New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Census: 47 Sample Size: 6 TYPE OF SURVEY: Standard Survey of 52 residential units The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 447	8:36-5.1(a) General Requirements (a) The assisted living residence, comprehensive personal care home or assisted living program shall provide and/or coordinate personal care and services to residents, based on assessment by qualified persons, in accordance with the New Jersey Nurse Practice Act, N.J.S.A. 45:11-23 and N.J.A.C. 13:37, this chapter, and the individual needs of each resident, in a manner which promotes and encourages assisted living values.	A 447		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/27/21

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A 447	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to coordinate and implement wound care interventions for 1 of 1 residents (Resident) in the facility reviewed for The facility identified one resident with . Findings included: 1. Resident had diagnoses that included . The surveyor identified a physician's order dated , for a cushion to be used when sitting in the wheelchair. The surveyor identified a physician's visit form dated which indicated, "] resolved." The surveyor reviewed a quarterly nursing assessment dated which indicated Resident had , was incontinent of , and required assistance with transfers. The assessment indicated the resident had but the location was not identified. The assessment indicated the resident had an " , but the location was not identified. The assessment indicated: " ...Ancillary Provider Required: [Consulting Company Named] A nurse's progress note dated indicated Resident had a to the . The surveyor reviewed a wound care nurse's visit report dated which indicated Resident had a on the A nurse's visit report dated	A 447		

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A 447	Continued From page 2 indicated Resident had an on the . The report indicated that after cleansing the with , a , was ordered to be applied and covered with a dressing. The report revealed, " has not arrived." A nurse's progress note, dated at 9:21 AM, indicated the resident had been transferred from the facility to a local hospital with a on the A medication administration record (MAR), dated indicated an cream was applied to the daily. Records did not include orders for the treatment, dressing. On 09/15/2021 at 11:22 AM, the Director of Nursing (DON) told the surveyor during an interview that Resident had been transferred from the facility to a local hospital for care the previous morning. The DON stated the resident received an ointment treatment to the area every morning. The DON stated the resident's condition had declined in the last four days. On 09/15/2021 at 4:43 PM, the Administrator (ADM) told the surveyor during an interview that Resident had recently fallen, hit his/her head, and had spent a few days in the local hospital. While in the hospital, Resident acquired a . The ADM stated the previous DON had coordinated the care for the resident but was not answering phone calls or returning messages about the situation. The ADM stated the previous DON's last day was, unexpectedly, 09/08/2021.	A 447		

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A 447	Continued From page 3	A 447		
	During an interview on 09/15/2021 at 4:44 PM, the Assistant Administrator (AADM) shared a text message from the previous DON which indicated the physician was informed of the [redacted] and that Resident [redacted] was seen for [redacted] care, and "We were on top of it."			
	During an interview on 09/15/2021 at 5:06 PM, Registered Nurse (RN) #12, the [redacted] care nurse, told the surveyor that she she had begun seeing Resident [redacted] on [redacted] She stated this was shortly after the resident had returned to the facility from the hospital and [redacted] were discovered. RN #12 continued to tell the surveyor that on [redacted], the treatment for the [redacted] was changed to a [redacted] treatment to be applied daily. She saw the resident twice a week and the facility was to apply the [redacted] treatments the days she was not there. RN #12 stated when she saw the resident on [redacted] looked infected and that the resident was complaining of more [redacted]. The resident had a poor appetite. RN #12 stated, "I sent [the resident] to the hospital."			
	During an interview with the DON and Administrator on 09/15/2021 at 6:00 PM, the DON told the surveyor that there was no order for [redacted] for Resident [redacted] and that the [redacted] order had not been written on the MAR. The Administrator stated this was a failure of the previous DON and that there was no related facility policy as this was a basic standard of care.			
A 935	8:36-11.4(b) Pharmaceutical Services	A 935		
	(b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's			

