New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90106	A. BUILDING: ________ B. WING ________	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW MOUNT LAUREL	400 FERNBROOKE LANE MOUNT LAUREL, NJ 08054

(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
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ 00156837 CENSUS: 92 SAMPLE SIZE: 4 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

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

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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00156837 Based on interview and record review, it was determined that the facility failed to implement their pharmacy policy to ensure medications were ordered and received by the provider pharmacy for administration in accordance with prescriber's orders for 1 of 4 residents, Resident #2, as evidenced by the following: At 9:45 a.m., the surveyor reviewed the closed medical record of Resident #2's who no longer resided at the facility. According to the "Face Sheet", the resident's move in date was March of 2021 with diagnoses which included Ex.Order 26 Resident #2 had a physician's order on 7/19/2022 to discontinue EX Order 26 § 4b1 . This order had one refill. On 7/27/2022, the prescriber ordered EX Order 26 § 4b1 EX Order 26 § 4b1 On 8/3/22, the physician identified that the EX Order 26 § 4b1 was not administered to the resident from 7/27-8/2/22, a total of seven (7) days, preceding the resident becoming unresponsive	A 310		

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A 310	Continued From page 2	A 310		

requiring transfer to the hospital. The ED confirmed that Resident #2 never received the prescriber's order for EX Order 26 § 4b1. dated 7/27/22 which, according to the pharmacy, had not been received. Because of this, the pharmacy did not dispense Ex.Order 26.4(b)(1) and the order did not appear on the eMAR.

The Health Services Director (HSD) told the surveyor that the pharmacy did not send the EX Order 26 § 4b1 refill from the 7/19/22 prescription neither had the pharmacy acknowledged the receipt of the 7/27/22 Ex.Order 26.4(b)(1) order. The surveyor then asked the HSD what system was put in place to ensure that the resident(s) Ex.Order 26.4(b)(1) orders were faxed, received and delivered by the pharmacy. The HSD stated that there was no system in place prior to the above incident and had no issues. She stated that the community was working with the pharmacy to put a system in place to follow up orders and refills with pharmacy.

On 8/12/22 at 2:03 p.m., the HSD emailed the surveyor the following policy from the facility's pharmacy manual:
Pharmacy Deliveries
5. Within 6 hours from receipt of delivery, the community shall review all manifestos ensure all items have been received
There was no documented evidence of reconciliation of the medications received with that which was ordered in accordance with the pharmacy policy. Therefore, the omission of the 7/27/2022 EX Order 26 § 4b1 order had not been identified.

The ED stated that the facility was working with the pharmacy to correct the issues.

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A 310	Continued From page 3 The facility failed to implement their pharmacy policy to ensure medications were ordered and received in accordance with prescriber's orders. The facility failed to ensure medications were faxed to the pharmacy, reconciled upon receipt of medications from pharmacy compared to what was ordered and ensure such orders appeared on the e MAR. The failure to implement their pharmacy policy to ensure the procurement, receipt and administration of medications resulted in Resident #2's failure to receive Ex.Order 26.4(b)(1) mg. in accordance with the physician's order. Refer to N.J.A.C. 8:36-11.2	A 310		
A 925	8:36-11.2 Pharmaceutical Services The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00156837 Based on interview and record review, it was determined that the facility failed to ensure that medications were ordered and received from the pharmacy for administration to residents in accordance with prescriber's orders for 1 of 4 residents reviewed, Resident #2. This deficient practice was evidenced by the following:	A 925		

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A 925	Continued From page 4 On 8/10/22 at 9:30 a.m., the surveyor interviewed the Executive Director (ED) regarding a Reportable Event Record/Report (RER) dated 8/3/22 that was sent to the Department of Health (DOH). The ED stated that Resident #2 had a prescriber's order for EX Order 26 § 4b1. dated 7/19/22 for quantity of EX Order 26 § 4b1. The ED stated that the EX Order 26 § 4b1 was not refilled by the facility's pharmacy. Additionally, the ED stated that Resident #2 received another prescriber's order for EX Order 26 § 4b1 dated 7/27/22 which, according to the pharmacy, had not been received. Because of this, the pharmacy did not dispense EX Order 26 § 4b1. and the order did not appear on the eMAR. The ED explained that as a result of the incident, the medication was not administered to the resident from 7/27 to 8/2/22. She added that the resident was transferred to the hospital on Ex.Order 26.4(after being observed unresponsive. The surveyor then inquired from the ED the system that was put in place to ensure that residents receiving Ex.Order 26.4(b)(1) where the dose was triturated based on PT/INR results (Prothrombin Time/International Normalized Ratio, a measure EX Order 26 § 4b1 as received and filled by the pharmacy The ED stated that the facility was working with the pharmacy to correct the issues. EX Order 26 § 4b1 The surveyor reviewed the updated RER provided by the ED which revealed, "... Resident has a diagnosis of EX Order 26 § 4b1 On 8/3/22 it was discovered that a EX Order 26 § 4b1 order was written on 7/19/22 for 7 days with one refill. The dose was	A 925		

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A 925	Continued From page 5	A 925		

discontinued on 7/26/22 and the refill was not sent to the community by the pharmacy. Therefore, medication was not received. Resident did not receive medication for 7 days. Resident was sent to the hospital on EX Order 26 §."

