STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315331	A. BUILDING _____ B. WING _____	06/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PASSAIC COUNTY	77 EAST 43RD STREET PATERSON, NJ 07514

(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 Standard Survey: 06/17/2019 Census: 140 Sample Size: 31 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items	F 582		7/19/19

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

Electronically Signed | 07/03/2019

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F 582	Continued From page 1 and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to issue the proper required Notice of Medicare Noncoverage (NOMNC) for 2 of 3 residents (#98, #118 and #239) reviewed for facility change notifications, residents remaining in the facility after Medicare Part A benefits expired. On 6/11/19 at 10:46 AM, the facility presented the surveyor with a list of residents who were discharged from the facility within 6 months and	F 582	I.CORRECTIVE ACTIONS FOR THOSE AFFECTED: There is no way to have this action corrected as the facility failed to have these letters sent timely. Social work director has been educated on notifying residents when changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan and provide notice to residents of the change as soon as is	

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F 582	Continued From page 2 should have received Beneficiary Notices. The surveyor reviewed 3 of the residents (Resident #98, #118 and #239) listed which were discharged from a Medicare Part A stay at the facility and were documented as having a discontinuation of their Medicare Part A insurance payment to the facility. Resident # 98 was admitted to the facility on [redacted] and readmitted on [redacted]. The last documented covered day of coverage for Medicare Part A service was [redacted]. The facility did not present the resident with the required NOMNC form to notify them of the termination of insurance. Resident #118 was admitted to the facility on [redacted] and readmitted on [redacted]. The last documented covered day of coverage for Medicare Part A service was [redacted] The facility did not present the resident with the required NOMNC form to notify them of the termination of insurance. Resident #223 was discharged home and received the required NOMNC form. On 06/11/2019 at 12:00 PM, the surveyor informed the the Director of Social Services (DSS) and the Director of Nursing (DON) that the facility did not provide the required NOMNC form to Resident #98 and Resident #118 after their Medicare Part A insurance had ceased and they were remaining in the facility. The DSS informed the surveyor that they were not aware that the NOMNC form had to be provided to these residents who continued their stay in the facility after their Medicare Part A insurance had ceased.	F 582	reasonably possible. II.ID OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents covered by Medicare/Medicaid have the potential to be affected. III.SYSTEMIC CHANGES: All residents that are going to have their Part A coverage terminated will receive a notice of Medicare Noncoverage (NOMNC) letter. IV.MONITORING: All Part A residents who have the potential to have their coverage terminated will be reviewed weekly in the (UR) Utilization Review weekly meetings by the Admissions director or her designee. NOMNC letters will be presented to any Part A residents that is being terminated of their overage. Admissions director or designee will audit all Part A terminations weekly times four weeks to ensure the proper notices were given. Findings will be reported to monthly QAPI meetings. Administrator will monitor.	

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F 582	Continued From page 3 NJAC 8:39-5.4 (b)(c)	F 582		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 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	F 656		7/19/19

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F 656	Continued From page 4 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to accurately develop and implement a person-centered comprehensive care plan to meet the resident's medical needs. This deficient practice was observed for 3 of 31 facility residents reviewed, Residents #8, # 20 and # 130, as evidenced by the following: 1. On 6/10/19 at 1:06 PM, the surveyor observed Resident #8 awake in bed. Resident #8 stated that he/she was prescribed an [redacted] medication. The surveyor reviewed Resident #8's records. Resident #8 was admitted to the facility on [redacted] with diagnoses which included [redacted] A review of the Electronic Medication Administration Record revealed the resident had a Physician's Order (PO) for [redacted] 1 tablet by mouth every 12 hours." [redacted] is an [redacted]. The surveyor reviewed the resident's current care plans. There was no care plan developed regarding the resident's PO for the [redacted] medication.	F 656	I.CORRECTIVE ACTIONS FOR THOSE AFFECTED: 1.The care plans for resident #8 were reviewed and updated immediately to include a plan of care related to active medications that the resident is currently taking. 2.Care plans for resident #20 were reviewed and updated immediately to include a plan of care related to resident□s behavior of wandering. 3.Care plan for resident #130 were reviewed and updated immediately to include a plan of care related to resident current behavior of wandering, refusal or medicine and yelling at staff. 4.Staff members were in-serviced on updating care plans immediately when residents are admitted/readmitted, when a new medication is added or discontinued, and with any change in condition noted. II.ID OTHERS WITH THE POTENTIAL TO BE AFFECTED: ALL RESIDENT CARE PLANS HAVE THE POTENTIAL TO BE AFFECTED. 1.All care plans of residents that were	

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F 656	Continued From page 5 On 6/13/19 at 1:20 PM, the surveyor interviewed the nurse assigned to the resident who stated that a care plan for the [redacted] medication should have been created. The nurse was unable to locate a care plan for the use of an [redacted] medication for Resident #8. At 2:15 PM, the surveyor discussed the care plan concern with the Administrator, Assistant Director of Nursing (ADON) and Director of Nursing (DON). They could not explain why a care plan was not developed regarding [redacted] that Resident #8 was prescribed. 2. On 6/13/19 at 2:04 PM, the surveyor observed Resident #20 in another resident's room. This incident was reported to the staff nurse who re-directed the resident back to their own room. Resident #20 was admitted on [redacted] and readmitted on [redacted] with diagnoses which included but not limited to [redacted]. Resident #20 required limited assistance and supervision of one staff assist with Activities of Daily Living (ADL). Resident #20 was documented as [redacted]. The surveyor reviewed the April and May 2019 Physician Monthly Progress Notes that documented that Resident #20 was [redacted] Further review of resident's record, revealed multiple episodes of wandering behavior since 08/06/18. The wandering behavior was never care planned. The resident was care planned for	F 656	admitted/readmitted to the facility were reviewed for complete and accurate documentation of interventions. No missing plans of care were identified. 2.Unit managers/floor nurses were in-serviced on related assessment, documentation, and care planning. 3.All nurses will be in-serviced on care planning and updating care plans as changes occurred quarterly and individually on specific issues as areas of necessary improvement are identified. III. SYSTEMIC CHANGES: 1.All care plans will be reviewed quarterly during care plan meetings for complete, thorough and accuracy by the IDCP team. 2.Unit Managers will do care plan audits for residents with special needs weekly and findings will be reported to the ADON and DON. 3.ADON and DON will audit special needs Care Plan monthly times 3 months. 4.All nurses and members of the IDCP team will be in-serviced on care planning and updating care plans as changes occurred quarterly and individually on specific issues as areas of necessary improvement are identified. 5.Resident□s care plan will be reviewed during morning meeting for those residents who are due for care plan	

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F 656	Continued From page 6 [redacted], but no interventions were documented regarding the wandering behavior exhibited when wandering into other resident's rooms and hallways. On 6/13/19 at 12:44 PM, the surveyor interviewed an LPN, who stated that the resident does not deliberately wander in other's rooms, but that the issue had more to do regarding the resident's [redacted] in relation to location of the resident's bed and room. The LPN further stated that the resident does this, "one to two times per shift", and that the wandering behavior should have been care planned. The surveyor also interviewed an RN on 6/13/19 at 1:12 PM, who stated, "the resident gets lost finding the bathroom and feels the wall to guide [themselves] while ambulating." The RN also stated that Resident #20 had been in other resident rooms before, and that, only the Unit Manager can update the care plan. The RN was not aware that Resident #20 was not care planned for the wandering behavior related to the resident's [redacted] On 6/13/19 at 2:15 PM, the DON and ADON verified that care plan to address wandering was not done. 3. On 6/12/19 at 11:00 AM, the surveyor observed Resident #130 in the room lying in bed with eyes closed. The surveyor reviewed Resident #130's medical records. The resident was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses that include [redacted] A review of the progress notes dated 4/15/19	F 656	review, quarterly, and noted with new behavior. IV.MONITORING: 1.The Unit Managers will audit care plans of residents with special needs weekly and report their findings to the ADON and DON. The ADON and DON will report the trends noted and related interventions to the Administrator and Quality Assurance Committee at the monthly QAPI meeting. 2.The ADON and DON will audit care plans and the care plan meeting process bi-weekly and report their findings quarterly to the Administrator and Quality Assurance Committee at the quarterly QA meetings.	

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F 656	Continued From page 7 through 6/14/19, documented that Resident #130 had ongoing behavioral concerns that included but not limited to, wandering on the unit, refusing care from staff, refusing medications, yelling to staff and family members and agitation. The surveyor reviewed the resident's current care plans. There was no care plan developed regarding the resident's behavior. The surveyor interviewed the Unit Manager who stated that the resident was exhibiting behavioral problems and that there was no care plan reflecting the behavior. On 6/13/19 at 1:30 PM, the surveyor discussed the care plan concern to the Administrator and DON. NJAC 8:39- 11.2 (e)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to follow professional standards of practice when the Physician failed to follow up on a resident's laboratory result, identified for 1 of 31 residents, Resident #92; and, nursing failed to document the administration of a medication on the Electronic Medical Administration Record (eMAR) for 1 of 31	F 658	I.CORRECTIVE ACTION FOR THOSE AFFECTED: 1.Resident #92 assessed and did not have any negative outcome from the deficient practice. The attending physician was notified of the lab result and he did not give any new order at the time the lab result was called into the doctor. A new	7/19/19

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F 658	Continued From page 8 residents, Resident #107. This deficient practice was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 1. On 6/10/19 at 12:54 PM, the surveyor observed Resident # 92 in the bed who was unable to answer questions. The surveyor reviewed Resident # 92's records. Resident # 92 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses which included [redacted]. The surveyor reviewed Resident # 92's laboratory results dated 2[redacted], which indicated a [redacted] which is out of range and considered low. There was a Physician's signature on the laboratory results which revealed that the physician reviewed the lab results and that there were no new orders. The surveyor also reviewed the resident's laboratory results and results from the Physician's Order of [redacted] three times daily on the eMAR from the dates of November	F 658	STAT lab was drawn and was within normal range. The nurse who called the original lab result to the doctor was individually in-serviced about questioning lab results that look questionable or not accurate. 2.Resident #107 assessed, and did not have any negative outcome from the deficient practice. The individual nurse was in-service about proper medication administration techniques and signing the Medication Administration Record (MAR) immediately after medications are administered. II.ID OTHERS WITH POTENTIAL TO BE AFFECTED: ALL RESIDENTS WITH MEDICATIONS AND LABS ORDERED HAVE POTENTIAL TO BE AFFECTED. An audit was completed for all residents lab order for [redacted] there were no negative findings. Med pass was done on nurses and the MAR was signed immediately the medications were administered. 1.All nurses were in-serviced on proper medication administration technique and the importance of signing the MAR immediately medications are administered. 2.All nurses were in-serviced about reporting lab results to physicians, if a lab result looks questionable, they should question it and or obtain an order to	

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F 658	Continued From page 9 2018 to May 2019, which revealed no incidence of [redacted]. A review of the Physician's Progress Notes from the dates of February 2019 to June 2019, revealed no documentation of the [redacted] laboratory result. On 6/13/19 at 12:10 PM, the surveyor interviewed Resident # 92's Physician regarding the above concern, who stated that the resident had no [redacted] episodes, [redacted] and eats by mouth during that day with [redacted] three times daily. The Physician stated that the laboratory result of [redacted] on [redacted], was a laboratory error. The Physician stated that he should have requested a repeat laboratory test to be done for the [redacted]. 2. On 6/11/19 at 9:56 AM, the surveyor observed the [redacted] floor Registered Nurse (RN) administer medication to Resident #107. The RN removed a [redacted] that was dated 6/11/19 from the resident's [redacted] and discarded the [redacted]. The surveyor interviewed Resident #107, who stated that the [redacted] was applied early this morning by the RN. The resident stated that there was no reason for the same RN to remove the [redacted]. The surveyor reviewed Resident #107's June 2019 eMAR for the application of [redacted] which was not signed as documented for 6/11/19. The surveyor interviewed the RN who stated, "I applied the [redacted] early this morning but forgot to document on the eMAR that it was applied."	F 658	repeat lab. III.SYSTEMIC CHANGES: 1.Nurses will continue to be in-serviced on proper medication administration procedure. Medication administration observations are done to ensure proper proficiency by ADON, DON, and Pharmacy Consultant. 2.Medication administration in-service will be scheduled by the ADON to occur every 3 months for all nurses. 3.Unit managers will randomly choose three lab results weekly for 3 months to see if there are any questionable lab results. Findings will be reported to the ADON, and DON on a bi-weekly basis for 3 months. 4.ADON and ADON will trend and present finding to administrator bi-weekly and report at the QAPI meeting monthly for three months, then at quarterly meetings times two. IV.MONITORING: 1.Unit Managers, Nursing Supervisors, will observe nurses during MED PASS to ensure that proper med pass techniques are followed. 2.ADON, DON will do med pass with nurses bi-weekly for three months to ensure adherence to medication administration techniques.	

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F 658	Continued From page 10 The surveyor observed the RN apply a new [redacted] onto the [redacted] of Resident #107 and document on the eMAR that it was administered. The surveyor reviewed the medical records for Resident #107. Resident #107 was admitted to the facility on [redacted] with diagnoses that included [redacted]. Resident #107 is documented as alert and oriented. On 06/13/19 at 02:20 PM the surveyor brought the aforementioned findings to the attention of the Administrator, Director of Nursing and Assistant Director of Nursing. The surveyor was informed that there should have been a repeat laboratory test done for the [redacted] for Resident #92, and the [redacted] should have been documented on the eMAR after the RN applied the [redacted] to Resident #107.	F 658	3.Pharmacy consultant will do a monthly Med Pass on all nurses. 4.Pharmacy consultant will audit lab results as well for any questionable result during monthly review. 5.Trends identified by DON and pharmacy consultant will be analyzed and report to the Administrator monthly, and to the Quality Assurance Committee at the quarterly meetings. 6.Nurses that are identified with deficient practice will be in-serviced individually, and then counseled by Unit Manager, ADON and DON.	
F 755 SS=D	NJAC 8:39-27.1 (a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		7/19/19

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F 755	Continued From page 11 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: Based on observation, interview and record review, it was determined that the facility failed to store controlled substances in a safe double locked area and keep accurate accountability records of a controlled substance. This deficient practice was observed in 1 of 3 units as evidenced by the following: On 6/7/19 at 11:40 AM, the surveyor inspected the [redacted] Floor [redacted] Side Medication Cart (MC). The Narcotic Container located within the MC was found unlocked and accessible. Within the Narcotic Container, the surveyor in the presence of the Licensed Practical Nurse (LPN) and Unit Manager in training performed an accountability check of the narcotic medications that were found in the unlocked Narcotic Container.	F 755	I.CORRECTIVE ACTION FOR THOSE AFFECTED: 1.Narcotic lock boxes on each unit were checked to ensure that they are locked and they were. 2.Nurses were in-serviced about ensuring that narcotic lock box is locked before closing the door to the med cart. Nurses can ensure this by attempting to open the lock box after shutting it closed. 3[redacted] was rechecked and the actual amount in the bottle of 180ml was written in the declining form. 4.STAT [redacted] level was done for the	

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F 755	Continued From page 12 The surveyor and LPN reviewed the quantities of medications found in the Narcotic Container with the "Individual Patient Controlled Substance Administration Record" (IPCSAR). The surveyor found that the quantities of [redacted] and [redacted] matched the quantities listed on the IPCSAR. The surveyor compared the quantity available of [redacted] which was approximately 180 ml. When the available amount of [redacted] was compared with the documented amount on the IPCSAR, 140 ml did not match. The surveyor interviewed the LPN, who performed a shift to shift count prior to her shift and could not explain the discrepancy between the [redacted] on hand and the documented amount on the IPCSAR. The surveyor discussed the quantity discrepancy of [redacted] with the Director of Nursing, Assistant Director of Nursing, the unit manager and the Administrator. They could not explain why there was discrepancy or why the discrepancy was not picked up by any of the nurses who performed the shift to shift count from 5/30/19 to 6/7/19. NJAC 8:39- 29.4(b)2	F 755	resident and result came back therapeutic. II.ID OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents who have Narcotic medication have potential to be affected by the deficient practice of not locking the narcotic lock box. 1.Nurses were in-serviced about ensuring that the narcotic lock box are locked prior to locking the med cart door. 2.Nurses can ensure that the narcotic lock box is locked by attempting to open it without the use of a key. 3.Unit Managers, ADON, and DON checked all med cart and no other lock box was open they were all locked. All residents on liquid narcotic have the potential to be affected by the deficient practice. 1.Unit managers, ADON, and DON checked all medication carts for liquid narcotic to ensure that there were no other discrepancies, and there was none found. 2.Nurses were in-serviced on count accuracy, the importance of shift-to-shift narcotic count, and while counting if a discrepancy is noted the Unit manager, Supervisor, ADON, and DON must be	

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F 755	Continued From page 13	F 755	made aware immediately. 1.When a new liquid narcotic is received from the pharmacy two nurses must sign for the medication acknowledging the amount received. 2.If there is a discrepancy the Unit manager, shift Supervisor, ADON and or DON must be made aware immediately so that pharmacy can be contacted. III.SYSTEMIC CHANGES: 1.Nurses in-service on ensuring narcotic lock box are locked before closing the door to the med cart. 2.Nurses will check narcotic lock box by pulling on the cover of the lock box to ensure that it is locked. 3.Unit managers will check narcotic lock box weekly to make sure that they are locked and report finding to ADON and DON weekly for three months. 4.ADON or DON will check narcotic lock box bi-weekly and report findings to the Administrator monthly times three months. 5.Pharmacy consultant will check narcotic lock box on monthly visits and report findings to ADON, DON, and Administrator. 6.Two nurses will sign all liquid narcotics upon receiving it from the pharmacy, if	

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F 755	Continued From page 14	F 755	there is any discrepancy a supervisor must be made aware immediately. 7.Unit managers will audit all Liquid narcotic weekly and report to ADON, and DON for three months. 8.ADON or DON will audit all Liquid narcotic Bi-weekly and report findings to Administrator monthly for three months. 9.All audits findings will be reported at the monthly (quality assurance) QAPI meeting IV.MONITORING 1.Unit managers will check narcotic lock box weekly to make sure that they are lock and report finding to ADON and DON for three months. 2.ADON or DON will check narcotic lock box to make sure they are locked bi-weekly and report finding to the Administrator monthly for three months. 3.Pharmacy consultant will check narcotic lock box on monthly visit and report finding to ADON, DON and Administrator. 4.Two nurses will sign all liquid narcotics upon receiving it from the pharmacy, if there is any discrepancy a supervisor must be made aware immediately. 5.Unit managers will audit all Liquid narcotics weekly and report to ADON, and DON for three months.	

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F 755	Continued From page 15	F 755	6.ADON or DON will audit all Liquid narcotic Bi-weekly and report findings to Administrator monthly for three months. 7.All audits findings will be reported at the monthly (quality assurance) QAPI meetings.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide adequate indications for the use of	F 757	I.CORRECTIVE ACTION FOR THOSE AFFECTED: 1.Resident #130 had no negative	7/19/19

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F 757	Continued From page 16 antibiotics for 1 of 12 residents (Resident #130) reviewed for unnecessary medications. This deficient practice was evidenced by the following: On 6/12/19 at 11:00 AM, the surveyor observed Resident #130 in the room lying in bed with eyes closed. The surveyor reviewed Resident #130's medical records. The resident was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses that included [redacted] The surveyor reviewed the Physician's Order dated [redacted] which revealed an order for [redacted] which denotes the most appropriate [redacted] necessary to treat a [redacted]. In addition, the [redacted] was ordered once a day for 7 days for the diagnosis of [redacted]). The surveyor reviewed the Progress Notes (PN) dated 4/15/19, which indicated, that Resident #130 "had confusion and was wandering around the unit" and, "this could be a symptom of a [redacted]" There were no further [redacted] documented in the PN. The [redacted] report dated [redacted] showed [redacted]. Resident #130 continued on the [redacted] even though the [redacted]. On 6/13/19 at 11:00 AM, the surveyor interviewed the Unit Manager (UM) who stated that the staff follow the facility's policy and procedure and guidelines to determine if a resident had a [redacted] The surveyor reviewed the facility's policy and	F 757	outcome from this deficient practice when resident was started on [redacted] by mouth for seven days for [redacted] even after [redacted] result came back negative. Residents primary care physician was made aware of the [redacted] results but continued the [redacted]. Nurses were in-serviced about waiting on [redacted] therapy at the facility. SBAR assessment will be completed by primary nurse, which will be reviewed by the unit managers and [redacted] criteria will be completed by nurses and unit managers. [redacted] criteria will be used along with test results prior to starting [redacted] ID OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents on [redacted] have the potential to be affected. 1.All residents that were on [redacted] therapy were assessed to ensure that they met the criteria to be on antibiotic. [redacted] criteria were in place 3.Nurses were in-service on SBAR, [redacted] criteria on the importance of having them completed before initiating [redacted] therapy. 4.All nurses will be in-serviced individually if they do not follow the proper protocol. II.SYSTEMIC CHANGES:	

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F 757	Continued From page 17 procedure titled Antibiotic Stewardship Program under McGeer Criteria for LTC U[redacted] indicated the following, "New Criteria for [redacted]:(Both criteria 1 &2 must be present). Consistent with these criteria, the standardized Suspected Infection SBAR form should be used for all residents suspected of having an [redacted]" The surveyor reviewed the Individual Infection Report dated [redacted] for Resident #130 which indicated that the resident did not meet the criteria for the diagnosis of [redacted] The resident was started on the [redacted] and remained on it even after the [redacted]. There was no documentation for the initial clinical use of or continued use of the [redacted] in light of a [redacted] or definitive symptoms. On 6/13/19 at 12:30 PM, the surveyor interviewed the Physician assigned to Resident #130 who acknowledged that the [redacted] results were [redacted]. On 6/13/19 at 1:45 PM, the surveyor met with the Administrator and Director of Nursing about the above concerns. No further information was provided. NJAC 8:39 - 27.1 (a)	F 757	1.All residents with antibiotic order will be reviewed by Unit Managers to ensure SBAR, test results and McGee□s criteria are complete and report findings to DON and ADON weekly for three months. 2.After all forms are completed, primary physicians will be made aware of clinical signs/symptoms along with test results. 3.If an order for [redacted] is given, a stop date will be obtained at that time also; family/resident will be made aware of the new order. 4.Unit Manager, primary nurse or Supervisor will update Resident□s care plan. 5.Nurses will document on resident on [redacted] every shift for the duration of the [redacted] for any adverse effect. 6.Unit Managers will audit residents on [redacted] weekly and report findings to the ADON and DON for three months. 7.ADON and DON will audit residents on [redacted] biweekly and report findings to the Administrator monthly for three months and at the quarterly meetings to the QA committee. III. MONITORING: 1.The Unit Managers will audit all residents with an order for [redacted] weekly and report findings to ADON and DON.	