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A 935	Continued From page 4 requirements, cautionary or accessory warnings, and all Federal and State laws and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record and policy review, it was determined that the facility failed to administer medications in accordance with prescriber's orders for two of 6 residents, (Resident [redacted] and [redacted] as observed during medication pass. This had the potential to affect all residents. Findings included: 1. Resident [redacted] was admitted with diagnoses which included [redacted]. On 09/14/2021 at 10:22 AM during the medication pass, Certified Medication Aide (CMA) #5 was observed administering a half tablet of [redacted] to Resident [redacted]. Prior to the [redacted] administration, CMA #5 removed the medication card from a locked area of the medication cart, removed the half tablet from the Bingo card blister pack and reconciled the number of doses remaining with those documented on the Controlled Drug Record form . During reconciliation of the medication pass, the surveyor identified that there was no current physician's order for [redacted] for Resident [redacted]	A 935		

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A 935	Continued From page 5 During an interview on 09/14/2021 at 10:40 AM, the Director of Nursing (DON) confirmed with the surveyor that Resident did not have a current order for The DON stated the resident had a previous prescription for which began on but was not reordered upon readmission to the facility on . The medication card was observed with the DON to contain two remaining half tablets. The Controlled Drug Record form was observed with the DON which identified Resident had received 16 doses of since readmission on During an interview on 09/14/2021 at 10:50 AM, CMA #5 told the surveyor that the resident would become angry if he/she were not given the CMA #5 stated they told the previous DON more than once about the situation. During an interview on 09/14/2021 at 12:23 PM, the consultant pharmacist confirmed that when Resident left the facility and was admitted to a hospital on , all medication orders were discontinued. The pharmacist stated that when the resident was readmitted on five medications were restarted, but not "this one 2. Resident was admitted with diagnoses which included . A physician's order dated indicated a , , was to be administered once daily, On 09/14/2021 at 10:31 AM, the surveyor observed CMA #5 administering one of to each of Resident	A 935		

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A 935	Continued From page 6 When CMA #5 indicated she had completed the administration of the [redacted], she was asked if she was sure the resident required only one [redacted] [redacted], and she said, "Yes." She was asked to read the prescriptive label on the bottle. After reading the label, the CMA said, "Oh, it says two [redacted]" CMA #5 then proceeded to administer [redacted] to each [redacted] of Resident #3. A review of the facility's policy titled, "Medication Orders," dated July 2013, indicated, "Prescription medications are dispensed only upon the clear, complete, and signed order (hardcopy or electronic) of a person lawfully authorized to prescribe." A review of the facility's policy titled, "Disposal of Medications," dated July 2013, indicated, "Discontinued medication orders ...should be appropriately removed from the patient's medication regime in the medication cart." A review of the facility's policy titled, "Medication Administration by the Assisted Living Community," dated July 2013, indicated, "Medications are administered in accordance with written orders of the physician or other authorized prescriber."	A 935		
A 940	8:36-11.5(b)(2)(i-iv)(1-3),(v-vi) Pharmaceutical Services (b) The registered professional nurse may choose to delegate the task of administering medications in accordance with N.J.A.C. 13:37-6.2 to certified medication aides, as defined in this chapter. 2. If an appropriate delegation is made, and	A 940		

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A 940	Continued From page 7	A 940		

in accordance with the facility's policies and procedures and all applicable State and Federal laws and regulations, the certified medication aide may:

i. Administer medications through the routes of oral, ophthalmic, otic, inhalant, nasal, rectal, vaginal, topical, and by the percutaneous endoscopic gastrostomy (PEG) tube route of administration;

ii. Administer any prescription or OTC medications as described in (b)1 above;

iii. Administer regularly scheduled medications, including prescription, OTC, and Schedule II-V medications;

iv. Administer "prn" or as-needed prescription, OTCand Schedule II-V medications except that residents receiving the following medications shall be assessed by the registered professional nurse at least once every seven days:

1. Residents receiving prn Schedule II narcotic analgesics;

2. Residents receiving Schedule III-IV narcotic analgesics; and

3. Residents receiving Schedule III-IV central nervous system agents;

v. Administer medications that have been dispensed by a pharmacy, in accordance with N.J.S.A. 45:14 et seq., N.J.S.A. 24:21 et seq., N.J.A.C. 13:39, and the requirements of this chapter; or

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A 940	Continued From page 8	A 940		

vi. Administer experimental and/or research medications in accordance with 45 CFR Part 46, Protection of Human Subjects, incorporated herein by reference, as amended and supplemented.

