

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315485	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2020
NAME OF PROVIDER OR SUPPLIER CARE ONE AT WALL			STREET ADDRESS, CITY, STATE, ZIP CODE 2621 HIGHWAY 138 WALL, NJ 07719		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D 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 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT VISIT. Survey Date: 08/03/2020 Census: 94 Sample: 6 Complaint #'s NJ00134518 NJ00134517 NJ00134273 NJ00133564	F 000			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: COMPLAINT #NJ00133564 Based on interview, record review, and review of pertinent facility documents it was determined that the facility failed to notify the physician of a Exec Order 26 § 4b1 individual's health info which led to a	F 684	1)- Resident #1 has been discharged from CareOne at Wall. - Director of Nursing reviewed Resident #1's medical record.	8/28/20	

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

TITLE

(X6) DATE

Electronically Signed

08/18/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	<p>Continued From page 1 delay in treatment.</p> <p>This deficient practice was identified for 1 of 3 (Resident #3) residents reviewed for physician notification of <small>Exec Order 26 § 4b1 individual's health info</small> and was evidenced by the following:</p> <p>The surveyor reviewed the closed medical record for Resident #3.</p> <p>A review of the resident's Admission Record face sheet (an admission summary) reflected that the resident was admitted with diagnoses which included, but were not limited to, <small>Exec Order 26 § 4b1 individual's health info</small></p> <p>A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated <small>Exec Order 26 § 4b1 individual's health info</small></p> <p>A review of the resident's progress notes (PN) dated 02/10/2020 at 11:40 AM, indicated the Licensed Practical Nurse (LPN) received a physician's order (PO) from the resident's Nurse Practitioner (NP) for a <small>Exec Order 26 § 4b1 individual's health info</small>. The PN indicated that the <small>Exec Order 26 § 4b1 individual's health info</small> was obtained and was waiting to be picked up from the lab.</p> <p>A review of the February 2020 Order Summary Report (OSR) revealed a verbal PO, dated</p>	F 684	<p>2) Director of Nursing, Assistant Director of Nursing, and Unit Managers conducted a review of the current residents with finalized <small>Exec Order 26 § 4b1 individual's health info</small> to ensure physician notification documentation was entered into the medical record.</p> <p>3) The Director of Nursing and Assistant Director of Nursing will in-service licensed nursing staff on documentation of physician notification.</p> <p>- The Unit Managers and/or designee will conduct a weekly audit of finalized <small>Exec Order 26 § 4b1 individual's health info</small> to ensure physician notification occurred and documented.</p> <p>4) Weekly for 4 weeks and monthly for 2 months, the Director of Nursing and/or designee will review the audit of finalized <small>Exec Order 26 § 4b1 individual's health info</small> to ensure physician notification occurred and documented as part of our monthly QAPI.</p> <p>- The Administrator and/or designee will monitor the effectiveness of the audit tool through the Quality Assurance program on a monthly basis for one quarter.</p>	

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F 684	<p>Continued From page 2</p> <p>02/10/2020, for <small>Exec Order 26 § 4b1 individual's health info</small></p> <p>[REDACTED]</p> <p>A review of the resident's <small>Exec Order 26 § 4b1 individual's health info</small> laboratory results, dated 02/14/2020 at 12:34 PM, indicated that the resident was <small>Exec Order 26 § 4b1 individual's health info</small></p> <p>[REDACTED]</p> <p>The laboratory report further offered <small>Exec Order 26 § 4b1 individual's health info</small>.</p> <p>A further review of the resident's PN did not indicate physician notification of the <small>Exec Order 26 § 4</small> results until 2/17/20 at 16:58 (4:58) PM. when an order was obtained for <small>Exec Order 26 § 4b1 individual's health info</small>. This reflected a three-day delay (02/14/2020, 02/15/2020, and 02/16/2020) in notification and treatment order.</p> <p>A review of the February 2020 OSR revealed that the resident received a PO, dated 02/17/2020, for the <small>Exec Order 26 § 4b1 individual's health info</small></p> <p>[REDACTED]</p> <p>At 10:58 AM, the surveyor interviewed an LPN #1 who stated the signs and symptoms of a <small>Exec Order 26 § 4b1 individual's health info</small></p> <p>[REDACTED] LPN #1 stated the elderly population frequently presented with <small>Exec Order 26 § 4b1 individual's health info</small></p> <p>[REDACTED] LPN #1 further stated that if she suspected that a resident had a <small>Exec Order 26 § 4b1 individual's health info</small>, she would call the resident's physician to notify them and obtain a PO for a <small>Exec Order 26 § 4b1 individual's health info</small>. LPN #1 added that as soon as the laboratory results</p>	F 684		

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F 684	<p>Continued From page 3</p> <p>came back, the physician should be called immediately to notify them of the results.</p> <p>At 11:53 AM, the surveyor interviewed LPN #2 who stated that signs and symptoms of a ^{Exec Ord} [REDACTED]</p> <p>[REDACTED]</p> <p>LPN #2 stated that if she received a ^{Exec Order 26 § 4b1 individual's health info} [REDACTED] during her shift, she would immediately notify the resident's physician and then document the communication with the physician in the resident's medical record.</p> <p>At 12:06 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that she recalled Resident #3 when the resident resided at the facility. The LPN/UM stated that when the resident first was admitted into the facility, he/she was alert with some confusion. The LPN/UM stated that the resident further presented with behaviors and was hallucinating. The LPN/UM further stated that most physicians did not treat a ^{Exec Order 26 § 4b1} [REDACTED]</p> <p>[REDACTED]</p> <p>laboratory result came back to prescribe an appropriate ^{Exec Order 26 § 4b1} [REDACTED]. The LPN/UM stated that she remembered the resident was ^{Exec Order 26 § 4b1 individual} [REDACTED] and the resident's primary care physician was not available so the covering physician was called on 2/17/20 and ordered the ^{Exec Order 26 § 4b1} [REDACTED]. The LPN/UM stated that the staff should call the resident's physician immediately of a positive or abnormal laboratory result.</p> <p>On 8/3/20 at 12:34 PM, the surveyor placed a call to the resident's primary care physician who was unavailable for an interview.</p>	F 684		

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F 684	<p>Continued From page 4</p> <p>On 8/3/20 at 12:38 PM, the surveyor placed a call to the facility's Medical Director who was unavailable for an interview.</p> <p>On 8/3/20 at 12:50 PM, the surveyor interviewed the facility's house NP who stated that the staff would be expected to notify the physician immediately of a <small>Exec Order 26 § 4b1 individual's health info</small> if the resident had <small>Exec Order 26 § 4b1 individual's health info</small> could be started.</p> <p>A review of the facility's, Change in a Resident's Condition or Status Policy and Procedure revised May 2017 indicated, "Our facility shall promptly notify the resident, his/her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status." The facility's Change in a Resident's Condition or Status Policy and Procedure further indicated, "Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.</p> <p>NJAC 8:39-27.1(a)</p>	F 684			