STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. BUILDING ______ B. WING ______	C 04/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807**

(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	F 000		

Complaint#: NJ163545, NJ163595, NJ163682

Census: 151

Sample: 9

The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.

Based on interviews, medical records reviews, and review of other pertinent facility documentation on 4/20/2023 & 4/24/2023, it was determined that the facility failed to protect residents from significant medication errors on NJ EX Order. 264b1 at approximately 9:00 p.m. when the Licensed Practical Nurse (LPN) administered subcutaneous insulin injections instead of NJ EX Order. 264b1, to two residents (Resident #1 and Resident #3) who are not NJ EX Order. 264b1 or had a Physician's Order for NJ EX Order. 264b1. During the 9:00 p.m. medication pass, the LPN assigned to Residents #1 & #3 did not verify the medication and administered the wrong medication (NJ EX Order. 264b1 instead of NJ EX Order. 264b1 [NJ EX Order. 264b1 Unit] as ordered to both residents. At approximately 11:15 p.m., the Registered Nurse Supervisor (RNS #1) for the 11:00 p.m. to 7:00 a.m. shift found Resident #1 NJ EX Order. 264b1 NJ EX Order. 264b1 or NJ EX Order. 264b1 and was NJ EX Order. 264b1. Resident #1 NJ EX Order. 264b1 NJ EX Order. 264b1) was checked, and he/she had a reading of NJ EX Order. 264b1 mg/dl [milligrams per deciliter]. NJ EX Order. 264b1 was given NJ EX Order. 264b1 times NJ EX Order. 264b1], but the Resident's BG still did not rise; 911 was called, and NJ EX Order. 264b1 (percent)] was

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/25/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 administered NJ EX Order. 264b1 was started by RNS #2. Resident #1 was admitted to the hospital with a diagnosis of NJ EX Order. 264b1. At approximately 11:30 p.m., RNS #1 found Resident #3 NJ EX Order. 264b1, moving his/her NJ EX Order. 264b1 up in the NJ EX with NJ EX Order. 264b1 NJ EX Order. Resident #3 NJ EX was checked. However, the Resident's NJ EX Order. 264b1 was NJ EX Order. for the device to register, so the reading result was NJ EX 911 was called; they were already present in the building, started NJ EX at the NJ EX Order. 264b1 NJ EX Order, and the 911 team NJ EX Order. 264b1 NJ EX Order. Resident #3 was NJ EX Order. 264b1 for excess NJ EX Order. 264b1 in the NJ EX Order., and the Resident's NJ EX increased to more than NJ EX Order. 264b1 after starting the NJ EX. Resident #3 left the building at 12:15 a.m. to go to the hospital for further evaluation and was admitted with a diagnosis of NJ EX Order. 264b1 The facility also failed to follow its policies titled "Administering Medications," "Identifying and Managing Medication Errors and Adverse Consequences," and "Physician Orders." The facility's failure to prevent Resident #1 & Resident #3 from significant medication errors placed Resident # 1, Resident #3, and all other NJ EX Order. 264b1 residents at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Assistant, Director of Nursing (ADON) on NJ EX Order. 264b1 at 6:40 p.m. The Administrator was presented with the IJ template that included information about the issue. The IJ began on NJ EX Order. 264b1 and continued	F 000		

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COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

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F 000	Continued From page 2 through NJ EX Order. 264b1 when the facility removed the LPN from duty that next morning at approximately 7:00 a.m., started in-servicing licensed nursing staff on medication administration, the standards of practice for safe medication administration, NJ EX Order. 264b1 vials being stored in different drawers, and Abuse and Neglect. On 4/24/2023, the Surveyors verified the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating licensed nursing staff on medication administration, the standards of practice for safe medication administration, NJ EX Order. 264b1 being stored in different drawers, and Abuse and Neglect. So, the noncompliance remained on NJ EX Order. 264b1 as a level D for no actual harm with the potential for more than minimal harm that is not immediate jeopardy.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		5/25/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656

Continued From page 3

under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Complaint#: NJ163545, NJ163595, NJ163682

Based on interviews, medical records review, and other pertinent facility documentation on 4/20/2023 and 4/24/2023, it was determined that the facility failed to implement a comprehensive care plan for residents on NJ EX Order: 264b1 medications for 2 of 9 residents (Resident #2 & #3). The facility also failed to follow its policy titled

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1. Resident #2 and resident #3 were discharged on NJ EX Order: 26 and are no longer at the facility. Chart reviewed completed for residents on NJ EX Order: 264b1 care plans reviewed and updated.

2. All residents have the potential to be affected.

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F 656	Continued From page 4 "Care Plans, Comprehensive Person-Centered." This deficient practice was evidenced by the following: Review of the Electronic Medical Records was as follows: 1. According to the Admission Record (AR), Resident #2 was admitted to the facility on NJ EX Order. 264b1 and readmitted on NJ EX Order. 264b1 with diagnoses which included but were not limited to NJ EX Order. 264b1 . According to the Minimum Data Set (MDS), an assessment tool, dated NJ EX Order. 264b1 Resident #2 had a Brief Interview of Mental Status (BIMS) score of NJ EX Order, which indicated the Resident was NJ EX Order. 264b1. The MDS also showed Resident #2 needed limited assistance and one-person physical assist with most Activities of Daily Living (ADLs). The MDS also showed Under "N0410. Medications Received" revealed "Indicate the number of Days the resident received the following medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days ..." included: "Enter Days" "6" for "E. NJ EX Order. 264b1 (... NJ EX Order. 264b1 NJ EX Order. 264b1)". A review of Resident #2's Order Summary Report (OSR), Active Orders as of NJ EX Order. 264b1 revealed the following Physician Orders (POs): NJ EX Order. 264b1) Solution NJ EX Order	F 656	3. Beginning NJ EX Order. 264b1 all licensed nursing staff were educated by the DON or her designee on the comprehensive care plan process and will be done as needed. New hires will be educated on the comprehensive care plan process upon hire and as needed. All new admission charts will be reviewed by the clinical team, if NJ EX Order. 264b1 t is present a care plan will be added for NJ EX Order. 264b1 Unit managers will also review and update care plans on a quarterly basis. 4. The Director of nursing or designee will complete random audit for anticoagulant care plan on 3 charts of residents with anticoagulant weekly x 4 weeks then monthly x4. All findings will be reported to the administrator at the Quarterly QAPI meeting.	

