

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Chatham Hills Subacute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Southern Blvd Chatham, NJ 07928	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37791</p> <p>Complaint #: NJ00167644</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to a.) clarify duplicate physician's orders for an over-the-counter medication, Ferrous Sulfate and b). failed to obtain a medication for pain. This deficient practice occurred for 2 of 7 residents, (Resident #63 and #133) reviewed for medication review.</p> <p>The deficient practice was evidenced by the following:</p> <p>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 case finding, 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.</p> <p>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 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.</p> <p>1). The surveyor reviewed the medical record for Resident #63.</p> <p>On 5/22/24 at 10:33 AM, the surveyor observed the resident who was seated in the Long-Term Care unit dining/recreational room. The resident was seated in their wheelchair and was participating in activities.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to: hypertension (elevated blood pressure), iron deficiency anemia secondary to blood loss (a condition in which blood lacks adequate healthy red blood cells), acute posthemorrhagic anemia (acute blood loss anemia, is a condition that occurs when a person quickly loses a large amount of blood) and anxiety disorder (a mental health disorder characterized by feeling worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>A review of the Admission Minimum Data Set (MDS), an assessment tool, used to facilitate the management of care, dated 04/23/24, reflected that the resident had a brief interview for mental status (BIMS) score of 99, which indicated that the resident was unable to complete an interview. Further review of the MDS section C1000, reflected the resident's cognitive skills for decision making were a 3 (three) which indicated that the resident's cognition is severely impaired.</p> <p>A review of the May 2024 Order Listing Report (OLR) revealed a physician order (PO):</p> <ol style="list-style-type: none"> 1. A PO dated 05/25/24 for Ferrous Sulfate oral solution 220 (44 Fe [Iron]) mg (milligrams)/5 ml (milliliters) give 5 ml by mouth one time a day for supplement. 2. A PO dated 05/28/24 for Ferrous Sulfate 325 (65 Fe) mg give 1 tablet by mouth one time a day for supplement. <p>A review of the May 2024, electronic medication administration record (eMAR) revealed an order for Ferrous Sulfate oral solution 220 mg/5ml, give 5 ml by mouth one time a day for supplement which was signed as being administered in the eMAR on 05/28/24 at 9:00 AM. Further review, revealed an order for Ferrous Sulfate 325 mg, give 1 tablet by mouth one time a day for supplement which was signed as being administered in the eMAR on 5/28/24 at 9:00 AM.</p> <p>On 5/28/24 at 1:10 PM, the surveyor interviewed the Long-Term care unit Licensed Practical Nurse (LPN) who acknowledged that she should have discontinued the Ferrous Sulfate 325 mg tablets. The LPN did not respond to the surveyor inquiry about both Ferrous sulfate tablets and liquid being signed as being administered at 9:00 AM on 05/28/24.</p> <ol style="list-style-type: none"> 2). The surveyor reviewed the closed medical record for Resident #133. <p>A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses which included but not limited to: hypertension, chronic kidney disease (long standing disease of the kidneys leading to renal disease), spinal stenosis (happens when space in the spinal cord is too small and could put pressure on the spinal cord and the nerves) and anxiety disorder (a mental health disorder characterized by feeling worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>A review of the Admission MDS, dated [DATE], reflected that the resident had a BIMS of 6 out of 15, indicating that the resident was severely cognitively impaired.</p> <p>A review of the September 2023 OLR revealed the following PO dated 06/13/23:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Pregabalin oral capsule 100 mg, give 1 capsule by mouth one time a day for pain take with 25 mg capsule= 125 mg.</p> <p>2. Pregabalin oral capsule 25 mg, give 1 capsule by mouth one time a day for pain take with 100 mg capsule=125 mg</p> <p>A review of the September 2023 eMAR revealed an order for Pregabalin oral capsule 100 mg, give 1 capsule by mouth one time a day for pain take with 25 mg capsule = 125 mg with an order date of 6/13/23 and an administration time of 9:00AM. A further review of the eMAR, revealed that the resident's medication was not signed as being administered on 9/6/23, 9/7/23, 9/8/23, 9/9/23, 9/10/23, 9/12/23, and 9/13/23.</p> <p>A review of the September 2023 eMAR revealed an order for Pregabalin oral capsule 25mg, give 1 capsule by mouth one time a day for pain take with 100mg capsule= 125 mg with an order date of 6/13/23 and an administration time of 9:00AM. A further review of the eMAR revealed that the resident's medication was not signed as being administered on 9/6/23, 9/7/23, 9/8/23, 9/9/23, 9/10/23, 9/12/23 and 9/13/23.</p> <p>A review of the facility Progress Notes (PN) revealed that the facility was documenting that the resident's Pregabalin capsules were unavailable from the pharmacy in either a medication administration notes or a nurses note from 9/6/23 until 9/13/23. The notes revealed that the medications were unavailable and were awaiting a delivery from the pharmacy.</p> <p>On 5/30/24 at 1:30 PM, the surveyor discussed the above concerns with the administration team which included the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and a Regional Nurse.</p> <p>On 05/31/24 at 10:40 AM, the DON acknowledge that the resident did not receive their Pregabalin 100 mg and Pregabalin 25 mg capsules from 9/6/23 and 9/13/23. She stated that the pharmacy needed a prescription to send out the medication and that the facility notified the physician and was awaiting a prescription from the physician.</p> <p>There was no additional information provided.</p> <p>A review of the facility's policy for Medication Administration schedule/policy that was dated 12/31/23 and was provided by the DON that revealed the following:</p> <p>7. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for a resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or facility's medical director to discuss concerns.</p> <p>A review of the facility's policy for Physician orders that was dated 10/31/23 and was provided by the DON that revealed the following:</p> <p>The nurses will clarify with the physician any orders needing clarifications.</p> <p>NJAC 8:39-11.2 (b), 29.2 (d)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41858</p> <p>NJ #167099</p> <p>Based on observations, interviews, and record review it was determined that the facility failed to ensure that staff wear the appropriate personal protective equipment (PPE) for residents on Enhanced Barrier Precautions (designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes) to address the risk for infection transmission, in accordance with the facility policy and acceptable standards of infection control practice. This was observed for 2 of 3 residents (Resident #41 and #18) reviewed for Enhanced Barrier Precautions on 2 of 2 units (North and South Unit) and was evidenced by the following:</p> <p>1. On 05/24/24 at 7:45 AM, during incontinence rounds with the Infection Preventionist on the South Unit, the surveyor observed an Enhanced Barrier Precautions sign outside of unsampled Resident #41's door. There was a PPE bin located under the sign. The IP entered the room with the surveyor and asked the resident for permission to conduct an incontinence check. The resident granted permission. The IP performed hand hygiene and removed gloves from a box. She then pulled the curtain and donned (put on) the gloves. At that time, the surveyor requested to speak with the IP in hallway and pointed out the signage at the door. The Enhanced Barrier Sign read Stop: Enhanced Barrier Precautions Everyone Must: . Wear gloves and a gown for the following High-Contact Resident Care Activities .Changing briefs or assisting with toileting. The IP acknowledged the signage and stated she needed to wear a gown and gloves for incontinence check. She then donned a gown and gloves and proceeded with the incontinence check.</p> <p>The surveyor reviewed the electronic medical record (eMR) for Resident #41.</p> <p>A review of the Admission Record (AR, an admission summary) revealed the resident was admitted to the facility with diagnoses which include but not limited to: Secondary Malignant Neoplasm of Breast (breast cancer cells spread from the primary (first) cancer in the breast to other parts of the body) and Hemothorax (a collection of blood in the space between the chest wall and the lung).</p> <p>A review of the Order Summary Report (OSR) revealed a physician order (PO) for Enhanced Barrier Precautions dated 4/23/24.</p> <p>A review of the care plan (CP) revealed: Focus: [name redacted] is on Enhanced Barrier Precaution related to being at risk for MDRO (Multi-Drug Resistant Organism) dated 4/23/24. Interventions: ENHANCED BARRIER PRECAUTIONS: wear gown and gloves during assistance with dressing, bathing, transferring, hygiene, changing linens, changing briefs & toileting, and during therapy.</p> <p>48423</p> <p>2.) On 05/22/24 at 12:04 PM, during the initial tour of the facility, the surveyor observed Resident #18 in their room, sitting in wheelchair, by the window. The resident showed the surveyor their gall bladder drain tube which was placed in a privacy bag and secured to the right-side armrest of the wheelchair. The surveyor did not observe any Enhanced Barrier Precaution (EBP) signs or a PPE bin at the door.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/23/24 at 10:34 AM, the surveyor observed the resident #18 sitting up in their bed. No EBP sign and PPE bin noted at the door.</p> <p>On 05/24/24 at 07:48 AM, during incontinence rounds with the Registered Nurse/ Unit Manager (RN/UM), the surveyor did not observe an EBP sign or a PPE bin at Resident#18's door. The RN/UM and the surveyor went to the room and the RN/UM checked the resident for incontinence. The surveyor observed the RN/UM wearing only gloves, no gown. The RN/UM picked up the biliary drain tube (a thin, flexible tube that allows bile to flow out from a blocked bile duct into a collection bag outside the body) to show the surveyor that it was attached to the drainage bag. The RN/UM stated, it (the tube) was inserted about 2 months ago.</p> <p>The surveyor reviewed the eMR for Resident #18.</p> <p>A review of the Resident #18's AR revealed the resident was admitted to the facility with diagnoses which included, but were not limited to: acute cholecystitis (inflammation of the gallbladder that develops over hours), immunodeficiency (failure of the immune system to protect the body adequately from infection, due to the absence or insufficiency of some component process or substance) due to conditions classified elsewhere, obstruction of bile duct (a condition that occurs when the bile ducts, which are small tubes that carry bile from the liver to the small intestines become blocked or narrowed), and encounter for change or removal of drains.</p> <p>A review of the OSR revealed a PO for Enhanced Barrier Precaution r/t [related to] being at risk for MDRO (Multidrug resistant organism) dated 05/22/24.</p> <p>A review of the CP revealed a focus of [Name Redacted] is on Enhanced Barrier Precautions related to being at risk for MDRO dated 4/23/24 and interventions: EBP: wear gown, and gloves during assistance with dressing, bathing, transferring, hygiene, changing linens, changing briefs & toileting, and during therapy.</p> <p>On 05/24/24 at 12:05 PM, during an interview with the surveyor , the RN/UM stated that EBP were used for any resident that had wounds, urinary catheters, feeding tubes and residents with IV antibiotics. The RN/UM explained the process was first to obtain the PO, enter them in the computer, then we put the EBP signs on the doors and place a PPE bin at the door and inform the resident's family. The RN/UM acknowledged that there should be a EBP sign on the door and the required PPE the staff should use when providing direct care to the resident. The RN/UM further stated, PPE is important and is required for the protection of the staff and the other residents.</p> <p>On 05/24/24 at 12:17 PM, the surveyor and the UM/RN walked to Resident # 18's room and checked the door, the UM/RN confirmed that there was no EBP sign on the door. She stated, Yes, there should be a sign on the door.</p> <p>On 05/30/24 at 12:50 PM, during a meeting with Regional Nurse #1, Regional Nurse #2, the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the survey team, the above-mentioned observations for Resident #41 and #18 was presented.</p> <p>On 05/31/24 at 9:41 AM, during a meeting with the survey team and the LNHA, the DON acknowledged that the staff did not use the proper PPE while checking resident's for incontinence.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's policy Enhanced Barrier Precautions Policy dated 4/18/24, revealed: Statement: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .f. changing briefs or assisting with toileting .5. EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk .10. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required, 11. PPE is available outside of the resident rooms.</p> <p>NJAC 8:39-19.4(a)(2)(c)</p>