STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315257	A. BUILDING ______ B. WING ______	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	**1420 SOUTH BLACK HORSE PIKE** **WILLIAMSTOWN, NJ 08094**

(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: NJ115162, NJ122493, NJ124095, NJ127567, NJ128093, NJ128398, NJ128455 CENSUS: 144 SAMPLE SIZE: 10	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ128398, NJ128093 Based on interview and record review, it was determined that the facility failed to investigate an incident of unknown origin for 1 of 2 sampled residents (Resident #6) according to facility policy. This deficient practice was evidenced by:	F 610	Submission of this Plan of Correction does not constitute an admission or agreement by the provider on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of	11/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/05/2019

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 610	Continued From page 1 The surveyor reviewed the medical record of Resident #6 on 9/19/19. The "Admission Record" dated [redacted] indicated Resident #6 was admitted to the facility on [redacted] diagnoses which included, but were not limited to: [redacted]. A Minimum Data Set (MDS), an assessment tool dated [redacted] revealed that Resident #6 had a Brief Interview for Mental Status (BIMS) score of [redacted] that Resident #6's cognition was [redacted] impaired. According to the MDS, Resident #6 required total staff assistance with Activities of Daily Living (ADLs). According to an Interdisciplinary Progress Note (IPN) dated [redacted] at 3:04 PM, the Nurse Practitioner documented Resident #6 was seen and examined at bedside due to an [redacted] on his/her [redacted]. According to an IPN dated [redacted] at 7:57 PM, the Licensed Nurse documented a change in condition was noted. Orders obtained included: [redacted], [redacted] every 12 hours times 7 days. A review of the change in condition evaluation form dated [redacted] indicated a "[redacted] with [redacted] noted on the [redacted]." A review of the Physician Order Sheet (POS), dated [redacted] with an order start date of 8/2/19 indicated, "[redacted] every 12 hours for [redacted] until [redacted] During an interview with the surveyor on 9/19/19	F 610	compliance. F610: Investigate / Prevent / Correct Alleged Violation 1) Resident #6□s event was investigated on 9/22/19, and the care plan was updated to prevent further occurrence. 2) All residents have the potential to be affected. 3) Educational training has been provided to the Nursing Home Administrator and the Director of Nursing on Abuse / Neglect Reporting by the Regional Nurse on 11/7/19. Staff will be educated on abuse / neglect reporting by 11/8/19. 4) Events of unknown origin will be reviewed by the Administrator and Nursing Administration team at the morning clinical meeting. Audits will be conducted for accuracy and timeliness daily for 4 weeks by Director of Nursing and Unit Managers/Supervisors; then monthly for 2 months. Results of the audits will be presented to the QAPI committee by the Director of Nursing Quarterly.	

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at 11:00 AM, Resident #6's [redacted] stated the [redacted] had a [redacted]. The [redacted] member further stated that the resident did not have the [redacted] to the [redacted] the day before.

During an interview with the surveyor on 9/19/19 at 2:33 PM, Licensed Practical Nurse (LPN #1) stated "Do not know how [he/she] got [redacted] to [redacted]." LPN #1 further stated Resident #6 cannot [redacted] him/herself.

During an interview with the surveyor on 9/19/19 at 1:58 PM, Registered Nurse (RN #2) stated [redacted] to the [redacted] require assessment, documentation, and the Medical Doctor (MD) and family must be informed. She further stated that the nurse that found the [redacted] should have done an incident report.

The Acting Director of Nursing (DON) was not able to provide to the surveyor an investigative report related to the origin of the [redacted]. During an interview with the surveyor on 9/20/19 at 10:28 AM, the DON stated that only a change in condition was written in an Interdisciplinary Progress Note (IPN). On 9/20/19 at 3:05 PM, the DON further stated that no investigation or incident report was done but should have been done.

A review of the facility "Accidents/Incidents" policy dated 6/1/96 with a revision date 11/28/16 indicated the following:

2. Assessments. Medical Assistance, Documentation:
2.1.6 The nurse will:
2.1.6.1 Enter the accident/incident into RMS [Risk

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F 610	Continued From page 3 management System] as a new event within 24 hours of the occurrence; 4. Follow-up/Investigation: 4.1 The CED [Center Executive Director], CNE [Center Nurse Executive], or designee will review all accidents/incidents to determine if: 4.1.1 Required documentation has been completed; and 4.1.2 Interventions to prevent further accidents/incidents have been identified and implemented. 4.2 The CED or designee will coordinate all investigations. 4.3 Investigations will be documented using the appropriate RMS investigation/QA form. 4.4 When conducting an investigation, the CED, CNE or designee will: 4.4.1 Make every effort to ascertain the cause of the accident/incident; 4.4.2 Initiate actions to prevent further accidents/incidents; 4.4.3 Use the RMS Witness Interview Form to conduct witness interviews from all staff and visitors who may have knowledge of the accident/incident; 4.4.4 Monitor that all aspects of the accident/incident and investigation involving patients are documented in RMS; 4.4.5 Investigation of employee accident/incident will be documented on the Supervisor Report of Employee Incident; 4.4.7 Complete the investigation within five working days. 4.4.8 Root cause analysis will be completed within 30 days of the occurrence. A review of the facility policy "Abuse Prohibition" dated 6/1/96 and revised on 7/1/19 indicated the following:	F 610		

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Injuries of unknown origin are defined as an injury with both of the following conditions:
The source of the injury was not observed by any person or the source of the injury could not be explained by the patient...

Process
1. The Center Executive Director, or designee, is responsible for operationalizing policies and procedures that prohibit abuse, neglect...injuries of unknown source...

7.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on:
whether abuse or neglect occurred and to what extent;
clinical examination for signs of injuries, if indicated;
causative factors; and
interventions to prevent further injury.
The investigation will be thoroughly documented within RMS. [Risk Management System]. Ensure that documentation of witnessed interviews is included.
Conduct interviews using the Alleged Perpetrator/Victim Interview record and Witness Interview Record.
Enter summary of the interviews into RMS.
Failure to report in the required time frames may result in disciplinary action, up to and including termination.
The CEO or designee will: Take all necessary corrective action depending on the results of the investigation.
Determine what preventive measures will be implemented by staff.

There was no evidence that this policy was

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F 610	Continued From page 5 followed. NJAC 8:39-27.1 (a)	F 610		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Complaint #: NJ128093, NJ128398 Based on observation, interview and review of medical records and other pertinent facility documentation, it was determined that the facility staff failed to monitor an [redacted] to assure the [redacted] was administered in accordance with Physician	F 693	Submission of this Plan of Correction does not constitute an admission or agreement by the provider on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of	11/8/19

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F 693	Continued From page 6 orders for 2 of 2 sampled residents (Resident #6, Resident #10). In addition, the facility staff failed to follow their [redacted] Administration by Pump Policy. This deficient practice was evidenced by the following: Definition: www.healthline.com/health/[redacted]: A [redacted] is a machine device used to provide [redacted] 1. The surveyor reviewed the medical record of Resident #6 on 9/19/19. The "Admission Record" dated [redacted], indicated that Resident #6 was admitted to the facility on [redacted] with diagnoses which included, but were not limited to: [redacted] Gastrostomy. A Minimum Data Set (MDS), an assessment tool dated [redacted] revealed that Resident #6 had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating [redacted] impaired cognition. According to the MDS, Resident #6 required total staff assistance with all Activities of Daily Living (ADLs). A "Physician's Order Sheet" (POS) dated [redacted] included an order initiated [redacted] for NPO [redacted] diet. [redacted] per hour] until [redacted]. Start date [redacted] Order every night shift [redacted] until tota[redacted] 9/10/19." During a tour of the unit on 9/19/19 at 11:00 AM,	F 693	compliance. F693: Tube Feeding Management / Restore Eating Skills 1) Resident #6's Physician was notified of the [redacted] administration discrepancy. Orders were obtained and implemented for Resident #6. Resident #10's [redacted] discarded, appropriately labeled and replaced at the time of the survey. Resident #6 and Resident#10's Responsible party was contacted on the noted changes. 2) All [redacted] residents have the potential to be affected. 3) Licensed nursing staff were in-serviced on the usage of the [redacted] administration beginning on 9/20/19 with completion by 11/8/19. Licensed nursing staff will have competency testing on the [redacted] and [redacted] administration beginning on 9/21/19 and be completed by 11/8/19. 4) [redacted] administration [redacted] audits will be completed by the Director of Nursing or Nursing Supervisor daily for 2 weeks; then weekly for 4 weeks. Results of the audits will be presented to the QAPI committee by the Director of Nursing quarterly.	

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F 693	Continued From page 7 the surveyor observed Resident #6 in a Geri-chair in an upright position. An [redacted] was in progress [redacted] which indicated the [redacted] of [redacted] The surveyor noted the label on the bottle indicated a start date of [redacted] at 6 PM. The surveyor observed the [redacted] had [redacted] in the bottle. The surveyor interviewed the assigned 7-3 shift Licensed Practical Nurse (LPN #1) on 9/19/19 at 11:20 AM. LPN #1 stated [redacted] bottle was started at 6 PM at [redacted] on [redacted]. LPN #1 stated the night nurse had a problem with the [redacted] LPN #1 also stated that [redacted] was the first day that Resident #6's [redacted] "was off." The nurse confirmed that she did not notice there was a problem on the morning of [redacted] The nurse further confirmed that [redacted] was administered to the resident from 6:00 PM on [redacted] through 11:00 AM on [redacted] for 11 hours. LPN #1 stated Resident #6 should have had at least received [redacted] During an interview with the surveyor on 9/19/19 at 11:26 AM., the Unit Manager (UM) called the 11-7 shift nurse (LPN #2) in the presence of the surveyor. According to the UM, LPN #2 indicated she had noticed an error on the [redacted] on [redacted] between 11 PM to 12 AM. LPN #2 indicated she [redacted] the [redacted] and that it was ok. The [redacted] continued to malfunction a couple of times, therefore LPN #2 obtained a new [redacted]. The UM indicated that when she spoke with a night supervisor, she was informed that no one requested a new [redacted] on [redacted]. The UM stated sometimes when you switch a [redacted] it will go back to [redacted] infused.	F 693		

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F 693	Continued From page 8 A written statement dated 9/20/19 signed by LPN #2, indicated the following: At approximately 1:00 AM on 9/19/19, LPN #2 heard the [redacted] beeping. She entered Resident #6's room and put the [redacted] on hold. She flushed the [redacted] and set the [redacted] back on run. Ten minutes later, the [redacted] started to beep again. LPN #2 noted "error flow" and once again put the [redacted] on [redacted]d the [redacted], then set it back on run. The [redacted] continued to beep. LPN #2 went back to the room, turned off the [redacted] and restarted the [redacted]. When the [redacted] started to beep again, LPN #2 decided to change the [redacted] During an interview with Registered Nurse (RN #2) on 9/19/19 at 1:58 PM, RN #2 stated that if an [redacted] is beeping, the [redacted] is primed and set to run. If the [redacted] continues to beep, the [redacted] should be replaced with a new one. RN #2 stated when she comes in, she checks how much [redacted] was administered to the resident. She further stated the [redacted] continues until completed. "If I notice the [redacted] not going as ordered, I report to the dietitian, call the MD and notify the UM. Also, the family." The facility provided a "Medication Error Investigation/QA" form dated [redacted] at 11 AM, which revealed the following: "[redacted] infused way behind schedule by approximately [redacted] [redacted] check. MD notified and got an order to give... [redacted] continuously till [redacted]9 at 4 PM and resume previous order." In the "Reason for medication error... Machine malfunction. Failure to replace machine as soon as error discovered." In the	F 693		

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F 693	Continued From page 9	F 693		

Effect On Resident section, "No effect on Patient."

2. The surveyor reviewed the medical record of Resident #10 on 9/20/19. The "Admission Record" dated [redacted] indicated that Resident #10 was admitted to the facility on [redacted] with diagnoses which included, but were not limited to: [redacted].

The MDS dated [redacted] revealed that Resident #10's cognition was [redacted] impaired. According to the MDS, Resident #10 required total staff assistance with all ADLs.

A review of the POS, dated [redacted] contained an order with a start date of [redacted], "Enteral Feed Order every shift [redacted]. Administer continuous via [redacted] until total nutrient [redacted] delivered."

On 9/20/19 the surveyor observed Resident #10 in bed with the [redacted] connected to the resident's [redacted]. The surveyor observed the [redacted] did not have resident's name, room number, date, start time and flow rate.

During an interview with the surveyor on 9/20/19 at 12:55 PM, RN #2 stated the 11-7 shift nurse hung the bottle of [redacted]. She confirmed the bottle did not have anything written on it. "I always check [redacted] to check for resident's name, room number, time hung and the ml per hour but today I did not get a chance to do that." RN #2 stated she labeled the bottle with the

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F 693	Continued From page 10 required information after this surveyor called attention to the missing information. RN #2 stated, "I filled out the information after you saw it. I could not fill in what time she hung it, because I don't know that." During an interview with the Acting Director of Nursing (DON) on 9/20/19 at 10:28 AM, the DON stated the [redacted] bottle should have been labeled. The DON further stated, "The nurse this morning should have checked the bottle to make sure it was properly labeled." Review of the facility policy [redacted]: Administration by [redacted]" dated 6/1/96 and revised dated of 10/1/18, indicated the following: Evaluate [redacted] for [redacted], or [redacted] If [redacted] is damaged, notify physician/advanced practice provider (APP) for replacement. Set up o[redacted]. Open ready to hang container and administration set. Fill in the information on the container's label (patient's name, room number, date, start time and [redacted] Se[redacted] instructions or adjust the [redacted] using the [redacted]. Assure [redacted] alarm is turned on, properly functioning and audible to staff. Evaluate fo[redacted] tolerance to[redacted] every four hours for [redacted], complaints of [redacted] ... If administering [redacted], flush [redacted] with 30 ml water every four hours or per order. Closed ready to hang system:	F 693		

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F 693	Continued From page 11 Each container of [redacted] may hang no longer than 48 hours. Change administration set with each new container of [redacted]. Enteral orders not administered and reason. Notification of physician/APP, if indicated; Any adverse reaction and interventions taken. NJAC 8:39-27.1(a)	F 693		