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F 656	Continued From page 5 UNIT/ML[.] NJ EX Order NJ EX Order u NJ EX Or NJ EX Order. 264b1 every NJ hours for NJ EX Order. 264b1 [.] It may increase the risk of NJ EX Order. 264b. Please observe for any NJ EX Order. 264b1, and NJ EX Order. 264b1 dated NJ EX Order. 264b1. A review of Resident #2's Care Plan (CP) showed no CP was developed, and no interventions were in place for NJ EX Order. 2 n (an NJ EX Order. 264b1 medication). 2. According to the AR, Resident #3 was admitted to the facility on NJ EX Order. 264b1 with diagnoses that included but were not limited to NJ EX Order. 264b1 NJ EX Order. 264b1 According to the MDS dated NJ EX Order. 264b1 Resident # 3 had a BIMS score of NJ NJ EX Or, which indicated the Resident was NJ EX Order. 264b1. The MDS also showed Resident #3 needed NJ EX Order. 264b1 and one-person physical assist with most ADLs and needed NJ EX Order. 264b1 with NJ EX Order. 264b1 assistance with bed mobility, transfer, and personal hygiene. The MDS also showed Under NJ EX Order. 264b. Medications Received" revealed "Indicate the number of Days the resident received the following medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days ..." included: "Enter Days" "7" for "E. NJ EX Order. 264b1 ... NJ EX Order. 26, or NJ EX Or NJ EX Order. 264b1)". A review of Resident #3's OSR, Active Orders as of NJ EX Order. 264b1, revealed the following POs:	F 656		

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F 656	Continued From page 6 NJ EX Order. 264b1 UNIT/ML[.] NJ EX Order. 264b1 every NJ E hours for NJ EX Order. 264b1 [.] It may increase the risk of NJ EX Order. 264b1 Please observe for any NJ EX Order. 264b1 A review of Resident #3's CP showed no evidence of a CP being developed and no interventions in place for NJ EX Order. 264 (an NJ EX Order. 264b1 medication). During an interview on 4/24/2023 at 10:59 a.m., the Registered Nurse (RN) who cared for Resident #2 stated, "If a resident is on NJ EX Order. 26, it [the medication] should be on the CP." She further stated that the CP is an informative guideline, and all residents on NJ EX Order. 264b1 should be carefully planned for it. During a telephone interview on 4/24/2023 at 12:20 p.m., the RN Supervisor stated, "If a resident is on NJ EX Order., it should be on the CP." She further stated the CP is anything the patient [Resident] has; it is the Resident's plan of care. During an interview on 4/24/2023 at 1:40 p.m., the Unit Manager/Licensed Practice Nurse (UM/LPN) stated the CP's purpose is to manage the patient's [Resident's] care. When the Surveyor asked the UM/LPN if NJ NJ EX Order. should be on the CP, he stated, "Yep," it [NJ EX Order. 264t should be on the care plan." During an interview on 4/24/2023 at 2:12 p.m., the DON stated, NJ EX Order. 264b or NJ EX Order. 264b1 [medications] should be on the CP with interventions." A review of the facility policy titled "Care	F 656		

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F 656	Continued From page 7 Plans-Comprehensive Person-Centered" dated October 2022 revealed the following: Under "Policy Statement" included "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implement for each resident." Under "Policy Interpretation and Implementation" " ...8. The comprehensive, person-centered care plan will: ...b. Describe the services that are to be furnished to attain or maintain the Resident's highest practicable physical, mental, and psychosocial well-being; ... 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). 13. Assessments of residents are ongoing, and care plans are revised as information about the residents and the Resident's condition change. 14. The Interdisciplinary Team must review and update the care plan: ...When the Resident has been readmitted to the facility from a hospital stay; ...." N.J.A.C.: 8.39-27.1 (a)	F 656		
F 755 SS=D	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.	F 755		5/25/23

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F 755	Continued From page 8 §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. This REQUIREMENT is not met as evidenced by: Complaint#: NJ163545, NJ163595 Based on observation, interview, medical record review, and other pertinent facility documents on 4/20/2023 and 4/24/2023, it was determined that the facility failed to maintain Professional Standards of practice by not a). administering medication according to Physician's Orders, and b). following the Pharmacy's cautionary warnings. The facility also failed to follow its policies titled "Administering Medications, "Charting and Documentation," and Physician Orders. This deficient practice was identified for 2 of 9 residents (Resident #7 and #8) reviewed for	F 755	1. Resident # 7- The physician was notified of the unavailability of NJ EX Order. 264b1 NJ EX Order. 264b1 Resident # 7 currently resides at the facility. Resident # 8 no longer reside at the facility Residents # 7 and # 8 did not experience adverse effects. 2. All residents have the potential to be affected by this practice. 3. On 5/22/2023 DON or her designee began educating all licensed nursing staff on Medication administration, Physician orders, documentation and facility process	

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F 755	Continued From page 9 standards of practice. 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 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 licensed or otherwise legally authorized physician or dentist." On 4/24/23 at 9:20 a.m., the Surveyor observed the Licensed Practical Nurse (LPN) during medication administration. While the LPN prepared the medication for Resident #7, she informed the Surveyor that Resident #7's prescribed order for NJ EX Order. 264b1 NJ EX Order. 264b1 milliliters by NJ EX Order. 264b1 daily for NJ EX Order. 264b1 was unavailable to be administered. The LPN informed the Surveyor that she would call the Pharmacy for a refill order and notify the Physician after completing medication administration to all her residents so that she is only making one call. The LPN noted the missing medication on a notepad on the medication cart. The LPN also told the Surveyor that she would make a note [document] in the resident's electronic medical record (EMR) of the unavailable medication and the Physician's notification. On 4/24/2023 at 9:20 a.m., the Surveyor observed the LPN prepare medications for Resident #7 in the following order:	F 755	on a medication that is missing from the medication cart. The nurse for resident #8 was educated on medication administration and following cautionary statements. 4. The Director of nursing or designee will complete random medication cart audits for missing medications weekly x 4 weeks then monthly x 4 months. All findings will be reported to the Administrator at the Quarterly QAPI meeting.	

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F 755	Continued From page 10 NJ EX Order. 264b1) Oral Tablet NJ EX O MG. Give NJ tablet by mouth daily for NJ EX Order. 264b1 (NJ EX Order. 264b1). NJ EX Order. 2 Tablet NJ EX MG NJ tablet by mouth NJ EX Orde daily for NJ EX Order. 264b1 . NJ EX Order. 264b1 oral tablet NJ MG. Give NJ tablet by mouth NJ EX Or times daily for NJ EX Order. 264 NJ EX Order. 264b1 . NJ EX Order. 264b1 MG. Give NJ E tablet by mouth in the morning NJ EX Order. 26 meals for NJ EX Order. 264b1 NJ EX Order. 264b1 Tablet NJ EX MG. Give NJ tablet by mouth at bedtime for NJ EX NJ EX Order. 264b1 . NJ EX Order. 264b1 rals Tablet. Give 1 tablet by mouth daily for Supplement. 1. According to the Admission Record (AR), Resident #7 was admitted to the facility on NJ EX Order. 264b1 with diagnoses which included but were not limited to NJ EX Order. 264b1 . Review of the Minimum Data Set (MDS), an assessment tool dated NJ EX Order. 264b1 Resident #7 had a Brief Interview of Mental Status (BIMS) score of NJ EX Orde which indicated the resident had NJ EX Order. 2 . The MDS also showed Resident #7 was dependent on staff for all Activities of Daily Living (ADLs). A review of the "Order Summary Report" (OSR) for Resident #7, dated NJ EX Order. 264b1 through NJ EX Order. 264b1 , revealed the following Physician Orders (POs): NJ EX Order. 264b1 MG/NJ EX ML give NJ EX Order by mouth NJ EX O time a day for NJ EX Or r NJ NJ EX Order. 2 dated NJ EX Order. 264b1 . NJ EX Order. 264b1 Oral Tablet NJ EX O MG. Give NJ	F 755		

