STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING _____ B. WING _____	C 02/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD 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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ152289, NJ152294, NJ152309, NJ152310 Census: 225 Sample Size: 7	F 000		
F 658 SS=F	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: C#: NJ152289, NJ152294, NJ152309, NJ152310 Based on interviews, medical record reviews, and review of other pertinent facility documents on 2/15/2022, 2/16/2022, and 2/19/2022, it was determined that the facility failed to administer medications according to physician's in order to maintain accurate medication administration documentation that indicated the pain status of the residents and failed to adhere to the acceptable standards of nursing practice for 6 of 7 residents (Resident #1, #2, #3, #4, #5 and #6). The facility also failed to follow its policies titled "Pain Management" and "Medication Administration- Documentation." This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title	F 658	1. Resident #1 was administered Ex.Order 26 medication on the following shift (2/13/22) with Ex.Order 26.4(b)(1). The medical director, NP, and the RN evaluated resident #1 on 2/15/22, 2/20/22, and 3/9/22 with no noted lasting negative effect from the omission of scheduled medications. Resident #2 was administered Ex.Order 26 medication on the following shift (2/13/22) with Ex.Order 26.4(b)(1) documented. The medical director, NP, and the RN evaluated resident #2 on 2/15/22, 2/20/22, and 3/9/22 with no noted lasting negative effects from the omission of the scheduled Ex.Order 26 medication. Resident #3 was administered Ex.Order 26 medication on the following shift (2/13/22)	3/15/22

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

Electronically Signed | 03/09/2022

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 658	Continued From page 1 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 human response 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 restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: "The practice of nursing as a Licensed Practical Nurse is defined as performing tasks, and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a Registered Nurse, or otherwise legally authorized Physician or Dentist." Review of the Electronic Medical Records (EMRs) were as follows: 1. According to the "Admission Record (AR)," Resident #1 was admitted to the facility on Ex Order 26. 4B1 with diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted] According to the Minimum Data Set (MDS), an assessment tool dated 2/4/2022, Resident #1 had a Brief Interview of Mental Status (BIMS) score of Ex Ord/15, indicating the resident was Ex Order 26. 4B1	F 658	with resolution of Ex.Order 26 documented. The NP, medical director and the RN evaluated resident #3 on 2/15/22, 2/20/22, and 3/9/22 with no noted lasting negative effects from the omission of the scheduled Ex.Order 26 medication. Resident #4 was administered Ex.Order 26 medication on the following shift (2/13/22) with Ex.Order 26.4(b)(1) documented. The medical director, NP and RN evaluated resident #4 on 2/15/22, 2/20/22, and 3/9/22 with no noted lasting negative effects from the omission of the scheduled Ex.Order 26 medication. Resident #5 was administered Ex.Order 26 medication on the following shift)2/13/22) with Ex.Order 26.4(b)(1) documented. The medical director, NP, and RN evaluated resident #5 on 2/15/22,2/20/22, and 3/9/22 with no noted lasting negative effects from the omission of the scheduled Ex.Order 26 medication. Resident #6 was administered Ex.Order 26 medication on the following shift (2/13/22) with Ex.Order 26.4(b)(1) documented. The medical director, NP and RN evaluated resident #6 on 2/15/22, 2/20/22, and 3/9/22 with no noted lasting negative effects from the omission of the scheduled Ex.Order 26 medication. Medication errors were completed for identified residents. 2. All residents have the potential to be	

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F 658	Continued From page 2 Ex.Order 26.4(b) The MDS also showed the resident needed assistance with some *Ex Order 26. 4B1* (ADLs), received a scheduled Ex.Order 26 regimen, and received Ex.Order 26 as needed (PRN). The MDS also showed that Ex.Order 26.4(b)(1) should be completed for the presence of Ex.Order 26, listed Ex.Order 26.4(b)(1) as *Ex Order 26. 4B1* and at level Ex out of 10, with 1 being the lowest and 10 being the highest Ex.Order 26. Review of the "Order Summary Report (OSR)" for Resident #1 dated 2/15/2022 included the following Physician's Orders (PO's): Ex.Order 26 Evaluation Q (every) shift for Ex.Order 26 evaluation, record pain on a 0-10 scale, dated 07/29/2021. *Ex Order 26. 4B1* (milligram). Give 1 tablet by mouth three times a day related to Ex Order 26. 4B1, dated 9/15/2021. *Ex Order 26. 4B1*. Give 1 tablet by mouth every 8 hours for *Ex Order 26. 4B1*, dated 09/02/2021. *Ex Order 26. 4B1*. Give 1 tablet by mouth two times a day for Ex Order 2, dated 12/15/2021. *Ex Order 26. 4B1* Give 1 tablet by mouth in the morning related to *Ex Order 26. 4B1*, dated 12/21/2021. *Ex Order 26. 4B1*. Give 1 tablet by mouth every 8 hours for *Ex Order 26. 4B1*	F 658	affected by this deficient practice. The missed medication report for 2/12/22 and 2/13/22 (239 pages) was reviewed on 2/19/22 and 159 residents with medication omissions were evaluated by nursing administration on 2/15/22-2/20/22 with no negative outcome noted for any identified resident. Medication errors were completed for each identified resident (159 residents). Staffing coordinator were counseled (2/20/22) by the administrator on notifying the DON if there is no nurse to administer scheduled medication. 3. Licensed nurses were educated by the Regional Director of Clinical / designee (2/15/22; 2/19/22; 3/9/22) on professional standards with emphasis on medication administration. Course content will include ensuring scheduled and PRN medications to all residents are administered and Ex.Order 26 s with documented Ex.Order 26.4(b)(1) must be completed each shift. The In-service will also include notifying the DON if a nurse is unavailable to administer scheduled and PRN medications as well as complete Ex.Order 26.4(b)(1). The staffing coordinator was educated by the administrator (2/20/22) on the importance of ensuring licensed nurses are available to distribute medications to all residents.	

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F 658	Continued From page 3 control, dated 8/30/2021. Ex Order 26. 4B1 . Give 1 tablet by mouth every 6 hours related to other Ex Order 26. 4B1, dated 9/15/2021. Take Ex.Order 26.4(b)(1) twice a day for Ex Order 26. 4B1 (Ex.Order), dated 8/25/2021. A review of the 02/01/2022-02/28/2022 Medication Administration Record (MAR) for Resident #1 confirmed the aforementioned PO's were not administered because there was no documneted evidence the staff assesed for Ex.Order 26 and gave the medication to the resident as evidenced by the following: Ex.Order 26 Evaluation Q (every) shift for Ex.Order 26 evaluation, record Ex.Order 26 on a 0-10 scale, on 2/12/2022 on the 11:00 p.m.-7:00 a.m. shift was blank. Ex Order 26. 4B1 . Give 1 tablet by mouth three times a day related to Ex Order 26. 4B1, on 2/13/2022 at 6:00 a.m was blank. Ex Order 26. 4B1 . Give 1 tablet by mouth every 8 hours for Ex Order 26. 4B1 on 2/13/2022 at 6:00 a.m. was blank. Ex Order 26. 4B1 . Give 1 tablet by mouth two times a day for Ex Order 2 , on 2/13/2022 at 4:00 a.m. was blank. Ex Order 26. 4B1 . Give 1 tablet by mouth in the morning related to Ex Order 26. 4B1	F 658	Medication pass competencies were completed (2/20/22) on the 2 identified nurses that failed to appropriately document on their medication administration from 2/12/22 to 2/13/22. 4. The DON/ designee will audit medication administration daily (all residents) for missed administration x 4 weeks, then weekly x 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at QAPI. The DON/ designee will conduct pain management audits of residents with Ex.Order 26 medication to ensure that Ex.Order 26 medication is provided when ordered and PRN Ex.Order 26 medications are administered when requested. Audits will be completed daily x 4 weeks (2/20/22-3/20/22) then weekly x 4 weeks and then monthly until compliance is met. The Administrator/ designee will audit licensed nursing to ensure that scheduled licensed nurses are available to administer all necessary schedule medications and PRN medications. The results of these audits will be submitted at QAPI. The Administrator is responsible for execution and monitoring of this POC.	

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F 658	Continued From page 4 [redacted], on 2/13/2022 at 6:00 a.m. was blank. [redacted]. Give 1 tablet by mouth every 8 hours for [redacted] on 2/13/2022 at 6:00 a.m. was blank. [redacted]. Give 1 tablet by mouth every 6 hours related to other [redacted] on 2/13/2022 at 12:00 a.m. and 6:00 a.m. was blank. Take Ex.Order 26.4(b)(1) twice a day for [redacted] on 2/13/2021 at 6:00 a.m. was blank. 2. According to the AR, Resident #2 was readmitted to the facility on [redacted] and originally admitted on [redacted] with diagnoses which included but were not limited to [redacted]. According to the MDS, dated 2/2/2022, Resident #2 had a BIMS score of [redacted]/15, indicating the resident was [redacted]. The MDS also showed the resident needed Ex.Order 26.4(b)(1) with most ADLs, received a scheduled [redacted] medication regimen, listed his/her [redacted] as [redacted] and at a level of [redacted] out of 10, with 1 being the lowest and 10 being the highest. Review of the OSR for Resident #2 dated 2/15/2022 included the PO's for the following:	F 658		

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Ex.Order 26.1 Evaluation Q (every) shift for Ex.Order 26 evaluation, record Ex.Order 26 on a 0-10 scale, dated 10/13/2019.

Ex Order 26. 4B1 . Give 1 tablet by mouth two times a day for *Ex Order 26. 4B1*, dated 8/25/21.

Ex Order 26. 4B1 (microgram). Give 1 tablet by mouth in the morning for *Ex Order 26. 4B1*, dated 12/31/2019.

Ex Order 26. 4B1 . Give 1 tablet by mouth every 6 hours for *Ex Order 26. 4B1*, dated 10/13/2019.

Ex Order 26. 4B1 Give 30 ML by mouth four times a day for *Ex Order 26. 4B1*, dated 1/11/2022.

Ex Order 26. 4B1 Give 1 tablet by mouth at bedtime for *Ex Order 26. 4B1* , dated 8/23/2021.

A review of the 02/01/2022-02/28/2022 MAR for Resident #2 confirmed the aforementioned PO's were not administered because there was no documneted evidence the staff assessed for Ex.Order 26 and gave the medication to the resident as evidenced by the following:

Ex.Order 26.1 Evaluation Q (every) shift for Ex.Order 26 evaluation, record Ex.Order 26 on a 0-10 scale on 2/12/2022 on 11:00 p.m. to 7:00 a.m. shift. was blank.

Ex Order 26. 4B1 . Give 1 tablet by mouth two times a day for *Ex Order 26. 4B1*, on 2/13/2021 at 5:00

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a.m. was blank.

[redacted]. Give 1 tablet by mouth in the morning for [redacted] on 2/13/2022 at 6:00 a.m. was blank.

[redacted] Give [redacted] by mouth four times a day for [redacted] on 2/9/2022 at 9:00 p.m. was blank.

[redacted] Give 1 tablet by mouth every 6 hours for [redacted], on 2/13/2022 at 12:00 a.m. was blank.

[redacted]. Give 1 tablet by mouth at bedtime for [redacted] on 2/9/2022 at 9:00 p.m. was blank.

3. According to the AR, Resident #3 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted].

According to the MDS, dated 12/9/2021, Resident #3 had a BIMS score of [redacted]/15, indicating the resident was [redacted]. The MDS also revealed Resident #3 needed [redacted] with most ADLs, and the resident received [redacted] medication PRN. Further review of the MDS also showed that a [redacted] assessment should be completed for the presence of [redacted] and the resident has [redacted], which has made it hard to [redacted] and has [redacted] day-to-day activities because of the [redacted]

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F 658	Continued From page 7 A review of the OSR for Resident #3 dated 2/15/2022 included the PO's for the following: *Ex Order 26. 4B1* . Give 1 tablet by mouth at bedtime for *Ex Order 26. 4B1* , dated 12/12/2021. Ex.Order 26. Evaluation Q (every) shift for Ex.Order 26. evaluation, record Ex.Order 26. on a 0-10 scale, dated 11/30/2021. *Ex Order 26. 4B1* . Give 1 tablet by mouth every 4 hours as needed for *Ex Order 26. 4B1* , dated 11/30/2021. A review of the 02/01/2022 through 02/28/2022 MAR for Resident #3 confirmed the aforementioned POs were not administered because there was no documneted evidence the staff assessed for Ex.Order 26. and gave the medication to the resident as evidenced by the following: *Ex Order 26. 4B1* . Give 1 tablet by mouth at bedtime for *Ex Order 26. 4B1* on 2/13/2022 at 9:00 p.m. was blank. Ex.Order 26. Evaluation Q Shift every shift for Ex.Order 26. evaluation record Ex.Order 26. on a 0-10 scale on 2/13/2022 on 11:00 p.m. to 7:00 a.m. shift. was blank. *Ex Order 26. 4B1* . Give 1 tablet by mouth every 4 hours as needed for *Ex Order 26. 4B1* . 6-10, on the 11:00 p.m. to 7:00 a.m. shift. was blank. A review of the Progress Notes (PNs) dated 2/14/2022 at 3:57 a.m., written by Licensed	F 658		

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Practical Nurse (LPN #4), revealed that Resident #3 "contacted Ex Order 26. 4B1 due to [redacted]. Resident requested to be taken to (the Ex Order 26. 4B1) ...."

During an interview on 2/19/2022 at 7:15 a.m., Resident #3 stated that the nurses on the unit were not showing up repeatedly on the night (11:00 p.m. to 7:00 a.m.) shift. The resident explained he/she did not receive his/her medication for the entire night shift when the resident called [redacted]. Resident #3 explained to the Surveyor that the resident was in Ex Order 26. 4B1 to his/her [redacted], Ex Order 26. 4B1 [redacted]. Resident #3 used the call button, the staff responded, and the resident told them that he/she was in [redacted] and needed his/her [redacted]. The resident stated he/she repeatedly asked for the [redacted] medication, but the nurse would not give the medication to him/her. The resident said he/she had no choice but to call [redacted] in the morning hours to take him/her to the [redacted]. Resident #3 continued to explain, Ex Order 26. 4B1 [redacted] The resident stated he/she received the needed medication Ex Order 26. 4B1 at the [redacted] by mouth and the symptoms were relieved slowly. When asked by the Surveyor what was the resident's [redacted] on a 0-10 scale, Resident #3 stated his/her [redacted] was [redacted].

4. According to the AR, Resident #4 was admitted to the facility on Ex Order 26. 4B1 with diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted],

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F 658	Continued From page 9 Ex Order 26. 4B1 . According to the MDS, dated 2/3/2022, Resident #4 had a BIMS score of /15, indicating the resident was Ex Order 26. 4B1. The MDS also showed the resident needed Ex.Order 26.4(b)(1) with most ADLs, and the resident received a scheduled n medication regimen and medication PRN. Further review of the MDS also showed that a Ex.Order 26.4(b)(1) should be completed for the presence of , and the resident had Ex.Order 26.4(b)(1) and at a level of out of 10, with 0 being the lowest and 10 being the Ex.Order 26.4(b)(1). Review of the OSR for Resident #4 dated 2/15/2022 included the PO's for the following: Evaluation Q (every) shift for evaluation, record on a 0-10 scale, dated 7/28/2021. Ex Order 26. 4B1 . Give 10 mL by mouth two times a day for Ex Order 26. 4B1 , 10 mL=30mg, dated 9/2/2021. Ex Order 26. 4B1 . Give 1 tablet by mouth every 8 hours for Ex Order 26. 4B1 , dated 2/7/2022. A review of the 02/01/2022-02/28/2022 MAR for Resident #4 confirmed the aforementioned PO's were not administered because there was no documneted evidence the staff assessed for and gave the medication to the resident as evidenced by the following: Evaluation Q (every) shift for	F 658		

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F 658	Continued From page 10 evaluation, record [redacted] on a 0-10 scale on 2/12/2022 on 11:00 p.m. to 7:00 a.m. shift. was blank. *Ex Order 26. 4B1* [redacted]. Give 10 mL by mouth two times a day for *Ex Order 26. 4B1* [redacted] on 2/13/2022 at 5:00 a.m. was blank. *Ex Order 26. 4B1* [redacted]. Give 1 tablet by mouth every 8 hours for [redacted] on 2/13/2022 at 6:00 a.m. was blank. 5. According to the AR, Resident #5 was readmitted to the facility on *Ex Order 26. 4B1* and originally admitted on *Ex Order 26. 4B1* with diagnoses which included but were not limited to *Ex Order 26. 4B1* [redacted]. According to the MDS, dated 1/22/2022, Resident #5 had a BIMS score of [redacted]/15, indicating the resident had *Ex Order 26. 4B1* [redacted]. The MDS also showed the resident needed Ex.Order 26.4(b)(1) with most ADLs, and the resident received a scheduled Ex.Order 26.4(b)(1) regimen and PRN. Further review of the MDS also showed that a Ex.Order 26.4(b)(1) should be completed for the presence of [redacted], and the resident has [redacted] almost *Ex Order 26. 4B1*, and the [redacted] is [redacted]. Review of the OSR for Resident #5 dated 2/15/2022 included the PO's for the following: [redacted] Evaluation Q (every) shift for [redacted] evaluation, record [redacted] a 0-10 scale, dated	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING _____ B. WING _____	C 02/19/2022

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F 658		F 658		

Continued From page 11

5/24/2018.

Ex Order 26. 4B1 . Give 2 tablets by mouth two times a day for *Ex Order 26. 4B1* 2 tablets = 80 MG, dated 10/26/2021.

Ex Order 26. 4B1 . Give 1 capsule by mouth every 8 hours for *Ex Order 26. 4B1*, dated 9/17/2021.

Ex Order 26. 4B1 . Give 1 tablet by mouth at bedtime for *Ex Order 26. 4B1*. Hazardous handling, dated 12/21/2021.

Ex Order 26. 4B1 . Give 1 tablet by mouth four times a day for *Ex Order 26. 4B1* (5-10), dated 12/21/2021.

Ex Order 26. 4B1 . Give 2 tablets by mouth at bedtime for *Ex Order 26. 4B1*, dated 3/14/2018.

Ex Order 26. 4B1 . Instill Ex.Order 26.4(b)(1) at bedtime for *Ex Order 26. 4B1* for 14 days, dated 2/8/2022.

A review of the 02/01/2022-02/28/2022 MAR for Resident #5 confirmed the aforementioned PO's were not administered because there was no documneted evidence the staff assessed for pain and gave the medication to the resident as evidenced by the following:

Ex.Order 26 Ex.Order 26 Evaluation Q shift for Ex.Order 26 evaluation, record on a 0-10 scale on 2/13/2022 on 3:00 p.m. to 11:00 p.m. shift and 11:00 p.m. to 7:00 a.m. shift. was blank.

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F 658	Continued From page 12	F 658		

Ex Order 26. 4B1 . Give 2 tablets by mouth two times a day for Ex Order 26. 4B1 2 tablets = 80 MG on 2/13/2022 at 5:00 p.m. was blank.

Ex Order 26. 4B1 . Give 1 capsule by mouth every 8 hours for Ex Order 26. 4B1 on 2/13/2022 and 2/14/2022 at 6:00 a.m., and 2/13/2022 at 10:00 p.m. was blank.

Ex Order 26. 4B1 . Give 1 tablet by mouth at bedtime for Ex Order 26. 4B1. Hazardous handling, on 2/13/2022 at 9:00 p.m. was blank.

Ex Order 26. 4B1 . Give 1 tablet by mouth four times a day for Ex Order 26. 4B1 (5-10) on 2/13/2022 at 9:00 p.m. was blank.

Ex Order 26. 4B1 . Give 2 tablets by mouth at bedtime for Ex Order 26. 4B1 on 2/13/2022 at 8:00 p.m. was blank.

Ex Order 26. 4B1 . Instill 1 Ex.Order 26.4(b)(1) at bedtime for Ex Order 26. 4B1 for 14 days on 2/13/2022 at 9:00 p.m. was blank.

6. According to the AR, Resident #6 was readmitted to the facility on Ex Order 26. 4B1 and originally admitted on Ex Order 26. 4B1 with diagnoses which included but were not limited to Ex Order 26. 4 .

