| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 061326 | A. BUILDING: _____ B. WING _____ | 03/10/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MERIDIAN NURSING & REHABILITATION AT SHREWS | 89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| S 000 | Initial Comments<br><br>The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43 E, enforcement of licensure regulations. | S 000 | | |
| S 560 | 8:39-5.1(a) Mandatory Access to Care<br><br>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 7 of 14 day shifts and Certified Nursing Assistants (CNAs) to total staff on 2 of 14 evening shifts.<br><br>Findings include:<br><br>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 at N.J.S.A. 30:13-18 (the Act), which established | S 560 | We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions:<br>-Based on the RCA the team identified the cause of the deficient practice to be failure to staff the facility to appropriate ratios based on NJ guidelines due to an global acute shortage of staff, specifically certified nursing assistants.<br><br>How we will identify other residents having the potential to be affected by the same deficient practice:<br>-All residents have the potential to be affected. | 4/10/22 |

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

Electronically Signed — 03/25/22

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| S 560 | Continued From page 1<br>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.<br>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and<br>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.<br><br>As per the "Nursing Staffing Report" completed by the facility for the weeks of 2/13/22 and 2/20/22, the staffing to residents' ratios that did not meet the minimum requirement of CNA to residents and CAN to total staff as documented below:<br><br>The facility was deficient in CNA staffing for residents on 7 of 14 day shifts and deficient in CNAs to total staff on 2 of 14 evening shifts as follows:<br><br>- 02/13/22 had 10 CNAs for 96 residents on the day shift, required 12 CNAs.<br>- 02/14/22 had 11 CNAs for 96 residents on the day shift, required 12 CNAs.<br>- 02/17/22 had 11 CNAs for 95 residents on the day shift, required 12 CNAs.<br>- 02/18/22 had 11 CNAs for 95 residents on the day shift, required 12 CNAs.<br>- 02/20/22 had 11 CNAs for 99 residents on the day shift, required 13 CNAs.<br>- 02/21/22 had 12 CNAs for 98 residents on the day shift, required 13 CNAs.<br>- 02/26/22 had 11 CNAs for 95 residents on the | S 560 | Measures put in place or systemic changes made to ensure that the deficient practice will not recur:<br>-Hackensack Meridian Health implementation of referral bonus program and sign on bonus program to increase applicant pool and increase retention.<br>-CNA classes to convert Provisional Nursing Aides to CNAs and thus increase staff.<br>-Re-engineered hiring process to expedite on-boarding process.<br>-Blast emails and blast text messages to help drive applicants.<br>-Continued relationships with local CNA/Nursing schools to help build the applicant pool.<br>-Hackensack Meridian Health job fairs at Community College.<br>-Offering critical shift pay to current staff, including nurses working as CNAs to work additional hours while we look to fill vacancies through internal job postings, job fairs, and external job postings.<br>-Contract with agency company as needs arise.<br><br>How the corrective actions will be monitored to ensure the deficient practice will not recur:<br>-Staffing Coordinator or designee will complete an audit of staffing and ratio requirements daily for one month, then weekly for 2 months and then monthly for 12 months. Audit will be given to the Director of Nursing.<br>-We will use additional agency, hospitality aides and assign nurses to direct patient | |

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| S 560 | Continued From page 2<br>day shift, required 12 CNAs.<br>- 02/14/22 had 8 CNAs to 21 total staff on the evening shift, required 11 CNAs.<br>- 02/18/22 had 9 CNAs to 20 total staff on the evening shift, required 10 CNAs.<br><br>During an interview with the surveyor on 3/3/22 at 9:50 AM, the Staffing Coordinator (SC) who said she is responsible for the schedule but does not have any responsibility to hire CNA's. SC said she was aware of the minimum staffing requirements; days 1-8 patients, evening is 1-10, night is 1-12. She went on to say, "Yes we meet the minimum requirements for CNA's." SC said they use Temporary Nurse Aides/Provisional Nurse Aides as well as agency.<br><br>During an interview with the surveyor on 3/3/22 at 10:42 AM, the Director of Nursing (DON) and Administrator who said that yes, they were aware of requirements 1-8 day, 1-10 evening, 1- 14 nights of direct care giver. The DON said I believe we are regularly meeting the requirements. She further said I can say we may not have been able to cover callouts.<br>A review of an undated facility policy titled Staffing did not include information regarding the state mandated minimum direct care staff (CNA) to resident ratio. | S 560 | care as needed.<br>-The Director of Nursing will report all findings to the QAPI Committee Quarterly. | |