At 9:45 a.m., the surveyor reviewed the closed medical record of Resident #2's who no longer resided at the facility. According to the "Face Sheet", the resident's move in date was March of 2021 with diagnoses which included EX Order 2 . Surveyor review of the "Service Plan Detail" dated 1/27/22, completed by a Registered Nurse (RN), indicated that the resident had no communication impairment and was able to communicate effectively and made needs known to staff. The "NJ HSE (Health Service Evaluation) Results," assessment, a tool used to gather information on a resident's needs dated 7/18/22, under "Neurocognitive" completed by a Registered Nurse (RN), indicated that the resident had no impairment and was oriented to person, place, time and situation.

Surveyor review of the resident's medical record revealed Progress Notes (PN) dated 8/3/22 at 7:23 a.m., written by a Licensed Practical Nurse (LPN) #1 that the resident was sent out via 911 (Emergency Medical transport) by LPN #2. LPN #1 documented, "RA [Residential Aide] found resident in bed unresponsive. Per LPN #2, resident shows signs of EX Order 26 § 4b1 . 911 called and resident sent to ... hospital."

The surveyor observed two (2) prescriptions dated 7/19/22 and 7/27/22, with the following Ex.Order 26.4(b)(1) orders:

On 7/19/22, D/C (discontinue) EX Order 26 § 4b1 EX Ord

New Jersey Department of Health

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A 925	Continued From page 6 EX Order 26 § 4b1 In addition, the surveyor reviewed the Electronic Medication Administration Record (eMAR) for the months of July and August 2022. The surveyor observed that in the month of July, Coumadin 4 mg was not documented as administered from 7/27 to 7/31/22; and for the Month of August, there was no Ex.Order 26.4(b)(1) order on the eMAR from 8/1 to 8/2/22. At 10:55 a.m., the surveyor interviewed the Health Services Director (HSD) regarding Resident #2. She stated that on Ex.Order 26.4(at approximately 7:30 a.m., the resident had a change in mental status and showed signs and symptoms of a Ex.Order 26.4(b and was transferred to the hospital to rule out, "Possible cerebrovascular accident (CVA)." The HSD told the surveyor that the resident's physician was notified of the resident's transfer to the hospital. The HSD added that while the physician was reviewing the resident's medications, the physician identified that the Ex.Order 26.4(b)(1) was not administered to the resident from 7/27-8/2/22, a total of seven (7) days prior to this event. During continued interview, the HSD told the surveyor that the pharmacy had not sent the Ex.Order 26.4(b)(1) refill from the 7/19/22 prescription neither had the pharmacy acknowledged the receipt of the new 7/27/22 EX Order 26 § 4b1. order. The surveyor then asked the HSD what system was put in place to ensure that the resident(s) Ex.Order 26.4(b)(1) orders were faxed, received and	A 925		

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A 925	Continued From page 7 delivered by the pharmacy. The HSD stated that there was no system in place prior to the above incident and had no issues. She stated that the community was working with the pharmacy to put a system in place to follow up orders and refills with pharmacy. The surveyor reviewed a Time-line provided by the HSD via email on 8/15/22 at 4:39 p.m., which documented, "EX Order 26 § 4b Resident passed away ... [Resident #2] was receiving care through Samaritan inpatient hospice. (Notified on Saturday by family)." On 8/16/22 at 1:30 p.m., the surveyor interviewed LPN #1 regarding Resident #2's EX Order 26 § 4b1 order dated 7/27/22. LPN #1 stated that on 7/27/22 (time unknown) that she faxed the EX Order 26 § 4b1 prescription to the pharmacy and placed the confirmation slip in the pile to be approved in the system by the next shift. The surveyor then inquired if LPN #1 followed up with pharmacy to ensure the medication order was received by pharmacy. LPN #1 stated, "No" and that there was no need and would show up in the system." On the same day at 7:30 p.m., the surveyor interviewed LPN #3 who was on duty on 7/27/22. LPN #3 stated that she was on duty from 7 p.m.-11 p.m. and was responsible to ensure that the medications faxed to pharmacy were approved in the system and would call pharmacy if there were any discrepancies. LPN #3 stated that Resident #2's EX Order 26 § 4b1 order was not in the system to be approved and that there was no EX Order 26 § 4b1 order or confirmation slip in the pile that she approved on 7/27/22. Surveyor review of the resident's medical record failed to provide documented evidence that the	A 925		

