| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315291 | A. BUILDING _____ B. WING _____ | C 09/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ATRIUM POST ACUTE CARE OF WAYNEVIEW | 2020 ROUTE 23 NORTH 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 |
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| F 000 | INITIAL COMMENTS<br><br>COMPLAINT # NJ 127598<br><br>CENSUS : 143<br><br>SAMPLE SIZE : 5 | F 000 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>COMPLAINT # NJ 127598<br><br>Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The nurse practice act for the State of New Jersey states; "The practice of nursing as a Registered Professional Nurse is defined as diagnosing, and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being,and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."<br><br>Reference: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of | F 658 | F- Tag<br>F 658<br>SS=D<br><br>What corrective action will be accomplished for those residents affected by the deficient practice?<br>Resident #3 was admitted on [redacted] with [redacted]; [redacted] and the other [redacted] and [redacted].<br><br>LPN#1 was re-in-service on timely documentation of treatment administration on 9/3/19.<br><br>All other LPN/ RN were re-in-service 9/3/19. | 9/30/19 |

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

Electronically Signed | 09/24/2019

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| F 658 | Continued From page 1<br>casefinding;reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."<br><br>Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 8/28/2019 and 9/3/2019, it was determined that the facility nursing staff failed to consistently document [redacted] care in the Treatment Administration Record (TAR), as well as follow the facility's policy "Dressings, Dry/Clean," for 1 of 5 sampled residents (Resident#3). This deficient practice was evidenced by the following:<br><br>1. According to the facility Admission Record, Resident #3 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted]<br><br>According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted]. The MDS documentation included that Resident #3 required assistance for Activities of Daily Living (ADLs).<br><br>Review of Resident #3's Care Plan (CP) dated 7/31/2019, under "Focus" revealed: [redacted] Interventions included but were not limited to: Administer Meds (Medications)/ vitamins as ordered, and | F 658 | How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>All residents with wound treatment order(s) have the potential to be at risk related to this citation.<br><br>An audit of all residents receiving [redacted] treatments was conducted; no negative outcome noted on 9/3/19<br><br>Resident no longer resides at the facility.<br><br>What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur?<br>ADON/Designee will in-service nurses on timely documentation of treatment administered and checking the electronic treatment administration record for completion before the end of each shift. This in-service will also be done on new hire orientation of nurses starting 9/3/19.<br><br>Managers and Nursing Supervisors will be monitoring treatment documentation before the end of each shift. Any concerns during audits will be addressed immediately to ensure compliance with standards of care 9/y for 6 months. 9/3/19 for 4 weeks and then monthly. | |

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| F 658 | Continued From page 2<br>meds/labs/ (laboratory values) treatments as ordered.<br><br>Review of a Physician Order Sheet (POS) dated August 2019, revealed an order for the following.: [redacted]<br><br>Review of the Treatment Administration Record (TAR), dated August 2019, contained the order to [redacted] every day shift. However, on 8/1/19, 8/12/19, 8/17/19, and 8/22/19, there was no documentation in the TAR indicating that the treatment had been administered as ordered.<br><br>During an interview on 9/3/2019 at 11:45 a.m., The Licensed Practical Nurse (LPN #1) stated that he/she was caring for Resident #3 on 8/12/2019, and 8/22/2019, and that he/she did the treatment but "Overlooked it and didn't sign it."<br><br>LPN #1 further stated that after a treatment you should "go back and sign it immediately" and that it should be signed out after the treatment is done.<br><br>During an interview on 9/3/2019 at 11:55 a.m., the Director of Nursing stated that "you must sign your treatments after you have done it, the nurse should have signed that she did it."<br><br>Review of a facility Employee In Service Record dated 9/3/2019, received post survey via e-mail on 9/4/2019, revealed that the staff were in serviced on the subject summary as follows: MARS (Medication Administration Record) and TARS (Treatment Administration Record) must be | F 658 | How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?<br><br>ADON/Designee will do random audits on timely treatment documentation weekly x 4 weeks and then monthly for 6 months unless any significant trends are identified.<br><br>Outcomes of the audits will be reported at the Quarterly QAPI meetings. Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Monitoring will occur for<br>4 weeks and then monthly for 6 months unless any significant trends are identified | |

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| F 658 | Continued From page 3<br>signed after medication and treatment administration.<br><br>Review of a facility policy titled "Dressings, Dry/Clean," with a revised date of 9/2013, revealed under Documentation section: The following information should be recorded in the resident's medical record, treatment sheet or designated [redacted] form:<br>1. The date and time the dressing was changed.<br>3. The name and title (or initials) of the individual changing the dressing.<br>9. The signature and title (or initials) of the person recording the data.<br><br>NJAC 8:39-27.1 (a) | F 658 | | |