with parameter order is potentially affected by this deficient practice. C. Facility will request for a replacement Pharmacy Consultant. Pharmacy Consultant will generate a separate report for all residents on [redacted] and [redacted] medication parameter to ensure these medications are plotted accurately and administration documentation is completed accurately. D. Pharmacy Consultant will complete a bi-weekly medication regimen review for all residents with [redacted] order and [redacted] medication with parameters to ensure medications are plotted accurately and medication administration documentation is accurate and corresponds with the orde for 2 months, then monthly thereafter. Report of the findings will be reported to the Director of Nursing and Administrator. Result of these audits will be reported to	

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F 756	Continued From page 31 medications that regulate [redacted] for the period of March 2019 to May 2019, a 6 month period. C. disregarded physician ordered [redacted] or [redacted] parameters for 2 of 6 resident (Resident #147 and #85). On 8/23/19 at 4:34 PM, the IJ removal plan was accepted and the facility initiated a drug regimen review for all residents with [redacted] parameters and/or [redacted] and any irregularities will be reported to the Director of Nursing (DON), Administrator and Medical Director. In addition, the facility initiated an immediate drug regimen review for any residents who was currently on a [redacted] order and [redacted] medication parameters. The survey team verified elements of the removal plan that addressed the immediate actions taken by the facility and continued to do so throughout the survey. A review of the Medication Administration Records (MAR) revealed errors wherein [redacted] was either administered or not administered outside the physician ordered [redacted] for the following identified timelines: 1.) According to the Admission Record (AR) Resident #39 was admitted to the facility on [redacted] with the medical diagnoses of [redacted] The Annual Minimum Data Set (MDS), an assessment tool that assesses a resident's functional capabilities and identifies health problems dated [redacted] documented that Resident #39 was	F 756	the QA Committee quarterly.	

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[redacted] The MDS also reflected that the resident had a diagnosis of [redacted].

The Physician Order Record (POR) dated 1/26/19, reflected an order for [redacted] that starts to work about [redacted], Monitoring of [redacted], were ordered to be conducted three times a day before meals. There was an order for [redacted] coverage to be given according to the following parameters: [redacted] notify the physician

On 7/4/19, 7/11/19, 7/14/19, 7/21/19, 7/25/19 at 7:30 AM, there were nurse's signatures documented on the MAR that [redacted] was administered. There was no documentation of the dose or site on the MAR.

On 7/14/19, 7/16/19, 7/21/19, 7/29/19 at 11:30 AM, there were nurse's signatures documented on the MAR that [redacted] was administered. There was no documentation of the dose or site on the MAR.

On 7/5/19 at 5:00 PM, there was a nurse's signatures documented on the MAR that [redacted] was administered. There was no documentation of the dose or site on the MAR.

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On 7/6/19 at 7:30 AM a nurse documented that Resident #39's [redacted] of [redacted] was administered. At 11:30 AM a nurse documented that Resident # 39's [redacted] was administered. According to the physician ordered [redacted] Resident #39 should not have received any [redacted]

The surveyor reviewed the Consultant Pharmacist (CP) Evaluation, a hand-written resident specific pharmacy report located on the resident's chart. This evaluation documented the following:

Resident #39 had no documentation from the CP that there were issues with the medication [redacted] being administered outside of the physician ordered parameters for the time frame of 6/15/19 to 8/20/19.

2.) According to the AR Resident # 71 was readmitted to the facility on [redacted] with the medical diagnoses of [redacted].

The quarterly MDS assessment tool dated [redacted] documented that Resident #71 had [redacted]

The POR revealed that there was an original order dated 3/12/2019 for the medication [redacted]

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F 756	Continued From page 34 to give 1 tablet 3 times a day and to hold the medication for s[redacted] The surveyor reviewed the MAR's for the period 3/12/19 until 8/20/19 and noted the following: - 3/1/19 to 3/31/19, the medication [redacted] was administered outside the physician ordered [redacted]) parameter 2 times out of 52 opportunities by 2 nurses. - 4/1/19 to 4/30/19, the medication [redacted] was administered outside the physician ordered [redacted] parameter 3 times out of 90 opportunities by 3 nurses. - 5/1/19 to 5/31/19, the medication [redacted] was administered outside the physician ordered [redacted] parameter 5 times out of 93 opportunities by 2 nurses. - 6/1/19 to 6/30/16, the medication [redacted] was administered outside the physician ordered [redacted] parameter 6 times out of 90 opportunities by 2 nurses. - 7/1/19 to 7/31/19, the medication [redacted] was administered outside the physician ordered [redacted] parameter 11 times out of 93 opportunities by 4 nurses. - 8/1/19 to 8/20/19, the medication [redacted] was administered outside the physician ordered [redacted] parameter 8 time out of 58 opportunities by 2 nurses. According to the "Consultant Pharmacist Evaluation" forms dated 3/18/19, 4/15/19,	F 756		

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5/13/19, 6/17,19, 7/15/19 and 8/20/19 there was no documentation referencing that the medication [redacted] was being administered outside of the physician ordered [redacted] parameters.

3.) According to the AR, Resident #147 was admitted to the facility on [redacted] with the medical diagnoses of [redacted]

The Significant Change MDS dated [redacted] documented that Resident #147 had [redacted]

On 8/21/19 at 10:30 AM, the surveyor reviewed Resident # 147's POR which reflected an original order dated 10/25/18, for [redacted] to administer one tablet daily and to hold the medication for [redacted] for the diagnoses of [redacted].

The surveyor reviewed the MAR's for the period 10/26/18 to 8/20/19 and there were no documented B/P's or HR's documented for the use of the medication [redacted] as prescribed by the physician.

The Consultant Pharmacist Evaluations dated 11/26/18, 12/21/18, 1/25/19, 2/25/19, 3/19/19, 4/11/19, 5/16/19, 6/18/19 and 7/12/19, did not contain documentation related to the omission of [redacted] and [redacted] related to the use of [redacted], when the physician had ordered specific [redacted] and [redacted] parameters for the use of the medication.

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On 8/20/19 12:24 PM, the surveyor interviewed the Pharmacy Consultant (CP) who stated that she comes in monthly to review residents' medications and when she finds concerns, she would write document any concerns or recommendations and give them to the DON and Administrator. The CP revealed that she did not find the problem of staff giving the residents [redacted] medication outside of the physician ordered parameters. The CP told the surveyor that "There are two ways to review medication administration on the computer program and the one way that I look to see if the medications were given as ordered by the physician must give me a false indicator. I should have looked at it a different way. Then I could have seen that there was an error." The CP indicated that she only randomly reviewed dates of administration of medications and did not look at the entire month of medication administration.

On 8/21/19 at 9:33 AM, the surveyor interviewed the DON who stated that there was not a facility protocol to do a daily review of each resident's MAR. The DON added the CP was responsible to come to the facility every month to review the MAR and physician orders. She also added that if there was a error the PC would notify the DON right away.

On 8/23/19 at 9:43 AM, the surveyor interviewed the CP by telephone who stated that she discussed this issue at the quarterly Quality Assurance Performance Improvement (QAPI), but did not reveal a date. The CP stated inservices were provided to the nurses relating to the importance of adhering to physicians orders in regards to blood pressure medications and parameters because the CP had noted this

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issue in other facilities. "In regards to [redacted] I have not identified a wide spread issue and I did not see that nurses were giving [redacted] out of the physician ordered parameters." The PC further stated that doses and sites of [redacted] should be documented and stated "Of course they should."

4. According to the admission record, Resident #85 was admitted to the facility on [redacted], with medical diagnoses including [redacted]

The quarterly MDS, dated [redacted] documented that the resident had [redacted]

The surveyor reviewed an untitled report for Resident # 85 which documented an original physician's order dated 02/10/19 for the medication [redacted] daily at 7:30 AM and 4:30 PM. The dosage of [redacted] to be administered was based on the following parameters:
If [redacted] = administer [redacted]
If greater than [redacted] call MD (medical doctor).

