DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315110	A. BUILDING ______ B. WING ______	01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW REHABILITATION AND CARE CENTER	**130 TERHUNE DRIVE WAYNE, NJ 07470**

(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 Survey Date: 01/06/2020 Census: 100 Sample Size: 26	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility staff failed to follow physician's orders to accurately document in the electronic Medication Administration Record (eMAR) the amount of a [redacted] administered to 1 of 26 residents reviewed, Resident #47. This deficient practice was evidenced by the following: On 12/27/19 at 10:20 AM, the surveyor observed the resident in bed awake and watching television. A review of the resident's Face Sheet (an admission summary), reflected that the resident was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses that included but were not limited to [redacted] The surveyor reviewed the Physician's Order Sheet (POS) which revealed that Resident #47	F 658	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this POC is not an admission that a deficiency exists or that one was cited correctly. The POC is submitted to meet requirements established by state and federal law. 1) In correcting deficiency F658 the facility has formulated a plan that will ensure the facility staff follow physicians' orders to accurately document in the electronic medication administration record (EMAR) the amount of nutritional supplement administered. Resident #47 was assessed and found to have no ill effects as a results of this deficiency. Resident #47's [redacted] order was revised on 1/4/2020 and an alert was added into our EMAR requiring nurses to document the amount of supplement consumed.	1/10/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/14/2020

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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had a Physician's Order (PO) dated 9/14/19 for the [redacted] by mouth 3 times per day. The PO further indicated to document the quantity (ml) that the resident consumed. [redacted] is a type of [redacted] providing complete and balanced nutrition.

A review of the October 2019 through December 2019 eMAR showed that the supplement was signed by nursing that it was administered as ordered by the Physician but there was no consistent documentation as to the quantity consumed by the resident as was also ordered by the physician. Review of the October 2019 eMAR revealed 49 undocumented amounts consumed, November 2019 revealed 11 undocumented amounts consumed and December 2019 revealed 42 undocumented amounts consumed.

On 12/31/19, the surveyor discussed the above concern with the Director of Nursing (DON) who agreed that there were many missing documented consumed quantities of [redacted] from October 2019 through December 2019 that should have been noted.

On 1/3/20 at 9:28 AM, the surveyor interviewed the Registered Nurse assigned to Resident #47 who agreed that the all nurses providing the [redacted] to the resident must document the amount the resident consumes in the eMAR.

On 1/3/20 at 1:30 PM, the surveyor spoke to the Administrator and DON regarding the discrepancy. There was no additional information provided.

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2) An audit of all residents who have orders to receive [redacted] was completed on 1/7/2020. No other residents were found affected by this deficiency.

3)Education was provided to all nursing staff regarding this new EMAR alert with instructions on how to document the amount of supplement consumed.

4)The Unit Manager/Designee will randomly audit 10 residents on [redacted] weekly for 4 weeks, then monthly for 3 months, and then quarterly to ensure compliance with recording the amount of supplement consumed.

5)Any negative findings will be reported to the DON/Administrator/Designee and will be immediately addressed.

6) The results of the audits will be reported monthly during the monthly QAPI meeting for 3 months, then quarterly in the quarterly meetings for a total of one calendar year.

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F 658	Continued From page 2 NJAC 8:39 - 27.1	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to assess and develop an individualized care plan for a resident with [redacted] [redacted] This deficient practice was identified for 1 of 2 residents (Resident #71) reviewed for limited range of motion (ROM). This deficient practice was evidenced by: On 12/27/19 at 10:11 AM, the surveyor observed Resident #71 lying in bed and noted the resident had limited [redacted]	F 688	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, the submission of this Plan of Correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1)In correcting deficiency F 688 the facility has formulated a plan that will ensure a resident who enters the facility without	1/10/20

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. The surveyor also noted there was an available for the resident's use.

On 12/31/19 at 8:39 AM, the surveyor observed the resident lying in bed positioned towards his/her left side and with the available for use. Resident #71 was unable to use the for repositioning when prompted by the surveyor.

A review of the resident's Face Sheet (an admission summary), reflected that the resident was admitted to the facility on , with diagnoses which included but was not limited to

A review of the Quarterly Minimum Data Set (QMDS), an assessment tool, with an Assessment Reference Date (ARD) of reflected that a brief interview for mental status (BIMs) was

The QMDS showed that the resident required total two person assistance with bed mobility, transfers, and toileting. In addition, the QMDS indicated that the resident had

A review of the Occupational Therapy Discharge Summary (OTDS) provided by the Occupational Therapist/Rehab Director (OT/RD) dated 7/18/17 documented that the goal for Resident #71 was to

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limited range of motion does not experience a reduction in range of motion. Unless, the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion.

2)The Director of Rehabilitation completed an evaluation on resident #71 on 12/31/2019. Resident #71 was placed on rehab program. A physician's order was received for the use of an and a care plan for the use of an was initiated on 1/2/2020.

3)An audit of all residents currently utilizing medical equipment to maintain mobility and ROM was completed on 1/10/2020. Physicians' orders were reviewed for compliance to ensure all medical devices had the proper orders. Care plans were reviewed to ensure that all residents utilizing an assistive device to maintain ROM and mobility, were care planned appropriately. No other residents were found to be affected by this deficiency. The policy was reviewed. The facility revised its procedure for initiating and discontinuing positioning and mobility devices. The new procedure requires nursing to submit a rehab request to assess the appropriateness of adding or removing a device.

Rehab screens will be conducted on all

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transfer out of bed with use of side rails and [redacted] with maximum assist. The transfer was documented on the OTDS as "was attempted but unable to complete tasks due to refusal and apprehension".

A review of the individualized care plan included, "2 1/2 side rails as enabler for bed mobility" but did not include the use of an [redacted]

The surveyor reviewed the 11/19/19 Rehabilitation Screen for Occupational Therapy (OT) which did not indicate that the resident had used a [redacted]

Further review of the electronic medical record revealed that there was no other assessment related to the use of the [redacted] after the 7/18/17 OTDS.

Review of the Physician's Progress Notes (PN) dated 11/15/19 revealed that Resident #71 was a [redacted]. The 11/15/19 Physician's Progress Note did not include any order or documentation related to the use of the [redacted].

On 12/31/19 at 8:58 AM, the OT/RD informed the surveyor that any resident with equipment similar to the [redacted], should be assessed at least annually for it's use and safety as a standard of practice.

The OT/RD provided the surveyor the OTDS dated 9/21/18 which did not include any documentation related to the use of the [redacted] The OT/RD stated that 9/21/18 was the last

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residents upon admission, quarterly, and with a significant change in status or decline in function. Education was provided to all nurses and rehab staff on the documentation requirements for utilization of medical equipment and on the new revised policy.

4) The Rehab Director/Designee will randomly audit the medical record of 5 residents who utilize medical devices to maintain ROM/Mobility to ensure compliance with documentation. Audits will be conducted weekly for 4 weeks, then monthly for 3 months then quarterly for one year.

The Unit Manager/Designee will randomly audit the medical record of 5 residents who utilize medical devices to maintain ROM/mobility to ensure compliance with physicians' orders, treatment administration records, and care plans.

All negative findings will be reported to the Administrator/DON/Designee to be immediately addressed.

These audits will be conducted weekly for 4 weeks, then monthly for 3 months, then quarterly for one year.

The results of these audits will be reported at the monthly QAPI committee meeting for 3 months, then in quarterly QAPI for 1 year.

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time the resident was on Skilled Occupational Therapy.

On 12/31/19 at 9:33 AM, the Certified Nursing Assistant (CNA) informed the surveyor that the resident experienced some [redacted], required total assistance with activities of daily living (ADLs) and utilized the bedside rail (with their [redacted]) for positioning with staff assistance. The CNA stated that she had never witnessed Resident #71 use the [redacted] for bed mobility and that there were no significant changes noted with the resident's functional ability.

On 12/31/19 at 1:17 PM, the survey team met with the Administrator, Director of Nursing (DON) and the Regional Nurse and were made aware of the above concerns.

On 1/2/2020 at 8:45 AM, both the MDS Coordinators #1 and 2 stated that Resident #71's [redacted] and the resident continues to be a 2 person assist with bed mobility.

On 1/3/2020 at 12:18 PM, the Administrator, DON, and OT/RD both acknowledged that there was no care plan and order for the [redacted] and that there should be an annual assessment of the resident's use of the [redacted].

A review of the undated facility policy regarding Assistive Devices and Equipment provided by the Administrator indicated: "Recommendations for the use of devices and equipment are based on the comprehensive assessment," and "the resident will be assessed for lower extremity and upper extremity strength, range of motion,

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balance and cognitive abilities when determining the safest use of devices and equipment."

A review of the undated facility policy regarding Comprehensive Person-Centered Care Plans provided by the DON indicated: "The comprehensive, person-centered care plan will: aid in preventing or reducing decline in the resident's functional status and/or functional levels; enhance the optimal functioning of the resident by focusing on a rehabilitative program."

NJAC 8:39-27.1(a)

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		1/10/20

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and

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F 758	Continued From page 7 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to consistently monitor, document and evaluate the ongoing benefits of an increased dose of [redacted] medication. This deficient practice was identified for 1 of 2 residents (Resident #14) reviewed for antipsychotic use. The deficient practice was evidenced by the following: On 12/30/19 at 9:55 AM, the surveyor observed	F 758	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this POC is not an admission that a deficiency exists or that one was cited correctly. The POC is submitted to meet requirements established by state and federal law. 1)In correcting deficiency F758 the facility has formulated a plan that will ensure the facility staff consistently monitor, document, and evaluate the ongoing	

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the resident seated on the side of the bed. The resident told the surveyor that he/she did not want to talk to anyone.

On 12/30/19 at 9:46 AM, the surveyor interviewed the RN who cares for Resident #14 who informed the surveyor that the resident was [redacted], independent with activities of daily living (ADLs) with minimal set up from the staff and preferred to stay in her room with door closed at all times.

On 12/30/19 at 9:58 AM, the Registered Nurse/Unit Manager (RN/UM) informed the surveyor that the resident was [redacted] with a diagnosis of [redacted] The RN/UM stated that Resident #14 does not get along with other people.

A review of the resident's Face Sheet (an admission summary), revealed that the resident was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted]

The surveyor reviewed the Quarterly Minimum Data Set (MDS), an assessment tool, with an Assessment Reference Date (ARD) dated [redacted] The included Brief Interview for Mental Status (BIMS) referenced a score of [redacted].
The MDS further identified that Resident #14 had received an [redacted] medication on a routine basis.

A review of the Physician's Progress Notes dated

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benefits of a change in psychotropic medications.

2) On 01/30/20 the psychiatrist visited the evaluated resident #14. He decreased the [redacted] as the resident denied having any further auditory or visual hallucinations and no other residents were found to be affected by this deficiency. Resident will be placed on close monitoring for the next 14 days.

3) An audit was completed by the unit managers on 01/09/20 to ensure that any residents receiving psychotropic medications are consistently monitored, have documentation and evaluations for the ongoing benefit of a change in psychotropic medications. No other residents were found to be affected by this deficiency.

4) Education was provided to the nurses on the importance of monitoring and documenting behaviors and the effectiveness of psychotropic medications especially during dose adjustments.

5) The unit managers/designee will randomly audit 5 charts weekly for 4 weeks, then monthly for 3 months, then quarterly for 1 year for compliance with monthly [redacted] summaries.

6) The unit managers/designee will randomly audit 5 charts weekly for 4 weeks, then monthly for 3 months, then quarterly for 1 year for compliance with ongoing monitoring by nurses, with dose

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F 758	Continued From page 9 5/31/19 for [redacted] Consultation follow up revealed that Resident #14 was [redacted] and continued to experience [redacted] at times and recommended to increase [redacted]. In addition, the 5/31/19 [redacted] Consultation indicated to call the doctor if symptoms worsen. A review of the December 2019 Physician's Orders dated 5/31/19 documented an order for the increase in [redacted] in the evening. Further review of the medical records revealed that there was no documented evidence that the resident was monitored after the resident's [redacted] dose was increased. On 1/2/2020 at 10:53 AM, the Director of Nursing (DON) informed the surveyor that the behavior monitoring should be documented in the electronic medical record. She stated that the Monthly Psychiatric Summary (MPS) should be done monthly. On 1/2/2020 at 12:59 PM, the DON informed the surveyors that there were no MPS notes and monitoring that was done from June 2019 through September 2019 when the [redacted] dose was increased on 5/31/19 for Resident #14. She further stated, "unfortunately we only have MPS that were completed for October and November 2019." The DON acknowledged that there should have been MPS monitoring for the use of [redacted] monthly. On 1/3/2020 at 9:34 AM, the Licensed Practical Nurse (LPN) informed the surveyor that Resident	F 758	adjustments for residents receiving psychotropic medications. All negative findings will be reported to the DON/Designee to be immediately addressed. 7)The results of each audit will be reported in monthly QAPI for 3 months then in quarterly QAPI for 1 year.	

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#14 was [redacted] and currently treated with [redacted]. The LPN stated that the resident was noted to have some behavior improvement. The LPN further stated that there had been no [redacted] noted for Resident #14.

On 1/3/2020 at 9:42 AM, the Registered Nurse/Unit Manager (RN/UM) informed the surveyor that the episodic behavior documentation should be done in the electronic medical record when behaviors are noted and the MPS should be done monthly. She further stated that the MPS and monitoring for use of [redacted] for Resident #14 were not being done accurately.

On 1/3/2020 at 12:18 PM, the survey team met with the Administrator, DON, and Regional Nurse and were made aware of the concerns.

On 1/6/2020 at 10:52 AM, there was no further information provided by the facility.

A review of the undated facility's Psychotropic Medication Use Policy provided by the DON reflected, "Residents will be monitored for effectiveness and potential adverse consequences related to psychotropic medication use," and "A psychotropic Drug Monitoring Summary progress note will be completed monthly."

NJAC 8:39-11.2 (b); 27.1 (a)