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 _____	09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 000	INITIAL COMMENTS Standard Survey Census: 105 Sample Size: 24 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 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) provide [redacted] therapy in accordance with the physician's order and b.) date [redacted] equipment weekly when changed. This deficient practice was identified for 1 of 3 residents (Resident # 21) reviewed for [redacted] therapy and was evidenced by the following: On 9/23/20 at 11:15 AM, the surveyor observed Resident #21 in bed. The resident had a [redacted]). There was a [redacted] over	F 695	What corrective action will be accomplished for those residents affected by the deficient practice? Resident #21 was assessed on 9/23/20 and found with no adverse reaction to the inaccurate [redacted] no date on [redacted] and no date on sterile [redacted] LPN was in-serviced on [redacted] [redacted] based on physician's order and dating [redacted] and sterile [redacted] once it's changed.	10/9/20

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

Electronically Signed | 10/10/2020

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F 695	Continued From page 1 the [redacted] that was attached to ribbed [redacted] which was connected to a [redacted] which was attached to [redacted] ing and connected to the [redacted] (a machine that delivers [redacted]. The [redacted] was set to deliver [redacted] The [redacted] was set at [redacted] There was no date written on the cannister o[redacted] and no date on the [redacted] to indicate when they were changed last. The the resident's eyes were open but the resident did not make eye contact and did not answer when spoken to, On 9/28/20 at 9:16 AM, the surveyor entered the resident's room with the Licensed Practical Nurse (LPN) who was assigned to the resident. The surveyor observed the [redacted] dated [redacted], the [redacted] dated [redacted], the sterile [redacted] bottle dated [redacted] the [redacted] was set at [redacted] was set at [redacted] The LPN confirmed the settings. The surveyor asked the LPN how often the [redacted] was to be changed. She stated weekly on Sunday by the 11 PM to 7 AM shift. The surveyor asked if they usually dated the [redacted] and sterile [redacted] bottles and she replied "yes." The surveyor reviewed Resident #21's medical record which revealed the following: According to the face sheet Resident # 21 was admitted to the facility with diagnoses which included [redacted] The current physician's order sheet (POS) had an	F 695	How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with [redacted] have the potential to be at risk related to this citation Audit was done on the [redacted] setting and it was changed to reflect physician's order of [redacted] on [redacted]. [redacted] and sterile [redacted] were changed and dated. An audit of all residents using [redacted] was conducted; no negative outcome noted. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? ADON/ Designee will in-service licensed nurses on [redacted] setting and [redacted] setting following physician's order and record in e-TAR every shift. This in-service will also be done on new hire orientation of nurses. ADON/Designee will in-service licensed nurses on dating the [redacted] and sterile [redacted] weekly. This in-service will be done on new hire orientation of nurses. Unit Managers and Nursing Supervisors will be monitoring h[redacted] setting, [redacted] dates, and sterile [redacted] dates daily x 90	

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F 695	Continued From page 2 order which read; [redacted]." The order had a start date of [redacted]. There was also an order which read; [redacted] every shift." The [redacted] Electronic Treatment Administration Record was initialed every day from [redacted] to indicate the setting for the [redacted] was at [redacted] The care plan, which had an initiation date of [redacted] and a revision date of [redacted] revealed the following: The Focus was; [redacted] Resident is [redacted] dependent with [redacted] resulting in [redacted]" The second intervention on that care plan read; "Administer [redacted] On 9/29/20 at 9:40 AM, the surveyor reviewed the facility's policy and procedure titled [redacted] Administration" which read; "1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for [redacted] administration. 2. Review the resident's care plan to assess for any special needs of the resident." There was no mention in the policy and procedure of labeling or dating the [redacted] or sterile [redacted] bottle. On 9/28/20 at 10:00 AM, the surveyor asked the Assistant Director of Nursing (ADON) about the order on the POS for the [redacted] to be set at [redacted] and added that when the surveyor observed the resident with the LPN earlier that day and on [redacted] it was set at [redacted]. The LPN overheard the conversation and stated "I fixed it. After you asked me to verify the setting I checked the order	F 695	days then weekly thereafter. Any concerns during audits will be addressed immediately to ensure compliance with standards of care. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? ADON/Designee will do audits on all patients with [redacted] dates, sterile [redacted] date and [redacted] settings following physician's order weekly x4 weeks then monthly x6 months unless any significant trends are identified. Outcomes of the audits will be reported to the Quarterly QAPI meetings Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Monitoring will occur for 4 weeks and then monthly for 6 months unless any significant trends are identified.	