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COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

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F 755	Continued From page 11 tablet by mouth daily for NJ EX Order. 264b1 b, dated NJ EX Order. 264b1 NJ EX Order. 2 Tablet NJ EX MG NJ E tablet by mouth NJ EX Orde daily for NJ EX Order. 264b1 dated NJ EX Order. 264b1 3. NJ EX Order. 264b1 oral tablet NJ MG. Give NJ E tablet by mouth NJ EX Orde times daily for NJ EX Order. 264 Retention dated NJ EX Order. 264b1 . NJ EX Order. 264b1 MG Give NJ E tablet by mouth in the morning before meals for H NJ EX Order. 264b1 dated NJ EX Order. 264b1 NJ EX Order. 264 NJ EX r Tablet NJ EX MG. Give NJ tablet by mouth at bedtime for NJ EX Order. 264b1 dated NJ EX Order. 264b1 . NJ EX Order. 264b1 Tablet Give NJ tablet by mouth daily for Supplement dated NJ EX Order. 264b1 Review of Resident #7's Electronic Medical Record (EMR) showed no documentation that the Pharmacy was notified for a NJ EX Order. 264b1 Suspension NJ EX O MG/ NJ EX ML refill. There was no documentation that the Doctor was notified about the unavailable medication. The EMR also showed no evidence of NJ EX Order. 264b1 during the review period. The Surveyor attempted to interview the resident (Resident #7) but was unable due to the resident's NJ NJ EX Order. 264b On 4/24/2023 at 9:40 a.m., the Surveyor observed the LPN prepare medications for Resident #8 in the following order: NJ EX Order. 264b1 Oral Tablet NJ MG. Give NJ E tablet by mouth daily for NJ EX Order. 264b1 NJ EX Order. 264b1 Tablet NJ EX Orde . Give NJ tablet by mouth daily for NJ EX Order. 264b1 NJ EX Order. 264b1 GM (Gram)/ NJ EX ML (Milliliter). Give NJ EX MG by mouth for NJ EX Order. 264b1 NJ EX Order. 264b1) Oral tablet NJ EX Hour NJ EX mg. Give NJ E tablet by mouth daily for NJ EX Ord ... DO NOT CRUSH OR CHEW.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. BUILDING ______ B. WING ______	C 04/24/2023

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F 755	Continued From page 12 NJ EX Order. 264b1 apply to both NJ EX Order topically for NJ EX Order NJ EX Order. 264b1 Oral NJ EX Order. 264b1 GM NJ EX Order. 264b1 of NJ EX Order. 264b1 by mouth for NJ EX Order. 264b1. NJ EX Order. 264b1 Tablet. Give NJ tablet by mouth daily for Supplement. NJ EX Order. 264b1 MG Tablet 1 tablet by mouth twice daily for NJ EX Order. 264b1 NJ EX Order. 264b1 l NJ E inhalation for NJ EX Order. 264 rinse mouth after use for NJ EX Order. 264b1 NJ EX Order. 264b1 MG Tablet. Give NJ tablet by mouth daily for NJ EX Order. 264b1. NJ EX Order. 264b1 units. Give NJ tablets by mouth daily for Supplement. The LPN crushed each pill separately, emptied it into separate cups (NJ EX ml cup), and added NJ EX Order in each cup in the same order the pill was removed from the medication cart. The LPN informed the Surveyor she was ready to administer the medications and walked towards Resident #8 for administration. At that time, the Surveyor stopped and requested the LPN return to the medication cart. The Surveyor and LPN reviewed the electronic Medication Administration Record (eMAR) against the bingo cards (blister packets containing the medications). The eMAR revealed Isosorbide NJ EX Order. 264b1 NJ E mg for NJ EX Order ... DO NOT CRUSH OR CHEW. The Surveyor asked the LPN if she followed the cautionary warning regarding the crushed NJ EX Order. 264b1 NJ EX MG. The LPN removed the cup containing the NJ EX Order. 264b1 from the rest of Resident #8's medications and administered the other medications as ordered. 2. According to the AR, Resident #8 was admitted to the facility on NJ EX Order. 264b1 with diagnoses which	F 755		

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F 755	Continued From page 13 included but were not limited to NJ EX Order. 264b1 NJ EX Order. 264b1. Review of the MDS dated NJ EX Order. 264b1 Resident #8 had a BIMS score of NJ EX 5, which indicated the resident was NJ EX Order. 264b1 ed. The MDS also showed Resident #8 was NJ EX Order. 264b1 on staff for all ADLs. Review of the "OSR" for Resident #8 dated NJ EX Order. 264b1 through NJ EX Order. 264b1 revealed the following POs: NJ EX Order. 264b1). Apply to both NJ EX Order. 264b1 NJ EX O time a day for NJ NJ EX and r NJ EX Order. 2 as scheduled, dated NJ EX Order. 264b1. NJ EX Order. 264b1 Tablet NJ MG. Give NJ tablet by mouth daily for NJ EX Order. 264b1, dated NJ EX Order. 264b1. NJ EX Order. 264b1 MG. Give NJ E tablet by mouth daily for NJ EX Order. 264b1), dated NJ EX Order. 264b1 NJ EX Order. 264b1 GM/ NJ EX ML (Milliliter). Give NJ EX ml by mouth for NJ EX Order. 264b1, dated NJ EX Order. 264b1. NJ EX Order. 264b1 oral tablet NJ EX Order. 264b1 NJ EX Order. 264b1 Hour NJ EX mg. Give NJ tablet by mouth daily for NJ EX Ord ... DO NOT CRUSH OR CHEW, dated NJ EX Order. 264b1 NJ EX Order. 264b1 Oral Packet NJ EX gm mix with NJ EX Order. 264b1 of NJ EX Order. 264b1 by mouth for NJ EX Order. 264b1 dated NJ EX Order. 264b1. NJ EX Order. 264b1. Give NJ E tablet by mouth daily for NJ EX Order. 264b1 dated NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Or MG Tablet. Give NJ tablet by mouth NJ EX Orde daily for NJ EX Order. 264b1, dated NJ EX Order. 264b1 NJ EX Order. 264b1 for NJ EX EX Order	F 755		

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F 755	Continued From page 14 NJ EX Order. 264b1 after use for NJ EX Order. 264 , dated NJ EX Order. 264b1 NJ EX Order. 264b1 MG Tablet. Give NJ E tablet by mouth twice daily for NJ EX Order. 264b1, dated NJ EX Order. 264b1. NJ EX Order. 264b1 units. Give NJ tablets by mouth daily for NJ EX Order. 264b1 dated NJ EX Order. 264b1. NJ EX Order. 264b1 or NJ EX Order. 264b1 and place in food or liquid according to pharmacy guidelines dated NJ EX Order. 264b1 During an interview on 4/24/2023 at 10:00 a.m., the LPN acknowledged the cautionary warning for the medication and stated, "The pill [NJ EX Order. 264b1 should not have been crushed, I should have followed the pharmacy warning [DO NOT CRUSH OR CHEW]." She continued to say the Doctor [Physician] should have been notified about the Pharmacy's cautionary warning and a substitute order or an order to change the pill to liquid if available. The LPN further stated, "I would have given the medication if you didn't stop me." During a second interview on 4/24/2023 at 10:43 a.m., the LPN informed the Surveyor that she had notified the Unit Manager/Licensed Practical Nurse (UM/LPN) about the unavailable dose of the NJ EX Order. 264b1 ML and stated, "I thought the UM/LPN had called the Pharmacy to reorder the medication. The LPN continued to say the process of reordering an unavailable medication is for the administering Nurse to contact the Pharmacy for a refill and notify the prescribing Doctor [Physician] of the unavailable medication. She further stated that the Doctor might give a verbal order for a substitute medication or a hold order until the medication is delivered from the Pharmacy. When asked by the Surveyor if the Pharmacy was called or if the Doctor was notified, the LPN stated, "No," I did not call the Pharmacy for a refill	F 755		

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F 755	Continued From page 15 for Resident #7's NJ EX Order. 264b1 NJ EX O MG/NJ EX ML or notify the Doctor about the unavailable dose. She further stated that this should all be documented in the resident's EMR. During an interview on 4/24/2023 at 1:40 p.m., the UM/LPN stated, "the Nurse on the cart is expected to call the Pharmacy if a medication is unavailable during a medication administration pass." He also said, "This should be done immediately during the medication administration pass if a medication is unavailable." When asked by the Surveyor what the LPN should have done when she did not have the medication, he stated that if a medication is unavailable during medication administration, the LPN is expected to call the Pharmacy for a STAT refill, notify the Doctor to obtain a substitute order if available in the back-up box, if not obtain a hold order from the Doctor until the medication is delivered from the Pharmacy. The UM/LPN further stated this should all be documented by the LPN in the resident's EMR. In the same interview, when asked by the Surveyor what the LPN should have done regarding the pharmacy cautionary warning, the UM/LPN stated, "We [Nurses] have to follow the cautionary warning from the pharmacy as listed on the eMAR." He further stated if a resident has an order to crush all medications and a particular medication cannot be crushed, the LPN is expected to notify the Doctor about the warning [DO NOT CRUSH OR CHEW] and obtain a substitute medication that can be crushed. During an interview on 4/24/2023 at 5:42 p.m., the DON stated, "If a medication is unavailable during medication administration, the Nurse	F 755		

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F 755	Continued From page 16 should immediately call the Pharmacy for a refill order and request a STAT delivery. The Nurse should also call the Doctor to obtain a substitute or hold the order for that medication until delivered from the Pharmacy." She further stated, "This should all be documented in the Resident's EMR." In the same interview, the DON stated, "If there is a cautionary warning for a medication [DO NOT CRUSH OR CHEW], I expect it [the medication] not to be crushed." She further stated, "The LPN should reach out to the Doctor [Physician]and obtain an order for a substitute medication that can be crushed if there is a cautionary warning for a particular medication." During the post-survey telephone interview on 4/28/2023 at 12:11 p.m., the Pharmacist stated that Resident #7's NJ EX Order. 264b1 MG/ NJ EX ML "was last reordered and delivered to the facility on NJ EX Order. 264b1." The Pharmacist further stated "that the NJ EX Order. 264b1 MG/ NJ EX ML is past due for a refill, and a refill request has not been received from the facility since last filled on NJ EX Order. 264b1 Review of the facility's undated Policy titled "Charting and Documentation" under Policy revealed... "All services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." Review of the facility policy last updated 10/2022	F 755		

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F 755	Continued From page 17 titled "Administering Medications" under Policy revealed... 2. "Medications must be administered in accordance with the orders, including any time frame. 5. The individual administering the medication must check the label against the Physician's order to verify the right resident, right medication, right dose, right time, and right method (route) of administration before giving the medication." A review of the facility policy titled "Physician Orders" with a revised date of December 2022 revealed the following: Under "Policy" included: "Medication and treatment orders will be accepted only from authorized, credentialed physicians or from other authorized, credentialed practitioners in accordance with state regulations regarding prescriptive privileges." Under "Purpose," included: "To ensure all medication and treatment orders are received from a credentialed practitioner before implementing." NJAC 8:39-27.1(a) NJAC 8:39-11.2(b)	F 755		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Complaint#: NJ163545, NJ163595, NJ163682 Based on interviews, medical records reviews, and review of other pertinent facility	F 760	1. Residents # 1 and #3 were transferred to the hospital NJ EX Order. 26 related to NJ EX Order. 264b1 episode. Residents were discharged to the community by the hospital The LPN was suspended on	5/25/23

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F 760	Continued From page 18 documentation on NJ EX Order. 264b1 it was determined that the facility failed to protect residents from significant medication errors on NJ EX Order. 264b1 at approximately 9:00 p.m. when the Licensed Practical Nurse (LPN) administered NJ EX Order. 264b1 instead of NJ EX Order. 264b1, to two residents (Resident #1 and Resident #3) who are not NJ EX Order. 264b1 or had a Physician's Order for NJ EX Order. 264b1. During the 9:00 p.m. medication pass, the LPN assigned to Residents #1 & #3 did not verify the medication and administered the wrong medication NJ EX Order. 264b1 instead of NJ EX Order. 264b1 [NJ EX Order. 264b1 Unit] as ordered to both residents. At approximately 11:15 p.m., the Registered Nurse Supervisor (RNS #1) for the 11:00 p.m. to 7:00 a.m. shift found Resident #1 NJ EX Order. 264b1 NJ EX Order. 264b1 or NJ EX Order. 264b1 h and was NJ EX Order. 264b1. Resident #1 NJ EX Order. 264b1) / NJ EX Order. 264b1 NJ EX Order. 264b1 was checked, and he/she had a reading of NJ EX Order. 264b1 mg/dl [milligrams per deciliter]. NJ EX Order. 264b1 was given NJ EX Order. 264b1 times IM NJ EX Order. 264b1 but the Resident's NJ EX Order. 264b1 still did not rise; 911 was called, and NJ EX Order. 264b1 (percent)] was administered via [through] a NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1 by RNS #2. Resident #1 was admitted to the hospital with a diagnosis of NJ EX Order. 264b1 At approximately 11:30 p.m., RNS #1 found Resident #3 NJ EX Order. 264b1, moving his/her NJ EX Order. 264b1 up in the NJ EX Order. 264b1 with NJ EX Order. 264b1 NJ EX Order. 264b1. Resident #3 BG was checked. However, the Resident's NJ EX Order. 264b1 was NJ EX Order. 264b1 for the device to register, so the reading result was NJ EX Order. 264b1 (NJ EX Order. 264b1. 911 was called; they were already present in the building, started NJ EX Order. 264b1 at the NJ EX Order. 264b1 NJ EX Order. 264b1 and the 911 team NJ EX Order. 264b1 NJ EX Order. 264b1 Resident #3 was NJ EX Order. 264b1 for excess	F 760	NJ EX Order. 264b1 and subsequently terminated. 2. All residents have the potential to be affected. 3. NJ EX Order. 264b1 the NJ EX Order. 264b1 NJ EX Order. 264b1 vials were separated on the medication carts to different drawers. All residents were ordered and received NJ EX Order. 264b1 instead of NJ EX Order. 264b1, all new residents will be ordered NJ EX Order. 264b1 instead of vials. All licensed nursing staff have an updated medication competency, new hires competency will be completed before working independently on the floor, annually and as needed. Beginning NJ EX Order. 264b1 all licensed nursing staff were educated by the DON or her designee on medication administration, the standards of practice for safe medication administration, NJ EX Order. 264b1 and NJ EX Order. 264b1 vials being stored in different drawers. New hires will be educated upon hire, annually and as needed. NJ EX Order. 264b1 LPN reported to NJ Division of Consumer Affairs and Board of nursing. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Director of Nursing or designee will complete random audits of medication carts for the presence of NJ EX Order. 264b1 and the separation of NJ EX Order. 264b1 and NJ EX Order. 264b1 weekly x 4 weeks, then monthly for three months. Random medication administration observation will be done weekly x 4 weeks, then monthly x 3 months. The findings of the audit will be reviewed at the	

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F 760	Continued From page 19 NJ EX Order: 264b1 in the NJ EX Order: 264b1 and the Resident's NJ EX Order: 264b1 increased to NJ EX Order: 264b1 mg/dl after starting the NJ EX Order: 264b1 Resident #3 left the building at 12:15 a.m. to go to the hospital for further evaluation and was admitted with a diagnosis of H NJ EX Order: 264b1 The facility also failed to follow its policies titled "Administering Medications," "Identifying and Managing Medication Errors and Adverse Consequences," and "Physician Orders." The facility's failure to prevent Resident #1 & Resident #3 from significant medication errors placed Resident # 1, Resident #3, and all other NJ EX Order: 264b1 residents at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Assistant, Director of Nursing (ADON) on NJ EX Order: 264b1 at 6:40 p.m. The Administrator was presented with the IJ template that included information about the issue. The IJ began on NJ EX Order: 264b1 and continued through NJ EX Order: 264b1 when the facility removed the LPN from duty that next morning at approximately 7:00 a.m., started in-servicing licensed nursing staff on medication administration, the standards of practice for safe medication administration, NJ EX Order: 264b1, and NJ EX Order: 264b1 vials being stored in different drawers, and Abuse and Neglect. On 4/24/2023, the Surveyors verified the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating licensed nursing staff on medication administration, the standards of practice for safe medication administration, NJ EX Order: 264b1 and NJ EX Order: 264b1 vials being stored in different drawers, and Abuse	F 760	facilities quarterly QAPI meetings.	

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F 760	Continued From page 20	F 760		

and Neglect. So, the noncompliance remained on NJ EX Order. 264b1 as a level D for no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

This deficient practice was identified for 2 of 9 residents (Resident #1 & #3) and was evidenced by the following:

According to the Facility Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by the healthcare facilities to report incidents on NJ EX Order. 264b1, with an event date of NJ EX Order. 264b1 and a "time of event" of 11:30 p.m., revealed the following: On NJ EX Order. 264b1, at approximately 11:15 p.m., Residents #1 and Resident #3 were sent to the hospital related to NJ EX Order. 264b1 episodes. Both were admitted with NJ EX Order. 264b1 and NJ EX Order. 264b1. Both residents do not have NJ EX Order. 264b1 therefore, further investigation was warranted. [The] Nurse assigned to both residents on NJ EX Order. 264b1 was suspended pending investigation.

1. According to the Admission Record (AR), Resident #1 was admitted to the facility on NJ EX Order. 264b1 with diagnoses which included but were not limited to NJ EX Order. 264b1

According to the Minimum Data Set (MDS), an assessment tool dated NJ EX Order. 264b1, Resident #1 had a Brief Interview of Mental Status (BIMS) score of NJ EX Order, which indicated the Resident was NJ EX Order. 264b1. Resident #1 only needed supervision and one-person physical assist with most Activities of Daily Living (ADLs). Further review of the MDS showed under "NJ EX Order. 264b1

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F 760	Continued From page 21 "Medications" revealed Under NJ EX Order. 264b1NJ EX Order. 26 included: that Resident#1 was not on NJ EX Order. 2 and had no order for NJ EX Order. 26. The MDS also showed Under NJ EX Order. 264b that the Resident was on NJ EX Order. 264b1 (...NJ EX Order. 264b1 NJ EX Order. 264 therapy. A review of Resident #1's "Medication Error Report (MER)" dated NJ EX Order. 264b1 3 and signed by the Attending MD (Medical Doctor)/[Physician], LNHA [Licensed Nursing Home Administrator], the Assistant Director of Nursing, and the Director of Nursing included the following: "Date of error: NJ EX Order. 264b1]", "Time of Error: 9 [:00] PM [p.m.]", "Physician Notified [,] Yes date/time: NJ EX Order. 264b1 DON/Supervisor/Manager notified? Yes, Name: DON date/time: NJ EX Order. 264b1 .... "Resident representative/Family notified? Yes[,] date/time: NJ EX Order. 26 5:30 p [p.m.]" [,] "Medication ordered: NJ EX Order. 264b1" [,] "Description of the error-record name of the medication, dose, route and time(s) administered: NJ EX Order. 264b1" [,] "Outcome to the resident (provide details including care provided after error): NJ EX Order. 264b1 NJ EX Order. 264b1 d sent to ER [Emergency Room] via 911". Under "Assessment and Summary of Medication Error," included: Under "Type of Error," "wrong medication." Under "Reason For Error," revealed "Other:" "did not verify medication" [.] Under "Corrective action taken:" revealed "staff education -LPN suspended pending outcome of the investigation" Under "Measures taken to prevent the recurrence of similar errors:" included: NJ EX Order. 264 vials changed to NJ EX Order. 264b1 + [and] NJ EX Order. 26 in separate areas of med [medication] cart" [.] Under "Signatures" [,] "Title" [,] "Date" included: "Person making error" LPN [,] NJ EX Order. 26 [;] "Person reporting error" LPN/ADON[,] NJNJ EX Order. 2 "DON" [,] RN DON [.]	F 760		

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COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

(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
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A review of Resident #1's "New Jersey Universal Transfer Form (NJUTF)" revealed "Date of Transfer: NJ EX Order. 264b1 and "Time of Transfer" 12:00 a.m. "Reason for Transfer:" included: "Pt [patient/resident] found NJ EX Order. 264b1 [,] NJ EX Order. 264b1, NJ EX Order. 264 [,] NJ EX Order. 2 NJ EX Order. 264b1 NJ EX Order. given" [.]

A review of Resident #1's "Order Summary Report (OSR) "Active Orders as of NJ EX Order. 264b1 revealed the following Physician Orders (POs):

NJ EX Order. 264b1 Solution NJ EX Order UNIT/ML (milliliters) (NJ EX Order. 264b1) NJ EX Order ML (milliliters) every NJ EX hours for NJ EX Ord (NJ EX Order. 264b1. It may increase the risk NJ EX Order. 264b1. Please observe for any NJ EX Order. 264b1 NJ EX Order. 264b1 dated NJ EX Order. 264b1.

A review of Resident #1's Medication Administration Record (MAR) dated NJ EX Order. 264b1 3 reflected that the LPN administered the above POs as ordered on NJ EX Order. 264b1 at 9:00 p.m.

A review of Resident #1's Progress Notes (PNs) revealed the following:

On NJ EX Order. 264b1 at 6:42 a.m., the PNs written by RNS #1 revealed at 11:15 p.m., this nurse noted [the] Resident [Resident #1] NJ EX Order. 264b1. NJ EX Order. 264b1 or NJ EX Order. 264b1] NJ EX Order. 264b1 given NJ EX and noted NJ EX no [not] rising. 911 was called, and NJ EX Order. 264b1] was started via NJ EX Order. 264b1). When 911 arrived, his/her NJ EX increased to NJ EX Order. 2 he/she left the building at 11:30 p.m.

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F 760	Continued From page 23 On NJ EX Order. 264b1 7:10 a.m., the PNs written by RNS #1 revealed: " ...the NP (Nurse Practitioner) at the hospital called and confirmed [the] resident admitted to [the] hospital for further evaluations." 2. According to the AR, Resident #3 was admitted to the facility on NJ EX Order. 264b1 with diagnoses that included but were not limited to NJ EX Order. 264b1 NJ EX NJ EX Order. 264b1. According to the MDS dated NJ EX Order. 264b1 Resident # 3 had a BIMS score of NJ EX Order which indicated the Resident was NJ EX Order. 264b1 The MDS showed Resident #3 needed NJ EX Order. 264b1 and one-person physical assist with most ADLs and needed NJ EX Order. 264b1 with two-person assistance with bed mobility, transfer, and personal hygiene. Further review of the MDS showed under "NJ EX Order. 264b1" "Medications" revealed Under NJ EX Order. 264b1" included: that Resident#1 was not on NJ EX Order. and had no order for NJ EX Order. 26. The MDS also showed Under "NJ EX Order. 26 that the Resident was on NJ EX Order. 264b1 NJ EX Order. 264b1) therapy. A review of Resident #3's "Medication Error Report (MER)" dated NJ EX Order. 264b1 and signed by the Attending MD (Medical Doctor)/[Physician], LNHA [Licensed Nursing Home Administrator], the Assistant Director of Nursing, and the Director of Nursing included the following: "Date of error: NJ EX Order. 264b1]", "Time of Error: 9 [:00] PM [p.m.]", "Physician Notified [,] Yes date/time: NJ EX Order. 264b, DON/Supervisor/Manager notified? Yes, Name: DON date/time: 4NJ EX Order. 264b.... "Resident representative/Family notified? Yes[,] date/time:	F 760		

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F 760	Continued From page 24 NJ EX Order. 264b1 5:30 p [p.m.]" [,] "Medication ordered: NJ EX Order. 264b1" [,] "Description of the error-record name of the medication, dose, route and time(s) administered: NJ EX Order. 264b1 [,] "Outcome to the resident (provide details including care provided after error): NJ EX Order. 264b1 NJ EX Order. 264b1 sent to ER [Emergency Room] via 911". Under "Assessment and Summary of Medication Error," included: Under "Type of Error," "wrong medication." Under "Reason For Error," revealed "Other:" "did not verify medication" [.] Under "Corrective action taken:" revealed "staff education -LPN suspended pending outcome of the investigation" Under "Measures taken to prevent the recurrence of similar errors:" included: NJ EX Order. 264b1 vials changed to NJ EX Order. 264b1 + [and] NJ EX Order. 264b1 in separate areas of med [medication] cart" [.] Under "Signatures" [,] "Title" [,] "Date" included: "Person making error" LPN [,] NJ EX Order. 264b1 [;] "Person reporting error" LPN/ADON[,] NJ EX Order. 264b1 "DON" [,] RN DON [.] A review of Resident #3's NJUTF revealed "Date of Transfer: NJ EX Order. 264b1 3 and "Time of Transfer" 12:15 a.m. [a.m.] [,] "Reason for Transfer:" included "Pt found NJ EX Order. 264b1 episode [,] NJ EX O reads NJ EX " [low]." A review of Resident #3's OSR, Active Orders as of 0 NJ EX Order. 264b1, revealed the following POs: NJ EX Order. 264b1 UNIT/ML[.] NJ EX Order. 264b1 NJ EX Order. 264b1 every NJ E hours for NJ EX Order. 264b1 [.] It may increase the risk of NJ EX Order. 264b1. Please observe for any NJ EX Order. 264b1. A review of Resident #3's MAR dated	F 760		

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F 760	Continued From page 25 NJ EX Order. 264b1 reflected that the LPN administered the above POs as ordered on NJ EX Order. 264b1 3 at 10:00 p.m. A review of Resident #3's PNs revealed the following: On NJ EX Order. 264b1 at 8:24 a.m., the PNs written by RNS #1 revealed, "This nurse found resident cold and NJ EX Order. 264b1 moving his/her NJ EX Order. 264b1 NJ EX in [the] NJ EX Order. 264b1 NJ EX Order. 264b1 BG checked and read NJ EX Order. 264b1 NJ EX Order. 264b1 10 NJ EX started by the 911 team present in the building. NJ EX Order. 264b1 Resident for NJ EX Order. 264 NJ EX Order. 264b1 in his/her NJ EX Order. Resident BG up to NJ EX Order. 264b1 NJ EX O after NJ started. Resident [#3] left [the] building at 12:15 a.m. to go to the hospital for further evaluation. NP called and notified us that [the] Resident will be admitted. This nurse notified the Family of [the] change in condition." A review of the LPN's "Agency Account" included: the date of "NJ EX Order. 264b1 revealed "In" 2:50 p.m. [p.m.] and "Out" 7:08 a.m. [a.m.]," indicating the LPN worked on the evening and overnight shift from NJ EX Order. 264b1 through NJ EX Order. 264b1 A review of the "Individual One-On-One Inservice" for the LPN dated NJ EX Order. 264b1, and signed by the LPN and the ADON revealed Under "Issue in-serviced on:" "Med [Medication] Pass" [.] Under "Education given:" included: "Being prepared, right resident, right drug [,] observe precautionary warnings, right time [,] correct technique, right route...." A review of the LPN's Statement dated 4 NJ EX Order. 264b1 revealed on NJ EX Order. 264b1 on the 3:00 p.m.-11:00	F 760		

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F 760	Continued From page 26 p.m. shift, at the beginning of the overnight shift, NJ E residents on his post developed NJ EX Order. 264b1 conditions that required EMT interventions. The NJ EX Orde patients [residents] were on NJ EX Order. 26; only one was NJ EX Order. 264. He recalled checking the brown bottle containing the vials of NJ EX Order. 26 to confirm the medication, but its [it is] possible that actually, it was [were] NJ EX Order. 2 vials mistakenly placed in the bottle. He didn't recall confirming or checking what was on the label of the bottle. During a telephone interview on 4/20/2023 at 2:15 p.m., RNS #1 stated, she was the Supervisor on duty. RNS #1 explained around 11:00 p.m.-11:15 p.m., she heard moaning, saw Resident #1, and observed him/her; he/she was NJ EX Order. 264b1, and NJ EX Order. She thought the Resident had a NJ EX Or NJ EX Order. 264b1 issue and checked his/ her NJ EX Order. 264b1 and vitals. The NJ EX Order. 264b1 was NJ EX, and the NJ EX Or dose of NJ EX Order. 264b1 was given. However, the NJ EX C was not going up, so another nurse started an NJ E on the patient [Resident] on NJ EX Order. 264b1]." She continued to say the 'NJ EX Order. 264b1 was improving, when 911 came, NJ EX Order. 264b1 went to NJ EX mg/dl, we [nurses] just NJ EX Order. V, at that time the Resident was NJ EX Order. 264b1 [but] NJ EX Order. 264b1, then 911 came and took him/her to the Emergency Room (ER) ...the Nurse Supervisor (RNS #2) [was] talking that Resident #1 was NJ EX Order. 264b1 and NJ EX Or, had eaten and he/she had no issues prior to this incident." When the Surveyor asked RNS #1 about Resident #3, she stated I saw the Resident NJ EX Orde NJ EX Order. 264b1 The Resident's NJ EX was checked, was NJ EX Ord and showed no NJ EX Order. 264b1, I wanted to start a line,	F 760		

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F 760	Continued From page 27	F 760		

another [nurse] checked NJ EX Order. 264b1, another [nurse] called 911, he/she was moving his/her NJ EX Orde, 911 team came and started NJ EX Order. 264b1 at NJ EX Order. 264b1 She continued to say his/her NJ EX Order. 264b1 r went to NJ EX Or mg/dl. The RNS further stated that the LPN who cared for Resident #3 was the same nurse who cared for Resident #1. "The Resident was not a NJ EX Order. 264b1 then 911 took him/her [to the hospital] for further evaluation."

During an interview on 4/20/2023 at 4:35 p.m., the DON stated the status of the LPN is he is suspended pending investigation. [The] Nurse worked a double shift on NJ EX Order. 264b1, the 2:30 p.m.-10:30 p.m. shift and the 10:30 p.m.-6:30 a.m. shift, the last time he worked. The med [medication] error was on NJ EX Order. 264b1 at 9:00 p.m., and it was addressed the next morning." She further stated that when the incidents occurred, corporate came in, and we immediately investigated that there was a possibility of what happened with the medications.

In the same interview, the DON stated, "[the] nurse (LPN) said this is [a] possibility what could've happened with [the] NJ EX Order. 264 and NJ EX Order. 264 I did not want him working on the floor, [due to the] possibility that NJ EX Order. 2 was given instead of NJ EX Order. 26 to the residents sent out on NJ EX Order. 264b1 NJ EX Orde. The medication error report is the incident report for medication. We are still investigating the incidents so we can have a solid plan moving forward. Corporate is still here. We are checking all residents on NJ EX Order. 26 and on NJ EX Order. 2 We are switching all NJ EX Order. 264b1 to NJ EX Order. 264b1 are in process ... the investigation is still ongoing ...."

During an interview on 4/20/2023 at 5:05 p.m.,

F 760 Continued From page 28 F 760

the Regional Director, in the presence of the Regional Clinical Director (RCD), stated, "We [the facility] reported to DOH yesterday started investigation for medication administration for all staff on [the] Rights of Medication [dated] NJ EX Order. 264b1. We switched all NJ EX Order. 2 vials to NJ EX Ord starting yesterday. We increased NJ EX Order. 264b1 inventory. We immediately suspended the nurse. He (LPN) had a med [medication] pass post orientation, and he passed."

In the same interview, the RCD stated we did an additional audit that all NJ EX Order. 264 residents had a bedtime snack. The Regional Director stated we started med [medication] pass competencies with all nurses yesterday ...provided education on syringes. "We self-identified and self-reported [it] was isolated to one employee." The RCD continued to say we worked on it immediately, on basics, in-services were done on Abuse and Neglect on NJ EX Order. 264b1, and [are] still in progress. In-service done on NJ EX Order. 264b1 and NJ EX Order. 264 vials are not to be stored in the same drawers. All in-services were started and ongoing. We are still investigating, not concluded yet.

During an interview on 4/24/2023 at 10:28 a.m., the ADON/Infection Preventionist (IP) stated RNS #1 called me [to say] we have three residents going out to [the] hospital. Supervisors always call [me] when sending out [residents to the hospital]. [The] Residents [were] sent out for NJ EX Order. 264b1 on NJ EX Order. 264b1. RNS #1 called me at approximately 1:30 a.m., and we talked about who was the nurse (LPN) and RNS #1 finished the med pass, and she checked other residents on the LPN's assignment with no issues. She then emailed the Administrator and the DON about the error. The

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F 760	Continued From page 29 LPN was [taken] off the [medication] cart at 1:30 a.m. by RNS #1. He took NJ EX Order. 264b1 but no medications and was sent home at the end of the shift. At approximately 2:00 a.m., I looked at all the Medication Administration Records (MARs) for all NJ residents. At 7:00 a.m., I was on the phone with the DON, the Regional Clinical [Supervisor], and Administrator. Then at approximately 8:00-9:00 a.m., the investigation was started. During the same interview, the ADON/IP stated she asked the LPN about the incident on NJ EX Order. 264b1 since he was due to return at 2:30 p.m. to start the shift. According to the ADON/IP, "the LPN said he probably made an error since he wasn't paying attention, so we educated him. He signed off on it, and I told him he was suspended pending investigation. I think the investigation is ongoing. I'm doing education. [The] LPN was trained prior [to the incidents] in medication pass; he missed a right of medication. The DON notified the doctor [Physician] and Family." In the same interview, she continued to say, "I started education that day on Abuse, and Neglect is the whole building, [the] 9 Rights of medications, syringes, NJ EX Order. 264b1 vials are in separate drawers in the med [medication] cart, but now NJ EX Order. 264b1 are in place, we, nurses triple checked the NJ EX Order. 264b1, nurses did med pass and NJ EX Order. 264b1 competencies. All new hires are being med passed." During a telephone interview on 4/24/2023 at 11:53 a.m., when the Surveyor asked him what happened concerning the medications, the LPN stated, Resident #1 got meds [medications] at the end of the 3:00 p.m. -11:00 p.m. shift. He further	F 760		

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F 760	Continued From page 30 stated that Resident #1 acted out with NJ EX Order. 264b1 NJ EX Order. 26; he was unsure of the time. The NJ EX O was NJ EX, started [an] NJ EX Ord e [and] called 911. "Later on, we discovered, Resident #3 was showing signs of not NJ EX Order. 264b1 /she was moving [his/her] NJ EX Order around in an NJ EX Order. 264b1, so we [me & RNS #1] and RNS #2, a whole team of nurses checked everything to include: NJ EX Order. 264b1 . Then, EMT (emergency medical team) was there [and] helped, NJ EX Order. 264b1 was NJ EX Or and took him/her to hospital." In the same telephone interview, the LPN continued to say, "[I] look in [the medication] cart for NJ EX Order. 2 look at the bottle. I know I picked up [the] NJ EX Order. 26 bottle; it's possible that I mixed it up." The LPN explained, "When I picked up the bottle and vial, it may be possible I picked up the NJ EX Order. bottle. All the NJ EX ML (milliliters) vials are the same. [The] NJ EX Order. 26 vials were mixed up in the cart, in brown bottles, [it was] not separated. The vial is in [a] brown bottle. All just mixed up on the cart. I might not have looked at the vial. When I took it out of the drawer, it's possible I didn't look at it." During a telephone interview on 4/24/2023 at 12:20 p.m., RNS #2 stated, around 11:15 p.m., we [the nurses] heard [a] NJ EX Order. 264b1, checked the rooms, and found Resident #1 NJ EX Ord . The NJ EX was checked, and it was NJ EX. She further stated that NJ EX Order. 264b1 was NJ EX Order. 264b1), and then the NJ EX went up to NJ EX and then NJ EX the second time. 911 was called, NJ EX NJ EX Order. 264b1 was started, and the NJ EX increased to NJ EX O During an interview on 4/24/2023 at 2:12 p.m.,	F 760		

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F 760	Continued From page 31 the Surveyor asked the DON about the breakdown, which led to Residents #1 and 3 receiving NJ EX Order. 264b1 instead of NJ EX Order. 264b1n. She replied, "I couldn't identify the breakdown. As we investigated, he (LPN) said it was a possibility he didn't practice the 9 [nine] rights of medication...." During a post-survey telephone interview on 4/26/2023 at 1:16 p.m., the Physician, Medical Director, stated he consulted with the hospital NJ EX Order. 264b1. The Medical Director explained to the Surveyor, "According to the NJ EX Order. 264b1 once you give NJ EX Order. 264b1, it shows up as NJ EX Order. 264b1 in your system." Both residents were given NJ EX Order. 264b1, so the lab results are the same. NJ EX Order. 264b1 shows as NJ EX Order. 264b1 in the lab results. During the same interview, when the Surveyor asked about Resident #1's NJ EX Order. 264b1 before the NJ EX Order. 264b1 was given, the Medical Director stated, "Most likely [the] medication error was NJ EX Order. 264b1, but we cannot test for NJ EX Order. 264b1 due to NJ EX Order. 264b1 being given ..." He further stated other causes were ruled out; the only cause of the NJ EX Order. 264b1 is NJ EX Order. 264b1, by exclusion. Resident #3 was in [the] same situation as Resident #1. A review of the facility policy titled "Administering Medications" with an updated date 10/2022 revealed the following: Under "Policy Statement": included: "Medications shall be administered in a safe and timely manner, and as prescribed." Under "Policy Interpretation and Implementation" included: " ...5. The individual administering the medication must check the label against the Physician's order to verify the right Resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication."	F 760		

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F 760	Continued From page 32 A review of the facility policy titled "Identifying and Managing Medication Errors and Adverse Consequences" with a revised April 2022 date revealed the following: Under "Policy Statement": included: "The Staff and practitioner shall try to prevent medication errors and adverse medication consequences and shall strive to identify and manage them appropriately when they occur." Under "Policy Interpretation and Implementation" included: "1. The staff and practitioner shall strive to minimize adverse consequences by a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication; b. Defining the appropriate indications for use; ..." A review of the facility policy titled "Physician Orders" with a revised date of December 2022 revealed the following: Under "Policy" included: "Medication and treatment orders will be accepted only from authorized, credentialed physicians or from other authorized, credentialed practitioners in accordance with state regulations regarding prescriptive privileges." Under "Purpose," included: "To ensure all medication and treatment orders are received from a credentialed practitioner before implementing." Under "Process" included: "Type of Order:" "1. Admission, Interim, Re-admission, and Renewal Orders: 2. Must be written on the appropriate Physician Order Sheet and Interim Plan of Care; 3. IV (intravenous) orders must be written on the appropriated IV Protocol Sheet (Central, Mid-line, or Peripheral) ..."	F 760		

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F 760	Continued From page 33 N.J.A.C.: 8.39-29.2 (d)	F 760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807**

(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
S 000	Initial Comments Complaint#: NJ163545, NJ163595, NJ163682 Census: 151 Sample: 9 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 deficieny 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: Complaint#: NJ163545, NJ163595, NJ163682 Based on interviews and review of facility documents on 4/20/2023 and 4/24/2023, it was determined that the facility failed to ensure staffing ratios were met for 14 of 14 day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include:	S 560	1. No residents were identified 2.. The deficient practice has the potential to affect all residents residing in the facility. 3 Bonuses are offered as needed for open shifts. beginning 5/22/2023 all Nursing	5/25/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061806	A. BUILDING: ______ B. WING ______	C 04/24/2023

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S 560	Continued From page 1 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. A review of Nursing Staffing Reports from 04/02/2023 through 04/08/2023; and 04/09/2023 through 04/14/2023 revealed the following 14 shifts: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: On 04/02/23 had 16 CNAs for 153 residents on the day shift, required 19 CNAs. On 04/03/23 had 16 CNAs for 153 residents on the day shift, required 19 CNAs. On 04/04/23 had 14 CNAs for 152 residents on the day shift, required 19 CNAs. On 04/05/23 had 16 CNAs for 151 residents on the day shift, required 19 CNAs.	S 560	staff were re-educated on the call out and lateness policy by DON or designee. advertisements signs for open CNA positions are placed in front of the building. The facility is recruiting on multiple employment search engines and multiple social media platforms for CNAs, and has a dedicated recruitment team. Reviewed Facility Staffing Agency contracts, additional Agency Contracts under review. 4. The DON/Designee will conduct weekly x 4 weeks C.N.A. staffing schedule audits. Then quarterly x 1 quarter. " The DON/Designee will report audit findings to the Administrator, and will be presented at the monthly QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061806	A. BUILDING: ______ B. WING ______	C 04/24/2023

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S 560	Continued From page 2 On 04/06/23 had 16 CNAs for 151 residents on the day shift, required 19 CNAs. On 04/07/23 had 15 CNAs for 151 residents on the day shift, required 19 CNAs. On 04/08/23 had 15 CNAs for 151 residents on the day shift, required 19 CNAs. On 04/09/23 had 16 CNAs for 151 residents on the day shift, required 19 CNAs. On 04/10/23 had 15 CNAs for 151 residents on the day shift, required 19 CNAs. On 04/11/23 had 16 CNAs for 151 residents on the day shift, required 19 CNAs. On 04/12/23 had 17 CNAs for 151 residents on the day shift, required 19 CNAs. On 04/13/23 had 14 CNAs for 152 residents on the day shift, required 19 CNAs. On 04/14/23 had 17 CNAs for 152 residents on the day shift, required 19 CNAs. On 04/15/23 had 17 CNAs for 152 residents on the day shift, required 19 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061806 Y1	A. Building B. Wing Y2	6/12/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/12/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/24/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315134	A. Building B. Wing	6/12/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 06/12/2023	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 06/12/2023	ID Prefix F0760 Reg. # 483.45(f)(2) LSC	Correction Completed 06/12/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/24/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO