STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315309	A. BUILDING _____ B. WING _____	C 12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	**23 SCHOOLHOUSE ROAD WHITING, NJ 08759**

(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 NJ# 149252 Survey Date: 12/6/21 Census: 133 Sample: 28+3+1 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 658 SS=D	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: Based on observation, interview, and record review it was determined that the facility failed to follow physician's orders and administer medication based on pain scale level parameters for the prescribed medication [redacted] (a medication to treat [redacted]) in accordance with professional standards of practice. The deficient practice was identified for 1 of 4 residents (Resident [redacted]) reviewed for [redacted] management. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical	F 658	Plan of Correction The Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws F658 Root Cause: Upon review of the F658 tag the facility noted the root cause of this	2/25/22

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

Electronically Signed 12/25/2021

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F 658	Continued From page 1 nurse is defined as performing tasks and responsibilities with in 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 licensed or otherwise legally authorized physician or dentist." This deficient practice was evidenced by the following: On 11/23/21 at 11:16 AM, the surveyor observed Resident [redacted] who was sitting up in bed with the head of the bed elevated and blanket pulled up to their chest. The resident stated that they had [redacted] in their [redacted] for the last few years. The resident continued that the [redacted] could be [redacted] and that [redacted] helped to ease the [redacted] On 11/30/21 at 12:10 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident was [redacted]. The LPN stated that the resident complained about [redacted] and was on pain management with [redacted] The surveyor reviewed the medical record for Resident [redacted]. A review of the Admission Record reflected that the resident was admitted to the facility in [redacted], with diagnoses which included [redacted]. A review of the active Order Summary Report reflected a physician's order for [redacted]	F 658	issue to be because the facilities lack of education and competencies on the following of doctors orders as written, as a result of multiple vacancies within the nursing leadership team, particularly in relation to staff education. (Resident number 115). I. Element 1: The residents chart was reviewed for current order for [redacted] mg every [redacted] hours for [redacted] scale [redacted] and as needed for [redacted] mg every [redacted] hours for [redacted] scale [redacted]. There were no orders for as needed [redacted] medication for [redacted] scales [redacted] The orders were reviewed with the MD and changed to reflect [redacted] mg every [redacted] hours as needed for [redacted]. A [redacted] management consult was also ordered. The resident reported that this is the only medication that manages resident [redacted] pain. Resident [redacted] no longer resident in the facility. II. Element 2: a. All residents receiving as needed pain medications could have the potential to be affected. All residents with as needed [redacted] medications orders are in the process of being reviewed. III. Element 3: a. The facility is conducting an ongoing in-servicing to the professional nursing staff on following doctor s orders. b. The facility has put in place a new Educator, and 2 new Unit Manager on the clinical team. c. The pharmacy consultant was contacted and the facility and consultant	

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F 658	Continued From page 2 tablet [redacted] (mg): give [redacted] tablet by mouth every [redacted] hours as needed for [redacted]. A review of the corresponding electronic Medication Administration Record (eMAR) for November [redacted], reflected that the resident was administered [redacted] out of the prescribed parameters [redacted] on the following dates and time: [redacted]: 11/12/21 at 8:07 PM [redacted]: 11/1/21 at 2:01 AM; 11/12/21 at 5:30 PM; 11/27/21 at 11:51 PM [redacted]: 11/5/21 at 5:54 AM; 11/8/21 at 1:17 AM; 11/18/21 at 2:28 AM; 11/20/21 at 5:11 AM; 11/21/21 at 8:59 AM; 11/28/21 at 5:48 AM; 11/29/21 at 6:03 AM [redacted]: 11/4/21 at 11:40 PM; 11/10/21 at 5:54 PM; 11/11/21 at 3:05 AM; 11/14/21 at 6:17 AM; 11/15/21 at 12:01 AM; 11/15/21 at 5:59 AM; 11/25/21 at 5:56 AM; 11/29/21 at 12:07 AM On 11/30/21 at 12:22 PM, the surveyor reviewed the resident's November 2021 eMAR with the LPN. The LPN confirmed the above dates and acknowledged that the resident should not have received [redacted] if the [redacted] level [redacted] On 12/1/21 at 10:16 AM, the acting Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Clinical Consultant and survey team, acknowledged that the [redacted] should not have been administered on the dates because the resident's reported a [redacted] A review of the facility's undated "Administering Medications" policy included that medications shall be administered in a safe and timely	F 658	agreed to revise the policy for Medication Administration to reflect proper sequencing, of as needed [redacted] medication when more than one medication is ordered for [redacted] management. The revision also includes numerical values defining the levels of [redacted] from [redacted] to [redacted]. IV. Element 4: a. The nursing supervisor will be responsible for reviewing all new admissions with as needed pain medications upon admission. The unit managers will also be responsible for conducting audits on all new admissions and any new orders for as needed pain medications within 72 hours of the ordered date. Weekly audits will be conducted by the Unit Manager or designee to monitor for compliance. These audits will be reported to the DON monthly times three months and will be reviewed in the QAPI monthly meetings. Based on the findings at this time it will be determined if further audits or actions are warranted.	

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F 658	Continued From page 3 manner, and as prescribed. The policy also included that medications must be administered in accordance with the orders, including any time frame. NJAC 8:39-11.2(b)	F 658		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		2/25/22

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F 690	Continued From page 4 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to consistently document catheter urinary output according to the physician orders. This deficient practice was identified for 1 of 1 resident reviewed for [redacted] (Resident [redacted]) and was evidenced as follows: On 11/23/21 at 10:15 AM, the surveyor observed Resident [redacted] lying in bed. The resident stated he/she had a [redacted] (used to empty the [redacted]) and that staff would empty it, but he/she would also have to remind the staff to empty his/her [redacted] when necessary. The surveyor reviewed the medical record for Resident [redacted]. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in [redacted], with diagnoses which included: [redacted] and [redacted]. A review of the most recent annual Minimum Data Set (MDS), an assessment tool, dated [redacted], reflected that the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated the resident had a [redacted]	F 690	Plan of Correction The Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F690 Root Cause: Upon review of the F690 tag the facility noted the root cause of this issue to be because the facilities lack of education and competencies on proper documentation of resident [redacted] as a result of multiple vacancies within the nursing leadership team, particularly in relation to staff education (Resident number [redacted]) I. Element 1. a. The residents chart was reviewed to reveal dates on non-compliance with Doctors orders for documentation of urinary output. b. An ongoing in-service was initiated among the professional nursing staff regarding following Doctors orders in monitoring [redacted]. II. Element 2.	

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F 690	Continued From page 5 A review of the resident's individualized care plan created [redacted], included that Resident [redacted] was alert with some forgetfulness, able to make needs known, and had an [redacted]) related to [redacted] and has a history of [redacted]. The intervention included: monitor and document intake and output as per facility policy. A review of the [redacted] Treatment Administration Record (TAR) reflected there was a physician's order (PO) start date on [redacted] for monitor [redacted] every shift for [redacted] care related to [redacted]. A review of the TARs from 5/1/21 to 11/29/21 revealed the [redacted] was blank for the following days and shifts: May 2021: [redacted] day shift [redacted] day and evening shifts [redacted] night shift [redacted] day shift [redacted] day shift [redacted] day shift [redacted] day and night shifts [redacted] night shift June 2021: [redacted] day shift [redacted] day shift [redacted] day shift [redacted] day shift [redacted] evening and night shifts [redacted] night shift [redacted] evening shift	F 690	a. All residents with [redacted] had the potential to be affected. All residents with [redacted] are being re assessed. III. Element 3. a. The ADON is in the process of reviewing / conducting competencies on all professional nursing staff on documentation of [redacted] on residents with [redacted] b. The facility has put in place a new Clinical Educator, and 2 new Unit Manager on the clinical team. IV. Element 4. a. Weekly audits will be conducted by each unit manager on each resident with [redacted]. The audit will be monitoring for compliance with Doctors orders. These audits will be done for a period of three months. The audits will be reviewed by the DON / designee. The findings will be presented to the QAPI monthly meetings by the DON. Based on the conclusion, the team will determine if further actions are recommended. V. Element 5: Completion Date: 02/25/2022	

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F 690	Continued From page 6	F 690		

[redacted] day shift
evening shift

July 2021:
[redacted] day and evening shifts
day shift
day shift
evening shift
day shift
evening shift
day shift
day shift
day shift
day and night shifts
day shift
day shift

August 2021:
[redacted] day shift
evening shift
evening shift
day shift
day shift
day, evening, and night shifts
day and night shifts
day shift
night shift
evening shift
day shift
day shift
day shift

September 2021:
[redacted] day shift
day shift
day shift
night shift
day shift
day shift

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F 690	Continued From page 7 October 2021: [redacted] day shift [redacted] day shift November 2021: [redacted] night shift [redacted] day shift [redacted] evening shift On 11/29/21 at 10:08 AM, the surveyor interviewed Nursing Aide (NA #1). NA #1 stated that she has worked at the facility for almost two years. She stated that she did not have Resident [redacted], but she could explain the process for monitoring and documenting [redacted] NA #1 stated that after she emptied the [redacted], she documented the [redacted] in the electronic medical record (EMR) which was done every shift. She further stated that she would inform the nurse of the [redacted] amount. At this time, NA #1 showed the surveyor how she would document the amount in the EMR. On 11/29/21 at 10:12 AM, the surveyor interviewed NA #2 who stated that when she provided care for Resident [redacted], she drained the [redacted] and documented the amount of [redacted] in the EMR during her shift and informed the nurse as well. On 11/29/21 at 10:26 AM, the Licensed Practical Nurse (LPN #1) stated that the nursing aides informed the nurses of the [redacted] amount from the [redacted] and then the nurses documented the [redacted] in the TAR every shift. LPN #1 stated that if the [redacted] was not documented in the TAR, the amount could possibly be documented in a Progress Note. The LPN acknowledge at this time that the information should be documented in the TAR since it was a PO.	F 690		

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F 690	Continued From page 8	F 690		

A review of the Progress Notes from [redacted] to [redacted], included no documentation for the [redacted] for Resident [redacted] for those dates and times that were left blank in the TAR.

On 11/29/21 at 10:30 AM, the Director of Nursing (DON) stated that the nursing staff were responsible for emptying the [redacted] every shift. She further stated the nurses were responsible for documenting it in the EMR.

On 11/30/21 at 9:07 AM, the DON stated that the aides also documented the [redacted] in the EMR, but she was unable to provide documentation for those dates which were left blank in the TAR. The DON acknowledged Resident [redacted] should have been documented in the TAR and that there was a lack of documentation throughout the TAR.

On 12/1/21 at 10:16 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Clinical Consultant/Registered Nurse and the survey team acknowledged the importance of documentation. LNHA confirmed that "if it is not documented, it's like it did not happen." At this time, the facility was unable to provide any further information regarding the missing [redacted] in the TAR for Resident [redacted].

A review of an in-service provided by the DON dated 11/29/21 included, the Certified Nursing Aides (CNAs) must report output to the primary nurse and the nurses should document foley output as per the medical doctor (MD) order.

A review of an undated facility policy for '[redacted]

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F 690	Continued From page 9 care, [redacted]" provided by the DON included that ....."monitor resident's daily [redacted] each shift ...empty the [redacted] at least every eight (8) hours ...." NJAC 8:39-27.1(b)(f)	F 690		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755		2/25/22

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F 755	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure a.) an accurate ordering, receiving and administration of narcotic medications that required Federal narcotic acquisition forms (DEA 222 form) were completed with sufficient detail to enable accurate reconciliation; b.) accurately document the administration of controlled medications; c.) ensure Narcotic Shift Count logs were completed in accordance with facility policy; and d.) maintain a system of record keeping that ensures an accurate inventory of controlled medications. This deficient practice was identified for 5 of 7 DEA 222 forms reviewed and 3 of 4 medication carts reviewed. The evidenced was as follows: On 12/1/21 at 11:59 AM, the surveyor reviewed the facility provided DEA 222 forms which revealed the facility did not complete Part 5 of the form (number received and date received), as instructed to on the reverse of the DEA 222 form. The inaccuracies were identified on the following order forms: #210697903, #210697905, #210697909, #210697910, #210697913. On 12/1/21 at 12:15 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Regional Clinical Nurse Consultant/Registered Nurse (RCC/RN). At that time, the DON acknowledged that Part 5 of the forms should have been completed when the facility received the medications and the quantities of the medications they received.	F 755	Plan of Correction The Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F755. 1. DEA 222 FORMS I. Element 1. a. Upon review of the DEA 222 forms mentioned, this deficient practice was identified with the past DON at the facility. II. Element 2 a. No resident was impacted by the deficient practice. III. Element 3 a. All DEA 222 forms will be reviewed by the DON / ADON or designee upon receipt of the narcotics from the pharmacy. The packing slips will be attached to the correct DEA 222 forms and section 5 will be correctly filled out / reconciled. IV. Element 4 a. An audit will also be conducted by the DON for accuracy monthly times three months. All findings will be presented to the monthly QAPI meeting for further discussion and or further actions. 2. NARCOTIC RECONILIATION SHEET I. Element 1. a. Both nurse 1 and nurse 2 were	

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F 755	Continued From page 11 A review of the instructions for submission of the DEA 222 form located on the reverse side of the form included "Part 5. Controlled Substance Receipt 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item ..." A review of the facility's "Controlled Substance Administration" policy dated revision date of 11/2021 did not include the ordering of Controlled Substances or instructions for completing a DEA 222 form. 2. On 11/30/21 at 12:54 PM, the surveyor in the presence of another surveyor and Licensed Practical Nurse (LPN #1) inspected the [redacted] cart. A reconciliation review of the narcotics located in the secured and locked narcotic box to the declining inventory sheet revealed that Resident [redacted] milligram (mg) ([redacted]; a medication used for [redacted]) declining inventory sheet revealed that there should be [redacted] tablets remaining. A review of the corresponding blister pack contained [redacted] tablets. LPN #1 stated that she had administered two tablets this morning but had forgotten to sign them out. She further stated that she was supposed to sign out the medications immediately after administering the medication. LPN #1 stated she and LPN #2 shared the cart today as their assignment. On 11/30/21 at 1:01 PM, LPN #2 joined the surveyors and LPN #1 and further reviewed [redacted] cart. A review of Resident [redacted] mg (a medication used for [redacted] declining inventory	F 755	approached regarding not signing declining sheets at the time that they popped the medications from the bingo card. Nurse 1 reported that she is aware that she should have signed the narcotic out after popping the medication but she had forgotten. An education was provided to nurse A. Nurse 2 stated said the same when questioned, she was also provided with an education. II. Element 2. a. No resident was impacted on the deficient practice. III. Element 3. a. An evaluation for competencies was conducted on nurse number one and nurse number two by the ADON. It was found that both nurses needed additional education in medication administration and correct procedure on reconciliation of narcotics. IV. Element 4. a. The ADON has initiated an ongoing in-service to all the professional nursing staff on medication administration and reconciliation of controlled substances. Audits for compliance will be conducted monthly times three by the ADON / designee. The findings will be reported to the DON whom will review and present it to the QAPI monthly meetings. If further actions are deemed necessary the team will decide on the next steps.	

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	315309	A. BUILDING _____ B. WING _____	C 12/06/2021

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F 755	Continued From page 12	F 755		

sheet revealed that there should be [redacted] tablets remaining in the blister pack. A review of the corresponding blister pack contained [redacted] tablets. LPN #2 acknowledged the discrepancy and stated that she believed she had until the end of her shift to sign for narcotics she had administered.

On 11/30/21 at 1:10 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the nurse should be signing the declining inventory sheet and the electronic medication administration record (eMAR) after the medication was administered. The ADON further stated the nurse had until the end of the shift to document controlled medication administration, but ideally the declining inventory sheet should be signed when the mediation was administered. She was unsure of what the facility policy stated. She also stated that the declining inventory and the eMAR were the same, except that the declining inventory sheet kept track of the remaining inventory and the eMAR was for the real time medication administration recording.

On 12/1/21 at 9:10 AM, the surveyor attempted to interview the facility's consultant pharmacist (CP) via telephone. The surveyor left message on CP's voicemail but did not receive a return phone call.

On 12/1/21 at 10:29 AM, the DON stated the nurses should have signed the declining inventory sheet immediately after pouring/popping the mediation.

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3. On 11/29/21 at 08:54 AM, the surveyor in the presence of LPN #3 reviewed the [redacted] Side medication (med) cart's "Med Cart Narcotic Log" and the November 2021 "Narcotic Bingo Card Log" which revealed the following:

Narcotic Bingo Card Log 11/1/21 3 PM - 11 PM shift "Signature" column was blank.

Med Cart Narcotic Log "Sign of Manager Receiving Narcotic" column was blank for the following dates and narcotics received:

5/31/21 [redacted]
9/10/21 [redacted]
9/10/21 [redacted]
9/11/21 [redacted]
9/11/21 [redacted]
9/17/21 [redacted]
10/30/21 [redacted]
11/8/21 [redacted]
11/11/21 [redacted]
11/11/21 [redacted]
11/11/21 [redacted]
11/12/21 [redacted]
11/12/21 [redacted]
11/20/21 [redacted]
11/20/21 [redacted]
11/20/21 [redacted]
11/22/21 [redacted]
11/24/21 [redacted]
11/27/21 [redacted]

At this time, the surveyor interviewed LPN #3 who stated that both the incoming and outgoing nurses on the shift performed a narcotic count together; then completed and signed the Narcotic Shift Count together in their designated area to verify the count. LPN #3 also stated that the "Med

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Cart Narcotic Log" was to be completed and signed when a narcotic was received and placed in the cart.

On 11/29/21 at 9:30 AM, the surveyor in the presence of LPN #4 reviewed the [redacted] Side medication cart's "Med Cart Narcotic Log" and the November 2021 "Narcotic Bingo Card Log" which revealed the following:

Narcotic Bingo Card Log 11/1/21 7 AM - 3 PM and 3 PM - 11 PM shifts "End of Shift total" column was not completed.

Med Cart Narcotic Log "Sign of Manager Receiving Narcotic" column was blank for the date and narcotic received on 11/20/21 for [redacted]

At this time, the surveyor interviewed LPN #4 who confirmed that both the incoming and outgoing nurses on the shift performed a narcotic count together; then completed and signed the Narcotic Shift Count together in their designated area to verify the count. LPN #4 also confirmed that the "Med Cart Narcotic Log" was to be completed and signed when a narcotic is received and placed in the cart.

On 11/30/21 at 1:42 PM, the surveyor in the presence of the LNHA, DON, and the survey team informed the facility about these concerns.

A review of the facility's "Storage of Controlled Substance" policy dated revision 8/2020 included that nursing staff must count controlled medications at each shift change and controlled substance inventory is regularly reconciled and documented on a control count sheet.

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F 755	Continued From page 15 A review of the facility's "Medication Diversion vs. Medication Discrepancy" policy dated 6/15/2020, included that the nurse coming on duty and the nurse going off duty must make the count together and documented. They must document and report any discrepancies to the Director of Nursing Services. NJAC 8:39-29.7(c)	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 761	Plan of Correction	2/25/22

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F 761	Continued From page 16 review it was determined the facility failed to ensure that all drugs and biologicals used in the facility were stored in accordance with professional standards and manufacturer's instructions. This deficient practice was identified for [redacted] medication carts and [redacted] mediation rooms inspected and was evidenced by the following: 1. On 11/29/21 at 8:41 AM, the surveyor in the presence of the Registered Nurse/ Infection Preventionist (RN/IP) observed Nursing [redacted] medication storage room. The medication refrigerator in the storage room contained one open multidose vial of [redacted] medication). The medication box was dated [redacted], the medication vial was not dated when it was opened. At this time, the surveyor interviewed the RN/IP who stated that this medication was "good for 30 days" and the "vial should be dated" once opened, and then proceeded to remove the medication from storage for disposal. On 11/29/21 at 8:54 AM, the surveyor in the presence of Licensed Practical Nurse (LPN #1) observed Nursing [redacted] medication cart. The surveyor observed the following opened and undated medications: 1. One open multidose bottle of facility stock [redacted] medication 2. One resident specific multidose [redacted] (a medication used to treat [redacted] At this time, the surveyor interviewed LPN #1 who	F 761	The Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Root Cause: Upon review of the F761 tag the facility noted the root cause of this issue to be because the facilities lack of education and competencies on the storage and labeling of all medication as a result of multiple vacancies within the nursing leadership team, particularly in relation to staff education. F761 I. Corrective Action A. On 12/7/2021 The Facility Administrator, Director of Nursing, Pharmacy Consultant and Medical Director met to review and update the facility policy for the storage and labeling of medications within the facility to reflect a change of labeling of the container and the medication itself to ensure the facility is in compliance with Federal regulation F761. B. On 12/7/2021 The Assistant Director of Nursing initiated in-services and educations for all clinical staff regarding the facilities updated policy for the storage and labeling of medications. C. On 12/7/2021 the Facility Director of Nursing/ Designee completed a whole house audit on all cart to ensure all medication are properly stored and	

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F 761	Continued From page 17 stated, "I usually date them when I open them." At this time, the RN/IP joined the LPN and surveyor. LPN #1 informed the RN/IP to dispose of the two undated medications and re-order. On 11/29/21 at 9:30 AM, the surveyor in the presence of LPN #2 observed Nursing [redacted] medication cart. The surveyor observed the following opened and undated medications: 1. One open bottle of [redacted] milligram (mg) facility stock 2. Two resident specific [redacted] 3. One resident specific [redacted] 4. Seven resident specific multidose [redacted] At this time, the surveyor interviewed LPN #2 who stated that she usually dated the [redacted] because some residents received the same medication and it helped to not "confuse the [redacted] or "mix them up." On 12/1/21 at 9:10 AM, the surveyor attempted to interview the facility's consultant pharmacist (CP) via telephone. The surveyor left a message to return the call, however no return call was received by the surveyor. On 12/1/21 at 10:14 AM, the surveyor in the presence of the survey team interviewed the Regional Clinical Consultant/Registered Nurse (RCC/RN) who stated that the facility revised their policy yesterday to date the medication container as well as the packaging box.	F 761	labeled with a date on both the medications container and the medication itself; All undated medications as per facility revised policy were destroyed and new orders placed. II. Identification of Others A. An assessment of the risk that this deficient practice could have had on facility residents at this facility was completed by the Director of Nursing. It was found that no residents were impacted. III. Systemic Change A. The Director of Nursing, Administrator , Medical Director, and Pharmacy Consultant met to review and update the facility protocol for ensuring all the proper storage and labeling of medications within the facility to reflect a change to label of both the medications container and the medication itself. B. The Facility Unit Manager/ Designee for each unit will complete a biweekly/ every 2 weeks for the next 3 months cart audit on all carts assigned to their unit to ensure all medications are properly stored and labeled with a date on the medication carton and on the medication itself and report findings to the Director of Nursing. IV. Quality Assurance A. The Director of Nursing will submit findings from the biweekly/ every 2 weeks cart audit report for the next 3 months to the QA/QAPI committee. Based on the findings at this time it will be determined if further audits or actions are warranted.	

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A review of the facility's "Medications Storage " policy dated revision date 9/2021, included that when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated, and the nurse shall place a "date opened" sticker on the container or vial.

2. On 11/30/21 at 12:28 PM, the surveyor in the presence of another surveyor and LPN #3 inspected the [redacted] medication cart. The surveyor found the following medications open and undated:

1. Resident specific oral respiratory inhaler [redacted] micrograms (mcg) with manufacturer instructions to discard 6 weeks after opening box and foil holder.

2. Resident specific [redacted] with manufacturer instructions to discard 6 weeks after opening.

3. Resident specific [redacted]

4. Resident specific [redacted] box with foil packet open and undated with 14 vials inside, with manufacturer instructions to store in original foil pouch, to protect from light. Discard any unused containers 15 days after first opening the pouch.

5. Resident specific [redacted] vial with manufacturer instructions to discard open vial after 28 days

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F 761	Continued From page 19 6. Resident specific [redacted] with manufacturer instructions to discard open pen after 28 days. At that time, LPN #3 stated that the [redacted] should be dated when opened and that the facility did not have a policy that indicated that we had to date the bottle if we dated the bag it was stored in. On 11/30/21 at 1:10 PM the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the facility policy was to date both the vial and the box. She stated that [redacted] and [redacted] both should be dated. She further stated you would want to date both in case the bottle became separated from the box/packaging, you would have to throw it all away and it would be a waste. N.J.A.C. 8:39-29.4	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		2/25/22

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F 812	Continued From page 20 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation it was determined the facility failed to maintain the ice machine chute to prevent microbial growth and food borne illness. This deficient practice was identified in the main kitchen and was evidenced by the following: On 11/22/21 at 09:55 AM, the surveyor toured the kitchen in the presence of the Food Service Director (FSD). The surveyor asked to see the cleaning log for the ice machine and who was responsible to clean and maintain the ice machine. The FSD replied that he cleaned it, and maintenance sometimes cleaned. The surveyor reviewed the cleaning log which indicated that the last date the ice machine was cleaned was 8/16/21. Prior to 8/16/21, the log was signed as cleaned monthly from January 2021 to August 2021. The FSD informed the surveyor that he had cleaned it in September and October but "just never signed the log." At this time, the surveyor asked the FSD to wipe the inside of the ice machine chute where the ice drops from. The FSD took a white paper towel and wiped the inside of the ice machine chute. The white paper towel now contained a black substance. The FSD informed the surveyor that he would need to clean the ice machine chute right away. On 12/01/21 at 09:52 AM, the surveyor reviewed the undated "Ice Machines and Ice Storage Chests" policy which included under the section	F 812	The Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Root Cause: Upon review of the F812 tag the facility noted the root cause of this issue to be because the facilities Maintenance Director failed to take apart the Ice Machine at the time of each quarterly cleaning. Furthermore, it was identified that the facility policy and procedure at the time of the Annual Survey was unclear on how often cleaning of the machine should occur. F812 I. Corrective Action A. On 12/7/2021 The Food Service Director coordinated with Maintenance Director to pull apart the facility ice machine located in the facility kitchen to fully inspect and clean all parts of the ice machine located in the facility Kitchen. B. On 12/7/2021 The Facility Administrator and Food Service Director met to review and update the facility policy for use of the ice machine to reflect and inspection scheduled of twice monthly and	

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F 812	Continued From page 21 Policy Interpretation and Implementation, the following: Ice making machines, ice storage chests/containers, and ice can all become contaminated by the following, 1.) unsanitary manipulation by employees, residents, and visitors; 2.) waterborne microorganisms naturally occurring in the water source; 3.) colonization by microorganisms; and 4.) improper storage of handling of ice. On 12/01/21 at 10:16 AM, the Licensed Nursing Home Administrator (LNHA) informed the surveyor in the presence of facility administration and the survey team, that "the ice machine log that was brought to you was the wrong log, because it's done quarterly by the maintenance department." The facility could not provide a policy for cleaning the ice machine by the maintenance department. The Regional Clinical Consultant/Registered Nurse (RCC/RN) stated that the facility only had a preventative policy. On 12/01/21 at 10:25 AM, the surveyor asked the facility administration about the monthly log provided to the surveyor by the FSD titled "Machine Cleaning log"; it was hanging on the side of the ice machine on the day of the observation. The LNHA responded, "that's something the FSD did on his own". At the same time, the RCC/RN was asked by surveyor if a blackish substance should be in the ice chute and the RCC/RN responded "no". On 12/01/21 at 10:50 AM, the surveyor interviewed the Maintenance Director regarding the cleaning ice machines. The Maintenance Director stated that his department cleaned the machine quarterly, but the FSD cleaned the ice machine every month and kept his own log.	F 812	a cleaning schedule of once monthly. II. Identification of Others A. An assessment of the risk this deficient practice could have on residents at this facility was completed by the Administrator, Food Service Director and Maintenance Director, and it was found that no residents were impacted by this deficient practice. III. Systemic Change A. The Facility Administrator and Food Service Director met to review and update the facility policy for use of the ice machine to reflect and inspection scheduled of twice monthly and a cleaning schedule of once monthly. B. The Food Service Director/ Designee and Maintenance Director/Designee will inspect and clean the Kitchen Ice Machine bi-weekly and maintain a monthly log to be submitted to the Administrator each month for the next 3 months. IV. Quality Assurance A. The Administrator will submit findings from the monthly ice machine inspection and sanitation to the QA/QAPI committee if further actions are deemed necessary the team will address. A. The QA/QAPI committee will meet monthly for the next 3-months an review all findings to assess whether further action is necessary. V. Completion Date: 02/25/2021	

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F 812	Continued From page 22 On 12/1/21 at 11:30 AM, the Maintenance Director provided the surveyor with the ice machine manufacturer's book which indicated that the ice machine had to be sanitized every six months. He explained that meant taking it apart and running a chemical through it. The surveyor asked if the chute was only cleaned every six months and the Maintenance Director replied, "No, the FSD cleans that monthly". NJAC 8:39-19.7	F 812		
F 924 SS=E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that corridors were equipped with firmly secured handrails on each side. The deficient practice was identified on 1 of 3 nursing units [redacted] and evidenced by the following: On 12/6/21 beginning at 8:25 AM, the surveyor in the presence of the facility's Maintenance Director (MD) toured the [redacted] nursing unit ([redacted] Unit). During the tour, the surveyor observed three (3) areas in the corridors that had no hand rails for residents to utilize in the following locations: 1. At 9:01 AM, the surveyor observed next to Resident room [redacted] a six (6) feet long section of corridor wall with no handrail and across by stairwell [redacted] was a three (3) feet long section of wall with no handrail. At this time, the MD informed the surveyor that there used to be an	F 924	Plan of Correction The Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Root Cause: Upon review of the F924 tag the facility noted the root cause of this issue to be because the facility failed to regularly monitor and audit all corridors to ensure they have firmly secured handrails F924 II. Corrective Action A. On 12/14/2021 The Maintenance Director coordinated with an outside	2/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315309	A. BUILDING _____ B. WING _____	C 12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

(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 924	Continued From page 23 imitation kitchen area with cabinets on the wall for the [redacted] residents, but the facility removed it. 2. At 9:15 AM, the survey observed next to Resident room [redacted] a twelve feet-six inch (12'-6") long section of corridor wall with no handrail and across by stairwell [redacted] was a three (3) feet long section of wall with no handrail. The MD confirmed this observation. 3. At 9:23 AM, the surveyor observed next to Resident room [redacted] a twelve feet six- inch (12'-6") long section of corridor wall with no handrail and across by stairwell [redacted] was a three (3) feet long section of wall with no handrail. The MD confirmed this observation. On 12/6/21 at 1:25 PM, the Licensed Nursing Home Administrator was notified of the finding at the Life Safety Code exit conference. NJAC 8:39-31.2(e)	F 924	contractor to complete a cost analysis of affected corridor area. B. ON 12/12/2021 The Maintenance Director coordinated with an outside contractor and complete the installation of a firmly secured handrail on the [redacted] floor of the facility. III. Identification of Others A. An assessment of the risk of this deficient practice could have on residents at this facility was completed by the administrator and maintenance manager, and it was found that no residents were impacted by this deficient practice. IV. Systemic Change A. The Facility Administrator and Maintenance Director met to review and update the facility protocol for ensuring all corridors are equipped with firmly secured handrails on each side and initiated a monthly audit of all corridors to ensure all are equipped with firmly secured handrails. B. The Maintenance Director will inspect all corridors with handrails once weekly an repair immediately any broken handrails and maintain a monthly log to be submitted to the Administrator monthly V. Quality Assurance A. The Administrator will submit findings from the monthly corridor inspection and repairs to the QA/QAPI committee Based on the findings at this time it will be determined if further audits or actions are warranted. B. The QA/QAPI committee will meet monthly for the next 3-months an review all findings to assess whether further action is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061523	A. BUILDING: _____ B. WING _____	C 12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 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 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
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: Based on interview 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 out of 42 shifts reviewed. 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	S 560	Plan of Correction The Plan of Correction is the facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Root Cause: Upon review of the S560 tag the facility noted the root cause of this	12/25/21

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

Electronically Signed | 12/25/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061523	A. BUILDING: _____ B. WING _____	C 12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at 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 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 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. On 11/24/21 at 11:38 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA), informed the surveyor that the facility was "good" with staffing and experiencing no staff shortages. The DON also stated that the facility used contracted agency staff and non-certified nursing aides as needed. As per the "Nurse Staffing Report" completed by the facility for the weeks of 11/7/21 to 11/13/21 and 11/14/21 to 11/20/21, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift; 1 direct care staff member to every 14 residents during the overnight shift as documented below: 11/07/21 had 3 CNAs for 125 residents on the day shift, required 16 CNAs. 11/08/21 had 14 CNAs for 124 residents on the	S 560	issue to be because of a nation shortage in the industry. S560 I. Corrective Action A. The Facility cannot retroactively respond to this deficient practice. II. Identification of Others A. An assessment of the risk this deficient practice could have on residents at this facility was completed by the administrator, Director of Nursing, and Staffing Coordinator, HR Manager and it was found that no residents were impacted by this deficient practice. III. Systemic Change A. The Facility Director of Nursing , Administrator , HR Manager initiated the following employee recruitment programs for the clinical department : i. Rates increased ii. Sign on with new agencies iii. Offer agency staff bonuses iv. Offer our staff bonuses v. New retention and recruitment plan vi. Job Fair vii. Posting new ads around town and via social media viii. Staff Testimonial videos for recruitment ix. Referral bonuses for our staff x. Referral bonuses relationship with local C N A school to provide additional staffing support. xi. Sign on bonus xii. Utilizing temporary nursing assistants B. The DON/designee will report findings to the administrator IV. Quality Assurance .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061523	A. BUILDING: _____ B. WING _____	C 12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

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S 560	Continued From page 2 day shift, required 16 CNAs. 11/09/21 had 8 total staff for 124 residents on the overnight shift, required 9 total staff. 11/10/21 had 14 CNAs for 124 residents on the day shift, required 16 CNAs. 11/11/21 had 15 CNAs for 124 residents on the day shift, required 16 CNAs. 11/13/21 had 15 CNAs for 124 residents on the day shift, required 16 CNAs. 11/14/21 had 13 CNAs for 127 residents on the day shift, required 16 CNAs. NJAC 8:39-5.1(a)	S 560	A. The DON/designee will aggregate findings from these rounds monthly and review the findings with the administrator quarterly on an ongoing basis. B. The DON/designee will provide a report of his/her findings to the QA committee for action as appropriate. C. The QA/QAPI committee will meet monthly for the next 3-months an review all findings to assess whether further action is necessary	