STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING ______ B. WING ______	C 08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

(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 C: # NJ00145832 Census: 48 Sample size: 3 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	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: C: # NJ00145832 Based on interviews and record review, as well as review of pertinent facility documents on 8/10/21, it was determined that the facility failed to follow physician's order and the facility policies on "Charting and Documentation" and "Documentation of Medication Administration" for 1 of 3 residents (Res #1), reviewed for resident care. This deficient practice is evidenced by the following: 1. According to the "ADMISSION RECORD", Res #1 was initially admitted on [redacted], with diagnoses that included but were not limited to: [redacted]	F 658	F658: Services Meet Professional Standards Element 1 1. Resident #1 was discharged on [redacted]. The physician was notified regarding missed doses with no new orders. 2. All Nurses were re-educated on the facility's protocol for physician orders and documentation of Medication Administration. Element 2 1. Residents who receive medication are identified at risk; an audit was conducted reviewing medication administration records for all residents in the last 30 days. Any identified omissions were	9/1/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/01/2021

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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The Minimum Data Set (MDS), an assessment tool, dated showed that Res #1's cognition was i t and required extensive assistance from staff with Activities of Daily Living (ADL).

Res #1's Care Plan (CP), initiated on showed that Res #1 was on therapy. Intervention included but was not limited to: Administer medication as ordered by the physician. The CP further showed that Res #1 had ADL self-care performance deficit related to Intervention included: Extensive assistance for personal hygiene. Furthermore, the CP showed that Res #1 had . Intervention included: Administer treatment as ordered.

The form "Order Recap Report (ORR)" from date range to showed an order for milligram (mg) give one (1) tablet by mouth at bedtime for

The form "MEDICATION ADMINISTRATION RECORD (MAR)" showed the aforementioned order. However, on and showed that the was not administered because the medication was not available. However, Res #1's primary physician was not notified. On and at 9:00 pm, there was no documentation to indicate that the medication was administered.

The ORR dated showed an order for

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discussed with the medical provider. Nurses were re-educated on physician notification when a medication is not available and was not administered.
2. An audit was conducted to review residents bathing schedule. Any identified omissions were reviewed with the residents and nursing staff.
Element 3
1. All Nurses were re-educated on the facility's protocol for Charting and Documentation of Treatment Administration record.
2. Licensed staff were reeducated to notify facility administration and the residents primary MD if medication is not available on hand.
3. The pharmacy consultant will conduct random chart audits to ensure medication is available on hand per order and MARS/TARS are without omissions.
4. All CNAs were re-educated on the facility's protocol for Charting and Documentation of Tasks specifically Bathing.

Element 4
1. The Director of Nursing or designee developed an audit tool with measurable goals that will be used to conduct surveillance on
a. Medication Administration Record Documentation
b. Treatment Administration Record Documentation
c. ADL Task – Bathing Administration Record Documentation
The tool will monitor for omission and interventions. This will be done

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F 658	Continued From page 2) apply topically to site every Monday and Friday after cleansing with solution, then apply and), then wrap with dressing daily. The form "TREATMENT ADMINISTRATION RECORD (TAR)" for the month of and showed the aforementioned order. However, there was no documentation to indicate that the treatment was administered to the Resident on , and The ORR dated showed an order for Unit/Gram (gm) apply to topically every day for care after cleaning with , cover with dry and wrap with dressing. The TAR for the month of showed the aforementioned order. However, there was no documentation to indicate that the treatment was administered on , and . The form "Task" dated and under "ADL-Bathing" showed no indication that the Resident was provided with bathing during the week of 5/9/21 to 5/15/21, 5/23/21 to 5/29/21, 5/30/21 to 6/5/21, 6/6/21 to 6/12/21, and 6/20/21 to 6/26/21. The progress notes (PN) did not indicate that the aforementioned orders/care were administered/provided to Res #1 on the aforementioned dates/time. The surveyor conducted an interview with the	F 658	Weekly x 4 weeks; Monthly x 3 months 1. Audit findings will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee at least quarterly for needed revisions to the action plan, improvement of our delivery services, and resident outcomes. Responsible party: Director of nursing Completion date 9/1/2021	

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Certified Nursing Assistant (CNA #1, one of the CNAs assigned to the Resident) on 8/10/21 at 12:12 pm. The CNA stated that the shower was documented in the Plan of Care (POC) under bathing. The CNA was unable to recall specific dates she was assigned to Res #1. She explained that if there was no documentation then it would be hard to recall if the shower was provided to Res #1 on the aforementioned dates.

The surveyor conducted an interview with the Registered Nurse (RN #1, one of the nurses assigned to Res #1 in [redacted] and [redacted]), however, the nurse was not available.

The surveyor conducted an interview with the Director of Nursing (DON) on 8/10/21 at 2:55 pm. The DON stated medications not provided to the Resident, the nurse was to notifiy the physician. The DON explained shower would be provided upon request for residents in short term unit. This was the unit where Res #1 was admitted . The DON explained that without documentation it would be hard to tell if the Resident received the medication/treatments/care.

The facility's policy titled, "Documentation of Medication Administration" reviewed on 3/2021, showed "...The facility shall maintain a medication administration record to document all medication administered...A Nurse...shall document all medications administered to each resident on the resident's medication administration record (MAR)...Reason(s) why a medication was withheld, not administered, or refused..."

The facility's policy titled, "Charting and Documentation" reviewed on 3/15/21, "...All services provided to the resident...shall be

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F 658	Continued From page 4 documented in the resident's medical record...1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records...2. Entries may only be recorded in the resident's clinical record by licensed personnel...in accordance with state law and facility policy. Certified Nursing Assistants may only make entries in the resident's medical chart as permitted by facility policy...6. Documentation of procedure and treatments shall include care-specific details...e. Whether the resident refused the procedure/treatment. f. Notification of family, physician or other staff, if indicated..." NJAC 8:39-11.2(b) NJAC 8:39-27.1(a) NJAC 8:39-27.2(i)	F 658		