STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	C 08/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	**794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052**

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F 000	INITIAL COMMENTS Complaint#: NJ144327 Census: 90 Sample Size: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		9/28/21

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

Electronically Signed | 09/20/2021

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F 842	Continued From page 1	F 842		

all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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F 842	Continued From page 2 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint#: NJ144327 Based on interviews, medical record review, and review of pertinent facility documents on 8/24/2021, it was determined that the facility failed to maintain an accurate medical record for physician's orders for 2 of 3 residents (Resident [redacted] and Resident [redacted]. The facility also failed to follow its policies titled "Administering Medications" and "Charting and Documentation." This deficient practice was evidenced by the following: Review of the Electronic Medical Record (EMR) were as follows: 1. Review of Resident [redacted]s "Admission Record" showed Resident [redacted] was admitted to the facility on [redacted], with diagnoses which included but were not limited to [redacted] According to the Minimal Data Set (MDS), an assessment tool dated [redacted], Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was moderately cognitively intact. The MDS also showed that Resident [redacted] needed extensive assistance with Activities of Daily Living (ADLs) and was coded as not having a [redacted].	F 842	F-TAG 842 1. Resident's [redacted] physicians order sheet was immediately updated by the Director of Nurses to reflect the discontinuation of the foley catheter. Resident [redacted] the care plan was updated. Resident [redacted] the ADL (Activity of Living)documentation was reviewed by the Director of Nurses and all corrections were made to reflect the resident's care needs. The Director of Nurses in-serviced LPN (Licensed Practical Nurse) on 9/25/21 on the policy and procedure of Documentation and orders on the Physician's Order sheet as well as the timely review of each record to ensure accuracy of the physician's record. For resident [redacted] The Director of Nurses immediately in-serviced the LPN (Licensed Practical Nurse) and gave individual counseling on the policy and procedure for documentation on residents MAR (Medication Administration Record) as well as documentation on the TAR (Treatment Administration Record). 2. All residents have the potential to be affected by this deficient practice when physician order sheets are not correct. All residents have the potential to be affected when documentation is omitted on MAR (medication Administration Records)and TAR (Treatment Administration Records).	

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F 842	Continued From page 3 A review of Resident [redacted]'s "Physicians Order Sheet (POS)" dated [redacted] contained the following physician orders: [redacted] as needed for [redacted] dated [redacted] However, further review of the EMR showed no physician's orders for the [redacted] or discontinuation of the [redacted] During an interview on 8/24/2021 at 3:20 PM, Resident [redacted] stated, "I used to have a [redacted] but that came out a while ago, I don't recall when, but I don't have one now." At the interview, the surveyor observed Resident [redacted] did not have a [redacted]. During an interview on 8/24/2021 at 5:02 PM, the Director of Nursing (DON) stated she did not know when Resident [redacted] was discontinued and needed to go into the chart to determine when it was discontinued. The DON also stated the physician's orders should have been updated to show the [redacted] was discontinued. However, the DON was unable to provide the physician's orders for the [redacted]. 2. Review of Resident [redacted]s face sheet showed the resident was admitted to the facility on [redacted], with diagnoses which included but were not limited to [redacted] According to the MDS dated [redacted], Resident [redacted] had a BIMS score of [redacted], indicating the resident was [redacted]. The MDS also showed Resident [redacted] needed extensive assistance with ADLs and was [redacted]	F 842	An audit was done on all current MAR (Medication Administration Record) as well as all current TAR (Treatment Administration Record) records to ensure all areas of documentation had been completed. #3 On 8/25/21, an inservice was given by the Director of Nurses (DON) with all nurses in regards to the policy and procedure for documentation in the resident's medical record. On 8/25/21, an inservice was done by the Director of Nurses with all nurses in regards to the proper documentation of physician orders on the Physician Order Sheet as well as the update to the resident care plan to reflect the new care needs of the resident. The Pharmacy Consultant will review with all nurses the policy and procedure for all documentation on resident MAR (Medication Administration Records) and TAR (Treatment Administration Records). 4. The Director of Nurses and Unit managers will review 5 charts daily x 30 days then 3 charts daily x 30 days for accuracy of Physician Order Sheets and to reflect any new orders for each resident. The Unit Managers will audit 10 MAR (Medication Administration Records) and 10 TAR (Treatment Administration Records) daily for recording of documentation of medications and treatments x 30 days. The Unit Managers and Director of Nurses will audit 5 care plans daily for updated and new physicain orders x 30 days. The Pharmacy Consultant will inform the Administrative	

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F 842	Continued From page 4 [redacted]. A review of Resident [redacted]'s POS dated [redacted] revealed the following physician's orders for medications: [redacted]) Tab [redacted] milligram (mg). Give 1 tablet daily at bedtime for mixed [redacted], dated [redacted]. [redacted]) tab [redacted] mg [redacted]). Give 1 tablet orally daily for [redacted], dated [redacted] [redacted] Tab [redacted] mg. Give 1 tablet orally at bedtime for [redacted] dated [redacted]. [redacted] daily AM (before noon) for [redacted]), dated [redacted]. [redacted] daily PM (after noon) for [redacted], dated [redacted]. Offer extra fluids every shift, dated [redacted] [redacted] before breakfast and before dinner, dated [redacted]. A review of Resident [redacted]'s Medication Administration Record (MAR) dated [redacted] showed blank spaces for the above physician's orders as follows: [redacted]) Tab [redacted] mg. Give 1 tablet daily at bedtime for mixed [redacted], on 7/30/2021 and 7/31/2021 at 9:00 PM.	F 842	team of any deficient findings each month. All findings will be reviewed at the Quality Assurance meeting x 2 quarters.	

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[redacted]) tab [redacted] mg [redacted]. Give 1 tablet orally daily for [redacted] on 7/30/2021 and 7/31/2021 at 9:00 PM.

[redacted]) Tab [redacted] mg. Give 1 tablet orally at bedtime for [redacted] on 7/31/2021 at 9:00 PM.

[redacted] daily (AM) for [redacted] on 7/6/2021, 7/9/2021, 7/13/2021, 7/14/2021, 7/19/2021, 7/21/2021, 7/22/2021, 7/28/2021, 7/20/2021, and 7/31/2021 at 8:00 AM, for the [redacted]

[redacted] daily (PM) for DM on 7/8/2021, 7/10/2021, 7/11/2021, 7/12/2021, 7/13/2021, 7/22/2021, 7/22/2021, and 7/31/2021. On 7/8/2021, 7/22/2021, and 7/31/2021 at 9:00 PM, for the [redacted].

Offer extra fluids every shift on 7/12/2021, 7/18/2021, 7/19/2021, 7/20/2021, and 7/26/2021 for the 11:00 PM-7:00 AM shift. On 7/8/2021, 7/13/2021, 7/30/2021, and 7/31/2021 for the 3:00 PM-11:00 PM shift.

[redacted] before breakfast and before dinner on 7/8/2021, 7/13/2021, 7/19/2021, 7/25/2021, 7/27/2021, and 7/28/2021 at 4:30 PM, and on 7/23/2021 at 7:00 AM.

During an interview on 8/24/2021 at 4:45 PM, the Licensed Practical Nurse (LPN) stated, Resident [redacted] "does not have a [redacted]." The LPN explained the resident had a [redacted] the pass, but she did not recall the date when the [redacted] was removed. The LPN also stated, "the order for the care of the [redacted] should have been discontinued." The LPN further stated, "the

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blanks on the MAR sheet do not indicate that the treatment was not done; it does indicate that they did not complete the documentation."

During an interview on 8/24/2021 at 5:02 PM, the DON further stated, "the omissions on the MARS and TARS mean that the staff forgot to initial it indicating the medication or treatment was not done." The DON further stated, "the policy for physician's orders was not followed."

A review with the facilities policy titled "Administrating Medications" dated revised December 2012, indicated the following: Under "Policy Statement": Medication shall be administered in a safe and timely manner, and as prescribed. Under "Policy, Interpretation and Implementation" #1. Only persons license or permitted by this state to prepare, administer, and document administration of medications may do so. #3. Medications must be administered in accordance with orders, including any required timeframe. #4. Medications must be administered within one hour of their prescribed time unless otherwise specified. For example, before and after meal orders. #18. If a drug is withheld, refused, or given at a time other than the scheduled time to the individual administering medication, shall initial and circle MAR space provided for that drug and dose. #19. The individual administering the medication must initial the Resident's MAR on the appropriate line after giving each medication and before administering the next ones. #20. As required or indicated for medication to individual administering, the medication will record in the resident's medical record. a. The date and time the medication was administered. b. The dosage. c. The route of administration. d. The injection

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site. e. Any complaints or symptoms for which the drug was administered. f. Any results achieved when those results were observed. g. The signature and title of the person administering the drug.

A review of the facilities policy titled "Charting and Documentation" dated revised April 2008. indicated the following: Under "Policy Statement": All services provided to a resident or any changes in a resident's, medical or mental condition, shall be documented in the resident's medical record. Under "Policy, Interpretation and Implementation" #1, All observations, medications, administered services performed, etc., must be documented in the resident's clinical record. #2. Entries may only be recorded in their resident's clinical record by the licensed personnel, i.e. (RN LPN/LVN) physicians, therapists, etc. In accordance with state law and facility policy, certified nurse's assistants may only make entries in a resident's medical chart as permitted by facility policy. 6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimal: a. The date and time the procedure/treatment was performed. b. The name and title of the individuals who provided to care. c. The assessment data and or any unusual findings obtained during the procedure or treatment. d. How the resident tolerated the procedure/treatment. e. Whether the resident refused the procedure/treatment f. Notification of family, physician or other staff if indicated. g. The signature and title of the individual documenting.

N.J.A.C. 8:39-27.1(d)
N.J.A.C. 8:39-11.2(h)