STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315239	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Childrens Specialized Hospital Mountainside	150 New Providence Road Mountainside, NJ 07092

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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45449 Based on observation, interview and record review, it was determined that the facility failed to ensure a.) a physician orders for administration was followed, route of administration was clarified (Resident 18), and b.) dosing was clarified for an eye ointment, prior to administration (Resident 44 and Resident #2) in accordance with professional standards of practice and facility policy. The deficient practice was identified for three (3) of seven (7) residents, administered by three (3) of five (5) nurses, observed during the medication administration observation, and 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: 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. 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. 1.) On 9/25/24 at 7:41 AM, the surveyor observed Licensed Practical Nurse (LPN #1) prepare two (2) medications for Resident #18. The medications orders were: Prograf (Tacrolimus; medication used to prevent rejection of a transplanted organ such as the kidney, liver, heart or lung) 0.5 milligram (mg) capsule, to be administered by mouth (PO) at 6:00 AM. The order was started on 3/17/24. Prograf 5 mg capsule, to be administered PO twice daily (BID) at 6:00 AM and at 6:00 PM. The order was started on 11/14/22. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, LPN #1 was observed removing both capsules from a unit dose package, opened the capsules and poured into a medication cup, drew approximately, drew water into a syringe then emptied the water into a medication cup, and opened the Prograf capsules into the water in the medication cup. LPN #1 drew another five (5) milliliters (mls) of water into a syringe. On 9/25/24 at 7:43 AM, the surveyor observed LPN #1 asked Resident #18 if they can administer the medication by mouth. Resident #18 turned their head left and right twice. LPN #1 attached an enteral tube to a port, administered Prograf through the gastronomy tube (g-tube) and was followed with a water flush of the enteral tube. On 9/25/24 at 7:49 AM, during an interview with the surveyor, LPN #1 was asked why she administered Prograf orders via g-tube without a physician's order for another route and was the physician's order for PO appropriate for Resident #18. The LPN stated she would discuss with the medical team and the Charge Nurse. The surveyor reviewed the medical record for Resident #18. A review of the resident's electronic Medical Record reflected Resident #18 was a long-term care resident with diagnoses that included vocal cord paralysis, developmental delay, oral phase dysphagia (problems with using the mouth, lips, and tongue to control food or liquid) and heart transplant. A review of the quarterly Minimum Data Set, an assessment tool, dated 8/8/24 reflected that Resident #18, sometimes able to be understood and sometimes was able to understand others. The Brief Interview for Mental Status (BIMS; an evaluation for aspects of cognition) was not conducted and the resident had short-term and long-term memory problems. Further review of the qMDS reflected the resident had a swallowing problem that involved loss of liquid/solids from the mouth when eating or drinking and holding food in mouth/cheeks or residual food in mouth after meals. A review of Resident #18's comprehensive person-centered care plan reflected Resident #18 had impaired swallowing and the interventions included that the resident was in a puree diet again, had a munching pattern that will not efficiently breakdown food, and safely manage solid foods and no liquids. A review of the physician's progress note dated 9/24/24, included that all medications were given through gastronomy button except for Tacrolimus which was taken orally (most of the time). The resident received pureed diet during daytime with GT supplementation. 2. On 9/25/24 at 9:23 AM, the surveyor observed the Registered Nurse (RN) prepare medications for Resident #44 that included Artificial Tears Lubricant Ophthalmic Ointment (mineral oil and petrolatum; to prevent irritation or to relieve dryness if the eyes), One (1) application every three (3) hours (8 applications per day). On 9/25/24 at 9:42 AM, the surveyor observed the RN administer the Artificial Tears Lubricant Ophthalmic Ointment in varying length in the left and right eye. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Resident #44's physician's order for the Artificial Tears Lubricant Ophthalmic Ointment revealed that the order did not indicate a length of measurement to reflect the dose for each administration. The order was started on 7/2/24. 3. On 9/25/24 at 11:36 AM, the surveyor observed LPN #2 prepare medications for Resident #2 that included Artificial Tears Lubricant Ophthalmic Ointment (mineral oil and petrolatum; to prevent irritation or to relieve dryness if the eyes), One (1) application every two (2) hours (12 applications per day). At that time, LPN #2 stated that Resident #2's family member administered the medication to the resident and had been doing so for years. The surveyor observed LPN #2 in the room, near the resident and resident representative during the medication administration. A review of the Resident #2's physician's order for the Artificial Tears Lubricant Ophthalmic Ointment revealed that the order did not indicate a length of measurement to reflect the dose for each administration. The order was started on 3/8/22. On 9/25/24 at 12:35 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concerns that occurred the medication pass for Resident #18 wherein the physician order for Prograf to be administered orally, was administered via g-tube to Resident #18 without clarification with the physician. The concern with Resident #44 and Resident #2 ophthalmic ointment order that did not include dosing and was also not clarified prior to administration. On 9/25/24 at 12:44 PM, the DON stated that Resident #18 was able to take the medication by mouth and via g-tube, and acknowledged the orders should have been clarified. A review of the provided facility policy, Medication Management, dated 1/9/24 included the following under procedures: B. Ordering and Transcribing 4. Orders for medication and fluids mist contain name and dosage, frequency, route of administration and an indication for use . D. Administration 6. Just prior to administration, compares the medication to the order and adheres to the 5 rights of medication administration rules: a. right patient b. right medication c. right dosage d. right time (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. right route NJAC 8:39-27.1(a), 29.2(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34421 Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) store potentially hazardous foods (PHF) in a manner to prevent food borne illness. This deficient practice was evidenced by the following: On 9/24/24 at 10:30 AM, in the presence of the Assistant Dietary Manager (ADM), the surveyor observed the following: In the walk-in refrigerator, the surveyor observed the following: -a 1/4 size steam table pan which contained green beans in a liquid with a sticker on the top of the container that indicated a use by date of 9/20/24, -an opened, half used package of sliced salami with no use by date on it, - an opened, half used package of un-sliced beef bacon with no use by date on it, In the reach in cheese refrigerator, the surveyor observed the following: -an opened package of un-sliced provolone with an open date of 9/8/24, - an opened package of shredded mozzarella with an open date of 9/15/24, -an opened package of sliced yellow cheese with an open date of 9/16/24, In the dry storage room, the surveyor observed an opened package of mixed grain cereal with an open date of 2/4/24. The ADM indicated that the PHF should been stored appropriately and thrown out according the facility policy, between five and seven days. The ADM also stated that all items should have use by dates on them. On 9/24/24 at 11:16 AM, the surveyor discussed the above concerns with the Administrator. A review of the undated policy titled, Disposition of Potentially Hazardous Foods which revealed that all potentially hazardous foods that are prepared in the hospital will have a shelf life of five days, all other potentially hazardous food that have been put into production will have a shelf life of seven days, and pre-prepared items should be discarded after seven days of package being opened form its original package. The policy also indicated that the products are to be dated after opening. NJAC 8:39-17.2(g)