STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315445	A. BUILDING _____ B. WING _____	05/20/2021

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ARBOR AT LAUREL CIRCLE, THE	100 MONROE STREET BRIDGEWATER, NJ 08807

(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 CENSUS: 33 SAMPLE SIZE: 15 + 12 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19. A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 582 SS=B	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.	F 582		5/30/21

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

Electronically Signed | 06/07/2021

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F 582	Continued From page 1 §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 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 interview and review of pertinent facility documents, it was determined that the facility failed to provide written notification to the beneficiary of the potential liability charges for	F 582	I. Discussion and written notification of the potential liability charges for services not covered by Medicare was provided to Resident #59.	

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F 582	Continued From page 2 services not covered, when the resident was discharged from Medicare [redacted] services with benefit days remaining. This deficient practice was identified for 1 of 3 residents reviewed for beneficiary notice reviews (Resident #59), and was evidenced by the following: On 05/18/21 at 1:53 PM, the surveyor reviewed the Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review (BPNR) that was completed by the facility for Resident #59. The BPNR reflected that the facility initiated Resident # 59's discharge from Medicare [redacted] Services on [redacted] when benefit days were not exhausted. The Resident #59 remained in the facility for long term care until [redacted]. The BPNR form completed by the Social Worker #2 (SW #2) further reflected that the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) Form section indicated, a copy was not provided to the Resident #59's representative because, "the resident did not receive therapy services from [redacted]." In addition, it reflected a copy of the Notice of Medicare Non-Coverage (NOMNC) form was provided which allowed the resident/resident's representative to appeal the decision. On 5/19/21 at 10:12 AM, the surveyor interviewed the SW #1 regarding the Resident # 59 SNF BPNR form. The SW #1 stated she was not the primary SW who took care of the SNF BPNR forms, but that she did help SW #2 often and could speak on it a little. The SW #1 stated she would have offered the therapy services and presented to the resident/resident's representative how much it would cost for those	F 582	II. All residents discharged from Medicare [redacted] services, with benefit days remaining, have the potential to be affected by the same deficient practice. III. Social workers will be re-educated by the Staff Development Coordinator or designee on the facility's Transfer Discharge Documentation policy to provide notice to residents of any changes in coverages of items or services covered by Medicare. IV. All residents discharged from Medicare [redacted] services, with benefit days remaining to be audited weekly x 4 weeks, then monthly x 2 months by the Director of Nursing or designee to ensure the facility provided notice to residents of any changes in coverages of items or services covered by Medicare. Results of the audits will be submitted to the QAPI Committee monthly. The committee will review findings and make recommendations as appropriate. At the conclusion of three months, a determination will be made of the need for further auditing.	

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F 582	Continued From page 3	F 582		

remaining days after the last covered day of Medicare [redacted] Services.

On 5/19/21 at 10:16 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA). The LNHA stated the facility did not have to offer the SNF ABN form because the Resident # 59 had finished his/her Medicare [redacted] Services, and that the resident was made aware they were "private pay." The LNHA emphasized once the Medicare Part A services ended, the facility does not provide an SNF ABN form, as the SNF ABN form was only for resident's discharged on Medicare [redacted]

The surveyor reviewed the invoice and communication record the LNHA provided, which reflected an email from SW #2 dated [redacted] at 2:18 PM. The email communication reflected that the resident representative had requested an appeal, but the appeal was denied and that his/her discharge date was going to be [redacted] The liability invoice reflected from [redacted] through [redacted] which was after the resident was discharged from Medicare [redacted]

On 5/20/21 at 9:22 AM, the surveyor interviewed the SW #2 regarding the SNF ABN form. The SW #2 stated, she did not provide the SNF ABN form because "it is only for Medicare [redacted] Services." The SW #2 further stated she provided the NOMNC because "it is for Medicare [redacted] Services." She emphasized the resident was getting the assisted living rate for [redacted] care services.

On 5/20/21 at 11:34 AM in the presence of the survey team, the LNHA stated that after Resident #59 was discharged from Medicare [redacted]

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F 582	Continued From page 4 services, the resident began private pay from [redacted] for [redacted] care. He added that the NOMNC was filled out and he thought "that was all we needed" and therefore they did not have to provide an SNF ABN form. The facility did not provide a policy pertaining to SNF Beneficiary Protection Notification review for residents who were discharged from Medicare Part A services with benefit coverage days remaining. NJAC 8:39-5.4 (b)(c)	F 582		
F 658 SS=E	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: a.) follow a physician's order during a wound dressing change to apply a skin protectant to a residents skin fold abrasion and a skin protectant paste to the [redacted], b.) obtain and apply an [redacted] powder in accordance with a physician's order, c.) accurately sign in the electronic Treatment Administration Record, and d.) address a resident's allergy of [redacted] before applying a [redacted]. This deficient practice was identified for 1 of 12 residents reviewed for professional standards of nursing practice (Resident #17).	F 658	I. Resident #17's wound treatment was completed as ordered by the physician (applying [redacted] protectant). Resident #17's incontinence brief was reapplied following [redacted] care plan (applying [redacted] protectant). Resident #17 was seen by the attending physician and orders were written to discontinue the [redacted] dressing and [redacted]. New treatment was completed, [redacted] tape used for dressing and eMar was signed accurately by the nurse.	6/18/21

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F 658	Continued From page 5 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 and 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 wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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 licensed practical nurse is defined as performing tasks and responsibilities within the framework of 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." The evidence was as follows: 1. On 5/18/21 at 11:16 AM, the surveyor observed Resident #17 in bed on a [redacted] mattress. The resident was awake and a Certified Nursing Aide (CNA) was cleaning up the resident's room after assisting him/her with morning care. The CNA stated that she was waiting for the nurse to perform a [redacted] treatment, and she was going to assist in turning the resident during the treatment. The CNA stated that the resident was alert and oriented to	F 658	II. All residents at risk with impaired skin integrity or receiving [redacted] treatment have the potential to be affected by this deficient practice. III. The CNA was re-educated immediately by the Staff Development Coordinator or designee on proper skin care protocols and incontinence care techniques to ensure physician orders are followed. All licensed nurses providing [redacted] treatment will be re-educated by the Staff Development Coordinator or designee on [redacted] assessment, proper treatment administration technique, and proper documentation to ensure the facility follows physician's orders during wound treatments, and that they accurately sign the electronic treatment administration record. IV. Up to 10 or 10% of residents with wound treatments to be randomly audited weekly x 4 weeks, then monthly x 2 months by the Director of Nursing or designee to ensure the facility follows physician's orders during [redacted] treatments, and that they accurately sign the electronic treatment administration record. Any resident with skin allergy to be audited weekly x 4 weeks, then monthly x 2 months by the Director of Nursing or designee to ensure proper skin care protocols and incontinence care techniques to ensure physician orders are	

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F 658	Continued From page 6 person, place and time but had occasional forgetfulness. She stated that the resident was noncompliant at times and would refuse to get out of bed. She added that the resident was refusing to get out of bed today as well. The CNA stated that the resident was dependent on staff for all care and was always incontinent of [redacted] and [redacted] The CNA added that he/she was aware when a new incontinent brief was needed. She stated that she would apply a skin protectant paste to the resident's [redacted] area to protect the skin from moisture with each incontinent change. The surveyor reviewed the medical record for Resident #17. A review of the resident's Face Sheet (an admission summary) reflected that the resident was admitted with diagnoses which included [redacted] The section to record allergies indicated that the resident had an allergy to "[redacted]." A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] indicated that the resident had a brief interview for mental status (BIMS) score of [redacted], indicating the resident had an [redacted] with [redacted]. It further included that the resident was always incontinent of [redacted] and [redacted] and was at risk for [redacted]. The use of [redacted] devices to the bed and chair were in use as well as medication/ointments to the skin to reduce the risk for skin breakdown.	F 658	followed. Results of the audits will be submitted to the QAPI Committee monthly. The committee will review findings and make recommendations as appropriate. At the conclusion of three months, a determination will be made of the need for further auditing.	

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A review of the resident's Physician Order Sheet (POS) signed on [redacted] included a physician's order (PO) dated [redacted] to apply [redacted] topically to the [redacted] every shift after care. In addition, there was a PO dated [redacted] to cleanse the [redacted] area to the [redacted] with [redacted] and pat it dry. The order included to "Apply [redacted]" surrounding the skin and a [redacted], and cover the [redacted] with a [redacted] dressing twice a day.

A review of the electronic Treatment Administration Record (eTAR) for [redacted] included the order for the [redacted] Protectant Paste dated [redacted]. The eTAR was plotted for the skin protectant paste to be applied after care every Day, Evening and Night shift. The PO dated [redacted] for the [redacted] was timed for twice a day in the Morning shift and Evening shift.

On 5/18/21 at 11:30 AM, the surveyor observed the Registered Nurse (RN) prepare the [redacted] treatment, but she did not remove the [redacted] pad from the drawer in the treatment cart.

At 11:57 AM, the surveyor observed the RN perform the [redacted] care to the [redacted] in the presence of the resident's assigned Licensed Practical Nurse (LPN) and the CNA. The RN did not have the [redacted] pad with her and performed the entire treatment without applying the [redacted] around the surrounding skin of the [redacted] The surveyor observed the LPN ask the RN about the [redacted] during the [redacted] treatment, but the RN continued without applying it, and the LPN did not stop the RN to

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get the [redacted] when she had seen it had not been applied. The RN applied a 3 x 3 [redacted] dressing labeled "gentle adhesive" without the [redacted] There was no evidence of skin irritation around the [redacted] area. When turning the resident on his/her left side, the surveyor observed that the resident's skin to the [redacted] was clean, dry and without breakdown or irritation. There was no evidence that the white skin protectant paste had been applied yet.

After the RN completed providing a [redacted] to the right lateral abdominal fold at 12:03 PM, the surveyor observed the LPN and CNA apply a new incontinent brief by using a draw sheet to turn the resident. The LPN and CNA turned the resident on the right side followed by the left side, then repositioned the resident on his/her back and secured the incontinent brief using the sticker tabs. Neither the CNA nor the LPN applied the [redacted] Paste in accordance with the physician's order before securing the incontinent brief.

At 12:07 PM, the surveyor interviewed the CNA about the [redacted] Protectant Paste, and the CNA stated that she usually applies it with every incontinent change and acknowledged that she did not apply it just now. She stated that she would wait and apply it after lunch during the next incontinent episode. The surveyor asked how they were protecting the resident's skin before the next incontinent episode if there was no skin protectant barrier cream on it now in accordance with the physician's order, and the CNA acknowledged there was nothing on his/her [redacted] currently to protect the skin from moisture. The CNA stated that she would have the resident turned again to apply the paste. At

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that time, the CNA told the LPN that she would need to apply the barrier paste, and the LPN asked the CNA, "You didn't do it yet?" The CNA replied, "No." The LPN and CNA began to explain to the resident that they would be turning him/her again to apply the paste to the [redacted]. The resident agreed to be turned for the paste application.

At 12:08 PM, in the presence of the LPN, the CNA applied the [redacted] Protectant paste to the resident's [redacted] area after surveyor inquiry.

At 12:12 PM, the surveyor observed the RN sign the eTAR for [redacted] for the PO dated [redacted] for the [redacted] which included to apply [redacted] to the surrounding skin. The RN stated that the [redacted] developed from friction within the [redacted] and increased [redacted] and that it was almost healed.

At 12:19 PM, the surveyor had the RN read the physician's order out loud after she signed the eTAR and she read the words, [redacted] Surrounding Skin" out loud. At that time, the RN acknowledged she forgot to apply the [redacted]. She then pulled out a box of [redacted] pads and stated that she had a ton of them and the purpose was to protect the skin and provide a barrier. She acknowledged she had inaccurately signed in the eTAR that she had applied the [redacted] with the rest of the wound care order when she had not done it. The surveyor asked the LPN why she mentioned to the RN to apply the [redacted], and the LPN stated that she had said that because she was usually the one who did the [redacted] treatment for Resident #17 so she knew it was supposed to be applied, but didn't want to

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interfere with what the RN was doing. Both the LPN and RN acknowledged that the [redacted] was not applied in accordance with the Physician's order. The LPN confirmed that they did apply the [redacted] skin protectant paste to the resident's [redacted], but after surveyor inquiry.

A review of the eTAR for [redacted] reflected that the LPN had signed for the application of the skin protectant paste to the [redacted] on [redacted] during the day shift.

The surveyor continued to review the medical record for Resident #17 which revealed that the resident had a [redacted] to the [redacted].

A review of the weekly clinical notes from the [redacted] Consultant [redacted] dated [redacted] revealed that the resident began to develop an '[redacted]" around the [redacted]. Recommendations included to "apply [redacted] to [redacted] and cover with [redacted] dressing daily."

A review of the subsequent weekly clinical notes from the [redacted] dated [redacted] included that there continued to be [redacted]" of the [redacted] and that a [redacted] was present around the [redacted]. Recommendations included to "apply [redacted] and [a medicated [redacted] powder] [redacted] powder to [redacted] and cover with [redacted] dressing daily.

A review of the Physician's Order Form revealed a handwritten order dated the same day on [redacted] to apply [redacted] powder and [redacted] to the [redacted] daily with dressing changes...cover with [redacted] dressing daily.

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A review of the [redacted] notes dated [redacted] continued to indicate that there was [redacted] of the [redacted] but that the [redacted] to the area was "improving." Recommendations continued to remain the same which included to apply the [redacted] and [redacted] powder to the [redacted] and cover with [redacted] dressing daily.

A review of the eTAR for [redacted] included that the nurses were signing for the PO dated [redacted] for [redacted] powder and [redacted] to [redacted] daily with dressing change" every day shift. In addition, there was a separate order dated [redacted] that included to "...Cover with [redacted] dressing daily." The nurses were signing that the treatments were being performed every day shift from [redacted] through [redacted], when the surveyor reviewed the eTAR.

On 5/18/21 at 1:51 PM, the surveyor interviewed the resident's assigned LPN a second time. The LPN stated that Resident #17 also had a [redacted] that required [redacted] dressing changes daily. She stated that she would do that dressing change right now.

On 5/18/21 at 2:06 PM, the surveyor observed the LPN remove the old dressing to the left hip that was dated [redacted]. The surveyor observed a [redacted] area around the [redacted] of the [redacted] The [redacted] area had a visible shine to it reflecting evidence of the [redacted] barrier that had been previously applied, but there was no evidence of any white powder residue indicative of [redacted] powder on the skin or on the old dressing. The LPN showed the surveyor what products she was using for the [redacted] which included a [redacted]

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[redacted] pad but it did not include the [redacted] powder. In the presence of the RN, the surveyor asked the LPN what the [redacted] area was from, and the LPN stated that it was "from the dressing." She then held up the old [redacted] dressing to show the surveyor that the [redacted] dressing edges very closely matched the same edges of the reddened irritated area of the skin. She then started lightly pressing on the [redacted] area to show the surveyor that the irritated skin was [redacted]). The resident denied [redacted]. The LPN stated that the [redacted] was supposed to provide a barrier for the application of the [redacted] dressing.

The next day on 5/19/21 at 10:08 AM, the surveyor interviewed the LPN a second time at the treatment cart. She showed the surveyor again what dressing she uses for the [redacted]. She pulled out a [redacted] dressing that reflects '[redacted]" and states that she uses the [redacted] dressing for both the [redacted], and the [redacted]. The LPN removed a box of [redacted] and the box of [redacted] pads that she uses for the [redacted], but she did not show the surveyor any [redacted] powder for the [redacted]

On 5/19/21 at 10:59 AM, the surveyor interviewed the Infectious Disease/ Nurse Practitioner (ID/NP) who works with the [redacted] The ID/NP stated that she has not personally seen the [redacted] of Resident #17 but that she could assist in answering any questions. The surveyor asked the ID/NP if they were aware of the resident's

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allergy to "[redacted]" and if the [redacted] dressing that indicated it was a "[redacted]" if that may be causing the "irritation" to the [redacted] of the [redacted] The ID/NP stated that she would have to get back to the surveyor on that. The ID/NP stated however that the WC/NP was documenting that the [redacted] area was irritated but that there was also an improving [redacted] to the area as well being treated with [redacted] powder. She stated that she would talk with the [redacted] if the [redacted] area could be from a possible allergy.

At 11:45 AM, the surveyor returned to interview the LPN to request if there was any [redacted] powder assigned to the resident and available in the treatment cart. The LPN looked through the drawers with the surveyor and confirmed it was not there. She then stated that sometimes it may be left in the resident's top drawer in his/her room, and the surveyor and the LPN went to the resident's room to look for any [redacted] Powder in the nightstand cabinet. The LPN confirmed it was not there. The surveyor asked if she had used the [redacted] Powder with the [redacted] treatment as indicated in the order and the LPN admitted that she did not use the powder. She acknowledged that not only was it not available, it also was not appropriate because "The [redacted] powder affects the adhesive" of the [redacted] dressing. She stated that if you apply powder, then the dressing won't stick to the resident's skin. She stated that she does not apply the [redacted] powder for this reason. She stated that she intended to the call the physician, and that she would notify them now. The surveyor and the LPN reviewed the signed eTAR together where the LPN had signed that [redacted] powder was applied to the [redacted] on [redacted] and the LPN

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acknowledged that she did not apply the [redacted] powder, even though she signed in the eTAR that she did. The LPN stated that maybe the powder ran out already, and that she had to order another bottle, but confirmed that it was only ordered [redacted] days ago and applied once a day. She stated that how long a bottle of [redacted] powder lasts for varies depending on the size of the area needing treatment. She could not speak to if [redacted] powder had ever been applied to the [redacted] The surveyor asked how they would get the [redacted] adhesive [redacted] to stick of there was powder, and the LPN confirmed she did not know. She stated she would call the physician.

On the same day on 5/19/21 at 12:07 PM, the surveyor conducted a phone interview with the Pharmacy Provider/Pharmacist. The Pharmacist stated that they had delivered two [redacted] bottles of [redacted] Powder on [redacted] and two [redacted] bottles on [redacted] for Resident #17 for unrelated orders, and no other bottles had been filled since [redacted]. The Pharmacist stated that they had received an order on [redacted] for the [redacted] powder, but the physician's order form was missing resident identifiers so they had to return the form back to the facility. The Pharmacist stated that they received it back on [redacted] with the updated identifiers and they sent a box of medicated packing, but missed the order for the [redacted] Powder. The Pharmacist stated that they could send it over right now, and confirmed it had not been sent yet. She reviewed her log and denied that any staff had called the Pharmacy Provider requesting the [redacted] to be sent. She confirmed it had not been processed. The Pharmacist stated that depending on the size of the areas being treated with the [redacted] back in [redacted] and [redacted] it was possible that

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there could have been some powder remaining to treat the [redacted].

On 5/19/21 at 1:43 PM, the Assistant Director of Nursing (ADON) stated that he does the wound rounds together with the [redacted] and stated that they believed that the irritation around the [redacted] was from a [redacted]h which was why the [redacted] powder was ordered. The ADON also acknowledged that the resident's allergy to "[redacted]" was not immediately considered but that the [redacted] was improving. He stated that he spoke with the [redacted] and that they were going to change the order for the [redacted] dressing to one that is non-adhesive and try a cream instead of the [redacted] powder and a [redacted] dressing instead of the [redacted] dressing. He acknowledged that the powder would make it difficult to stick. The ADON confirmed that the [redacted] was a skin barrier and would help reduce risk of irritation from the dressing if for any reason the adhesive was causing the [redacted] The ADON was unable to provide documented evidence that the resident's allergy of [redacted] was addressed for the particular [redacted] being used that indicated it was a [redacted]." The ADON provided the surveyor a copy of the medications available in back up, which included [redacted] Powder.

On 5/20/21 at 11:06 AM, the surveyor interviewed the Director of Nursing (DON), the ADON and the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. The DON acknowledged that the CNA or the LPN should have applied the paste to the resident's [redacted] before surveyor inquiry. The facility administration acknowledged that the skin protectant should have been applied prior to

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securing the incontinent brief. The ADON stated that the CNA, LPN, and RN were nervous with a surveyor watching which was why they missed the [redacted] Paste to the [redacted] and the [redacted] to the surrounding skin of the [redacted]. He further added that the resident's [redacted] and surrounding skin of the [redacted] had been protected with the barrier and [redacted] in the past because the resident did not have skin breakdown to those areas. The ADON acknowledged that one bottle of [redacted] powder was available in back-up, but could not provide evidence if it was accessed and removed. He confirmed there was none on the treatment cart to use for the resident and neither he nor the DON could speak to if [redacted] powder was used around the [redacted] when they were signing that they were applying it. They confirmed it had not been delivered from the Pharmacy since [redacted]. They stated that the process was that if a medication was not available they should inform the ADON or call the Pharmacy provider to request the delivery of the specified order. The DON confirmed that the nurses should not be inaccurately signing for the [redacted] and the [redacted] Powder if it was not being administered to the resident, in accordance with professional standards of nursing practice. The DON stated that the resident had no adverse effects, and acknowledged that despite the same [redacted] dressing being used since the start of the [redacted] at the end of [redacted] the irritation of the [redacted] to the [redacted] only started after [redacted]. The ADON stated that they first thought it was [redacted] related as it also produces a [redacted] glow to the skin, but now they are ruling out if the [redacted] was playing a role in the ongoing irritation. They confirmed that it was not addressed with the physician that it was

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F 658	Continued From page 17 okay to use the [redacted] dressing despite the resident's allergy to [redacted], in accordance with professional standards of nursing practice. The ADON stated that the [redacted] was not available to interview today. A review of the facility's undated protocol for: Medication Not Available, included that if a medication was not available to be administered to the resident, the nurse will call the pharmacy and clarify why the medication is not there. Should the problem continue, the ADON would be notified and he will call the Consultant to have the pharmacy resolve the issue... A review of the [redacted] Prevention and Management policy revised 2020 included that all risk factors are identified...there will be documentation in the clinical record to determine tissue tolerance to pressure as indicated. The physician will b notified of any tissue intolerance or skin conditions requiring interventions... NJAC 8:39-27.1(a)	F 658		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure: a.) medications were sequenced to	F 698	I. Resident # 377 was assessed by the attending physician for any adverse effects.	6/18/21

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F 698	Continued From page 18 accommodate a resident's [redacted] schedule in accordance with professional standards of practice in a timely manner, and b.) a physician's order was followed to maintain left arm precautions. This deficient practice was identified for 1 of 1 resident reviewed for [redacted] (Resident #377), and was evidenced by the following: 1. On 5/17/21 at 10:40 AM, the surveyor was unable to interview Resident #377 because he/she had left the facility for a [redacted] treatment [redacted]). The Registered Nurse #1 (RN #1) at the medication cart on the [redacted] wing stated that the Resident #377 went out for a [redacted] treatment on [redacted], and [redacted] at 8:30 AM and returned to the facility between 2:30 PM - 3:30 PM. The surveyor reviewed the medical record for Resident #377. A review of the Face Sheet (an admission summary) for Resident #377 reflected that the resident was admitted to the facility with a diagnosis which included, but not limited to: [redacted]. A review of the resident's Physician's Order Sheet (POS) for [redacted] and the electronic Medication Administration Record (eMAR) for [redacted] reflected the following physician orders (PO), with their plotted administration	F 698	The resident's medication times were sequenced to accommodate times out of the facility to ensure resident #377 received services consistent with professional standards of practice. A limb alert was in placed on the [redacted] of resident #377 to ensure they received services consistent with professional standards of practice. II. All residents with physician orders for [redacted] and or [redacted] precautions have the potential to be affected by this deficient practice. No additional residents were impacted by the deficient practice. III. The Policy and procedure for [redacted] patients has been revised. The medication administration times list has been revised to reflect proper sequencing of patients on [redacted] to accommodate times out of the facility. All residents admitted with physician orders for limb precautions will receive an alert bracelet to the precaution [redacted] All licensed nurses will be re-educated by the Staff Development Coordinator or designee on the proper assessment and care of dialysis patients, including residents with limb precautions. IV. All residents receiving [redacted]	

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F 698	Continued From page 19 times: - A PO dated [redacted] to adminsiter [redacted] (mL) [redacted] four times a day at 7:30 AM, 11:30 AM, 4:30 PM and 9 PM for [redacted]. - A PO dated [redacted] for an [redacted] medication, [redacted] milligrams (mg) by mouth three times a day at 6 AM, 2 PM and 10 PM for [redacted]. - A PO dated [redacted] for an [redacted] medication, [redacted] mg by mouth three times a day at 6 AM, 2 PM and 10 PM for [redacted]. A review of the [redacted] NON-PRN Medication Notes (justification within the eMAR for why the medication was not given) from [redacted] to [redacted] reflected the following: - The medications [redacted] and [redacted] were not sequenced during the days and times that Resident #377 was out of the facility to [redacted] from 8:30 AM until approximately 2:30 PM to 3:30 PM. The eMAR for [redacted] reflected that on [redacted] and [redacted] the scheduled doses for [redacted] at 11:30 AM, [redacted] mg at 2 PM, and [redacted] mg at 2 PM were documented as "Not Administered" because: "resident out on pass." Further review of the POS and the eMAR for [redacted] reflected that the physician orders weren't corrected to accommodate the resident's [redacted]	F 698	to be audited weekly x 4 weeks, then monthly x 2 months by the Director of Nursing or designee to ensure the facility provides services consistent with professional standards of practice. Results of the audits will be submitted to the QAPI Committee monthly. The committee will review findings and make recommendations as appropriate. At the conclusion of three months, a determination will be made of the need for further auditing.	

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F 698	Continued From page 20 schedule until [redacted]. On 5/19/21 at 10:39 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) regarding medication reconciliation. The ADON stated the night shift 11 PM - 7 AM, conducted the 24-hour chart check. He further stated they called the Attending Physician on [redacted] to get the medications [redacted] and [redacted] administration times changed because they "realized the resident was not in the facility during the scheduled administration times." On 5/20/21 at 10:51 AM, in the presence of the survey team the Director of Nursing (DON) stated the nurses were educated on what to do when medications are not administered during their scheduled medication pass. She further stated, "if nurses see anything, they know it should be addressed right away." The DON concluded the nurses monitored the resident and there were no adverse effects or events for the missed doses of [redacted] and [redacted] doses. A review of the facility's policy [redacted] Disease, Care of a Resident revised 09/2010, included "Residents with [redacted] will be cared for according to currently recognized standards of care." The policy did not address what that meant nor did it specifically address the sequencening of medications to accommodate a resident's [redacted] schedule. A review of the Medication Administration Policy dated [redacted] provided by the DON and the ADON, did not address the need to sequence medications in accordance with the resident's individualized [redacted] schedule.	F 698		

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2. On 5/18/21 at 10:51 AM, the surveyor observed Resident #377 lying in bed watching tv. The surveyor interviewed the resident. The Resident #377 stated that "therapy seems to be helping" and his/her goal was to go back home. He/she further stated they received their medications prior to leaving the facility for [redacted] on [redacted] and [redacted] at 8:30 AM.

The surveyor attempted to review the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, but it had not yet been complete as the resident was admitted to the facility less than [redacted] days ago.

A review of the Resident #377 individualized, Interdisciplinary Plan of Care, dated [redacted] reflected that the resident was admitted with a diagnosis of [redacted] with [redacted]. The care plan further reflected that the resident had a [redacted] creates [redacted] that can be [redacted].) The interventions included the resident would go to the [redacted] center as scheduled three (3) times and week, [redacted] and addition to checking the [redacted]."

A review of the current PO dated [redacted] indicated to maintain "[redacted] precautions" [redacted] due to medical reason).

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A review of the [redacted] eMAR from [redacted] to [redacted] reflected the following:

- Occuring on all three shifts (Day, Evening and Night) the nurses were signing that they were obtaining [redacted] for Resident #377 and that they were taking them at times in his/her [redacted] as the resident's [redacted]), which did not follow the PO and care plan for [redacted] precautions. The [redacted] was taken in the Resident #377 [redacted] times out of [redacted] opportunities by five (5) nurses RN #1, RN #2, RN #3, RN #4, and the Licensed Practical Nurse #1 (LPN #1).

On 5/19/21 at 12 PM, the surveyor interviewed the LPN #1. Both the LPN #1 and the surveyor reviewed the electronic medical record at the medication cart. The LPN #1 confirmed that the Resident #377 had a [redacted] and that he/she had an order for [redacted] precautions. The LPN #1 stated arm precautions meant that [redacted] or [redacted] would be taken on the [redacted] with the precautions. The surveyor continued to interview the LPN #1 how she would identify if the resident had a [redacted] alert or [redacted] precautions, and the LPN #1 replied "when I performed a skin assessment, I would see the [redacted] and know the resident had an [redacted] precaution." She further stated residents usually came from the hospital and they would already have a [redacted] precaution bracelet on them. The LPN #1 concluded she "did not recall" having an inservice on [redacted] precautions but stated the resident did have a [redacted] precautions bracelet on for his/her [redacted].

On 5/19/21 at 1:10 PM, in the presence of the

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survey team, the ADON/IP stated he completed a resident roster and he reviewed it daily. He further stated that the Resident #377 had a [redacted] precautions: [redacted] which was placed on his 24-hour report that he presented to the survey team.

On 5/20/21 at 10:57 AM, the ADON stated he spoke to the nurses regarding the Resident #377 arm precautions. He stated the nurses knew that the Resident #377 had [redacted] precautions and they would not take a [redacted] in his/her [redacted]. The ADON further stated the computer system defaulted to the [redacted] when taking a [redacted] and that the nurses may have "clicked it wrong" in the system without changing it from the default. He stated that he interviewed all the nurses and that they do not take [redacted] in the [redacted] for Resident #377 and that it may have been a documentation error. He stated that the resident did not have any adverse incident with the [redacted]. He confirmed that staff need to pay closer attention.

At that time, the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) did not provide any additional documentation from the resident's progress notes that refuted the surveyor's findings. In addition, no [redacted] education in-service records were provided to the surveyor team. The DON stated that Resident #377 was hospitalized on [redacted] and has not returned back to the facility yet.

On 5/20/21 at 12:00 PM, the surveyor was unable to return to interview the resident due to his/her current hospitalization.