This REQUIREMENT is not met as evidenced by:
Based on interview, record and policy review, it was determined the facility failed to complete Certified Medication Aide (CMA) competency training for medication pass delegation for five of ten CMAs, CMAs #6, #14, #15, #16, and #17, reviewed for CMA medication pass competency training in accordance with this regulation and facility policy. This had the potential to affect all residents.

Findings included:

A review of CMA records was completed. The following was found:

1. CMA #6 had a start date of [redacted].
Competency records indicated medication pass training on 01/08/2021, 04/09/2021, and 07/15/2021. This did not follow the facility's time frame for med pass observation for new employees as per policy..
2. No medication pass competency training records for CMA #14, hired on [redacted].
3. No medication pass competency training records for CMA #15 hired, on [redacted].
4. No medication pass competency training records for CMA #16 hired, on [redacted]
5. CMA #17 had a start date of [redacted]
Competency records indicated medication pass

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A 940	Continued From page 9	A 940		

training on 03/01/2021, 03/04/2021, 03/09/2021, and 03/15/2021. This did not follow the facility's time frame for med pass observation for new employees as per policy.

During an interview on 09/14/2021 at 2:40 PM, the Administrator (ADM) told the surveyor that the previous Director of Nursing (DON) had left the facility without fulfilling the expected 30-day notice. The ADM stated they had a call out to the previous DON to find out if competency files were "anywhere else." The ADM stated she was not surprised at the lack of records.

During an interview on 09/15/2021 at 9:22 AM, CMA #6 told the surveyor that she had been at the facility about [redacted] months and the previous DON "never did a med pass with me."

During an interview on 09/15/2021 at 3:15 PM, CMA #14 told the surveyor that her medication passes were observed by other CMAs. She said, "No nurse watched me. I know they are supposed to."

No other competency training records were provided prior to the survey exit.

A review of the facility's undated policy titled, "Medication Administration Observation," indicated, "Purpose: To ensure Medication aides are following all protocol and administering medication correctly ...Policy: It is the policy of Fox Trail Deptford for the Registered Nurse to watch a new medication aide during their first week 3 times. The Registered Nurse shall watch the medication pass 1 time during the second week. The Registered Nurse shall watch the medication pass 1 time during their third week. The registered Nurse shall watch the medication pass 1 time during their 4th week. The

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A 940	Continued From page 10 Registered Nurse shall watch the medication pass once a month for the next 3 months then quarterly their after."	A 940		
A1089	8:36-16.3(b) Physical Plant (b) Means of ventilation shall be provided for every bathroom or water closet (toilet) compartment. Ventilation shall be provided either by a window with an openable area or by mechanical ventilation. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure mechanical ventilation was in working order in residents' bathrooms which had no windows in 42 out of 48 resident bathrooms throughout the facility. Findings included: On 09/14/2021 at 10:38 AM, in the presence of the Maintenance Director (MD), the surveyor observed residents' rooms across the facility. The observations and testing consisted of attaching a piece of lightweight tissue paper to an antenna-like clip. The clip was suspended towards the vents in residents' bathrooms. The ventilation was considered operational if the air	A1089		

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A1089	Continued From page 11	A1089		

flow drew the tissue paper upward towards the vent grid. The observations and testing was conducted in ██ rooms in both Buildings ██ and ██. The entire ██ rooms in Building ██ and ██ of the ██ rooms in Building ██ for a total of ██ bathrooms which had no windows to the outside were without a working ventilation system .

During an interview on 09/15/2021 at 11:32 AM, the MD told the surveyor there was no routine preventative maintenance program for the ventilation systems in the residents' bathrooms throughout the facility all of which had no windows to the outside. He stated a working ventilation system helped draw out moisture to decrease moisture from building up which could promote mold and mildew growth. He stated he would get the system replaced.

During an interview on 09/15/2021 at 3:56 PM, the Certified Assisted Living Administrator (CALA) told the surveyor that the facility did not have a policy which addressed when or how the ventilation systems in residents' rooms should be checked. She said she would work closely with the maintenance director going forward to ensure the failed ventilation systems in the identified residents' rooms did not result in mold growth.