According to the MDS, dated 11/24/2021, Resident #6 had a BIMS score of Ex Or /15,

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F 658	Continued From page 13 indicating the resident was *Ex Order 26. 4B1*. The MDS also showed the resident needed Ex.Order 26.4(b)(1) with most ADLs, and the resident received a scheduled Ex.Order 26 medication regimen and Ex.Order 26.4(b)(1) PRN. Further review of the MDS also showed that a Ex.Order 26.4(b)(1)t should be completed for the presence of Ex.Order 26. The resident has Ex.Order 26.4(b)(1), which has made it Ex.Order 26.4(b)(1), and has Ex.Order 26.4(b) day-to-day activities because of Ex.Order 26.4(b)(1). Review of the OSR for Resident #6 dated 2/16/2022 included the PO's for the following: *Ex Order 26. 4B1* Give 1 tablet by mouth one time a day for *Ex Order 26. 4B1*, dated 1/15/2022. *Ex Order 26. 4B1*. Give 3 tablets by mouth three times a day for *Ex Order 26. 4B1*, dated 1/15/2022. *Ex Order 26. 4B1*. Give 1 tablet by mouth two times a day for *Ex Order 26. 4B1* dated 1/15/2022. *Ex Order 26. 4B1* Give 1 capsule by mouth one time a day for *Ex Order 26. 4B1*, dated 1/15/2022. *Ex Order 26. 4B1*. Give 2 tablets by mouth two times a day for *Ex Order 26. 4B1*, dated 1/15/2022. *Ex Order 26. 4B1*. Give 2 capsules by mouth three times a day for Ex Order 2, dated 2/7/2022. *Ex Order 26. 4B1*	F 658		

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F 658	Continued From page 14 Ex Order 26. 4B1 as per sliding scale: if 0-149 = 0 units Call MD (Physician) if Ex Order 26. 4B1 is less than 70mg/dl (milligram/per decilitre); 150-200 = 2 units; 201-250 = 4 units, 251-300 = 6 units; 301-350 = 8 units; 351-400 =10 units; 401+ Call MD if is greater than 400mg/dl, Ex Order 26. 4B1 before meals for Ex Order 26. 4B1, dated 1/15/2022. Ex Order 26. 4B1 . Inject 20 units Ex Order 26. 4B1 at bedtime for Ex Order 26. 4B1, dated 1/15/2022. Ex Order 26. 4B1 . Give 1 tablet by mouth one time a day for Ex Order 26. 4B1, dated 1/15/2022. Ex Order 26. 4B1 . Give 1 tablet by mouth one time a day for Ex Order 26. 4B1, dated 1/15/2022. A review of the MAR dated 02/01/2022-02/28/2022 for Resident #6 confirmed the aforementioned PO's were not administered because there was no documneted evidence the staff gave the medication to the resident as evidenced by the following: Ex Order 26. 4B1 . Give 1 tablet by mouth one time a day for A-fib Ex Order 26. 4B1 on 2/7/2022 and 2/12/2022 at 9:00 a.m. was blank. Ex Order 26. 4B1 . Give 3 tablets by mouth three times a day for Ex Order 26. 4B1 on 2/13/2022 and 2/14/2022 at 6:00 p.m. was blank. Ex Order 26. 4B1 . Give 1 tablet by mouth	F 658		

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F 658	Continued From page 15 two times a day for *Ex Order 26. 4B1* [redacted] on 2/7/2022 and 2/12/2022 at 9:00 a.m. was blank. *Ex Order 26. 4B1* [redacted]. Give 1 capsule by mouth one time a day for *Ex Order 26. 4B1* on 2/7/2022 and 2/12/2022 at 9:00 a.m. was blank. *Ex Order 26. 4B1* [redacted]. Give 2 tablets by mouth two times a day for *Ex Order 26. 4B1* [redacted] on 2/7/2022, 2/12/2022, and 2/15/2022 at 9:00 a.m., 2/13/2022, and 2/14/2022 at 5:00 p.m. was blank. *Ex Order 26. 4B1* [redacted]. Give 2 capsules by mouth three times a day for [redacted], on 2/8/2022, 2/9/2022, 2/12/2022, 2/15/2022, and 2/16/2022 at 10:00 a.m., 2/8/2022, 2/9/2022, 2/11/2022, 2/12/2022, 2/15/2022 at 2:00 p.m., and 2/8/2022, 2/13/2022 and 2/14/2022 at 8:00 p.m. was blank. *Ex Order 26. 4B1* [redacted] t as per sliding scale: if 0-149 = 0 units Call MD (Physician) if *Ex Order 26. 4B1* is less than 70mg/dl (milligram/per decilitre); 150-200 = 2 units; 201-250 = 4 units, 251-300 = 6 units; 301-350 = 8 units; 351-400 =10 units; 401+ Call MD if [redacted] is greater than 400mg/dl, *Ex Order 26. 4B1* [redacted] before meals for *Ex Order 26. 4B1* on 2/7/2022, 2/12/2022 and 2/15/2022 at 7:30 a.m. and 11:30 a.m., and 2/9/2022 and 2/13/2022 at 4:30 p.m. was blank. *Ex Order 26. 4B1* [redacted]. 20 units subcutaneously at bedtime for *Ex Order 26. 4B1* [redacted] on 2/13/2022, 2/14/2022, and 2/15/2022	F 658		

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F 658	Continued From page 16 at 9:00 p.m. was blank. Ex Order 26. 4B1 [redacted]. Give 1 tablet by mouth one time a day for [redacted] Ex Order 26. 4B1 on 2/7/2022 and 2/12/2022 at 9:00 a.m. was blank. Ex Order 26. 4B1 [redacted]. Give 1 tablet by mouth one time a day for Acute on Ex Order 26. 4B1 [redacted] on 2/7/2022, 2/12/2022, and 2/15/2022 at 9:00 a.m. was blank. During an interview on 2/16/2022 at 10:02 a.m. with the Unit Manager/Licensed Practice Nurse (UM/LPN), when the Surveyor asked her what blank spaces mean on the MAR, she stated blank spaces mean the medication or medication treatment was not done, not administered assigned out. The UM/LPN further stated that if a resident did not receive medication for some reason, the doctor (physician) would be notified. The reason for not administering the medication would be documented on the MAR and in the Progress Note (PN). During a telephone interview on 2/16/2022 at 11:11 a.m., LPN #1 indicated that on 2/12/2022, on the 11:00 p.m.to 7:00 a.m. shift, she was the only nurse on the [redacted] floor and was assigned to units 1A and 1B. LPN #1 also stated that LPN #2 was the only nurse assigned to the Ex Order 26. 4B1 floor on the 11:00 p.m. to 7:00 a.m. shift on 2/12/2022. The LPN explained that on 2/12/2022, on the 11:00 p.m.to 7:00 a.m. shift, she was the only nurse on the [redacted] floor for units Ex Order 26. 4B1, and [redacted], with the resident census of 105. LPN #1 further explained that she could not care for all of the [redacted]-floor residents and only provided care for some residents. She stated some residents were crying, complaining they were not getting their	F 658		

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F 658	Continued From page 17 medications, and came up to the nurses' station, and she administered those residents their medications. LPN #1 also stated that a resident called the [redacted] from the [redacted] floor. LPN #1 further stated that the next night on 2/13/2022, on the 11:00 p.m.to 7:00 a.m. shift, she was again the only nurse on the [redacted] floor (units *Ex Order 26. 4B1*) with the resident census of 103. She further stated that a resident called [redacted] and went to the [redacted] because he/she did not receive [redacted] medications as no nurse was on his/her cart. The LPN explained, on 2/13/2022, during the 11:00 p.m. to 7:00 a.m. shift, she sent out a mass text message to the Director of Nursing (DON), the Human Resources (HR) Director, and other facility staff that they were only two nurses on duty in the entire building, for a census of over two hundred residents. The Surveyor attempted to contact LPN #2 several times but received no response. During an interview on 2/16/2022 at 3:33 p.m., the Director of Nursing (DON) stated the Supervisor was on vacation, and a Supervisor did not work on 2/12/2022 and 2/13/2022. The DON also confirmed that she received the text message sent out on 2/13/2022 during the 11:00 p.m. to 7:00 a.m. shift by LPN #1. The DON explained that the text message was at 2:07 a.m., and she did not hear the text message alert. When asked by the Surveyor why she did not get more nurses or why she did not come into assist the 11:00 p.m. to 7:00 a.m. shift, the DON responded that LPN #1 should have called instead of texting; she did not see the text message until the morning. The shift was almost	F 658		

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F 658	Continued From page 18 over, so she did not go to the facility to help. The DON further explained that the staffing schedules are looked at before the weekend begins. She explained that the Staffing Coordinator should have been aware that the nursing staff was short because there was only one nurse on the schedule for 2/12/2022 on the 11:00 p.m. to 7:00 a.m. shift on units *Ex Order 26. 4B1* . The DON also stated pain medications should be given when requested, and if a resident did not receive [redacted] medication, the nurse would be written up; I did not write up the nurses from this past weekend yet. During a second interview on 2/19/2022 at 10:35 a.m., when the Surveyor asked what blank spaces mean on the MAR, she stated blank spaces mean the medication was not administered or not documented. The DON further stated she was not aware of the residents' medications being missed and the police being called until after the fact, the following day (2/13/2022) after the shift was over. A review of a 7/2019 facility policy titled; "Pain Management" revealed the following: Under "Purpose" included: "The facility is committed to reducing physical and psychosocial symptoms associated with pain to assist the resident in achieving their highest practicable level of functioning. The facility recognizes that a resident's response to pain is subjective and individual ...The facility promotes resident self-reporting as the most reliable indicator of pain. Facility clinicians use objective pain scales when caring for residents that are able to assist in determining the severity of pain and effectiveness on interventions." Under "Policy" revealed " ...3. Include the resident ...in the following: Evaluation	F 658		

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F 658	Continued From page 19 of pain ...Determine Resident's pain goal and acceptable level of pain. 4. Identify the potential cause(s) for resident pain. Evaluate alleviating and/or exacerbating factors. Review effectiveness of past and current treatment, as well as specific spiritual and cultural issues related to pain." Review of a 1-2019 facility policy titled "Medication Administration-Documentation" revealed the following: Under "Policy" included: "The facility shall maintain a medication administration record to document all medications administered." Under "Procedure" included: " ...3. Documentation must include, as a minimum: ...e. Reason (s) why a medication was ...not administered ...."	F 658		
F 697 SS=H	N.J.A.C.: 8:39-27.1 (a) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: C#: NJ152289, NJ152294, NJ152309, NJ152310 Based on interviews, review of the medical records, and review of other pertinent facility documents, on 2/15/2022, 2/16/2022, and	F 697	1. Resident #1 was administered [redacted] medication on the following shift (2/13/22 8am) with resolution of [redacted]. The resident s [redacted] was completed and the plan of care is currently being followed. The	2/20/22

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F 697	Continued From page 20 2/19/2022, it was determined that the facility failed to consistently follow residents' care plans, evaluate residents for [Ex.Order 26] and ensure that [Ex.Order 26] were administered according to the physician's orders (PO's) for residents who were experiencing [Ex.Order 26]. The facility also failed to follow its policies titled [Ex.Order 26.4] Management" and "Medication Administration-Documentation." This deficient practice occurred on 2/12/2022 and 2/13/2022 on the 11:00 p.m. to 7:00 a.m. shift, on 5 of 8 units and for 5 of 7 residents (Resident #1, #2, #3, #4 and #5) reviewed, and was evidenced by the following: A review of a facility's policy dated 7/2019 and titled; "Pain Management" included the following: Under "Purpose": "The facility is committed to reducing physical and psychosocial symptoms associated with pain to assist the resident in achieving their highest practicable level of functioning. The facility recognizes that a resident's response to pain is subjective and individual ...The facility promotes resident self-reporting as the most reliable indicator of pain. Facility clinicians use objective pain scales when caring for residents that are able to assist in determining the severity of pain and effectiveness on interventions." Under "Policy" revealed " ...3. Include the resident...in the following: Evaluation of pain...Determine resident's pain goal and acceptable level of pain. 4. Identify the potential cause(s) for resident pain. Evaluate alleviating and/or exacerbating factors. Review effectiveness of past and current treatment, as well as specific spiritual and cultural issues related to pain." A review of a facility's policy dated 1-2019 and titled "Medication Administration-Documentation" revealed the following: Under "Policy" included:	F 697	Medical Director, NP and the RN evaluated resident #1 (2/15/22, 2/20/22, 3/9/22) with no noted lasting negative effect from the omission of scheduled medications. Resident #2 was administered [Ex.Order 26] medication on the following shift (2/13/22) with [Ex.Order 26.4(b)(1)] [Ex.Order 26]. The resident s [Ex.Order 26] completed and the plan of care is currently being followed. The Medical Director, NP and RN evaluated resident #2 (2/15/22, 2/20/22, 3/9/22) with no noted lasting negative effect from the omission of scheduled medications. Resident #3 was administered [Ex.Order 26] medication on the following shift (2/13/22) with [Ex.Order 26.4(b)(1)]. The resident s [Ex.Order 26] was completed and the plan of care is currently being followed. The Medical, Director, NP and RN evaluated resident #3 (2/15/22, 2/20/22, 3/9/22) with no noted lasting negative effect from the omission of scheduled medications. Resident #4 was administered [Ex.Order 26] medication on the following shift (2/13/22) with [Ex.Order 26.4(b)(1)] [Ex.Order 26]. The resident s [Ex.Order 26] was completed and the plan of careis currently being followed. The Medical Director, NP and RN evaluated resident #4 (2/15/22, 2/20/22, 3/9/22) with no noted lasting negative effect from the omission of scheduled medications. Resident #5 was administered [Ex.Order 26] medication on the following shift (2/13/22) with [Ex.Order 26.4(b)(1)] [Ex.Order 26]. The resident s [Ex.Order 26]	

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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
F 697	Continued From page 21 "The facility shall maintain a medication administration record to document all medications administered." Under "Procedure" included: " ...3. Documentation must include, as a minimum: ...e. Reason (s) why a medication was ...not administered ...." During a tour on 2/15/2022, the surveyors interviewed Resident #2 at 11:45 a.m. Resident #2 told the surveyors that on Saturday night (2/12/2022) during the 11:00 p.m. to 7:00 a.m. shift, the resident was supposed to receive his/her routine Ex.Order 26.4(b)(1) at 12:00 a.m. but never received it. Resident #2 stated he used the call bell to call for his medication and was told by the Certified Nursing Assistant (CNA #1) that the resident did not have a nurse. Resident #2 stated he/she was in Ex.Order 26. but did not have a nurse that night, so he/she could not get the Ex.Orde n medication administered and had to call Ex.Order. When asked by the Surveyor the Ex.Order 26. level on a 0 to 10 scale, with 10 being the most severe, Resident #2 stated that his/her Ex.Order 26. was a Ex.Ord. Resident #2 explained to the surveyors that since he/she did not receive the Ex.Order 26. Ex.Ord., the resident started to feel *Ex Order 26. 4B1* and said to CNA #1, *Ex Order 26. 4B1* However, the resident still didn't get it, so this was when Resident #2 *Ex Order 26. 4B1*, and the *Ex Order 26. 4B1* came. Resident #2 further explained to the surveyors that his/her next dose of Ex.Order 26. medication was scheduled for six hours later at 6:00 a.m. The resident also did not receive the 6:00 a.m. Ex.Order 26. medication and the early morning medications due on the 11:00 p.m. to 7:00 a.m. shift. Resident #2 stated that he/she received the Ex.Order 26. Ex.Ord. and the other medications due on the following shift at 7:45 a.m.	F 697	Ex.Order 26.4 was completed and the plan of care is currently being followed. The medical director, NP and RN evaluated resident #5 (2/15/22, 2/20/22, 3/9/22) with no noted lasting negative effect from the omission of scheduled medications. 2. All residents have the potential to be affected by this deficient practice. The missed medication report (239 pages) was reviewed on 2/15/22 by nursing administration and residents with Ex.Order 26.4(b)(1) omissions (49) were evaluated by nursing administration (on 2/13/22,2/15/22, 2/20/22) and the residents with missed Ex.Order 26.4(b)(1) were evaluated by the medical director, NP, and the UMs(on 2/15/22, 2/20/22, 3/9/22) with no last negative effects noted. Any resident with missing documentation for the Ex.Order 26.4(b)(1) (159) had the Ex.Order 26.4(b)(1) completed on subsequent shifts(2/13/22-2/20/22) and negative findings regarding pain was addressed. All residents care plans for Ex.Order 26. were reviewed by the UMs (on 2/19/22) and it was determined that the plan of care was being followed. Medication errors (159) were completed for each identified resident. 3. Nursing administration reviewed the	

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	315174	A. BUILDING _____ B. WING _____	C 02/19/2022

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F 697	Continued From page 22 Review of the facility's daily census report dated 2/12/2022 showed the facility had 105 residents on the [redacted] floor as follows: 24 residents on unit [redacted], 23 residents on unit [redacted], 28 residents on unit [redacted], and 30 residents on unit [redacted]. A review of the facility's staff assignment sheets dated 2/12/2022 revealed that the facility had only one nurse (Licensed Practical Nurse) LPN #1 assigned to the [redacted] and [redacted] units. No nurse was assigned to care for the 58 residents on the [redacted] and [redacted] units. Further review of the facility's daily census report dated 2/12/2022 showed the facility had a total of 110 residents on the [redacted] floor as follows: 29 residents on unit [redacted], 28 residents on unit [redacted], 23 residents on unit [redacted], and 30 residents on unit [redacted]. A review of the facility's staff assignment sheets dated 2/12/2022 revealed the facility had only one nurse, LPN #2, assigned to the [redacted] and [redacted] units. No nurse was assigned to care for the 57 residents on the [redacted] and [redacted] units. Review of the facility's daily census report dated 2/13/2022 showed the facility had 103 residents on the [redacted] floor as follows: 22 residents on unit [redacted], 23 residents on unit [redacted], 28 residents on unit [redacted], and 30 residents on unit [redacted]. A review of the facility's staff assignment sheets dated 2/13/2022 revealed the facility had only one nurse (LPN #1) on the floor and assigned the LPN to the [redacted] and [redacted] units. No nurse was assigned to care for the 42 residents on the [redacted] and [redacted] units.	F 697	policies on medication administration and Ex.Order 26.4(b)(1) on 2/19/22. The policies were determined to be in compliance with state and federal guidelines. Licensed nurses were educated by the Regional Director of Clinical/ designee on Ex.Order 26.4(b)(1) with emphasis on consistently following residents' care plans, evaluating residents for [redacted] and ensuring that Ex.Order 26.4(b)(1) were administered. Education completed on 2/15/22, 2/19/22, 3/9/22. Course content included ensuring scheduled and PRN [redacted] medications to all residents are administered as indicated by the physician6s order; following the resident s plan of care for [redacted]; and completing Ex.Order 26.4(b)(1) with documented pain scale each shift. The In-service completed by the Regional Director on 2/15/22, 2/19/22, and 3/9/22 also included notifying the DON if a nurse is unavailable to administer scheduled and PRN [redacted] medications as well as complete Ex.Order 26.4(b)(1). The staffing coordinator was counseled and educated by the administrator (on 2/20/22) on the importance of ensuring licensed nurses are available to distribute medications and complete [redacted] evaluations for all residents. In the event the DON is to be notified that there is a call out/ shortage for licensed nurses.	

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F 697	Continued From page 23 Review of the Electronic Medical Records (EMRs) were as follows: 1. According to the "Admission Record (AR)," Resident #2 was originally admitted to the facility on Ex Order 26. 4B1 with diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated 2/2/2022, Resident #2 had a Brief Interview of Mental Status (BIMS) score of [redacted]/15, indicating the resident was Ex.Order 26.4(b)(1) [redacted] The MDS also showed the resident needed Ex.Order 26.4(b)(1) with most Activities of Daily Living (ADLs) and received a scheduled Ex.Order 26.4(b)(1) regimen. Further review of the MDS also showed that a Ex.Order 26.4(b)(1) should be completed for the presence of [redacted], and the resident has Ex.Order 26.4(b)(1) with a [redacted] intensity rating of [redacted] out of 10, with 1 being the lowest and 10 being the highest [redacted] A review of Resident #2's CP revealed the following: Under "Focus": Resident is on Ex Order 26. 4B1 [redacted] due to an alteration in comfort R/T Ex.Order 26.4(b)(1) and Ex Order 26. 4B1, undated. Under "Goals": Resident's [redacted] goal is to be Ex.Order 26.4(b)(1) [redacted] ...able to verbalize [redacted] needed ...will achieve Ex.Order 26.4(b)(1) [redacted] while at rest through the review date (undated), under "Interventions": Administer medications as	F 697	4. The DON/ designee will audit medication administration daily for missed administration of [redacted] medications(2/20/22- 3/20/22) and [redacted] 4 weeks, then weekly x 4 weeks and then monthly until compliance is met. A sample of resident [redacted] care plans will be audited by the DON/designee (on 2/19/22) to ensure the current plan of care is being followed. The results of these audits will be submitted at QAPI. The DON/ designee will conduct [redacted] audits of residents with [redacted] medication to ensure that [redacted] medication is provided when ordered and PRN [redacted] medications are administered when requested. Audits will be completed weekly x 4 weeks and then monthly until compliance is met. The administrator / Designee will audit licensed nursing staff to ensure that scheduled licensed nurses are available to administer all necessary schedule medications and PRN medications. The results of these audits will be submitted at QAPI. The DON is responsible for execution and monitoring of this POC.	

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F 697	Continued From page 24 ordered, Evaluate the effectiveness of Ex.Order 26 [redacted] as needed. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, Identify and record previous Ex.Order 26.4(b)(1) and management of that Ex.Order 26 and impact on function. Identify previous response to Ex.Order 26.4(b)(1) [redacted] side effects, and impact on function. Identify, record, and treat the resident's existing conditions which may increase Ex.Order 26.4(b)(1) [redacted] t, Monitor for S/S of Ex.Order 26 with each interaction. If the resident appears to be Ex.Order 26.4(b)(1) utilize appropriate non-pharmacological and pharmacological interventions. Monitor/document for probable cause of each Ex.Order 26.4(b)(1) Remove/limit causes where possible. Monitor/document for side effects of Ex.Order 26 medication. Observe for Ex.Order 26.4(b)(1), new-onset or increased Ex.Order 26.4(b)(1) [redacted]. Report occurrences to the physician, Notify physician if interventions are unsuccessful or if the current complaint is a significant change from residents the past experience of Ex.Order 26, PMR consult, PMR Referral, Provide distraction/activities as needed, Report to Nurse resident c Ex.Order 26.4(b)(1) or requests for Ex.Order 26 [redacted] undated. Review of the "Order Summary Report (OSR)" for Resident #2 dated 2/15/2022 included the Physician Orders (PO's) for the following: Ex.Order 26. Evaluation Q (every) shift for Ex.Order 26. evaluation, record Ex.Order 26 on a 0-10 scale, dated 10/13/2019. *Ex Order 26. 4B1* [redacted]	F 697		

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F 697	Continued From page 25 Ex Order 26. 4B1. Give 1 tablet by mouth every 6 hours for Ex.Order 26.4(b)(1), dated 10/13/2019. A review of the 02/01/2022-02/28/2022 Medication Administration Record (MAR) for Resident #2 confirmed the staff failed to perform a Ex.Order 26.4(b)(1) and the aforementioned PO's were not administered on 2/12/2022 on the 11:00 p.m. to 7:00 a.m. shift as follows: Ex.Order 26 Evaluation Q shift for Ex.Order 26.4(b)(1) on 2/12/2022 on the 11:00 p.m. to 7:00 p.m. shift. was blank. Ex Order 26. 4B1 . Give 1 tablet by mouth every 6 hours for Ex Order 26. 4B1, on 2/13/2022 at 12:00 a.m. was blank. During an interview on 2/15/2022 at 2:59 p.m., CNA #1 stated that Resident #2 rang the call light and told him he/she needed Ex.Order medications. CNA #1 said the nurse (LPN #2) knew Resident #2 needed his/her medication because Ex.Orc reported it to her. When asked by the Surveyor what the nurse did or said when Ex.Orde told her Resident #2 needed his/ her medications, CNA #1 stated she did not say anything when Ex.Orc told her Resident #2 needed his/her meds. CNA #1 stated Resident #2 was Ex.Order 26.4(b) and called 911. 2. According to the AR, Resident #3 was admitted to the facility on Ex Order 26. 4B1 with diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted].	F 697		

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F 697	Continued From page 26 According to the MDS, dated 12/9/2021, Resident #3 had a BIMS score of [redacted]/15, indicating the resident was *Ex Order 26. 4B1*. The MDS also revealed Resident #3 needed Ex.Order 26.4(b)(1) [redacted] with most ADLs, and the resident received Ex.Order 26 medication as needed (PRN). Further review of the MDS also showed that a Ex.Order 26 assessment should be completed for the presence of Ex.Order 26, and the resident has frequent Ex.Order 26, making it Ex.Order 26.4(b)(1) and has Ex.Order 26.4(b)(day-to-day activities because of the Ex.Order 26.4(A review of Resident #3's CP revealed the following: Under "Focus": Alteration in comfort R/T (actual) Ex.Order 26.4(b)(1), undated. Under "Goals": Resident is able to Ex.Order 26.4(b)(1) and request Ex.Order 26 medications as needed, and the resident will achieve Ex.Order 26.4(b)(1) pain while at rest through the review date, undated, under "Interventions": Administer medications as ordered, Monitor for S/S of Ex.Order 26 with each interaction. If the resident appears to be in Ex.Order 26.4 utilize appropriate non-pharmacological and pharmacological interventions. Monitor/document for probable cause of each Ex.Order 26.4(b)(1). Remove/limit causes where possible. Monitor/document for side effects of Ex.Order 26 medication. Observe for Ex.Order 26.4(b)(1), new-onset or increased Ex.Order 26.4(b)(1) [redacted] Report occurrences to the physician, Notify physician if interventions are unsuccessful or if the current complaint is a significant change from residents the past experience of Ex.Order 26, Report to Nurse resident Ex.Order 26.4(b)(1) or requests for Ex.Order 26.4(b)(1), Utilize non-pharmacological Ex.Order 26 interventions to promote Ex.Order 26.4(b)(1) Vocalizations	F 697		

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(grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing), pain, undated.

Review of the OSR for Resident #3 dated 2/15/2022 included the PO's for the following:

Ex.Order 26.4(b)(1) Evaluation Q (every) shift for Ex.Order 26.4(b)(1) evaluation, record Ex.Order 26.4(b)(1) on a 0-10 scale, dated 11/30/2021.

Ex Order 26. 4B1 .
Give 1 tablet by mouth every 4 hours as needed for *Ex Order 26. 4B1* . 6-10, dated 11/30/2021.

A review of the 02/01/2022-02/28/2022 MAR for Resident #3 confirmed the staff failed to perform a Ex.Order 26.4(b)(1) and the aforementioned PO's were not administered on 2/12/2022 and 2/13/2022 on the 11:00 p.m. to 7:00 a.m. shift as follows:

Ex Order 26. 4B1 .
Give 1 tablet by mouth every 4 hours as needed for *Ex Order 26. 4B1* . 6-10, on 2/13/2022 on the 11:00 p.m. to 7:00 a.m. shift.

Ex.Order 26.4(b)(1) Evaluation Q shift every shift for Ex.Order 26.4(b)(1) evaluation record Ex.Order 26.4(b)(1) on a 0-10 scale on 2/13/2022 on the 11:00 p.m. to 7:00 a.m. shift.

A review of the Progress Notes (PNs) dated 2/14/2022 at 3:57 a.m., written by Licensed Practical Nurse (LPN #4), revealed that Resident

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F 697	Continued From page 28 #3 "contacted emergency services due to Ex.Order 26. Resident requested to be taken to Ex Order 26. 4B1 ...." During an interview on 2/19/2022 at 7:15 a.m., Resident #3 stated that the nurses on the unit were not showing up repeatedly on the night (11:00 p.m. to 7:00 a.m.) shift. The resident explained he/she did not receive his/her medication for the entire night shift when the resident called Ex Order. Resident #3 explained to the Surveyor that the resident was in Ex Order 26. 4B1 to his/her Ex Order 26. 4B1 . Resident #3 used the call button, the staff responded, and the resident told them that he/she Ex.Order 26.4(b)(1) and needed his/her Ex.Order 2 Ex Orde. The resident stated he/she repeatedly asked for the Ex.Order 26 medication, but the nurse would not give the medication to him/her. The resident said he/she had no choice but to call Ex Order in the morning hours to take him/her to the Ex Order 26. 4B1. Resident #3 continued to explain, Ex Order 26. 4B1 The resident stated he/she received the needed medication Ex Order 26. 4B1 at the Ex Order 26. 4B1 by mouth and the symptoms were relieved slowly. When asked by the Surveyor what was the resident's Ex.Order 26.4(b)(1) on a 0-10 scale, Resident #3 stated his/her pain was over Ex Ord. 3. According to the AR, Resident #1 was admitted to the facility on Ex Order 26. 4B1 with diagnoses which included but were not limited to Ex Order 26. 4B1 .	F 697		

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F 697	Continued From page 29 According to the MDS, dated 2/4/2022, Resident #1 had a BIMS score of [redacted]/15, indicating the resident was *Ex Order 26. 4B1*. The MDS also showed that the resident needed ADL Ex.Order 26.4(b)(1) and received a scheduled Ex.Order 26.4(b)(1) regimen and PRN. The MDS also showed that Ex.Order 26.4(b)(1) should be completed for the presence of [redacted] listed [redacted] as *Ex Order 26. 4B1* and at level [redacted] out of 10, with 1 being the lowest and 10 being the highest [redacted] A review of Resident #1's Care Plan (CP) revealed the following: Under "Focus": Resident has alteration in comfort R/T (related to Ex.Order 26.4(b)(1) [redacted], *Ex Order 26. 4B1*, dated 7/30/2021. Under "Goals": Resident [redacted] will improve as part of the healing process ...will achieve Ex.Order 26.4(b)(1) [redacted] while at rest through the review date, dated 7/30/2021, under "Interventions": Administer medications as ordered, Evaluate the effectiveness of [redacted] interventions as needed. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on Ex.Order 26.4(b)(1) [redacted], Identify, record and treat the resident's existing conditions which may increase Ex.Order 26.4(b)(1) [redacted], Monitor for S/S (Signs and Symptoms) of [redacted] with each interaction. If resident appears to be [redacted] utilize appropriate non-pharmacological and pharmacological interventions; monitor/document for side effects of Ex.Order 26.4(b)(1). Observe for Ex.Order 26.4(b)(1) [redacted]. Report occurrences to the physician, Report to Nurse resident complains of [redacted] or requests Ex.Order 26.4(b)(1),	F 697		

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F 697	Continued From page 30 Ex.Order 26.4(b)(1) frequently ...", dated 7/30/2021. Review of the OSR for Resident #1 dated 2/15/2022 included the PO's for the following: Ex.Order 26. Evaluation Q (every) shift for Ex.Order 26 evaluation, record Ex.Order 26 on a 0-10 scale, dated 07/29/2021. *Ex Order 26. 4B1* Give 1 tablet by mouth two times a day for Ex.Order 26 dated 12/15/2021. *Ex Order 26. 4B1* . Give 1 tablet by mouth every 8 hours for *Ex Order 26. 4B1*, dated 09/02/2021. A review of the 02/01/2022-02/28/2022 Medication Administration Record (MAR) for Resident #1 confirmed the staff failed perform a Ex.Order 26.4(b)(1) and the aforementioned PO's were not administered on 2/12/2022 on the 11:00 p.m. to 7:00 a.m. shift (2/12/2022 into 2/13/2022) as follows: Ex.Order 26. evaluation Q shift every shift for Ex.Order 26 evaluation. Record Ex.Order 26 on a 0-10 scale on 2/12/2022 on 11:00 p.m. to 7:00 a.m. shift. was blank. *Ex Order 26. 4B1* . Give 1 tablet by mouth two times a day for Ex.Order 26, on 2/13/2022 at 4:00 a.m. was blnak. *Ex Order 26. 4B1* . Give 1 tablet by mouth every 8 hours for *Ex Order 26. 4B1*, on 2/13/2022 at 6:00 a.m. was blank.	F 697		

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During an interview on 2/15/2022 at 3:25 p.m., Resident #1 stated that on the 11:00 p.m. to 7:00 a.m. shift, he/she missed his/her [Ex Order] on Saturday into Sunday because there was no nurse on the [Ex] unit. The resident stated he/she had to wait until the 7:00 a.m. nurse came on duty to give the medications, and his/her Ex.Order 26.4(b)(1) was a [Ex]/10.

4. According to the AR, Resident #4 was admitted to the facility on Ex Order 26. 4B1 with diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted].

According to the MDS, dated 2/3/2022, Resident #4 had a BIMS score of [Ex Ord]/15, indicating the resident was Ex Order 26. 4B1. The MDS also showed the resident needed Ex.Order 26.4(b)(1) with most ADLs; the resident received a scheduled [Ex.Order 2] medication regimen and additionally received [Ex.Order 2] medication PRN. Further review of the MDS also showed that a Ex.Order 26.4(b)(1) should be completed for the presence of [Ex.Order 26.4] and the resident had [Ex.Order 26] frequently with a Ex.Order 26.4(b)(1) rating of [Ex] out of 10, 0 being the lowest and 10 being the highest [Ex.Order 26].

Review of Resident #4's CP revealed the following:

Under "Focus": Resident may have Alteration in comfort R/T [Ex.Order 26.4(b)(1)], [Ex Order 26. 4B1], dated 7/28/2021. Under "Goals": Residents [Ex.Order 26.4(b)(1)] is to have a Ex.Order 26.4(b)(1) through the review date, dated 7/28/2021, under "Interventions": Monitor for S/S of [Ex.Order 26] with each

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F 697	Continued From page 32 interaction If resident appears to be in Ex.Order 26. utilize appropriate non-pharmacological and pharmacological interventions and Ex.Order 26.4 dated 7/28/2021. Review of the OSR for Resident #4 dated 2/15/2022 included the PO's for the following: Ex.Order 26 Evaluation Q shift for Ex.Order 26 evaluation, record Ex.Order 26 on a 0-10 scale, dated 7/28/2021. *Ex Order 26. 4B1* . Give 1 tablet by mouth every 8 hours for *Ex Order 26. 4B1* , dated 2/7/2022. A review of the 02/01/2022-02/28/2022 MAR for Resident #4 confirmed the staff failed to perform a Ex.Order 26.4(b)(1) and the aforementioned PO's were not administered on 2/12/2022 on the 11:00 p.m. to 7:00 a.m. shift (2/12/2022 into 2/13/2022) as follows: *Ex Order 26. 4B1* . Give 1 tablet by mouth every 8 hours for *Ex Order 26. 4B1* on 2/13/2022 at 6:00 a.m. was blank. Ex.Order 26. Evaluation Q Shift every shift for Ex.Order 26 evaluation record Ex.Order 26. on a 0-10 scale on 2/13/2022 on 11:00 p.m. to 7:00 a.m. shift. was blank. 5. According to the AR, Resident #5 was readmitted to the facility on *Ex Order 26. 4B1* and originally admitted on *Ex Order 26. 4B1* with diagnoses which included but were not limited to *Ex Order 26. 4B1* [redacted]. According to the MDS, dated 1/22/2022, Resident	F 697		

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F 697	Continued From page 33 #5 had a BIMS score of /15, indicating the resident had Ex Order 26. 4B1. The MDS also showed the resident ADLs; the resident received a scheduled medication regimen and additionally received medication PRN. Further review of the MDS also showed that a Ex.Order 26.4(b)(1) should be completed for the presence of, and the resident has y, and the is. A review of Resident #5's CP revealed the following: Under "Focus": Alteration in comfort R/T S/P (status post) (previous) Residents on medications, Ex.Order 26.4(b)(1), undated. Under "Goals": Resident Ex.Order 26.4(b)(1) as part of the healing process, and resident is able to verbalize Ex.Order 26.4(b)(1) medications as needed through the review date, undated, under "Interventions": ...Administer medications as ordered ...Evaluate the effectiveness of interventions as needed. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on Ex.Order 26.4(b)(1) ...remind of non-pharmacological interventions, i.e. (for example): Ex.Order 26.4(b)(1) available on request to recreation, Report to Nurse resident complaints of resident is able to verbalize Ex.Order 26.4(b)(1) medications as needed, undated. Review of the OSR for Resident #5 dated 2/15/2022 included the PO's for the following: Evaluation Q (every) shift for	F 697		

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F 697	Continued From page 34 evaluation, record Ex.Order 26. on a 0-10 scale, dated 5/24/2018. Monitor resident Ex.Order 26.4(b)(1)) every shift and record the number of Ex.Order 26.4(b)(1) dated 11/3/2020. *Ex Order 26. 4B1* . Give 1 capsule by mouth every 8 hours for *Ex Order 26. 4B1*, dated 09/17/2021. A review of the 02/01/2022-02/28/2022 MAR for Resident #5 confirmed the staff failed to perform an Ex.Order 26.4(b)(1) . Also, the aforementioned PO's were not administered on 2/12/2022 and 2/13/2022 on the 11:00 p.m. to 7:00 a.m. shift (2/12/2022 into 2/13/2022 and 2/13/2022 into 2/14/2022) as follows: Monitor residen Ex.Order 26.4(b)(1)) every shift and record the number of Ex.Order 26.4(b)(1) on 2/13/2022 at 11:00 p.m. to 7:00 a.m. shift. was blank. *Ex Order 26. 4B1* . Give 1 capsule by mouth every 8 hours for *Ex Order 26. 4B1* on 2/13/2022 & 2/14/2022 at 6:00 a.m. were blank. Ex.Order 26 Evaluation Q (every) shift for Ex.Order 26. evaluation, record Ex.Order 26. on a 0-10 scale on 2/13/2022 from 11:00 p.m. to 7:00 a.m. was blank. Review of Resident #1's, #2's, #3's, #4's, and #5's EMR showed no documented evidence that the residents' CP was followed had a Ex.Order 26.4(b)(1) completed or received their Ex.Order 26 medications according to the PO's order.	F 697		

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F 697	Continued From page 35 During an interview on 2/16/2022 at 9:26 a.m., the Staffing Coordinator confirmed she received a text on 2/11/2022 on the 11:00 p.m. to 7:00 a.m. shift, at 12:00 a.m. but did not see the text until she woke up. According to the Staffing Coordinator, the text was also sent to the DON and the HR Director. Since there was no response from the group, she assumed it was resolved. The Staffing Coordinator further stated she was aware that nursing was short-staffed, but the HR Director also handles the weekend schedule. During a telephone interview on 2/16/2022 at 11:11 a.m., LPN #1 indicated that on 2/12/2022, on the 11:00 p.m.to 7:00 a.m. shift, she was the only nurse on the [redacted] floor and was assigned to units [redacted] and [redacted]. LPN #1 also stated that LPN #2 was the only nurse assigned to the [redacted] floor on the 11:00 p.m. to 7:00 a.m. shift on 2/12/2022. The LPN explained that on 2/12/2022, on the 11:00 p.m.to 7:00 a.m. shift, she was the only nurse on the [redacted] floor for units [redacted], and [redacted], with the resident census of 105. LPN #1 further explained that she could not care for all of the [redacted]-floor residents and only provided care for some residents. She stated some residents were crying, complaining they were not getting their medications, and came up to the nurses' station, and she administered those residents their medications. LPN #1 also stated that a resident called the police from the [redacted] floor. LPN #1 further stated that the next night on 2/13/2022, on the 11:00 p.m.to 7:00 a.m. shift, she was again the only nurse on the [redacted] floor (units [redacted], and [redacted]) with the resident census of 103. She further stated that a resident called [redacted] and went to the [redacted] because	F 697		

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F 697	Continued From page 36 he/she did not receive [redacted] medications as no nurse was on his/her cart. The LPN explained, on 2/13/2022, during the 11:00 p.m. to 7:00 a.m. shift, she sent out a mass text message to the Director of Nursing (DON), the Human Resources (HR) Director, and other facility staff that they were only two nurses on duty in the entire building, for a census of over two hundred residents. According to LPN #1, Resident #3 called down to the [redacted] floor from the [redacted] floor to get his/her medication. She told the resident that she would notify the nurse on the [redacted] floor. LPN #1 explained she called LPN #4, who did not give the resident the [redacted] medication, so the resident called 911. LPN #1 also stated Resident #3 was [redacted]. During a telephone interview on 2/16/2022 at 1:00 p.m., when asked by the surveyor if she received a text from LPN #1 about being the only nurse on the floor on 2/11/2022 on the 11:00 p.m. to 7:00 a.m. shift, the HR Director confirmed that she received a group text from the nurse during the night between 12:30 a.m. to 2:30 a.m. According to the HR Director, she replied to the nurse's text message but did not follow up with anyone else. She explained that the nurse should have contacted the on-call Supervisor. The HR Director explained that she does not take calls off shift and the Supervisor handles that on-off shifts. She was unsure who was the on-call Supervisor. During a telephone interview on 2/16/2022 at 1:13 p.m., LPN #4 confirmed she was assigned to the [redacted] floor on the [redacted] and [redacted] units on Sunday (2/13/2022) on the 11:00 p.m. to 7:00 a.m. shift. The LPN stated there was no other nurse on the floor, and she told the HR Director. LPN #4 explained that Resident #3 requested his/her [redacted]	F 697		

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F 697	Continued From page 37 medication at 3:00 a.m., but she did not want to take the keys because she did not count the cart with anyone. The LPN continued to explain the facility is short-staffed every night. During an interview on 2/16/2022 at 3:33 p.m., the Director of Nursing (DON) stated the Supervisor was on vacation, and a Supervisor did not work on 2/12/2022 and 2/13/2022. The DON also confirmed that she received the text message sent out on 2/13/2022 during the 11:00 p.m. to 7:00 a.m. shift by LPN #1. The DON explained that the text message was at 2:07 a.m., and she did not hear the text message alert. When asked by the Surveyor why she did not get more nurses or why she did not come into assist the 11:00 p.m. to 7:00 a.m. shift, the DON responded that LPN #1 should have called instead of texting; she did not see the text message until the morning. The shift was almost over, so she did not go to the facility to help. The DON further explained that the staffing schedules are looked at before the weekend begins. She explained that the Staffing Coordinator should have been aware that the nursing staff was short because there was only one nurse on the schedule for 2/12/2022 on the 11:00 p.m. to 7:00 a.m. shift on units Ex Order 26. 4B1, and [redacted]. The DON also stated [redacted] medications should be given when requested, and if a resident did not receive [redacted] medication, the nurse would be written up; I did not write up the nurses from this past weekend yet. During a second interview on 2/19/2022 at 10:35 a.m., when the surveyor asked what blank spaces mean on the MAR, she stated blank spaces mean the medication was not administered or not documented. The DON	F 697		

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F 697	Continued From page 38 further stated she was not aware of the residents' medications being missed and the police being called until after the fact, the following day (2/13/2022) after the shift was over.	F 697		
F 725 SS=F	N.J.A.C.: 8:39-27.1(a) Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 725		3/15/22

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by:
C#: NJ152289, NJ152294, NJ152309, NJ152310

Based on interviews and review of pertinent facility documents on 2/15/2022, 2/16/2022, and 2/19/2022, it was determined that the facility failed to ensure there were sufficient nursing staff to provide care for all residents on 2/12/2022 and 2/13/2022 on the 11:00 p.m. to 7:00 a.m. shifts. The facility also failed to follow its policy titled "Staffing Hours." This deficient practice occured on 5 of 8 units, affected 5 of 7 residents (Resident #1, #2, #3, #4, and #5) reviewed and had the potential to affect all other residents. This was evidenced by the following:

During a tour on 2/15/2022, the surveyors interviewed Resident #2 at 11:45 a.m. Resident #2 told the surveyors that on Saturday night (2/12/2022) during the 11:00 p.m. to 7:00 a.m. shift, the resident was supposed to receive his/her routine [redacted] at 12:00 a.m. but never received it. Resident #2 stated he/she used the call bell to call for his/her medication and was told by the Certified Nursing Assistant (CNA #1) that the resident did not have a nurse. Resident #2 stated he/she Ex.Order 26.4(b)(1) but did not have a nurse that night, so he/she could not get the [redacted] medication administered and had to call [redacted]. When asked by the Surveyor the Ex.Order 26.4(b)(1) on a 0 to 10 scale, with 10 being the most severe, Resident #2 stated that his/her [redacted] was a [redacted].

Resident #2 explained to the surveyors that since he/she did not receive the [redacted], the resident started to feel Ex Order 26. 4B1 and said to CNA #1, Ex Order 26. 4B1 However, the resident still didn't get it, so this was

1.
Resident #1 was administered [redacted] medication on the following shift (2/13/22) with Ex.Order 26.4(b)(1). The medical director, NP, and the RN evaluated resident #1 on 2/15/22, 2/20/22, and 3/9/22 with no noted lasting negative effect from the omission of scheduled medications.

Resident #2 was administered [redacted] medication on the following shift (2/13/22) with Ex.Order 26.4(b)(1) documented. The medical director, NP, and the RN evaluated resident #2 on 2/15/22, 2/20/22, and 3/9/22 with no noted lasting negative effects from the omission of the scheduled [redacted] medication.

Resident #3 was administered [redacted] medication on the following shift (2/13/22) with Ex.Order 26.4(b)(1) documented. The NP, medical director and the RN evaluated resident #3 on 2/15/22, 2/20/22, and 3/9/22 with no noted lasting negative effects from the omission of the scheduled [redacted] medication.

Resident #4 was administered [redacted] medication on the following shift (2/13/22) with Ex.Order 26.4(b)(1) documented. The medical director, NP and RN evaluated resident #4 on 2/15/22, 2/20/22, and 3/9/22 with no noted lasting negative effects from the omission of the scheduled [redacted] medication.

Resident #5 was administered [redacted]

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F 725	Continued From page 40 when Resident #2 called Ex Order, and the paramedics and police came. Resident #2 further explained to the surveyors that his/her next dose of Ex.Order 26 medication was scheduled for six hours later at 6:00 a.m. The resident also did not receive the 6:00 a.m. Ex.Order 26. medication and the early morning medications due on the 11:00 p.m. to 7:00 a.m. shift. Resident #2 stated that he/she received the Ex.Order 26. Ex Ord. and the other medications due on the following shift at 7:45 a.m. Review of the facility's daily census report dated 2/12/2022 showed the facility had 105 residents on the Ex Order floor as follows: 24 residents on unit Ex Ord., 23 residents on unit Ex Ord., 28 residents on unit Ex Ord., and 30 residents on unit Ex Ord.. A review of the facility's staff assignment sheets dated 2/12/2022 revealed that the facility had only one nurse (Licensed Practical Nurse) LPN #1 assigned to the Ex Ord. and Ex Ord. units. No nurse was assigned to care for the 58 residents on the Ex Ord. and Ex Ord. units. Further review of the facility's daily census report dated 2/12/2022 showed the facility had a total of 110 residents on the Ex Order 26. 4(b) floor as follows: 29 residents on unit Ex Ord., 28 residents on unit Ex Ord., 23 residents on unit Ex Ord., and 30 residents on unit Ex Ord.. A review of the facility's staff assignment sheets dated 2/12/2022 revealed the facility had only one nurse, LPN #2, assigned to the Ex Ord. and Ex Ord. units. No nurse was assigned to care for the 57 residents on the Ex Ord. and Ex Ord. units. Review of the facility's daily census report dated 2/13/2022 showed the facility had 103 residents on the Ex Order floor as follows: 22 residents on unit	F 725	medication on the following shift)2/13/22) with Ex.Order 26.4(b)(1) documented. The medical director , NP, and RN evaluated resident #5 on 2/15/22,2/20/22, and 3/9/22 with no noted lasting negative effects from the omission of the scheduled Ex.Order 26 medication. Resident #6 was administered Ex.Order 26 medication on the following shift (2/13/22) with Ex.Order 26.4(b)(1) documented. The medical director, NP and RN evaluated resident #6 on 2/15/22, 2/20/22, and 3/9/22 with no noted lasting negative effects from the omission of the scheduled Ex.Order 26 medication. Medication errors were completed for identified residents. 2. All residents have the potential to be affected by this deficient practice. Facility schedules were evaluated by the administrator on 2/19/22 and determined to have adequate nursing staff is scheduled to provide medications and care currently. The missed medication report (239 pages) was reviewed by nursing administration and residents with medication omissions (159) were evaluated with no negative outcome noted for any identified resident. Nursing leadership and the medical director met with a reducing poly pharmacy and BID medication pass initiative in order to	

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F 725	Continued From page 41 Ex Ord, 23 residents on unit Ex Ord, 28 residents on unit Ex Ord, and 30 residents on unit Ex Ord. A review of the facility's staff assignment sheets dated 2/13/2022 revealed the facility had only one nurse (LPN #1) on the floor and assigned the LPN to the Ex Ord and Ex Ord units. No nurse was assigned to care for the 42 residents on the Ex Ord and Ex Ord units. During an interview on 2/15/2022 at 3:25 p.m., Resident #1 stated that on the 11:00 p.m. to 7:00 a.m. shift (on Saturday into Sunday), the resident missed his/her pills because there was no nurse on the Ex O unit. The resident stated he/she had to wait until the 7:00 a.m. nurse came on duty to give the resident the medications, and the Ex.Order 26.4(b)(1) was a Ex /10. During an interview on 2/19/2022 at 7:15 a.m., Resident #3 stated that the nurses on the unit were not showing up repeatedly on the night (11:00 p.m. to 7:00 a.m.) shift. The resident explained he/she did not receive his/her medication for the entire night shift when the resident called Ex Order. Resident #3 explained to the Surveyor that the resident was in Ex Order 26. 4B1 to his/her Ex Order 26. 4B1 . Resident #3 used the call button, the staff responded, and the resident told them that he/she was Ex.Order 26.4(b)(1 and needed his/her Ex.Order 2 Ex Ord. The resident stated he/she repeatedly asked for the Ex.Order 26 medication, but the nurse would not give the medication to him/her. The resident stated he/she had no choice but to call Ex Order in the morning hours to take him/her to the Ex Order 26. 4B1. Resident #3 continued to explain, Ex Order 26. 4B1	F 725	ensure that necessary medications are administered. The medical director determined optimum times to improve resident□s quality of life and streamline the number of medications administered by nursing. The medications for the 11-7 shift were rescheduled in compliance with manufacturers recommendation to shift administration of medications for when residents are awake. Reducing medications and shifting medications to waking hours will improve the resident6s quality of life while allowing nursing to focus on administering essential medications on the 11-7 shift. This was completed from 2/20/22-2/25/22 Facility schedules were evaluated by administration on 2/19/22 with adequate staffing noted to provide medications was noted at this time. 3. The facility policy on medication administration was reviewed by the nursing administration on 2/19/22 and determined to be in compliance with state and federal guidelines. The staffing coordinator was educated (on 2/20/22) on ensuring that adequate staffing levels are reached to provide care and medications to all residents. If nursing staff does not meet adequate levels, the DON and administrator must be notified. If the DON and/or administrator is not responding continued attempts to reach either one must occur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING _____ B. WING _____	C 02/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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F 725	Continued From page 42 Ex Order 26. 4B1 The resident stated he/she received the needed medication Ex Order 26. 4B1 at the Ex Order 26. 4B1 by mouth and the symptoms were relieved slowly. When asked by the Surveyor what was the resident's Ex.Order 26.4(b)(1) on a 0-10 scale, Resident #3 stated his/her Ex.Order 26 was Ex Order 26 . During an interview on 2/15/2022 at 2:59 p.m., CNA #1 stated that Resident #2 rang the call light and told him he/she needed his medications. CNA #1 said the nurse (LPN #2) knew Resident #2 needed his/her medications because he reported it to the nurse. When asked by the Surveyor what the nurse did or said when he told her Resident #2 needed his/ her medications, CNA #1 stated she did not say anything when he told her the resident needed his/her meds. CNA #1 stated Resident #2 was Ex Order 26. 4B and called Ex Order . During an interview on 2/16/2022 at 9:26 a.m., the Staffing Coordinator confirmed she received a text on 2/11/2022 on the 11:00 p.m. to 7:00 a.m. shift, at 12:00 a.m. but did not see the text until she woke up. According to the Staffing Coordinator, the text was also sent to the Director of Nursing (DON) and the Human Resources (HR) Director; since there was no response from the group, she assumed it was resolved. The Staffing Coordinator further stated she was aware that nursing was short-staffed, but the HR Director also handles the weekend schedule. During a telephone interview on 2/16/2022 at 11:11 a.m., LPN #1 indicated that on 2/12/2022, on the 11:00 p.m.to 7:00 a.m. shift, she was the only nurse on the Ex Order floor and was assigned to units Ex Orde and Ex Orde. LPN #1 also stated that LPN #2 was the only nurse assigned to the Ex Order 26. 4B1 floor	F 725	The Regional Director / designee in-serviced licensed nurses (on 2/1522, 2/19/22, 3/9/22) on ensuring that residents needs were met and medications are administered. Nursing supervisors were educated to notify administration and the MD if there was not enough nursing staff to administer medications and care. Additional recruiting efforts were initiated to employ and maintain nursing staff including new contracts with traveling agencies, additional ads to attract nursing staff, generous incentives to attract staff of other facilities, sign on and referral bonuses initiated. 4. The administrator / Designee will audit schedules to actual payroll punches to ensure nursing staff is provided to meet the medication needs of the residents. Audits will be completed weekly x 4 weeks and then monthly until compliance is met. The results of these audits will be presented at monthly QAPI. The DON/ designee will audit medication administration daily for missed administration x 4 weeks and then weekly x 4 weeks and then monthly until compliance is met. The results of these audits will be submitted at QAPI.	

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	315174	A. BUILDING _____ B. WING _____	C 02/19/2022

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DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	**1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096**

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F 725	Continued From page 43 on the 11:00 p.m. to 7:00 a.m. shift on 2/12/2022. The LPN explained that on 2/12/2022, on the 11:00 p.m.to 7:00 a.m. shift, she was the only nurse on the [redacted] floor for units Ex Order 26. 4B1, and [redacted], with the resident census of 105. LPN #1 further explained that she could not care for all of the [redacted]-floor residents and only provided care for some residents. She stated some residents were crying, complaining they were not getting their medications, and came up to to the nurses station and she administered those residents their medications. LPN #1 also stated tha a resident called the [redacted] from the [redacted] floor. LPN #1 further stated that the next night on 2/13/2022, on the 11:00 p.m.to 7:00 a.m. shift, she was again the only nurse on the [redacted] floor (units Ex Order 26. 4B1 and [redacted]) with the resident census of 103. She further stated that a resident called [redacted] and went to the [redacted] because he/she did not receive [redacted] medications as no nurse was on his/her cart. The LPN explained, on 2/13/2022, during the 11:00 p.m. to 7:00 a.m. shift, she sent out a mass text message to the Director of Nursing (DON), the Human Resources (HR) Director, and other facility staff that they were only two nurses on duty in the entire building, for a census of over two hundred residents. According to LPN #1, Resident #3 called down to the [redacted] floor from the [redacted] floor to get his/her medication. She told the resident that she would notify the nurse on the [redacted] floor. LPN #1 explained she called LPN #4, who did not give the resident the pain medication, so the resident called [redacted]. LPN #1 also stated Resident #3 was [redacted]. During a telephone interview on 2/16/2022 at 1:00 p.m., the Surveyor asked the HR Director if she	F 725	The Administrator is responsible for execution and monitoring of this POC.	

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F 725	Continued From page 44 received a text from LPN #1 about being the only nurse on the floor on 2/11/2022 on the 11:00 p.m. to 7:00 a.m. shift. The HR Director confirmed that she received a group text from the nurse during the night between 12:30 a.m. to 2:30 a.m. According to the HR Director, she replied to the nurse's text message but did not follow up with anyone else. She explained that the nurse should have contacted the on-call Supervisor. The HR Director explained that she does not take calls off shift and the Supervisor handles that on-off shifts. She was unsure who was the on-call Supervisor. During a telephone interview on 2/16/2022 at 1:13 p.m., LPN #4 confirmed she was assigned to the [redacted] floor on the [redacted] and [redacted] units on Sunday (2/13/2022) on the 11:00 p.m. to 7:00 a.m. shift. The LPN stated there was no other nurse on the floor, and she told the HR Director. LPN #4 explained that Resident #3 requested his/her pain medication at 3:00 a.m., but she did not want to take the keys because she did not count the cart with anyone. The LPN continued to explain the facility is short-staffed every night. During an interview on 2/16/2022 at 3:33 p.m., the Director of Nursing (DON) stated the Supervisor was on vacation, and a Supervisor did not work on 2/12/2022 and 2/13/2022. The DON also confirmed that she received the text message sent out on 2/13/2022 during the 11:00 p.m. to 7:00 a.m. shift by LPN #1. The DON explained that the text message was at 2:07 a.m., and she did not hear the text message alert. When asked by the Surveyor why she did not get more nurses or why she did not come into assist the 11:00 p.m. to 7:00 a.m. shift, the DON responded that LPN #1 should have called instead of texting; she did not see the text	F 725		

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F 725	Continued From page 45 message until the morning. The shift was almost over, so she did not go to the facility to help. The DON further explained that the staffing schedules are looked at before the weekend begins. She explained that the Staffing Coordinator should have been aware that the nursing staff was short because there was only one nurse on the schedule for 2/12/2022 on the 11:00 p.m. to 7:00 a.m. shift on units [redacted], and [redacted]. The DON also stated pain medications should be given when requested, and if a resident did not receive [redacted] medication, the nurse would be written up; I did not write up the nurses from this past weekend yet. During a post-survey telephone interview on 3/1/2022 at 11:25 a.m., the on-call RN Supervisor stated she was scheduled to be on-call on the weekend of 2/12/2022, which started on Saturday at 7:00 a.m. through Monday 7:00 a.m. The RN Supervisor explained she called out by text to the Staffing Coordinator and is almost a hundred percent positive she also texted the DON. Several attempts have been made during and after the survey to contact LPN #2, who did not respond. A review of the facility's policy titled "Staffing Hours," last revised on 4/2019, included the following: "Our facility provides adequate staffing to meet needed care and services for our resident population." Under "Procedure: 1. Our facility maintains adequate staffing on each shift to ensure that our residents ' needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services ...."	F 725		

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F 725	Continued From page 46 REF: F658 and F697. N.J.A.C. 8:39-27.1 (a)	F 725		

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
	060804	A. BUILDING: _____ B. WING _____	C 02/19/2022

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DEPTFORD CENTER FOR REHABILITATION AI	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C#: NJ152289, NJ152294, NJ152309, NJ152310 Based on facility document review on 2/15/2022, 2/16/2022, and 2/19/2022, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 16 of 21 day shifts for CNAs, 5 of 20 evening shifts for total staff reviewed and 6 of 20 overnight shifts for total staff reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening	S 560	1. The facility schedules were reviewed by the administrator on 2/19/22 and staffing was added to meet the minimum requirement of direct care staff to resident requirement. Additional recruitment efforts were employed including new contracts with traveling agencies, additional ads to attract nursing staff, generous incentives to attract staff of other facilities, initiation of referral and sign on bonuses. 2. All residents have potential to be affected by this deficient practice. The facility schedules were reviewed by the administrator on 2/19/22 and additional staff was added to meet the requirements for direct care staff to resident ratio. 3. The staffing coordinator was educated by the administrator on 2/20/22 on ensuring that adequate staffing levels are reached to comply with the NJ state requirement for direct care staff to resident ratio including a C.N.A. ration of 8:1 on day	3/15/22

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

Electronically Signed | 03/09/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of 01/30/2022 through 02/12/2022, the facility was deficient in CNA staffing for residents on 11 of 14-day shifts, deficient in total staff for residents on 3 of 14 evening shifts and deficient in total staff for residents on 3 of 14 overnight shifts as follows: On 01/30/22 had 17 CNAs for 226 residents on the day shift, required 29 CNAs. On 01/30/22 had 13 total staff for 226 residents on the overnight shift, required 17 total staff. On 01/31/22 had 19 CNAs for 226 residents on the day shift, required 29 CNAs. On 02/01/22 had 26 CNAs for 222 residents on the day shift, required 28 CNAs. On 02/03/22 had 19 CNAs for 222 residents on the day shift, required 28 CNAs. On 02/04/22 had 23 CNAs for 222 residents on the day shift, required 28 CNAs. On 02/05/22 had 22 CNAs for 222 residents on the day shift, required 28 CNAs. On 02/05/22 had 20 total staff for 222 residents on the evening shift, required 23 total staff. On 02/06/22 had 22 CNAs for 221 residents on the day shift, required 28 CNAs. On 02/06/22 had 19 total staff for 221 residents on the evening shift, required 23 total staff. On 02/06/22 had 14 total staff for 221 residents on the overnight shift, required 16 total staff.	S 560	shift; 10:1 on evening shift; and 14:1 on night shift. 4. The Administrator / Designee will audit schedules to ensure direct care staff to resident ratio requirement is met. Audits will be completed weekly x 4 weeks and monthly until compliance is met. The results of these audits will be presented at monthly QAPI. The Administrator is responsible for execution and monitoring of this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 On 02/07/22 had 16 CNAs for 221 residents on the day shift, required 28 CNAs. On 02/07/22 had 20 total staff for 221 residents on the evening shift, required 23 total staff. On 02/08/22 had 25 CNAs for 222 residents on the day shift, required 28 CNAs. On 02/11/22 had 21 CNAs for 217 residents on the day shift, required 28 CNAs. On 02/12/22 had 17 CNAs for 215 residents on the day shift, required 27 CNAs. On 02/12/22 had 10 total staff for 215 residents on the overnight shift, required 16 total staff. 2. For the week of 02/13/2022 through 02/19/2022, the facility was deficient in CNA staffing for residents on 5 of 7-day shifts, deficient in total staff for residents on 2 of 6 evening shifts and deficient in total staff for residents on 3 of 6 overnight shifts as follows: On 02/13/22 had 22 CNAs for 213 residents on the day shift, required 27 CNAs. On 02/13/22 had 19 total staff for 213 residents on the evening shift, required 22 total staff. On 02/13/22 had 15 total staff for 213 residents on the overnight shift, required 16 total staff. On 02/14/22 had 20 CNAs for 211 residents on the day shift, required 27 CNAs. On 02/14/22 had 18 total staff for 211 residents on the evening shift, required 22 total staff. On 02/14/22 had 14 total staff for 211 residents on the overnight shift, required 16 total staff. On 02/17/22 had 22 CNAs for 211 residents on the day shift, required 27 CNAs. On 02/18/22 had 23 CNAs for 220 residents on the day shift, required 28 CNAs. On 02/18/22 had 13 total staff for 220 residents on the overnight shift, required 16 total staff. On 02/19/22 had 22 CNAs for 220 residents on	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 the day shift, required 28 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315174 Y1	A. Building B. Wing Y2	3/23/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 03/15/2022	ID Prefix F0697 Reg. # 483.25(k) LSC	Correction Completed 02/20/2022	ID Prefix F0725 Reg. # 483.35(a)(1)(2) LSC	Correction Completed 03/15/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/19/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060804 Y1	A. Building B. Wing Y2	3/23/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/15/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/19/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO