

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Arbor Ridge Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 261 Terhune Drive Wayne, NJ 07470	
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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>32513</p> <p>Based on interview, record review and review of facility policy, the facility failed to provide the SNF ABN (skilled nursing facility advance beneficiary notice) for two (Residents (R) 91 and R109) of three residents reviewed for beneficiary notices. This failure placed the residents at risk of not knowing the costs or appeals process when they remained at the facility.</p> <p>Findings included.</p> <p>Review of the facility policy titled, Medicare Advanced Beneficiary and Medicare Non-Coverage Notices, dated September 2022 revealed, .The requirement to notify and explain via the SNFABN that the individual is no longer receiving Medicare Part A services based on the SNF's belief that Medicare Part A will not pay for the resident's stay separate and unrelated to the admission and discharge requirement under 42 CFR 483.15, which outlines the notification and requirements under which an individual may be discharged from the facility or when the transfer or discharge is not initiated by the resident . Termination-In the situation in which the facility proposes to stop furnishing all extended care items or services to a beneficiary because it expects the Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care the SNF ABN is issues to the beneficiary before such extended care items or services are terminated. The resident or representative is informed that they may choose to continue receiving the skilled services that may not be paid for by Medicare, and assume financial responsibility .</p> <p>1. Review of the SNF Beneficiary Notification Review for Residents who received Medicare Part A Services form, provided by the Administrator, revealed R91 had a Medicare A start date of 02/07/24 and a last covered Medicare Part A Day of 04/30/24. There was no documentation provided that R91 had received the SNF ABN form.</p> <p>2. Review of the SNF Beneficiary Notification Review for Residents who received Medicare Part A Services form, provided by the Administrator, revealed R109 had a Medicare A start date of 04/12/24 and a last covered Medicare Part A Day of 04/30/24. There was no documentation provided that R109 had received the SNF ABN form.</p> <p>During an interview on 10/16/24 at 10:05 AM, the Administrator stated, In April, we had a social worker that either lost or threw them away. We had a Medicare audit and that is when we identified there was a problem. He left in July but we just can't find the notices.</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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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39- 5.4(b)(c)

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview, and policy review, the facility failed to protect the resident's right to be free from sexual abuse by a resident for one of four residents (Resident(R) 39) reviewed for abuse out of 27 sample residents when R32, who had no cognitive impairment, kissed R39's hand, who lacked any capacity to give consent. This had the potential to affect all the residents on the 2nd floor of the facility who were at risk of abuse.</p> <p>Findings include:</p> <p>1. Review of R39's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R39 admitted to the facility on [DATE] with diagnoses including dementia, schizophrenia, obsessive compulsive disorder, anxiety disorder, major depressive disorder and mood disorder.</p> <p>Review of R39's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/09/24 revealed a Brief Interview for Mental Status (BIMS) score of zero out of 15 which indicated R39 was severely cognitively impaired.</p> <p>2. Review of R32's "Admission Record" located in the "Profile" tab of the EMR, revealed R32 admitted to the facility on [DATE] with diagnoses including major depressive disorder, and anxiety.</p> <p>Review of R32's quarterly MDS" with an ARD of 06/21/24 revealed a BIMS score of 15 out of 15 which indicated no impairment.</p> <p>Review of R32's care plan, located under the "Care Plan" tab of the EMR and dated 01/24/20, revealed The resident had a psychosocial wellbeing problem related to ineffective coping skills.</p> <p>Review of "Nurse's Notes" located in the EMR under the "Notes" tab, revealed no documentation related to the incident that occurred on 10/06/24 between R32 and R39.</p> <p>Review of Investigation Summary and Conclusion provided by the facility, dated 10/16/24, revealed R32 admitted to kissing R39 on the hand but the facility found that abuse did not occur.</p> <p>During an interview on 10/16/24 at 10:27 AM Family Member (FM)1 said he was at the facility on Sunday 10/06/24 sitting and talking in the dining room. He said his mom told him to look over at another table where R32 was touching on R39. He said he looked over and saw R32 kissing R39's hand and he reported it to Recreation Aide (RA)1. She went over to the table and told R32 to stop, and he wheeled himself out of the dining room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/24 at 10:58 AM, RA1 said on 10/06/24 she was in the dining room from about 3:30 PM to 4:00 PM getting ready to take the residents back to their rooms after their church service activity. Another resident and their family were sitting close by, and the resident told her That guy is touching that person over there and when she looked she saw R32 sitting next to R39 but his hands were on the table and she did not see anything. She said R39 was chewing on her clothing, but she went over and told R32 that he had to leave the room, and he did. She did not report the incident to a supervisor because she did not see a supervisor around.</p> <p>During an interview on 10/16/24 at 1:18 PM the Assistant Director of Nursing (ADON) said she became aware od the incident on 10/09/24 after FM1 came to her and reported it. She said he told her on Sunday while he was in the dining room with his mom, along with an activity aide. He said his mom told his look at a resident that was messing with a female resident. When he looked over he said R32 kissing R39's hand. He told her he reported it to RA1 but by the time the aide looked R32 was not touching R39 anymore. He was asked to write a statement but to her knowledge he did not. She spoke with RA1 who told her she did not witness anything but asked R32 to leave. But she did not report it to anyone since she didn't witness anything.</p> <p>During an interview on 10/16/24 at 2:28 PM the Administrator stated he interviewed R32 who admitted to kissing R32's hand and told him it was the 1st time that he had done that, but he did not ask R32 why he decided to do it that day? He stated R32 meant it in a friendly gesture and there was no sexual intention. And that was why they concluded it was not abuse. He stated even though R32 was unable to tell anyone how it affected her he would still agree it was not abuse.</p> <p>NJAC 8:39-9.4(f)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview, and policy review, the facility failed to report an allegation of sexual abuse by a resident for one of four residents (Resident (R) 39) reviewed for abuse out of 27 sample residents when R32 kissed R39 hands who lacked the ability to give consent, this had the potential to affect all the residents on the 2nd floor of the facility who were at risk of abuse.</p> <p>Findings include:</p> <p>1. Review of R39's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R39 admitted to the facility on [DATE] with diagnoses including dementia, schizophrenia, obsessive compulsive disorder, anxiety disorder, major depressive disorder and mood disorder.</p> <p>Review of R39's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/09/24 revealed a Brief Interview for Mental Status (BIMS) score of zero out of 15 which indicated R39 was severely cognitively impaired.</p> <p>2. Review of R32's "Admission Record" located in the "Profile" tab of the EMR, revealed R32 admitted to the facility on [DATE] with diagnoses including major depressive disorder, and anxiety.</p> <p>Review of R32's quarterly "MDS" with an ARD of 06/21/24 revealed a BIMS score of 15 out of 15 which indicated no impairment.</p> <p>Review of Investigation Summary and Conclusion provided by the facility, dated 10/16/24, revealed R32 admitted to kissing R39 on the hand but the facility found that abuse did not occur Further review revealed the incident was not report to the state until 10/09/24 after a family member reported it to the facility.</p> <p>During an interview on 10/16/24 at 10:27 AM Family Member (FM)1 said he was at the facility on Sunday 10/06/24 sitting and talking in the dining room. He said his mom told him to look over at another table where R32 was touching R39. He said he looked over and saw R32 kissing R39's hand and he reported it to Recreation Aide (RA)1 at the time of the incident.</p> <p>During an interview on 10/16/24 at 10:58 AM RA1 said on 10/06/24 she was in the dining room from about 3:30 PM to 4:00 PM when another resident and their family were sitting close by, and the resident told her That guy [R39] is touching that person over there and when she looked she saw R32 sitting next to R39 but his hands were on the table and she did not see anything. She did not report the incident to a supervisor because she did not see a supervisor around.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/24 at 1:18 PM the Assistant Director of Nursing (ADON) said she became aware of the incident on 10/09/24 after FM1 came to her and reported it. She said FM1 told her on Sunday while he was in the dining room with his mom, along with an activity aide his mom told him to look at a resident that was messing with a female resident. When he looked over he said R32 kissing R39's hand. He told her he reported it to RA1 but by the time the aide looked R32 was not touching R39 anymore. She spoke with RA1 who told her she did not witness anything but asked R32 to leave. But she did not report it to anyone since she didn't witness anything.</p> <p>During an interview on 10/16/24 at 2:28 PM the Administrator confirmed the allegation was not reported timely.</p> <p>During an interview on 10/17/24 at 1:36 PM the Director of Nursing (DON) said she expected staff to report any allegations immediately</p> <p>NJAC 8:39-9.4(f)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview and policy review, the facility failed to ensure that MDS assessment was completed timely for one residents R32. This had to affect all the residents with MDS assessments.</p> <p>Findings include:</p> <p>Review of R32's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR), revealed R32 admitted to the facility on [DATE] with diagnoses including major depressive disorder and anxiety.</p> <p>Review on 10/14/24 of R32's Annual Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 09/20/24 was listed as Pending. Further review revealed the ARD date for completion was 10/15/24.</p> <p>During an interview on 10/17/24 at 10:00 AM with the MDS Coordinator (MDSC) who stated she has asked for additional help to assist with completing the assessments timely. She knew the 09/20/24 assessment was not completed within the times frames, and it should have been within 14 days.</p> <p>During an interview on 10/17/24 at 1:36 PM the Director of Nursing (DON) said she expected that assessments were completed in a timely manner and completed within the timeframes.</p> <p>NJAC 8:39-11.1</p>

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview and review of the Resident Assessment Instrument Manual, the facility failed to ensure that a significant change Minimum Data Set (MDS) assessment was completed timely for one residents R27 out of 27 residents reviewed in the sample. This had the potential to affect all residents with a significant change.</p> <p>Findings Include:</p> <p>Review of R27's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed readmission to the facility on [DATE].</p> <p>Review on 10/14/24 of R27's Significant change MDS under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 07/30/24. Further review revealed the ARD date for completion was 08/04/24.</p> <p>Review of Physician Orders under the Orders tab of the EMR, dated 07/17/24, revealed an order for hospice.</p> <p>During an interview on 10/17/24 at 10:09 AM with the MDS Coordinator (MDSC) and Regional MDS coordinator (RMDS) the MDSC stated she was on vacation at the time the significant change assessment should have been completed. The RMDS have had problems with hospice notifying them after a resident goes on hospice and has told the nurses to let them know when they make an order for hospice. She stated there are per-diem staff that help when the MDSC is out, and she would periodically check to ensure assessments were being completed timely. She said this one was missed but that she caught it on the 30th and initiated it but she said it was not completed timely within the 14 days and it should have been.</p> <p>During an interview on 10/17/24 at 1:36 PM the Director of Nursing (DON) said she expected that assessments were completed in a timely manner and completed within the timeframes.</p> <p>Review of the Minimum Data Set Resident Assessment Instrument (RAI) revealed, Guidelines for Determining the Need for an SCSA For Residents With Terminal Conditions. The key in determining if an SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual. If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration, an SCSA assessment is required. Similarly, if the resident enrolls in a hospice (Medicare Hospice program or other structured hospice program), but remains a resident at the facility, an SCSA should be performed if the terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration. The facility is responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.</p> <p>NJAC 8:39-11.2(i)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513</p> <p>Based on interview, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a quarterly assessment was coded accurately for one (Resident (R)83) in a total sample of 30. The facility failed to accurately code hospice for R83. This failure placed the residents at risk of unmet care needs.</p> <p>Findings included.</p> <p>Review of the October 2024 RAI, manual, page 1-5 revealed, .An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations .It is important to note here that information obtained should cover the same observation period as specified by the MDS [minimum data set] items on the assessment, and should be validated for accuracy (what the resident's actual status was during the observation period) by the IDT (interdisciplinary team) completing the assessment .</p> <p>Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R83 was admitted to the facility on [DATE] with a diagnosis of a brain tumor.</p> <p>Review of the Physician Orders located in the Orders tab of the EMR revealed R83 was admitted to hospice services on 03/27/24.</p> <p>Review of the quarterly MDS located in the MDS tab of the EMR with and Assessment Reference Date of 06/28/24, Section O revealed R83 was not coded for hospice care.</p> <p>During an interview on 10/15/24 at 11:47 AM, the MDS Coordinator (MDSC) stated, I missed the quarterly assessment indicating hospice. It was an error.</p> <p>NJAC 8:39-33.2(d)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513</p> <p>Based on interview, record review, and review of facility policy, the facility failed to ensure a psychotropic medication contained a 14-day stop date, as required for one (Resident (R)106) of five residents reviewed for unnecessary medications. This failure placed the residents at risk of being administered a medication unnecessarily.</p> <p>Findings included.</p> <p>Review of the facility policy titled, Psychotropic Medication Use, dated July 2022 revealed, .A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior . Psychotropic medications are not prescribed or given on a PRN (as needed) basis unless that medication is necessary to treat a diagnoses specific condition that is documented in the clinical record .PRN orders for psychotropic medications are limited to 14 days .</p> <p>Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R106 was admitted to the facility on [DATE] with a diagnosis of cancer and pneumonia.</p> <p>Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date of 09/19/24 revealed R106 had a Brief Interview of Mental Status (BIMS) score of 13 out of 15 which indicated he was cognitively intact and had been administered an antianxiety medication during the observation period.</p> <p>Review of the current Physician Orders located in the Orders tab of the EMR revealed a 10/01/24 Order for Alprazolam (an antianxiety medication) 0.25 mg give one table every 12 hours as needed for Anxiety. There was no stop date on the Order.</p> <p>During an interview on 10/16/24 at 1:15 PM the Director of Nursing (DON) stated, R106 should have been reassessed to see if the medication needed to be continued.</p> <p>NJAC 8:39-27.1(a)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513</p> <p>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure a valid physician order for a narcotic was obtained for one (Resident (R)25) of six sampled residents reviewed during medication pass. The facility failed to obtain a documented physician order for narcotic medication and failed to ensure there was documentation of symptoms for the use of narcotics. This failure placed the resident at risk of receiving medication</p> <p>Findings included.</p> <p>Review of an undated facility policy titled, Administering Medications, revealed, .Medications are administered in a safe and timely manner and as prescribed .Medications are administered in accordance with prescriber orders, including any required time frames .</p> <p>Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R25 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease.</p> <p>Review of a significant change Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 06/03/24 revealed R25 had a Brief Interview of Mental Status (BIMS) score of zero out of 15 which indicated she was severely impaired in cognition, had not been administered an antianxiety medication during the observation period and was on hospice.</p> <p>On 10/16/24 at 8:44 AM, the narcotic book on medication cart two-north, cart two was reviewed with Licensed Practical Nurse (LPN) 5. During the observation, the October 2024 Narcotic Sheet revealed missing initials on 10/14/24 for the 3:00 PM to 11:00 PM shift. In addition, there were initials signed out for the 10/16/24 3:00 PM to 11:00 PM, even though that shift had not started yet.</p> <p>On 10/16/24 at 9:04 AM, a full narcotic count was conducted with LPN5 and the Director of Nursing (DON). During the narcotic count, the last page in the narcotic book revealed a sign-out sheet for R25's Lorazepam Oral Concentrate (an anti-anxiety medication) 2 MG/ML (milligrams/milliliter) Give 0.25 ml by mouth every 2 hours as needed for Anxiety for 14 days. Start Date: 07/22/24 and End Date: 08/05/24</p> <p>The narcotic sign-out sheet revealed that R25 had received two doses of Lorazepam signed out by LPN 3. One for 09/22/24 at 3:30 PM and the other one for 09/22/24 at 6:00 PM (48 days past the discontinued date). There was no documentation the facility notified the doctor of the resident's and obtained an order for the administration of the discontinued medication.</p> <p>On 10/16/24 at 9:17 AM, Unit Manager (UM) 2 confirmed the medication had been signed-out in September despite the medication having been discontinued on 08/05/24.</p> <p>During an interview on 10/16/24 at 9:21 AM, the DON stated, If a medication has been discontinued, then it should not have been administered.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Arbor Ridge Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 261 Terhune Drive Wayne, NJ 07470	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/24 at 3:28 PM, with the DON and LPN 3, LPN 3 was asked if she was aware that the Lorazepam order for R25 had been discontinued in August. LPN 3 stated, Yes. LPN 5 was asked to share what happened that evening. LPN 3 stated, I signed it out, she (R25) was like exhausted, like yelling out. I called the doctor because she didn't have an order, so I called R25's physician and she gave me an order for 24 hours and that's what I gave to her. LPN 3 was asked why she did not write the physician's order, knowing that she did not have an order to administer the medication, after speaking with the physician or write a Nursing Progress Note to indicate R25's behavior and if the medication was effective. LPN 5 stated, It was a busy day. I might have forgotten, sorry. During the interview, the DON stated that it was her expectation that a physician order should have been entered into the EMR and a Nursing Progress Note written as to R25's behaviors and effectiveness of the medication. In addition, the discontinued medication should have been removed from the refrigerator and destroyed.</p> <p>NJAC 8:39-29.2(d)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>32513</p> <p>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure the label on an insulin pen matched the physician order for one (Resident (R) 87) of six residents reviewed during medication pass observation. This failure placed the resident at risk of receiving the wrong dose of medication.</p> <p>Findings included.</p> <p>Review of the facility policy titled, Medication Labeling and Storage, dated 2001 revealed, Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices .If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items .Only the dispensing pharmacy may label or alter the label on a medication container or package .</p> <p>During a medication storage observation on 10/16/24 at 7:35 AM, Licensed Practical Nurse (LPN) 5 obtained an insulin pen from the top drawer of the medication cart. He stated that he would be administering the insulin to R87. LPN5 asked how much insulin he would be administering to R87. LPN 5 stated, 15 units. Review of the label on the insulin pen revealed, Glargine insulin (long-acting insulin) 36 units every day. Review of the Medication Administration Record (MAR) for October 2024 revealed the insulin order had changed to 15 units on 10/08/24. During the observation LPN5 was asked what the process was when an order changed to an existing medication. LPN5 stated, Pharmacy will send us a new pen with the correct order. LPN 5 was asked why this had not been done since 10/08/24 when the order changed. LPN 5 stated, I don't know.</p> <p>During an interview on 10/16/24 at 8:41 AM, the Director of Nursing (DON) was asked what her expectation was regarding labeling of medications when the order changed. The DON stated, Staff are to call and verify the order with the physician, if the order is different, and then notify the pharmacy who will send us the corrected label. The DON further stated that we have change stickers to use until the new label arrives.</p> <p>NJAC 8:39-29.4(a)(h)(d)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>30347</p> <p>Based on observation, staff interview, and facility policy review, the facility failed to ensure kitchen staff properly air-dried pans prior to storage. This failure had the potential to increase the risk of foodborne illness and had the potential to affect all 107 residents who resided in the facility and who received dietary services. There were five residents receiving tube feedings, but they also received food from the kitchen. The facility had a census of 107 residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Sanitization, dated 11/2022 (sic), revealed, Policy Statement: The food service area is maintained in a clean and sanitary manner. Policy Interpretation and Implementation: . 7. Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross contamination .</p> <p>During an observation and interview on 10/14/24 at 9:22 AM, the Food Service Director (FSD) confirmed five pans, 12 inches by 6 inches by 8 inches deep that had been cleaned and stacked for use were still wet and had food particles on them when they were unstacked. The pans were found to have been stacked wet and not allowed to air dry. The FSD stated, they should be dry before they are put away, my normal dishwasher is on vacation and the person washing everything didn't let them dry before stacking them. They need to be rewashed.</p> <p>During an observation and interview on 10/14/24 at 9:33 AM, the FSD confirmed six pans, 10 inches by 12 inches by 6 inches deep; eight pans 10 inches by 6 inches by 6 inches deep: fifteen pans 12 inches by 24 inches by 4 inches deep that had been cleaned and stacked for use were still wet when they were unstacked. The pans were found to have been stacked wet and not allowed to air dry. The FSD stated, they should be dry before they are put away, we're just going to rewash everything.</p> <p>NJAC 8:39-17.2(g)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347</p> <p>Based on interview, record review, and review of facility policy, the facility failed to maintain a complete and accurate medical record for two residents (Residents (R) 210 and R 90) in a total sample of 30. The facility failed to ensure daily, weekly, and monthly weights were in the medical record to ensure continuity of care. This failure placed the residents at risk of unmet care needs.</p> <p>Findings included.</p> <p>Review of the facility policy titled, Charting and Documentation, dated 2001 revealed, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .</p> <p>1. Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R210 was admitted to the facility on [DATE] with a diagnosis of heart failure.</p> <p>Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 09/26/24 revealed R210 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated R210 was cognitively intact for daily decision-making and was administered a diuretic medication during the observation period.</p> <p>Review of the Physician Orders located in the Orders tab of the EMR revealed an 09/24/24 Order for Daily weights at 8 am weight (sic) pt [patient] before breakfast. Notify MD [Medical Doctor] if weight is greater than or equal to 3-pound increase in one day or if increase is greater than or equal to 5 lbs. in one week.</p> <p>Review of the daily weights located in the Weights and Vitals tab of the EMR revealed the following:</p> <p>09/19/24: 126.0 lbs.</p> <p>09/21/24: 126.1 lbs.</p> <p>There were no daily weights from 09/25/24 to 10/02/24 in the medical record.</p> <p>10/02/24: 132.8 lbs.</p> <p>No weight documented for 10/03/24.</p> <p>10/04/24: 134.4 lbs.</p> <p>10/05/24: 135.8 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No weight documented for 10/06/24.</p> <p>10/07/24: 133.3 lbs.</p> <p>There were no further weights documented in the medical record.</p> <p>During an interview on 10/15/24 at 1:15 PM, Licensed Practical Nurse (LPN) 2 stated, R210 gets up early and we weigh him when they are getting him ready. We give the aides a list of the weights that are needed on a sheet of paper and the names of who are daily weights. Once they are done, we pass them along to the Unit Manager (UM) for review.</p> <p>During an interview on 10/15/24 at 1:22 PM, UM1 stated, I collect the paper from the nurse and then put all the weights into an excel spreadsheet. The Director of Nursing (DON) then takes it for review.</p> <p>During an interview on 10/15/24 at 1:23 PM, the DON stated, I put the list of daily weights in a binder for the aides, then the aides put the weight in for the day, the nurse compares them for weight changes. UM1 does the tracking (of the weights). The only weights we allow in the PCC (point click care-electronic medical record) are those entered by the dietician.</p> <p>During a follow-up interview on 10/15/24 at 1:51 PM, the DON stated, We have been putting the weights in a binder for safekeeping. The Registered Dietician (RD) and the Physician can review them anytime.</p> <p>2. Review of the undated Admission Record located under the electronic medical record (EMR) under the Profile tab, revealed R90 was admitted to the facility on [DATE] with a diagnosis which included muscle wasting and atrophy, malignant neoplasm and pancreas.</p> <p>Review of R90'S Progress Notes, found under the Progress Notes tab of the EMR a Nutrition Note, dated 08/20/24 indicated, This RD[Registered Dietician] was notified by nursing that R90 is not tolerating bolus feeds . R90 continues with poor appetite.Recommendations . 5. Weekly weights.</p> <p>Review of Resident (R) 90's electronic medical record (EMR) on 10/15/24 at 12:25 PM, under the Vitals tab, weights revealed only three entries:</p> <p>08/14/24 - 154lbs.</p> <p>09/04/24 - 131.4 lbs.</p> <p>10/02/24 - 132 lbs.</p> <p>A request as made for R90'S weekly weights was made on 10/16/24.</p> <p>Further review of R90's EMR on 10/16/24 at 3:06 PM, under the Vitals tab, weights revealed eight entries dated:</p> <p>08/22/24 - 132 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>08/29/24 - 131.9 lbs.</p> <p>09/04/24 - 131.4 lbs.</p> <p>09/11/24 - 132.5 lbs.</p> <p>09/18/24 - 131.9 lbs.</p> <p>09/25/24 - 132.2 lbs.</p> <p>10/02/24 - 132 lbs.</p> <p>10/09/24 - 131.7 lbs.</p> <p>The additional weight entries were located in a binder at the nurse's station on the second floor and had not been entered into R90's medical record.</p> <p>During an interview on 10/16/24 at 11:05 AM the Registered Dietitian stated, The weights were on a sheet in a notebook and not in the EMR.</p> <p>32513</p> <p>NJAC 8:39-35.2(c)(d)(6)(g)</p>