STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING _____ B. WING _____	C 07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT#: NJ 153290 CENSUS: 120 SAMPLE SIZE: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities based on this complaint survey	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		8/17/22

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

Electronically Signed | 08/03/2022

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: C#: NJ153290 Based on interviews, medical record reviews, and review of other pertinent facility documents on 7/8/2022, it was determined that the facility failed to notify the resident's Physician of medications that were not administered and failed to follow its policy titled "Physician/Family Notification" This deficient practice was identified for 1 of 3 residents reviewed (Resident [redacted] and was evidenced by the following: A review of the Electronic Medical Record (EMR)	F 580	1. Resident [redacted] has been discharged and is no longer in the facility. 2. All residents who have medications ordered by a physician have the potential to be affected by the deficient practice. The Unit Managers and Nursing Supervisors reviewed the current Medication Administration Records (MAR) of facility's active residents to determine whether any other residents were affected by the same deficient practice.	

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F 580	Continued From page 2 was as follows: According to the "Admission Record (AR)," Resident [redacted] was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident [redacted] had a Brief Interview of Mental Status (BIMS) score of [redacted], indicating the resident was [redacted]. The MDS also showed the resident needed minimal assistance with Activities of Daily Living (ADLs). Review of the Order Recap Report (ORR) for Resident [redacted] dated [redacted] through [redacted] included the following "Physician's Order (PO's)": [redacted] (Milliliter) [redacted] ML [redacted] four times a day related to [redacted] dated [redacted]. [redacted] MG/ [redacted] ML. [redacted] ML [redacted] two times a day related to [redacted] dated [redacted]. [redacted]) MCG (Microgram). 1 [redacted] orally every 6 hours related to [redacted] dated [redacted] Separate each [redacted] for [redacted] to allow maximum absorption. Review of the Medication Administration Record (MAR) for Resident [redacted] dated [redacted] confirmed	F 580	3. All nurses were in-serviced on the facility's policy regarding "Physician/Family Notification." Emphasis was made on ensuring that the nurse notifies the resident's Physician of medications that were not administered as prescribed. 4. The Assistant Director of Nursing or Designee will conduct medical record audits of of 5 residents per month x 4 months to ensure that the resident's physician was notified if medications were not administered to resident as ordered. Any issues will be corrected immediately. Findings will be reported to the Director of Nursing monthly and will be presented in quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plan.	

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F 580	Continued From page 3 the above PO's were not administered, as evidenced by the following: [redacted] ML[redacted] ML[redacted] r four times a day related to [redacted]; on 1[redacted] at 9:00 p.m., the MAR was initialed by the Licensed Practical Nurse (LPN) and coded 9. (9= sleeping). [redacted] ML[redacted] ML[redacted] two times a day related to [redacted]; on [redacted] at 9:00 a.m., the MAR was initialed by the LPN and coded 7. (7=Other/See Nurses Notes). [redacted]) MCG.[redacted] every 6 hours related to [redacted] at 12:00 p.m., the MAR was initialed by the LPN and coded 7. (7=Other/See Nurses Notes). A review of Resident [redacted] Progress Notes (PNs) dated [redacted] at 8:30 a.m. and 11:55 a.m. revealed that the pharmacy did not deliver the medications. Further review of Resident [redacted] PNs showed no documentation that the resident's Physician was notified of the above-missed doses of medications. During the survey, the LPNs who failed to administer the above medications as ordered by the Physician were not available for an interview. During an interview on 7/5/2022 at 12:02 p.m., the Registered Nurse (RN) working in the [redacted] Unit stated to the Surveyor that if a medication is unavailable or not administered, the Physician should be made aware, and this should	F 580		

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F 580	Continued From page 4 be documented in the PNs. During an interview on 7/5/2022 at 12:31 p.m., the Director of Nursing (DON) stated to the Surveyor that if a medication is unavailable or not administered, the Physician should be made aware, and this should be documented in the PNs. During an interview on 7/8/2022 at 2:48 p.m., the Physician stated to the Surveyor that if a medication is unavailable or is not administered, the nurse is expected to notify the Physician, and it should be documented in the PNs. The Physician further stated that he was not notified of the resident not receiving his/her medications. A review of the facility's undated policy and procedure titled "Physician/Family Notification" policy revealed: The resident, family, significant other, legal representative, responsible party, and or Physician shall be notified of the following: 3. In the event that the president's plan of care, treatment or medications are significantly altered.	F 580		
F 658 SS=D	N.J.A.C:8:39-13.1.1(c) 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:	F 658		8/17/22

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F 658	Continued From page 5 C#: NJ153290 Based on interviews, medical record review, and review of other pertinent facility documents on 7/8/2022, it was determined that the facility failed to administer medications according to the Physician's Order, failed to adhere to the acceptable standards of nursing practice, and failed to follow its policies titled "Medication Shortages/Unavailable Medications and Charting and Documentation," for 1 of 3 residents reviewed (Resident [redacted]. This deficient practice was evidenced by the following: Reference: "The practice of nursing as a Licensed Practical Nurse is defined as performing tasks, and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a Registered Nurse, or otherwise legally authorized Physician or Dentist." A review of the Electronic Medical Record (EMR) was as follows: According to the "Admission Record (AR)," Resident [redacted] was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident # [redacted] had a Brief Interview of Mental Status (BIMS) score of [redacted], indicating the resident was [redacted]. The MDS also showed the resident	F 658	1. Resident [redacted] no longer a resident in the facility. Review of Resident's medical records reflected that resident was not adversely affected by the deficient practice that transpired on [redacted]. The 2 facility nurses involved were counseled and re-in-serviced on the following: (a) Administration of Medications according to the Physician's Order, (b) Adhering to the acceptable standards of nursing practice related to Proper Medication Administration, and (c) Following facility's Policies re: "Medication Shortages/Unavailable Medications and Charting and Documentation." 2. All residents with MD Orders for medications are at risk for the same deficient practice. Unit Managers and Nursing Supervisors reviewed the current Medication Administration Records (MARs) of active residents to ensure that no other residents were affected by the same deficient practice. 3. All nurses were in-serviced and educated on the following: (a) Administration of Medications according to the Physician's Order, (b) Adhering to the acceptable standards of nursing practice related to Proper Medication Administration, and (c) Following facility's Policies re: "Medication Shortages/Unavailable Medications and Charting and Documentation,"	

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F 658	Continued From page 6 needed minimal assistance with Activities of Daily Living (ADLs). Review of the "Order Recap Report (ORR)" for Resident [redacted] dated [redacted] through [redacted] included the following Physician's Order (PO's): [redacted] MG (Milgram)/ ML (Milliliter) [redacted] ML [redacted] four times a day related to [redacted] dated [redacted] [redacted] ML. [redacted] ML [redacted] two times a day related to [redacted] dated [redacted]. [redacted]) MCG (Microgram). [redacted] every 6 hours related to [redacted] dated [redacted]. Separate each [redacted] for [redacted] to allow maximum absorption. Review of the Medication Administration Record (MAR) for Resident [redacted] dated [redacted] confirmed the aforementioned PO's were not administered, as evidenced by the following: [redacted] ML) [redacted] ML [redacted] four times a day related to [redacted]; on [redacted] at 9:00 p.m., the MAR was initialed by the Licensed Practical Nurse (LPN) and coded 9. (9= sleeping). [redacted] MG (Milligram)/ [redacted] ML (Milliliter) ML [redacted] two times a day related to [redacted]; on [redacted] at 9:00 a.m., the	F 658	4. Unit Managers or designee will review the Medication Administration Records (MARs) of 10 residents x 4 months, to check whether medications are administered in accordance with physician's orders. If medications were not given to a resident, medical records will be reviewed to ensure that the physician was notified and that it is documented in accordance with facility's policy. Findings will be reported to the Director of Nursing and Administrator monthly and will be presented at the quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and/or action plan.	

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F 658	Continued From page 7 MAR was initialed by the LPN and coded 7. (7=Other/See Nurses Notes). [redacted]) MCG (Microgram) 1 [redacted] every 6 hours related to [redacted], on [redacted] at 12:00 p.m., the MAR was initialed by the LPN and coded 7. (7=Other/See Nurses Notes). A review of Resident [redacted]'s Progress Notes (PNs) dated [redacted] at 8:30 a.m. and 11:55 a.m. revealed the pharmacy did not deliver the medications. Further review of Resident [redacted]s PNs showed no documentation that the resident's Physician was notified of the above-missed doses of medication. During the survey, the LPNs who failed to administer the above medications as ordered by the Physician were not available for an interview. During an interview on 7/8/2022 at 12:02 p.m., the Registered Nurse (RN) working in the Subacute Unit stated that when a medication is unavailable, the nurse usually checks the Pyxis (an automated medication dispensing system). If the medication is not in the Pyxis, the Physician is notified of the unavailable medication. The RN further stated the Physician would then give a substitute medication order or a hold order for the unavailable medication, and the new order is faxed to the pharmacy. The RN also stated the pharmacy is notified (by) via a phone call of the new order, and an estimated delivery time is obtained. All of this information should be documented in the PNs by the nurse. During an interview on 7/8/2022 at 12:31 p.m., the Surveyor asked the Director of Nursing (DON)	F 658		

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F 658	Continued From page 8	F 658		

the procedure when the pharmacy does not deliver medications for newly admitted residents. The DON stated the nurses are trained to check the Pyxis for unavailable medications. If the medications are unavailable, the nurses will call the pharmacy first to see if the delivery was in route then notify the Medical Doctor (Physician). The DON further stated the [redacted] treatments are common medications kept in the Pyxis. She explained that if a specific medication is unavailable in the Pyxis, the nurse is expected to notify the Physician for a hold order or for a substitute medication order for the unavailable medication. The DON stated the nurse should document all this information in the PNs.

During an interview on 7/8/2022 at 2:48 p.m., the Surveyor asked the Attending Physician what should be done when a medication is unavailable. The Physician explained that usually, if a medication was not administered, the nurse is expected to call the Physician and notify him. The Physician further stated [redacted] treatments are common medications and are usually in the Pyxis, and he was not sure why it was not administered as ordered. The Physician explained that if a medication is unavailable, he will usually give an order for a substitute medication or an order to hold the unavailable medication. The Physician stated, "We make adjustments to make it work for the resident. If I have to call the pharmacy for a STAT delivery, I will do that."

A review of the facility policy dated April 2018 titled "Medication Shortages/Unavailable Medications" policy revealed: When medications are not received or are unavailable for the customers, the licensed nurse will urgently initiate

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F 658	Continued From page 9 action in cooperation with the attending Physician and the pharmacy provider. Under procedure: C: If a medication shortage is noted after pharmacy hours: 2: If the order medication is unavailable in the emergency stock supply, a licensed nurse calls the pharmacy's emergency answering service and requests to speak with the registered pharmacist on call to determine a plan of action which may include: a. Emergency/Stat delivery. A review of the facility policy updated 1/2022 titled "Charting and Documentation" under policy Interpretation and Implementation: 7. Documentation of procedures and treatments will include care-specific details, including Notification of family, Physician, or other staff if indicated. N.J.A.C:8:39-27.1(a)	F 658		