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| F 000 | INITIAL COMMENTS<br><br>Survey Date:<br><br>Census: 94<br><br>Sample: 19 + 2 closed records<br><br>A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. | F 000 | | |
| F 641 SS=B | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to ensure that an accurate Minimum Data Set (MDS), an assessment tool, was completed. This deficient practice was identified for 1 of 21 sampled residents reviewed, (Resident [redacted]).<br><br>This deficient practice was evidenced by the following:<br><br>According to the admission record, Resident [redacted] was admitted to the facility with diagnoses, including but not limited to; [redacted] | F 641 | We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions:<br>-Resident [redacted] MDS ARD [redacted] Quarterly assessment modified in section [redacted] to code [redacted]. Resident has a [redacted] that is used for hydration only.<br>-Education was provided to the MDS Coordinator and Registered Dietician at the time of notification of error. Educated by MDS Supervisor.<br><br>How we will identify other residents having the potential to be affected by the same deficient practice:<br>-All residents that have a [redacted] have | 4/10/22 |

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| F 641 | Continued From page 1<br>[redacted]).<br><br>A review of the care plan for Resident [redacted] revealed that he/she is at risk fo [redacted] and received [redacted] (milliliter) [redacted] twice a day with an effective date of [redacted]. The interventions included, but were not limited to; Check [redacted] before each [redacted] monitor [redacted] status, maintain [redacted], report signs/symptoms of [redacted].<br><br>A review of the MDS dated [redacted], for Resident [redacted], revealed under section [redacted] that [redacted] was not checked to indicate that the resident had a [redacted] also known as [redacted]). The MDS also revealed that section [redacted] nor [redacted]. were checked to indicate the amount of [redacted] Resident #[redacted] received from the [redacted].<br><br>During an interview with the surveyor on 3/7/2021 at 12:50 PM, the assigned Registered Dietitian (RD) stated that she is familiar with Resident [redacted]. The RD reported that she had completed Section [redacted] of the MDS dated [redacted]. The RD acknowledged that Resident [redacted] had a [redacted] and received [redacted] twice a day. The RD confirmed that the MDS was not completed correctly.<br><br>NJAC 8.39-11. | F 641 | the potential to be affected.<br><br>Measures put in place or systemic changes made to ensure that the deficient practice will not recur:<br>-Education was provided to all MDS Coordinators regarding proper coding of MDS and use of RAI Manual for clarification when needed.<br>-MDS Supervisor will re-educate all MDS Coordinators and Registered Dieticians regarding proper and accurate coding of [redacted] on MDS.<br>-Shared protected document updated and monitored weekly between MDS Coordinators and Registered Dieticians of all residents currently with [redacted] being used for [redacted] and/or [redacted] in facility.<br>-Quality review of MDS quarterly assessments of current residents with [redacted] by MDS Supervisor prior to submission, to ensure the MDS is accurately coded in [redacted], noted within the specified ARD to include modifications and re-submissions as indicated as based on findings.<br><br>How the corrective actions will be monitored to ensure the deficient practice will not recur:<br>-MDS Coordinators and Registered Dieticians will conduct weekly audits on residents in the facility with [redacted], regardless of [redacted] and/or [redacted] status. Auditing will be conducted weekly for three months, then monthly and PRN. | |

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| F 641 | Continued From page 2 | F 641 | MDS and Dietary will collaborate and ensure accurate coding on MDS assessments.<br>-MDS Supervisor to conduct quality monitoring of MDS assessments prior to submitting to ensure accuracy of Section [redacted] to reflect the residents current [redacted] status and services provided for resident, within the specified ARD times.<br>-Results discussed with DON and reported to Monthly QAPI, with quality monitoring schedule modified based on findings. | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to a.) implement infection control measures for the handling and storage or [redacted] equipment and b.) have a physician order for the use of [redacted] for [redacted] of [redacted] residents reviewed for [redacted] care, (Resident [redacted]). This deficient practice was evidenced by the following:<br><br>During the initial tour of the [redacted] floor on 2/28/22 at | F 695 | We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions:<br>-Replaced [redacted] not stored properly for resident [redacted] and ensured it was stored appropriately.<br>-Received order for [redacted] from the attending physician.<br>-Provided one on one education with nursing staff involved to ensure [redacted] | 4/10/22 |

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| F 695 | Continued From page 3<br>10:44 AM, Resident [redacted] was observed with a [redacted] in his/her [redacted] connected to wall [redacted] at [redacted]. The [redacted] had a piece of white tape dated [redacted]. Resident [redacted] said he/she does wear [redacted] sometimes.<br><br>On 3/3/22 at 10:14 AM, Resident [redacted] was observed lying in bed without the [redacted]. The [redacted] was observed to be draped over a back scratcher on the bedside table, uncovered and exposed.<br><br>On 3/3/22 at 10:15 AM, the surveyor along with the Registered Nurse Unit Manager (RNUM #1) went to Resident [redacted]'s room. RNUM #1 said no, the [redacted] is not supposed to be hanging (over back scratcher exposed to air). It is supposed to be in bag. I will get a new one.<br><br>A review of the Resident Face Sheet revealed Resident [redacted] was admitted to the facility with diagnoses including but not limited to: [redacted].<br><br>A review of the most recent Minimum Data Set (MDS), an assessment tool dated [redacted], revealed Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating Resident [redacted] was cognitively intact. The MDS further showed under section [redacted] that Resident [redacted] used [redacted] while a resident.<br><br>A review of the current Physician's Orders did not include a physician order for [redacted] use.<br><br>A review of a Progress Note (PN) dated [redacted] at | F 695 | tubing is stored according to policy.<br><br>How we will identify other residents having the potential to be affected by the same deficient practice:<br>-All residents using [redacted] have the potential to be affected.<br><br>Measures put in place or systemic changes made to ensure that the deficient practice will not recur:<br>-All nursing staff was inserviced to review appropriate storage of [redacted].<br>-Audit of all current residents using [redacted] to ensure appropriate storage and orders in place.<br>-The Director of Nursing will implement an audit tool for tracking of [redacted] orders and appropriate storage.<br>-Storage bags will be provided upon admission for all patients.<br><br>How the corrective actions will be monitored to ensure the deficient practice will not recur:<br>-Unit manager/supervisor will audit daily, those patients/residents with the need for [redacted] to ensure orders are in place and storage is appropriate. This will occur for one month reported to DON or designee.<br>-The Director of Nursing or designee will monitor the completion of audit tools weekly for one month; will monitor two times per month for three months using audit tool; and will monitor monthly thereafter using audit tool.<br>-The Director of Nursing will report findings | |

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| F 695 | Continued From page 4<br>1:36 PM, revealed "as needed [redacted] in use [redacted]."<br>A PN dated [redacted] timed at 1:20 PM, indicated [redacted] in place.<br>A PN dated [redacted] timed at 11:02 AM, revealed resident was placed on [redacted]). Resident Currently on [redacted]<br>A PN dated [redacted] timed at 11:19 AM, revealed [redacted] ([redacted]) noted to be [redacted].<br><br>A review of a care plan revealed a Focus area of [redacted] Use with an effective date of [redacted] Interventions included "Provide [redacted] as ordered by MD (Medical Doctor).<br><br>On 3/3/22 at 10:19 AM, RNUM #1 reviewed Resident [redacted]s Physician Orders and said he/she should have a PRN (as needed) order. She went on to say there was one, but I don't see an order. She went on to say there definitely should have been a physician order. I don't know why it was discontinued on [redacted]<br><br>During an interview with the surveyor on 3/3/22 at 10:47 AM, the Director of Nursing (DON) said Resident [redacted] uses [redacted] intermittently and will ask staff to take it off and put it back on.<br>The DON said when the [redacted] is taken off, we should have the [redacted] in a bag. She said it was nursing discretion to put [redacted] on and absolutely should be contacting a physician to obtain order.<br><br>A review of a facility policy titled (facility name) [redacted] Therapy, Precautions, and Adverse Reactions with a last revised date of 9/2021, | F 695 | to the QAPI Committee quarterly. | |

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| F 695 | Continued From page 5<br>revealed under the Procedure section [redacted]. Obtain a physician's order for [redacted] and [redacted] of administration.<br><br>NJAC 8:39-27.1(a) | F 695 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. | F 756 | | 4/10/22 |

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| F 756 | Continued From page 6<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review and review of other facility documentation, it was determined that the facility failed to address the recommendation identified by the Consultant Pharmacist. This deficient practice was identified for 1 of 5 Residents reviewed for unnecessary medications, psychotropic medications, and medication regimen review (Resident #37) and was evidenced by the following:<br><br>According to the Resident Face Sheet Resident [redacted] was admitted to the facility with diagnoses that included [redacted] and [redacted]<br><br>A review of the "Physician Order Activity Detail Report" with active orders as of [redacted] revealed a physician's order dated [redacted], for the resident to receive [redacted] milligrams capsule [redacted] times per day with meals for [redacted]. There was another physician's order dated [redacted], for the resident to receive [redacted] micrograms once daily for [redacted].<br><br>A review of the Consultant Pharmacist (CP) Evaluation dated [redacted], indicated "separate | F 756 | We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions:<br>-Reassessed and reviewed resident [redacted] pharmacy consultant recommendations for any additional concerns.<br>-The attending physician for Resident [redacted] was contacted to review recommendations and orders; no new orders were received, provider<br>preferred to maintain the current schedule and not accept recommendations. New labs were ordered by MD.<br>-Contacted consultant pharmacist regarding lack of follow up for recommendation.<br><br>How we will identify other residents having the potential to be affected by the same deficient practice:<br>-All patients with medication recommendations from pharmacy consultants have the potential to be affected.<br><br>Measures put in place or systemic changes made to ensure that the deficient | |

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| F 756 | Continued From page 7<br>[redacted] and [redacted] by 4 hours." Upon review of the [redacted] and [redacted] Medication Administration Record (MAR) for Resident [redacted], the [redacted] was scheduled to be administered at 6:30 am and the [redacted] was scheduled to be administered at 8:00 am, 12:00 pm, and 5:00 pm. The first [redacted] dose is scheduled to be given 1.5 hours after the [redacted] not 4 hours as recommended by the CP.<br><br>On 03/04/22 at 10:21 AM, the surveyor and the Registered Nurse Unit Manager (RNUM #2) reviewed the MAR for Resident # [redacted]. He stated that the [redacted] and [redacted] was not separated by 4 hours as recommended.<br><br>During an interview with the surveyor on 03/04/22 at 12:42 PM, the Director of Nursing (DON) stated that the Assistant Director of Nursing (ADON) spoke with the physician, and the physician did not want to follow the recommendation of the CP. She further stated that the ADON forgot to write a note saying same.<br><br>During an interview with the surveyor on 03/07/22 at 10:56 AM, the corporate nurse confirmed that there is no documentation that the pharmacy recommendation was acknowledged.<br><br>During an interview with the surveyor on 03/08/22 at 11:20 AM, the ADON acknowledged that there is no documentation that the physician accepted or denied the pharmacy consultant recommendations.<br><br>A review of the Consultant Pharmacist Services | F 756 | practice will not recur:<br>-Discussed with pharmacy consultant to ensure that on the spot review with unit manager or designee occurs for all recommendations related to timing of medication administration.<br>-Unit manager or designee will review all monthly consultant pharmacy recommendations to ensure all recommendations have been addressed and appropriate documentation is in place.<br><br>How the corrective actions will be monitored to ensure the deficient practice will not recur:<br>-The Director of Nursing or designee will review consultant pharmacy monthly reports each month ongoing to ensure all recommendations have been addressed.<br>-The Director of Nursing will report findings to the QAPI committee Quarterly. | |

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| F 756 | Continued From page 8<br>policy with an effective date of 4/2021, the Consultant Pharmacist will provide specific activities related to medication regimen review including: 1. A documented review of the medication regimen based on applicable federal and state guidelines.<br><br>NJAC 8:39 - 27.1(a) | F 756 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive | F 758 | | 4/10/22 |

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| F 758 | Continued From page 9<br>psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to ensure that as-needed (PRN) [redacted] medications were administered for no more than 14 days without further evaluation with corresponding documentation. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medication use (Resident [redacted]) and was evidenced by the following:<br><br>On 2/28/2022 at 10:46 AM the surveyor observed Resident [redacted] lying in bed. Resident [redacted] was complaining of [redacted]. The certified nursing assistant alerted the assigned nurse in the presence of the surveyor of Resident [redacted] complaint. Resident [redacted] stated to the surveyor | F 758 | We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions:<br>-Reassessed resident [redacted] and continued need for [redacted] medication.<br>-Discussed with the attending physician and confirmed continued use for PRN Ativan, order continued.<br>-Physician documented rationale in resident [redacted] medical records.<br><br>How we will identify other residents having the potential to be affected by the same deficient practice:<br>-All residents with PRN [redacted] | |

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| F 758 | Continued From page 10<br>that he/she had a [redacted] on their [redacted] that started prior to admission to facility and has been going on for weeks.<br><br>According to the Resident Face Sheet, Resident #[redacted] was admitted to the facility after hospitalization for [redacted].<br><br>A review of the Admission Minimum Data Set (MDS), an assessment tool, revealed that Resident [redacted] had a Brief Interview for Mental Status score of 1[redacted] indicating the resident was [redacted]. In addition, according to section [redacted] of the MDS, Resident [redacted] had a current diagnosis of [redacted] and section [redacted] revealed Resident [redacted] had received [redacted] medications on 3 out of 7 days during the look back period.<br><br>According to Resident [redacted]'s Care Plan Activity Report, Resident [redacted] had a care plan under the heading Focus: [redacted] STATE: [redacted] Medications, Effective: [redacted]. The [redacted] STATE care plan revealed that Resident [redacted] was on [redacted] medication and "target symptoms of [redacted] will be managed with the use of minimal dose of the [redacted] medication."<br><br>During a review of Resident [redacted]s Physician Order Activity Detail Report revealed the following order dated [redacted] mg (milligram) give[redacted] tablet [redacted] mg) by oral route every [redacted] hours for 14 days as needed. | F 758 | medications have the potential to be affected.<br><br>Measures put in place or systemic changes made to ensure that the deficient practice will not recur:<br>-All licensed nursing staff will be educated on the need for documentation by the physicians if PRN [redacted] medications are recommended to be continued past the initial 14 days and convey this information to the attending physician.<br>-Facility leadership will review with all providers the requirement of documenting his/her rationale for continuing PRN [redacted].<br>-The Director of Nursing will implement an audit tool to review all PRN [redacted] medications for required documentation.<br>-The Director of Nursing or designee will review all consultant pharmacy recommendations to physicians in regards to PRN [redacted] medications.<br><br>How the corrective actions will be monitored to ensure the deficient practice will not recur:<br>-The Director of Nursing or designee will monitor the completeness of pharmacy consultants recommendations for all PRN [redacted] medications to physicians for 3 months using the audit tool.<br>-The Director of Nursing will report findings to the QAPI Committee quarterly. | |

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On 03/02/22 12:03 PM the surveyor reviewed the [redacted] Consultant Pharmacist (CP) physician recommendations sheet for Resident [redacted]. The following recommendation was documented as follows:

1. "In the geriatric population, [redacted] increases the risk of [redacted]. If continuing present therapy, please document the risk vs. benefit." There was no evidence that the physician accepted or did not accept the recommendation, as neither box was checked off and no comment or reason for not accepting the recommendation was documented. A physician signature was observed; however, it was undated.

On 3/2/2022 at 1:43 PM, the surveyor requested documentation of the physician's rationale for the [redacted] CP recommendation for [redacted] from facility staff.

During an interview with the surveyor on 3/3/2022 at 10:39 AM, the Director of Nursing (DON) stated "I found additional documentation in the chart for Resident [redacted]. The nurse practitioner documented on [redacted] that resident [redacted] can be very [redacted] at times and the nurse practitioner recommended continue [redacted] prn on [redacted]. So that would be the rationale for the use of the [redacted]" The surveyor asked the DON what the ordering physician responsibility would be for continued use of PRN [redacted] medications beyond 14 days. The DON replied, "We (the facility) are responsible for documenting the behaviors during the 14 days. After the 14 days are up, we speak with the physician, and he/she

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| F 758 | Continued From page 12 | F 758 | | |

will decide whether to continue the prn order." The surveyor again questioned what responsibility the ordering physician would have to continue the use of a prn [redacted] medication beyond the initial 14-day period. The DON was unable to provide any further information.

A review of the Medication Administration Records (MAR) for Resident [redacted] dated [redacted], revealed that Resident [redacted] had the following order and received prn [redacted] on the following dates:

[redacted] mg tablet give [redacted] tablet ([redacted] mg) by oral route every [redacted] hours for 14 days as needed [redacted] Start Date: [redacted] (admission). Resident [redacted] was administered prn [redacted] on the following dates: 1/8, 1/9, 1/12, 1/13, 1/14, 1/15, 1/16, 1/17, and 1/18/2022.

Review of the [redacted] MAR revealed that Resident [redacted] had the following orders and received prn [redacted] on the following dates:

[redacted] mg tablet give [redacted] tablet [redacted] mg) by oral route every [redacted] hours for 14 days as needed for [redacted]. Start Date: [redacted]. Resident [redacted] received prn [redacted] on the following dates: 2/5, 2/6, 2/7, 2/8, 2/9, 2/15, 2/16, 2/17, and 2/18/2022.

[redacted] mg tablet give [redacted] tablet ([redacted] mg) by oral route every [redacted] hours for 14 days as needed. Start Date: [redacted]. Resident [redacted] received prn [redacted] on the following dates: 2/19, 2/10, 2/21, 2/23, 2/24, 2/26, 2/27, 2/28, and 3/1/2022.

A review of a Nurse Practitioner (NP) Progress

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Note, dated [redacted] timed at 8:44 PM for Resident [redacted] revealed under the objective section that Resident [redacted] "can be [redacted] at times," per RN (registered nurse.) Under the assessment/plan section concerning [redacted] the NP wrote, "cont (continue) [redacted]) PRN." Resident [redacted] had additional orders for prn [redacted] on the following dates: [redacted] and [redacted] without a documented rationale.

On 3/7/2022 at 10:55 AM the surveyor conducted an interview in the presence of the facility DON, Administrator and Assistant Director of Nursing (ADON). The surveyor questioned if the facility had a policy and procedure on the process of responding to the CP monthly medication regimen review. The facility responded, "We do not have a policy and procedure for how we respond to the CP monthly recommendations. I can tell you what we do. If it is clinically significant the CP lets us know right away and we follow up. The list of recommendations the CP sends to the facility after their monthly review is provided to staff and we give our staff a week to complete the recommendations. The DON or designee (ADON) is responsible for ensuring that all CP recommendations have been addressed at the end of the month. We do not have a policy or procedure for our end of the process."

On 3/9/2022 at 9:43 AM the surveyor conducted an additional interview in the presence of the facility Administrator, DON, Corporate Vice President of Nursing (CVPN), and Assistant Administrator. The CVPN provided the following, "It was documented on admission that the resident was [redacted]." The surveyor questioned the CVPN

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whether Resident [redacted] would have required a documented physician rationale for the additional 14-day PRN orders for [redacted] on [redacted] and [redacted]. The CVPN responded, "Yes." The surveyor then questioned the CVPN if the facility was able to find any documented physician rationale for the continued use of prn [redacted] for the ordered dates of [redacted] and [redacted] The CVPN/facility was unable to provide documented written rationales for prn [redacted] ordered for Resident [redacted] on [redacted] and [redacted].

A review of a facility policy titled Unnecessary Drugs - [redacted] Last Revised: 11/2017, reveled under the Purpose heading:

"Ensure that each resident's entire drug/medication is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being."

In addition, the following was revealed under the Policy heading:

4. "PRN orders for psychotropic drugs are limited to 14 days. Except as provided in part 5, if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order."

5. "PRN orders for [redacted] drugs are limited to 14 days and cannot be renewed unless the

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| F 758 | Continued From page 15<br>attending physicians or prescribing practitioner evaluates the resident for the appropriateness of that medication."<br><br>N.J.A.C. 8:39-27.1(a) | F 758 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous food and maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following:<br><br>1 On 2/28/2002 at 12:01 PM the surveyor observed the Dietary Supervisor (DS) monitor food | F 812 | We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions:<br>-Temperatures in the [redacted] Room did not meet the minimum temperature required.<br>-The steam table in the [redacted] Room was not turned on at 10:00am, which is our | 4/10/22 |

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| F 812 | Continued From page 16<br>temperatures prior to the lunch meal in the main dining room. The DS performed hand hygiene with alcohol-based hand rub and then donned a clean pair of disposable gloves. The DS then removed a digital thermometer from a sealed plastic package. The DS sanitized the thermometer probe with an alcohol pad and then proceeded to insert the thermometer probe into the pan of [redacted] Vegetables on the steam table. The DS obtained a final temperature of 111.3 degrees Fahrenheit (F). The DS removed the thermometer and proceeded to clean the thermometer probe with an alcohol pad. The surveyor questioned the DS whether the temperature of the [redacted] Vegetables was safe to serve to the residents in the dining room for the lunch meal. The DS replied, "Yes." The DS then inserted the thermometer probe into the meatballs and marinara sauce. The DS obtained a final temperature of 95.0 F. The surveyor questioned the DS if the temperature was appropriate to serve the meatballs and marinara sauce. The DS responded, "Yes." The DS sanitized the thermometer probe and proceeded to take the temperature of the spaghetti noodles. A final temperature of 95.0 F was obtained, and when questioned if the temperature was safe to serve the DS responded, "Ahh, yes. Spaghetti doesn't hold temperature for long." The DS then proceeded to clean the thermometer probe with an alcohol pad and inserted the thermometer probe into the chicken and corn soup. A final temperature of 146.0 F was obtained. The surveyor asked the DS if the soup was at a proper temperature to serve and the DS responded, "Yes." After cleaning the thermometer probe the DS proceeded to take the temperature of the chicken noodle soup. A final temperature reading | F 812 | normal protocol.<br>-Evaluated the timing between food preparation and placement into the steam table and determined the length of time was longer than it can be.<br>-Provided one on one education with the dietary staff involved to ensure processes identified and policy are followed accordingly.<br><br>How we will identify other residents having the potential to be affected by the same deficient practice:<br>-All residents that eat in the [redacted] Room have the potential to be affected.<br><br>Measures put in place or systemic changes made to ensure that the deficient practice will not recur:<br>-All Dietary staff will be educated on our policy Hackensack Meridian Nursing & Rehab Serving Food, which includes checking food temperatures.<br>-All Dietary staff will be educated on corrective actions to follow when temperatures are not within range.<br>-All Dietary staff will be educated on the new process of food prep, transport and placement to ensure length of time is decreased and temperature of food items remain within acceptable range.<br>-All Dietary staff will be educated on the importance of turning the steam table on in the Main Dining Room at 10am to ensure appropriate time needed to heat up.<br><br>How the corrective actions will be | |

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| F 812 | Continued From page 17<br>of 127.1 F was obtained. When questioned whether the final temperature of the soup was safe to serve the DS replied, "Yes, it is ok to serve."<br><br>On 2/28/2022 at 12:10 PM the surveyor observed the DS preparing to plate and serve the above referenced food to the residents in attendance in the main dining room. The surveyor proceeded to question the DS what the minimum hot holding temperature was for the hot foods on the buffet line. The DS replied, "The minimum hot holding temperature is 140 F and above. The soup is ok, I'm going to take the food back to the kitchen and get hotter food." The DS further replied that the kitchen was replacing the food that was below the minimum hot holding temperature and would bring the residents' new food. The surveyor questioned the DS what the process was for reheating foods that don't meet the minimum hot holding temperature. The DS stated, "All foods must be 140 F." The surveyor further questioned what time the lunch menu items had been prepared and how long the foods had been held prior to the lunch meal. The DS responded, "I'm not sure I just came in to work."<br><br>The Director of Food Service (DOFS) entered the main dining room on 2/28/2022 at 12:18 PM. The DOFS replaced the following foods on the steam table from the kitchen and proceeded to take temperatures of the following foods:<br><br>1. Spaghetti: The DOFS obtained a final temperature of 106.5 F. The DOFS stated, "It should be at least 140 F. I will reheat."<br>2. Meatballs: 155 F | F 812 | monitored to ensure the deficient practice will not recur:<br>-The Director of Food Services or designee will do temperature tests of all food on the steam table in the Main Dining Room prior to service daily for two weeks.<br>-The Director of Food Services or designee will then perform temperature tests of all food on the steam table in the Main Dining Room four times per week for the next two months.<br>-The Director of Food Services or designee will create a satisfaction survey and receive feedback weekly for one quarter from patients who frequently dine in the Main Dining Room.<br>-The Director of Food Services will report all findings to the QAPI Committee Quarterly | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315136 | A. BUILDING _____ B. WING _____ | 03/10/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERIDIAN NURSING & REHABILITATION AT SHREWSBURY | 89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702 |

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|---|---|---|---|---|
| F 812 | Continued From page 18<br>3. Key Largo Vegetables: 162 F<br><br>At 12:24 PM on 2/28/2022 the surveyor questioned the DOFS what the process was for reheating hot foods that were under 135 F. The DOFS responded, "The food needs to be reheated to a minimum of 165 F for 15 seconds before we can serve the food. The DS should not have served those foods because they were below the minimum hot holding temperature of 135 F." The DOFS further stated, "She is a supervisor, and she should know that."<br><br>A review of a facility policy titled Serving Food, Last Revised: 08/2013, revealed Under the heading Purpose section "To ensure that all foods are served in a sanitary manner to prevent food-born illnesses. To ensure that all foods are presented properly. To ensure the quality of all food." In addition, the following was revealed under the Procedure heading: Step 3. "Prior to services all food temperatures will be taken and documented in the Food Temperature Log. Hot foods must be 140 F or above. Cold foods must be 41 F or below. If foods are not in range corrective actions must be taken. All corrective actions must be documented."<br><br>N.J.A.C. 8:39-17.2(g) | F 812 | | |