The surveyor reviewed Resident # 85's POR which documented a revised physician's order dated 02/22/19, for the medication [redacted]

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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
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[redacted] daily at 9:00 PM. The [redacted] was to be administered based on the following parameters as listed in the MAR:
If [redacted] = administer
[redacted]

The surveyor reviewed Resident # 85's POR which revealed a revised physician's order dated 2/22/19, for the medication [redacted] daily at 7:30 AM, 11:30 AM and 4:30 PM. The dosage of [redacted] to be administered was based on the following parameters as listed in the MAR:
If [redacted] = administer
[redacted]

The surveyor reviewed Resident # 85's POR which documented a revised physician's order dated 6/18/19, for the medication [redacted] daily at 7:30 AM, 11:30 AM and 4:30 PM. The dosage to be administered was based on the following parameters:
If [redacted] = administer
[redacted]

The surveyor reviewed Resident # 85's POR which documented a revised physician's order dated 06/18/19, for the medication [redacted] daily at 9:00 PM. The

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dosage to be administered was based on the following parameters:
If [redacted] administer
[redacted]

The surveyor reviewed the electronic MAR's for the time period of 2/1/19 until 8/21/19, and noted the following:

- 2/1/19 until 2/28/19, the [redacted] was administered outside the physician ordered parameters 1 time out of 24 opportunities by 1 nurse. In addition, on 2/19/19, [redacted] was not administered when it should have been given per physician parameters.

- 3/1/19 until 3/31/19, revealed that [redacted] was administered outside the physician ordered parameters 26 times out of 124 opportunities by 6 nurses. On 3/6/19 and 3/7/19, at 7:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 3/2/19, 3/3/19, 3/4/19, 3/5/19, 3/6/19, 3/7/19, 3/8/19, 3/9/19, 3/10/19, 3/11/19, 3/12/19, 3/13/19, 3/14/19, 3/18/19, 3/19/19, 3/22/19, 3/23/19, 3/24/19, 3/26/19, 3/27/19, 3/28/19, 3/29/19, 3/30/19 and 3/31/19 at 11:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 3/4/19, 3/12/19, 3/16/19, 3/18/19, 3/22/19 and 3/25/19 at 4:30 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR.

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F 756	Continued From page 40 - 4/1/19 until 4/30/19, revealed that [redacted] was administered outside the physician ordered parameters 24 times out of 120 opportunities by 6 nurses. On 4/24/19, at 7:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 4/1/19, 4/5/19, 4/7/19, 4/14/19, 4/16/19, 4/17/19, 4/18/19, 4/19/19 and 4/24/19 at 11:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 4/5/19, 4/6/19, 4/12/19, 4/15/19, 4/28/19 and 4/29/19 at 4:30 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. - 5/1/19 until 5/31/19, revealed that [redacted] was administered outside the physician ordered parameters 32 times out of 124 opportunities by 8 nurses. On 5/16/19, at 7:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 5/1/19, 5/2/19, 5/4/19, 5/5/19, 5/6/19, 5/9/19, 5/11/19, 5/12/19, 5/15/19, 5/16/19, 5/20/19, 5/22/19, 5/23/19, 5/24/19, 5/26/19, 5/28/19 and 5/30/19 at 11:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 5/5/19, 5/7/19, 5/8/19, 5/19/19 and 5/27/19 at 4:30 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR.	F 756		

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F 756	Continued From page 41 - 6/1/19 until 6/30/19, revealed that [redacted] was administered outside the physician ordered parameter 20 times out of 120 opportunities by 6 nurses. On 6/1/19, 6/2/19, 6/3/19, 6/6/19, 6/11/19, 6/12/19, 6/14/19, 6/16/19, 6/17/19, 6/25/19, 6/26/19, 6/27/19, 6/28/19, 6/29/19 and 6/30/19 at 11:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 6/1/19, 6/2/19, 6/7/19, 6/15/19, 6/21/19, 6/29/19 and 6/30/19 at 4:30 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] site on the MAR. - 7/1/19 until 7/31/19, revealed that [redacted] was administered outside the physician ordered parameter 26 times out of 120 opportunities by 11 nurses. On 7/5/19, 7/6/19 and 7/9/19 at 7:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 7/1/19, 7/3/19, 7/6/19, 7/7/19, 7/9/19, 7/10/19, 7/11/19, 7/14/19, 7/15/19, 7/16/19, 7/17/19, 7/20/19, 7/21/19, 7/22/19, 7/23/19, 7/24/19, 7/35/19, 7/26/19, 7/27/19, 7/30/19 and 7/31/19 at 11:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 7/2/19, 7/9/19, 7/11/19, 7/14/19, 7/16/19, 7/19/19 and 7/26/19 at 4:30 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 7/16/19, at 9:00 PM, there were nurse's signatures documented on the MAR that	F 756		

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indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR.

- 8/1/19 until 8/21/19, revealed that [redacted] was administered outside the physician ordered parameter 10 times out of 80 opportunities by 6 nurses. On 8/1/19, 8/2/19, 8/3/19, 8/5/19, 8/6/19, 8/7/19, 8/8/19, 8/9/19, 8/10/19, 8/11/19, 8/12/19, 8/14/19, 8/16/19, 8/17/19, 8/19/19, and 8/20/19 at 11:30 AM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] site on the MAR. On 8/2/19, 8/5/19, 8/6/19, 8/9/19, 8/19/19 and 8/20/19 at 4:30 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR. On 8/10/19, at 9:00 PM, there were nurse's signatures documented on the MAR that indicated [redacted] was administered however, there was no documentation of [redacted] on the MAR.

A review of the CPE revealed there were no documention by the CP that [redacted] was being administered on numerous occasions during the period 2/1/19 through 8/8/19 for Resident #85.

The facility "Pharmacy Agreement" dated 10/29/2019 reflected that the CP would be responsible for:
- Monthly onsite review of drug regimen of each resident on the facility census and would report any irregularities to the nurses in charge and/or the attending physician and the Administrator.
- Written reports as needed to the Quality Assurance and Pharmacy and Therapeutics

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F 756	Continued From page 43 Committees on the status of the facilities pharmaceutical services and staff performance. NJAC 8:39 - 29.2 (d), 29.3 (a)	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, staff interview and review of other documents provided by the facility, it was determined that the facility failed to ensure a medication error rate of less than 5 percent. A medication pass observation conducted on 8/9/19. The surveyor observed 2 of 3 nurses administer 27 medications to 4 residents, the surveyor obseerved 3 errors resulting in a 11.1 % error rate. The deficient practice was evidenced by the following: A medication pass observation was conducted starting on 8/9/19 at 9:30 AM with licensed practical nurse (LPN) #1. Resident #267 had diagnosis of [redacted] and was prescribed [redacted]) to control his/her [redacted]. On 8/19/19 at 10:00 AM LPN #1 administered [redacted] to Resident #267. The resident's clinical record revealed an order for [redacted] to be administered daily in the morning.	F 759	Plan of Correction: F759 SS=D 1. Corrective Action(s): A. Resident #267 was found to have been affected by error #1. The physician was made aware, and the resident was monitored for [redacted]. No adverse effect was noted from this error. The resident□s family were made aware. B. Resident #267 was found to have been affected by error #2. The physician was made aware, and no new orders were received. No adverse effect was noted from this error. The resident□s family were made aware. C. Resident #86 was found to have been affected by error #3. The physician was made aware, and a new order was received to give the missed dose. No adverse effect was noted from this error. The resident□s family were made aware.	10/25/19

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F 759	Continued From page 44 ERROR #1 Resident #267 also had an order for [redacted] LPN #1 administered [redacted] 1 tablet. On 8/19/19 at 12:45 AM, the surveyor reviewed the electronic physician order sheet (ePOS) with LPN #1. LPN #1 stated that she should have looked at the dose on the bottle. ERROR #2 On 8/22/19 at 9:07 AM LPN #2 prepared and administered medications to Resident #86. LPN #2 administered [redacted] to Resident #86. Resident #86's ePOS revealed an order for [redacted] (give 4 tablets once daily) for a total dose of [redacted] daily. At 1:53 PM the surveyor reviewed the ePOS with LPN#2. LPN #2 stated that she did not realize that she was to administer 4 tablets for a total dose of [redacted]. ERROR #3 On 8/26/19 at 11:30 AM the above concerns were reviewed with the Administrator and the Director of Nursing (DON). The DON told the team that the nurses reported the errors to their respective Unit Managers and the nurses had been in-serviced. According to a Pharmacy Consultant in- service form dated 12/17 it is documented under Medication Pass: Accuracy- The Rights of Med Pass	F 759	D. LPN #1 and LPN #2 were educated on the Rights of medication administration. 2. Identifying Other Residents: All residents with physicians orders to administer medications, have the potential to be affected. Nurses were re-educated on following the Rights of medication administration. 3. Measures Put in Place: 1. The facility will continue in its effort to maintain proper standards of practice. The DON or designee will continue to educate the nurses on the Rights of Proper Medication administration. 2. DON or designee will perform a medication pass assessment on each nurse during their orientation, annually and as needed. Nurses not meeting the passing rate will be put on a 30 day PIP and monitored closely. 4. Monitoring Measures: The DON or designee will perform weekly random audits to monitor nurses during medication pass for errors 4 weeks, then monthly X two months. Pharmacy Consultant will perform competencies on random staff monthly and as needed to ensure acceptable performance is sustained. Results of audits will be reviewed immediately by the clinical team and any deficient practices addressed until resolved. Results from audits shall be	

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F 759	Continued From page 45 Right Patient Right Drug- Compare the pharmacy label/package to the MAR/eMAR- the medication and strength must matched exactly what is ordered. Right Dose- Ensure that the number of tablets is equivalent to the ordered amount. Medication Administration (General): " Medication checked against the MAR/EMAR before administering." The facility failed to follow the recommendations from the Pharmacy Consultants regarding medication administration. The facility did not have a specific policy in place for medication administration. NJAC 8:39-29.2 (d)	F 759	submitted to QA committee monthly for 6 months for review and action as needed, then quarterly thereafter until desired outcomes are met and sustained for 3 months.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		10/25/19

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providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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F 880	Continued From page 47 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, it was determined that the facility failed to follow and implement infection control protocols to prevent the spread of infection during medication administration. The deficient practice was evidenced by the following: On 8/19/19 at 9:09 AM, the surveyor observed a Registered Nurse (RN) #1 using the blood pressure cuff prior to administering medication to Resident #161. After taking the blood pressure, the RN #1 placed the blood pressure cuff on top of the medication cart. She did not disinfect the blood pressure cuff after it had been used on a resident. At 10:00 AM Licensed Practical nurse (LPN) #1 prepared medication for Resident #267. Included in the medication was [redacted] an [redacted] medication to be administered according to the parameters set forth by the physician. LPN #1 dropped the digital wrist blood pressure monitor on the floor while opening the door. She picked up the digital wrist blood pressure monitor off of the floor and placed it in her pocket. At 10:15 AM LPN #1 entered the room and used the digital wrist blood pressure monitor on Resident #267 without disinfecting it, she then returned the blood pressure monitor in her packet. Resident #267 was on contact	F 880	1. Corrective Action(s): Residents' #267, #161 and #69 were found to have been affected by the deficient practice with no negative outcome to them. 2. Identifying Other Residents: All residents with physicians' orders for blood pressure monitoring have the potential to be affected. Nurses were re-educated on following the facilities policy and infection control guidelines for disinfecting blood pressure cuffs. 3. Measures Put in Place: A. The facility will continue in its effort to maintain proper standards of practice. The DON or designee will continue to educate the nurses on following the facilities policy and infection control guidelines for disinfecting blood pressure cuffs. B. DON or designee will monitor this practice during medication pass assessments. C. Residents on isolation for infections will be assigned a blood pressure apparatus for their sole use. This will be maintained in the resident's isolation	

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F 880	Continued From page 48 isolation for [redacted]. The nurse went to the bathroom, washed her hands, then removed the blood pressure monitor from her pocket and disinfected it. The surveyor interviewed LPN #1 on 8/19/19 at 12:23 PM. LPN #1 stated that she should have disinfected the blood pressure monitor prior to use it on Resident #267. On 8/22/19 at 9:20 AM the surveyor observed LPN #2 administered medication to Resident #69. LPN #2 used the blood pressure monitor cuff then returned the blood pressure cuff to the medication cart. LPN #2 did not disinfect the blood pressure cuff after use. The surveyor interviewed LPN #2 on 8/22/19 at 1:53 PM regarding the facility's protocol after using the blood pressure cuff. She stated that she should have used the disinfect wipes to disinfect the blood pressure cuff. On 8/26/19 at 10:30 AM the facility was made aware of the above observations. The DON stated that the nurses were aware that the blood pressure cuff should be disinfected after each patient use. A review of the Medication Pass administration indicated under Medication Preparation : "Clean stethoscope with alcohol wipe and disinfect blood pressure cuff between resident." NJAC 8:39-19.4 (a)	F 880	cart. 4. Monitoring Measures: The DON or designee will perform weekly random audits to monitor infection control and disinfecting of blood pressure cuff by nurses during medication pass for 4 weeks, then monthly X two months. Results of audits will be reviewed immediately by the clinical team and any deficient practices addressed until resolved.Results from audits shall be submitted to QA committee monthly for 6 months for review and action as needed, then quarterly thereafter until desired outcomes are met and sustained for 3 months.	