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F 695	Continued From page 3 and I changed it to [redacted] On 9/28/20 at 1:30 PM, the survey team met with the Administrator, the Director of Nursing, the ADON, and the Regional Nurse to discuss the concern with the [redacted] set incorrectly and the [redacted] not having been dated when changed. The Administrator said the dating of the [redacted] and bottles of sterile [redacted] was not in their policy but it was their protocol. NJAC 8:38-27.1 (a)	F 695		
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 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	F 761		10/10/20

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F 761	Continued From page 4 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 and interview and review of pertinent facility documentation, it was determined that the facility failed to a.) label and date [redacted] when opened in 2 of 5 medication carts inspected, b.) remove [redacted] medications from the medication cart that had no label in 1 of 5 medication carts inspected, and c.) replace the [redacted] floor emergency kit #2 (E-kit) when expired for 1 of 2 E-kits inspected. The deficient practice was evidenced by the following observed during the unit inspections: 1. On 9/23/20 9:30 AM, the surveyor inspected the middle cart on the unit [redacted] with Licensed Practical Nurse #1 (LPN#1) and observed a [redacted] container that was opened but not dated. LPN #1 stated she wasn't aware when the [redacted] container was opened and that the [redacted] would expire in three months once opened. In addition, the surveyor observed inside the top drawer of the medication cart five [redacted] mg capsules in a blister pack with no resident's name. LPN #1 stated she floats the different units and did not know where the medication came from. 2. On 9/23/20 9:40 AM, the surveyor inspected the top medication cart on unit [redacted] with the Registered Nurse (RN). The surveyor observed the [redacted] container opened and not dated. The RN stated she had only been back to work approximately two weeks prior to the survey	F 761	1. What corrective action will be accomplished for those residents affected by the deficient practice? The [redacted] that were found on med carts with no dates were removed from the med cart and was discarded on 9/23/20. How will the facility identify other residents having the potential to be affected by the same deficient practice? All 5 Med carts with [redacted] box have the potential to be at risk related to this citation. An audit of all 5 med carts were conducted; no negative outcome noted on 9/23/20. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? ADON/ Designee will in-service licensed nurses on dating [redacted] when opening a new box. This in-service will also be done on new hire orientation of nurses. Unit Managers and Nursing Supervisors	

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F 761	Continued From page 5 and did not know when the [redacted] container was opened. The manufacturer specifications for the [redacted] indicated to use the within three months of opening. On 9/23/20 at 2:25 PM, the surveyor asked the Administrator (LNHA) and Director of Nursing (DON) who was doing the unit inspections since the Consultant Pharmacist was unable to come into the facility to perform this function. The LNHA stated that the nurse managers were performing the unit inspections daily and monthly. On 9/24/20 at 9 AM, the LNHA provided the audit tool used by the nurse managers for the unit inspections from [redacted] and the policy for Storage of Medications. According to the audit tool for [redacted] 2020, the nurse managers documented that the unit inspections were performed every shift from [redacted] 2020 to [redacted] 2020. Included in the audit tool instructions under #1 and #3 the following: "1. Check all open vials/flex pens for date of expiration, and IV solutions and antibiotics for expiration. 3. Check E-kit for expiration and proper lock and replacement." The facility policy titled Storage of Medications with a revision date of 3/18/17, indicated under Policy Interpretation and Implementation #3 the following: "Drug containers that have been missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. Medications that are	F 761	will be monitoring opened [redacted] for dates daily x 90 days then weekly thereafter. Any concerns during audits will be addressed immediately to ensure compliance with standards of care. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? ADON/ Designee will do audit on all [redacted] used in all 5 med carts for weekly x 4 weeks then monthly x 6 months unless any significant trends are identified. Outcomes of the audits will be reported to the Quarterly QAPI meetings. Any concerns during audits will be addressed immediately to ensure compliance with standard of care. Monitoring will occur for 4 weeks and then monthly for 6 months unless any significant trends are identified. 2. What corrective action will be accomplished for those residents affected by the deficient practice? The [redacted] medication that had no label were removed from the med cart and was destroyed on 9/23/20. How will the facility identify other residents having the potential to be affected by the	

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F 761	Continued From page 6 stored in more than one layer of packaging will have both the medication containers as well as the outer medication box/wrapper labeled with appropriate date opened on a II layers of storage." 3. The surveyor inspected the [redacted] medication storage room in the presence of the unit LPN #2 on 09/23/2020 at 10:02 AM. The E-kit #2 located in the [redacted] storage room was noted to have expired on 6/20/2020. LPN #2 confirmed the expiration date. The surveyor interviewed the Unit Manager LPN (UMLPN) on 09/23/2020 at 12:02 PM. The UMLPN stated she had identified the expired E-kit prior to the surveyor identifying that the kit had expired on 6/2/2020. The UMLPN stated she called the pharmacy for a replacement and the new kit had been delivered to the facility. The surveyor interviewed the LNHA on 9/24/2020 at 1:00 PM regarding the expired E-kit #2. The LNHA stated there was always a 'swing kit' available in the facility to replace an expired or incomplete E-kit. The LNHA stated nurse managers were responsible for inspecting unit medication storage rooms during the time that Consultant Pharmacists were not permitted to enter the facility due to the COVID 19 pandemic. The LNHA provided the surveyor with the undated Provider Pharmacy policy regarding Emergency Pharmacy Service and Emergency Kits on 9/29/2020 at 11:52 AM. The policy indicated the following: "kits are monitored/inventoried by the consultant pharmacist at least every thirty days for	F 761	same deficient practice? All 5 med carts have the potential to be at risk related to this citation. An audit of all 5 med carts were conducted; no negative outcome noted on 9/23/20. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? ADON/ Designee will in-service licensed nurses on unlabeled antibiotics. This in-service will also be done on new hire orientation of nurses. Unit Managers and Nursing Supervisors will be monitoring 5 med carts daily x 90 days then weekly thereafter. Any concerns during audits will be addressed immediately to ensure compliance with standard of care. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? ADON/ Designee will do random audits on all 5 med carts for unlabeled meds weekly x 4 weeks then monthly x 6 months unless any significant trends are identified. Outcomes of the audits will be reported to the Quarterly QAPI meetings.	

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F 761	Continued From page 7 completeness and expiration dating of the contents. . . the opened emergency kit is exchanged for the unopened 'swing kit' in the nursing office and the pharmacy is notified that a replacement kit is needed." NJAC 8:39-29.3 and 29.4(h)	F 761	Any concerns during audits will be addressed immediately to ensure compliance with standard of care. Monitoring will occur for 4 weeks and then monthly for 6 months unless any significant trends are identified. 3. What corrective action will be accomplished for those residents affected by the deficient practice? [redacted] Emergency Kit #2 with expired item was removed from the unit and was replaced. How will the facility identify other residents having the potential to be affected by the same deficient practice? All 3 emergency kits have the potential to be at risk related to this citation. An audit of all 3 E-kits were conducted; no negative outcome noted on 9/23/20. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? ADON/ Designee will in-service licensed nurses on expired items in all 3 E-kit. This in-service will also be done on new hire orientation of nurses. Unit Managers and Nursing Supervisors will be monitoring 3 E-kits daily x 90 days	

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F 761	Continued From page 8	F 761	then weekly thereafter. Any concerns during audits will be addressed immediately to ensure compliance with standards of care. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? ADON/ Designee will do weekly audits on all E-kits on each nursing station x 4 weeks then monthly x 6 months unless any significant trends are identified. Outcomes of the audits will be reported to the Quarterly QAPI meetings. Any concerns during audits will be addressed immediately to ensure compliance with standard of care. Monitoring will occur for 4 weeks and then monthly for 6 months unless any significant trends are identified.	