A review of the facility's policy [redacted]

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F 698	Continued From page 24 Disease, Care of a Resident revised 9/2010 included ... ..."Resident with [redacted] will be cared for according to currently recognized standards of care ....Staff caring for resident with [redacted] ...shall be trained in the care and special needs of these residents .....Education and training of staff includes, specifically: The care of [redacted] and [redacted] The facility did not provide any documentation regarding the education and inservice training for staff caring for resident with limb precautions.	F 698		
F 755 SS=E	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, 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-	F 755		6/18/21

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F 755	Continued From page 25 §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: a.) provide pharmaceutical services by ensuring the proper administration time of an iron medication ([redacted]) by separating from an interacting medication ([redacted]) during the medication pass for 1 of 5 residents (Resident #2), in accordance with manufacturer's specifications and professional standards of practice, b.) remove expired controlled drugs from the electronic backup supply machine from [redacted] until [redacted], and c.) maintain an accurate accountability and reconciliation for the back-up supply of a controlled analgesic drug ([redacted] from [redacted] to [redacted]. This deficient practice was identified for 1 of 1 electronic backup storage machine which contained 3 of 27 controlled drugs that were expired, and 1 of 27 controlled drugs that had an inaccurate count. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states:	F 755	I. 1. Resident # 2 was assessed by the attending physician for any adverse effects. 1 The medication orders for Resident #2 were corrected to show cautionary warning on the EMAR, separating [redacted] and [redacted], to provide pharmaceutical services that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and to meet the needs of each resident. 2.All the expired control drugs found in the electronic back up supply machine (Cubex), were removed immediately by the ADON. The pharmacy was notified, the medications were reordered and replaced with current dates per facility protocol to ensure all controlled drugs were in order and maintained properly. 3.The discrepancy of extra [redacted] mg tab found in the Cubex was	

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F 755	Continued From page 26 "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; 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." 1. On 5/18/21 at 9:21 AM during the medication pass, the surveyor observed the Licensed Practical Nurse (LPN) preparing medications for Resident #2. The LPN removed three (3) different plastic bags from the medication cart with the resident's name on the top right-hand corner of each bag. Each bag had a label timed for 8 AM, 9 AM, and 10 AM labeled consecutively on the upper right-hand corner. The LPN explained that the provider pharmacy places the resident's medications in unit dose form in plastic bags that are labeled on the outside with the resident's name in the upper right hand corner, the time of administration on the upper left hand corner and the list of the specific medications contained in the bag on the front of the bag. The LPN further explained that she had removed the resident's 8 AM, 9 AM and 10 AM bags because the resident had one (1) 8 AM medication that needed to be administered with food and the resident had just finished breakfast so she was administering that medication with the 9 AM medications. In addition, the LPN stated that the resident also had one (1) 10 AM medication, [redacted] ([redacted] (a medication used to treat a [redacted]), and was able to administer the Iron with the 9 AM medications because she was allowed to administer medications one (1) hour before 10 AM.	F 755	investigated immediately and resolved and an established system of records of receipt and disposition of all controlled drugs was put in place to enable an accurate reconciliation. II. All residents have the potential to be affected by these deficient practices. No additional discrepancies identified. III. 1.All licensed nurses will be re-educated by the Staff Development Coordinator or designee on the proper protocols for labeling and maintaining cautionary warnings to assure the accurate acquiring, receiving, dispensing, and administering of all drugs and to meet the needs of each resident. 2.The Pharmacy Representative conducted education on how to run daily cycle count in the Cubex. A biweekly analysis of activities in the Cubex will be conducted by the DON and nursing supervisor to review all accesses to the Cubex including times, cycle count, used and unused medications, and tracking of expired medications identifying discrepancies, removals and restocking of medications. 3.A policy for performing shift-to-shift count on the electronic back up supply machine (Cubex) was put in place for accountability and accuracy. Regular medications will be restocked by a nurse, and controlled medications will be	

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F 755	Continued From page 27 On 5/18/21 at 9:27 AM, the surveyor observed the LPN administer nine (9) medications which included one tablet of [redacted] milligrams (MG) of [redacted]; a medication used to treat [redacted]) from the 9 AM bag and one tablet of [redacted] MG of [redacted] from the 10 AM bag. Upon returning to the medication cart, the surveyor asked the LPN if there was a reason that the [redacted] medication had a time of administration of 10 AM and was not included in the 9 AM bag. The LPN stated that she was unsure but thought the [redacted] was ordered twice a day and thought the facility administered twice a day medications at 10 AM. The LPN then checked the electronic medication administration record (EMAR) which revealed that there were no cautionary warnings noted for the [redacted] In addition, the LPN noted that there were other medications that were ordered twice a day and administered at 9 AM. The LPN had discarded the labeled bags of medication and could not check the cautionary labels on the bags. The LPN stated that she thought the pharmacy provider added cautionary warnings and would have to check why the [redacted] had a 10 AM administration time. The surveyor reviewed the medical record for Resident #2. A review of the resident's face sheet indicated that the resident had diagnoses which included dementia. According to the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the	F 755	restocked by two nurses with a read back of number of medications being restocked for accuracy. The 11-7 shift will perform daily controlled Medication cycle count and document same. IV. 1.A random sample of 10 or 10% of residents EMAR and medication packs to be audited weekly x 4 weeks, then monthly x 2 months by the Director of Nursing or designee to evaluate compliance with cautionary warnings and to assure the accurate acquiring, receiving, dispensing, and administering of all drugs and to meet the needs of each resident. 2.Random audits of Cubex shift-to-shift controlled med counts weekly x 4 weeks, then monthly x 2 months by the Director of Nursing or designee to ensure that drug records are in order and that an account of all controlled drugs are maintained and periodically reconciled. 3.See above Results of the audits will be submitted to the QAPI Committee monthly. The committee will review findings and make recommendations as appropriate. At the conclusion of three months, a determination will be made of the need for further auditing.	

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management of care dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had a [redacted].

A review of the current Physician's Order Sheet (POS) reflected an order dated [redacted] for [redacted] MG, one tablet three daily to be administered at 9 AM, 1 PM, and 5 PM. In addition, there was a physician's order dated [redacted] for [redacted] MG, one tablet two times daily to be administered at 10 AM and 7 PM. There were no cautionary warnings associated with either medication order.

A review of the [redacted] EMAR reflected the same physician's orders for the [redacted] and [redacted] with no cautionary warnings.

On 5/18/21 at 10:47 AM, the surveyor conducted a phone interview with the Order Entry Technician from the provider pharmacy who verified the medication bag system that the LPN had explained. The Order Entry Technician also explained that the administration time noted on the upper right-hand corner of the medication bags was decided by the facility.

On 5/18/21 at 10:54 AM, the surveyor conducted an interview with the Registered Pharmacist (RP) from the provider pharmacy who stated that the times of administration were decided by the facility and a twice a day administration frequency would automatically be 9 AM and 5 PM according to the provider pharmacy records. The RP further explained that the provider pharmacy would change the medication time only if a physician's order was received with a different administration

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time indicated. The RP added that according to his records for Resident #2 the times of administration were decided by the facility for 10 AM and 7 PM. The RP further added that the times of 10 AM and 7 PM would avoid an interaction between the [redacted] and the Iron. The RP stated that the provider pharmacy does not include separation cautionary warnings on the labels of the bags of medication. The RP stated that the nurses would have to enter that information on the EMAR that was used by the facility because the provider pharmacy does not utilize the same EMAR computer system. The RP further explained that the medication name would be on the bag with cautionary warnings such as "with food" or "do not crush" but separations of medications was too much information to type on the bags. The RP added that when there was a need for two medications to be separated the pharmacy provider would call the nursing facility and speak with a nurse to let them know and then the nurses would have to get clarification to change the time and add that information to the EMAR.

On 5/18/21 at 11:16 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that he was familiar with the EMAR system. The ADON stated that cautionary warnings were entered into the computer by the nurses and should be followed. The surveyor with the ADON reviewed the EMAR for [redacted] for Resident #2 which revealed that cautionary warnings for the medications were inconsistent and there were no cautionary warnings for the [redacted]. The ADON added that [redacted] usually required a different time to separate due to interaction alerts from other medications.

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F 755	Continued From page 30 On 5/18/21 at 12:02 PM, the surveyor interviewed the ADON who stated that he had reviewed the EMAR again and that the [redacted] was timed for 10 AM to separate from the 9 AM medications. The ADON added that having the 10 AM time would highlight to the nurses that the [redacted] be separated. The ADON added that the nurses had to include cautionary warnings on the EMAR because the provider pharmacy does not utilize the same EMAR computer system. The ADON acknowledged that the Iron physician's order on the EMAR should have had a cautionary warning to "separate one hour from other meds." On 5/18/21 at 12:11 PM, the surveyor conducted a phone interview with the Consultant Pharmacist (CP). The CP stated that he was aware that the provider pharmacy would call the facility to notify the nurse if the pharmacy received orders for medications that should be separated. The CP added that the nurses would have to change the times of administration on the EMAR and enter the cautionary information. The CP also stated that Iron interacts with several medications and would recommend separating the Iron from other medications such as [redacted]. The CP added that the 10 AM time of administration would highlight for the nurses the need to separate the Iron. On 5/19/21 at 8:41 AM, the surveyor with the LPN reviewed Resident #2's 10 AM medication bag containing the [redacted] which revealed a label for [redacted] MG one tablet with a cautionary "with water." The LPN stated that she was told that she should have separated the [redacted] from the 9 AM medication bag but was unaware because there was no cautionary warning written on the label of the bag.	F 755		

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On 5/19/21 at 1:03 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), ADON and the Executive Director (ED). The facility Nurse Consultant was included via a conference call. The ADON acknowledged that the EMAR computer system was not the same as the provider pharmacy and therefore the provider pharmacy could not enter any information on the EMAR. The ADON stated that the nurses were responsible for entering cautionary warnings on the EMAR and the cautionary warnings should be followed.

On 5/20/21 at 10:07 AM, the surveyor interviewed Resident #2 who stated that he/she had a [redacted] and was unaware of the medications that he/she took. The resident added that the nurses brought him/her the medications that he/she needed to take.

A review of the Medication Administration policy dated [redacted] provided by the DON and ADON reflected that the right medication was to be administered at the time ordered. In addition, the right time of the medication was to be administered no sooner than one hour before the time on the EMAR or no later than one hour after and to read cautionaries on the EMAR and medication package.

The manufacturer specifications for [redacted] include to avoid administering with antacids containing [redacted] and using [redacted] together with [redacted] may decrease the effects of the [redacted]. In addition, the administration of [redacted] should be separated by at least two hours from [redacted]

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2. On 5/20/21 at 8:45 AM, the surveyor interviewed the ADON who stated that he was responsible for the controlled drugs (CD) maintained in the electronic backup supply. The ADON stated that an inventory count for all the CD maintained in the backup supply machine was not done on a scheduled basis. The ADON added that an inventory count was performed for a specific CD when that CD was removed or restocked. The ADON further explained that if there was a discrepancy then he would verify the count of that CD and do an investigation.

At that time, the ADON provided the surveyor with a printed list of the names of the CD in the electronic backup supply machine and included on the list was a maximum and minimum level to be maintained and soonest expiration dates. The ADON stated that the list was sent to him by the provider pharmacy.

On 5/20/21 at 8:56 AM, the surveyor observed the ADON with the DON preparing to perform an inventory of the CD stored in the electronic backup supply machine in the medication room.

At that time, the ADON, with the DON, stated that there was no need for two (2) verification codes for the inventory to be completed because each had administrative responsibilities and an inventory count could be done by the ADON. The surveyor observed the DON leave the medication room.

On 5/20/21 between 8:56 AM to 9:40 AM, the surveyor observed the ADON perform an inventory count of each CD stored in the

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F 755	Continued From page 33 electronic backup supply machine. During the CD inventory count, the surveyor observed the ADON identify the following expired CD: -9 of 9 tablets of [redacted] ([redacted] had an expiration date of April 2021. The electronic screen indicated the "soonest expiration date" was April 30, 2021. -9 of 10 tablets of [redacted] [redacted] MG had an expiration date of January 2021. The electronic screen indicated the "soonest expiration date" was January 30, 2021. -4 of 9 tablets of [redacted] had an expiration date of January 2021. The electronic screen indicated the "soonest expiration date" was January 30, 2021. During the CD inventory count, the ADON stated that the "soonest expiration dates" noted in the computer were not always correct. The ADON also stated that he was unsure why there were expired CD. The ADON stated that he thought the provider pharmacy representative had recently been in the facility to reorganize the CD in the electronic back up machine and thought any expired medications would have been removed. The ADON was unsure when that reorganization had occurred. The ADON added that the indicated "soonest expiration date" was accurate for the [redacted] and [redacted] but thought the electronic system would have notified him that there was expired CD. The ADON acknowledged that the expired CD should have been removed before the expiration date. The	F 755		

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ADON was unable to speak to why there was expired CD in the electronic back up supply since January 2021. The ADON stated that the system would have to be changed.

On 5/20/21 at 10:18 AM, the surveyor interviewed the ADON who stated that he had spoken with the provider pharmacy liaison she was unable to answer any questions regarding the electronic CD back up supply machine. The ADON added that the pharmacy liaison instructed him to have the surveyor call the provider pharmacy and ask for a representative that could help with questions regarding the CD in the electronic back up supply machine.

On 5/20/21 at 11:04 AM, the survey team met with the LNHA, DON, ADON and ED. The ADON stated that there was no written policy or protocol for the CD in the electronic back up supply machine.

On 5/20/21 at 11:18 AM, the surveyor conducted a phone interview with the CP who stated that he did not have any responsibility regarding notifying the administration of expired CD in the electronic backup supply machine. The CP stated that the backup supply was an active inventory of CD and any expired CD should be removed before the expiration date.

On 5/20/21 at 1:34 PM, the surveyor conducted a phone interview with a RP#2 who stated that she could not answer questions regarding the electronic CD backup supply machine and would have to forward the request to the proper individuals.

The surveyor made a second attempt to call on

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5/20/21 at 3:38 PM and was unable to interview a provider pharmacy representative regarding the CD electronic backup supply machine.

A review of the facility policy for "Controlled Drugs" dated April 2019 provided by the DON and ADON reflected that controlled substances are reconciled at the end of each shift.

3. On 5/20/21 at 8:45 AM, the surveyor interviewed the ADON who stated that he was responsible for the controlled drugs (CD) maintained in the electronic backup supply. The ADON stated that an inventory count for all the CD maintained in the backup supply machine was not done on a scheduled basis. The ADON added that an inventory count was performed for a specific CD when that CD was removed or restocked. The ADON further explained that if there was a discrepancy then he would verify the count of that CD and do an investigation.

At that time, the ADON provided the surveyor with a printed list of the names of the CD in the electronic backup supply machine and included on the list was a maximum and minimum level to be maintained and soonest expiration dates. The ADON stated that the list was sent to him by the provider pharmacy. The ADON explained that he was performing the inventory count by using the printed list to make sure he counted each CD. The ADON was unaware if there was a computerized program he could use instead of utilizing the printed list to perform an inventory count.

The ADON further explained that the inventory

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count was done by entering a "blind" count into the computer, meaning that the person entering the actual count physically being done would not have knowledge of what the count was supposed to be according to the computer records. The ADON added that if the two (2) counts did not match then there was a discrepancy and the computer system would prompt whoever was doing the count and the nurses would have to notify either himself or the DON. The surveyor observed the electronic backup supply machine which had no prompt on the screen that there was a discrepancy.

On 5/20/21 at 8:56 AM, the surveyor observed the ADON with the DON preparing to perform an inventory of the CD stored in the electronic backup supply machine in the medication room.

At that time, the ADON, with the DON, stated that there was no need for two (2) verification codes for the inventory to be completed because each had administrative responsibilities and an inventory count could be done by the ADON. The surveyor observed the DON leave the medication room.

On 5/20/21 between 8:56 AM to 9:40 AM, the surveyor observed the ADON perform an inventory count of the CD stored in the electronic backup supply machine.

During the CD inventory count, the surveyor observed the ADON identify the count for the [redacted] MG tablets as 31 and entered the amount into the electronic system which then initiated a prompt on the screen "Count different-are you sure?" The ADON verified more than once that the count was 31 tablets. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315445	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR AT LAUREL CIRCLE, THE	100 MONROE STREET BRIDGEWATER, NJ 08807

(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 755	Continued From page 37	F 755		

ADON stated that after completing the inventory he would have to investigate why the count for the [redacted] was incorrect.

On 5/20/2021 at 9:40 AM, the surveyor observed the ADON complete the CD inventory count and the screen indicated that "You have 1 unresolved discrepancy." The ADON then checked the electronic transaction list for [redacted] which indicated that on [redacted] there was 16 tablets and one (1) tablet was removed which left a remaining 15 tablets. The screen also indicated that on [redacted] the [redacted] was restocked, and 15 tablets were added, which calculated to a total count of 30 tablets. The ADON stated that the count of 31 was over by 1 tablet and could not explain why there was a discrepancy. The ADON acknowledged that the discrepancy should have been found sooner. The ADON also stated that he would have to investigate how the discrepancy occurred.

On 5/20/21 at 10:18 AM, the surveyor interviewed the ADON who stated that he had spoken with the provider pharmacy liaison she was unable to answer any questions regarding the CD in the electronic back up supply machine. The ADON also stated that the liaison had informed him that there was a computerized system that could be generated to complete an inventory count and it was called a "cycle count." The ADON added that the pharmacy liaison instructed him to have the surveyor call the provider pharmacy and ask for a representative that could help with questions regarding the CD in the electronic back up supply machine.

On 5/20/21 at 11:04 AM, the survey team met with the LNHA, DON, ADON and ED. The ADON

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stated that there was no written policy or protocol for the CD in the electronic backup supply machine. The ADON stated that he was continuing to investigate the discrepancy with the Tramadol inventory count.

On 5/18/21 at 1:24 PM, the surveyor conducted a phone interview with the CP who stated that he did not have any responsibility regarding maintaining the accountability of the CD in the electronic back up supply machine. The CP stated that CD should be maintained for inventory and reconciliation accountability.

On 5/20/21 at 1:34 PM, the surveyor conducted a phone interview with the RP#2 who stated that she could not answer questions regarding the CD in the electronic backup supply machine and would have to forward the request to the proper individuals.

The surveyor made a second attempt to call on 5/20/21 at 3:38 PM and was unable to interview a provider pharmacy representative regarding the CD electronic backup supply machine.

A review of the facility policy for "Controlled Drugs" dated April 2019 provided by the DON and ADON reflected that controlled substances are reconciled at the end of each shift.

NJAC 8:39-11.2(b), 29.2(d), 29.4(b,3) (c) (f) (g) (k) (c)