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F 757	Continued From page 18	F 757	2.ADON and DON will audit all residents with an order for [redacted] biweekly and report findings to Administrator monthly times three months. 3.Nurses will be in-serviced on the protocol before initiating [redacted] therapy: completing SBAR, do tests, complete McGee□s criteria and notify physician of findings. 4.Individual nurses who failed to follow the protocol after training, will be counseled. 5.DON will report audit findings to the Quality Assurance Committee during the quarterly meeting times two.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		7/19/19

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F 761	Continued From page 19 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to identify/ manage appropriate refrigerator temperatures where medications were being stored in 1 of 3 unit refrigerators, and failed to lock 1 of 6 Narcotic Medication Storage Boxes (NMSB). This deficient practice was evidenced by the following: On 6/7/19 at 11:35 AM, the surveyor in the presence of the [redacted] Floor Licensed Practical Medication Nurse (LPN) inspected the [redacted] Medication Cart. The NMSB was found to be unlocked with [redacted] #3 tablets stored in the box. The LPN stated, "I forgot to push down on the top," which automatically locks the box. On 6/7/19 at 11:51 AM, the surveyor accompanied by the [redacted] Floor Unit Manager (UM), inspected the medication refrigerator located on the [redacted] floor. The thermometer located in the [redacted] floor refrigerator showed a temperature of 30 Degrees Fahrenheit (F). The "Refrigerator/Freezer Temperature Log" posted on the outside of the refrigerator door indicated, "Refrigerator Temperature 41 Degrees or Less."	F 761	I.CORRECTIVE ACTIONS FOR THOSE AFFECTED 1.All medications in the fridge were disposed of accordingly; new ones reordered and delivered STAT. The fridge was replaced. The accurate temperature log for medication was attached to the fridge. Staff in-serviced about the right temperature range for the fridge. II.ID OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents who had medications in the fridge have potential to be affected by the deficient practice. 1.Primary nurses, and unit managers checked all medication refrigerator's temperature logs to make sure that the temperatures were accurate, and they were. 2.Nurses were in-serviced on the temperature range for medication refrigerator.	

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F 761	Continued From page 20 The surveyor reviewed previous temperatures listed on the log, 6/5/19 32 F at 7 AM, 6/6/19 31 F at 8 AM and 6/7/19 31 F at 7 AM. On 6/11/19 at 11:14 AM, the surveyor met with the Director of Nursing (DON), the Assistant Director of Nursing and the Administrator. The DON stated that the NMSBs all have automatic locks, sometimes the doors need to be pushed down to lock the boxes. The DON added that all the Narcotic Lock boxes located on the medication carts should be checked to make sure that they are locked after opening them. The DON also stated that the wrong "Refrigerator/Freezer Temperature Log" was being used. The appropriate log indicated, "Refrigerator Temperature: 36-46 Degrees." The DON could not explain why the low temperatures were logged and no follow up was attempted to correct the low temperatures documented. NJAC 8:39- 29.4(b)2	F 761	III.SYSTEMIC CHANGES: 1.Nurses will check med fridge temperature and will record it on the log, if any temperature is out of range the nurse should report findings to Unit Managers, and or Supervisor immediately. 2.Unit Managers will audit the med fridge temperature log bi-weekly and report findings to ADON or DON for three months. 3.ADON or DON will audit med fridge temperature log monthly and report findings to Administrator monthly times three months. 4.Pharmacy Consultant will audit med fridge temperature log monthly and report findings to ADON, DON and Administrator. 5.All reports and findings will be reported at the monthly QAPI meeting. 6.Individual in-service will be done with nurses and will be counseled if they fail to report and temperature not within range. IV.MONITORING: 1.Unit Managers will audit the med fridge temperature log bi-weekly and report findings to ADON and DON for three months. 2.ADON or DON will audit med fridge	

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F 761	Continued From page 21	F 761	temperature log monthly and report findings to Administrator monthly times three months. 3.Pharmacy Consultant will audit med fridge temperature log monthly and report findings to ADON, DON and Administrator. 4.All reports and findings will be reported at the monthly QAPI meeting.	