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A 925	Continued From page 8 prescription dated 7/27/22 for EX Order 26 § 4b1 . had been received by the pharmacy. Upon receipt of the 7/27/22 medication delivery, there was no documented evidence that the medications received were reconciled with those that were ordered to ensure residents medications were available for administration in accordance with the physician's orders resulting in the failure of Resident #2 receiving EX Order 26 § 4b1 to prevent blood clots related to Ex.Order 26	A 925		
A 963	8:36-11.5(f) Pharmaceutical Services (f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00156837 Based on interview and record review, it was determined that there was no documented evidence that medications were administered in accordance with prescriber's orders for 1 of 4 residents reviewed for medications, Resident #2. This deficient practice was evidenced by the following: On 8/10/22 at 9:45 a.m., the surveyor reviewed the closed medical record for Resident #2 who no longer resided at the facility. According to the "Face Sheet", the resident's move-in date was	A 963		

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A 963	Continued From page 9 March of 2021 with diagnoses which included Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1) Surveyor review of the "Service Plan Detail" dated 1/27/22, completed by a Registered Nurse (RN), indicated that the resident had no communication impairment and was able to communicate effectively and made needs known to staff. Surveyor review of the Electronic Medication Administration Record (eMAR) for the month of July and August 2022 revealed that the resident's 7/27/22 order for Ex.Order 26.4(b)(1) daily by mouth for 7 days was not contained on the eMAR and thereby not documented as administered to the resident for 7 days, from July 27 to August 2, 2022. Ex.Order 26.4(b)(1) is an Ex.Order 26.4(b)(1)t used to prevent blood clots in patients with a diagnosis of Ex.Order 26.4(b)(1). Resident #2 was transferred to the hospital on Ex.Order 26.4(b having been found to be unresponsive and later expired on EX Order 26 § 4b at in-patient hospice. During interview with the Executive Director (ED) and the Health Services Director (HSD) at 9:30 a.m., and at 10:55 a.m., both confirmed that Resident #2 was not administered the EX Order 26 § 4b1 EX Order 26 § 4b1 7/27-8/2/22 as ordered by the physician. The resident was transferred to the hospital on 8/3/22 to rule out Ex.Order 26.4(b)(1) and later expired on EX Order 26 § 4b at in-patient hospice. Refer to 8:36-11.2	A 963		

September 9, 2022

Re: Plan of Correction

Deficient Practice: A310, 8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1: Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights.

1. Resident #2 no longer resides at community
2. All Residents could potentially be affected by this practice.
3. The Remedi Stamp will be utilized for Prescriptions which includes Faxed, Time, and Initial once verification of transmission is received.
   Original prescriptions will be verified in the eMAR system. After order is verified, the prescription will then be filed into the medical record.
4. Remedi Pharmacy Manual processes/procedures will be reviewed with the Health Services Director, Executive Director, and Wellness Nurses. Wellness nurses will be in-serviced to notify Health Services Director/RN if any prescriptions are not populated in the eMAR by the end of the daily shift. If a problem is identified, Health Services Director/RN will notify the Executive Director of the concern and implement a plan of action. Any incidence will be reviewed at monthly safety meeting.

Completion date: September 15, 2022

Deficient Practice: A925, 8:36-11.2 Pharmaceutical Services. The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations.

1. Resident #2 no longer resides at community
2. All residents could potentially be affected by this practice.
3. Pharmacy produces a "soon to be expiring" report daily. This report will be reviewed by RN/Wellness nurse daily to identify any upcoming expiring medications.
4. Wellness nurses to be in-serviced- Health Services Director/RN will be notified of any medications on the "soon to be expiring" report that presents any potential concerns. Health Services Director/RN will notify Executive Director of any identified concerns. Any concerns to be reviewed during monthly safety meeting.

Completion date: September 15, 2022

Deficient Practice: A963, 8:36-11.5(f) Pharmaceutical Services

(f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders.

1. Resident #2 no longer resides at community

2. All residents could potentially be affected by this practice.

3. Original prescriptions will be used to verify orders. Prescriptions will not be filed in chart until order is verified in eMAR system. Any outstanding prescriptions would indicate a potential problem at which time Nurse will follow up with pharmacy.

4. Wellness nurses to be in-serviced to utilize original prescriptions to verify orders in the eMAR. Any outstanding prescriptions by the end of their shift would indicate a problem that requires follow up with the pharmacy. Wellness Nurse to notify the Pharmacy and Health Services Director/RN of problem as soon as it is identified. Any concerns will be reviewed during monthly safety meeting.

Completion date: September 15, 2022

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
90106 (Y1)	A. Building B. Wing (Y2)	9/12/2022 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW MOUNT LAUREL	400 FERNBROOKE LANE MOUNT LAUREL, NJ 08054

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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 09/15/2022	ID Prefix A0925 Reg. # 8:36-11.2 LSC	Correction Completed 09/15/2022	ID Prefix A0963 Reg. # 8:36-11.5(f) LSC	Correction Completed 09/15/2022
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	
8/10/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO