STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315372	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White House Healthcare and Rehabilitation Center	560 Berkeley Avenue Orange, NJ 07050

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19106 Based on observation, interview and record review, it was determined that the facility failed to a.) ensure the physician signed and dated monthly medication orders and b.) ensure the physician or the non-physician practitioner (NPP) performed face-to-face monthly visits. The deficient practice was identified for 19 of 32 residents reviewed (#29, 129, 22, 51, 65, 121, 97, 116, 53, 10, 101, 11, 2, 69, 33, 80, 138, 75, 118) and occurred over a 6 month period. The deficient practice was evidenced by the following. 1. A review of the hybrid medical record for Resident #29 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for January, February, March, April, or May 2024. 2. A review of the hybrid medical record for Resident #129 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for January, February, March, April, or May 2024. One physician progress note (5/4/24) was electronically entered into the medical record, however, no other physician or NPP progress notes were documented for January, February, March, or April 2024. 3. A review of the hybrid medical record for Resident #22 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for January, February, March, April, or May 2024. 34033 4. On 5/30/24 at 10:48 AM, the surveyor observed Resident #51 in bed in their room and the resident was unable to be interviewed. The surveyor reviewed the hybrid medical records (paper and electronic) for Resident #51. A review of the resident's Admission Record, (one page summary of important information about a resident) revealed diagnoses that included Alzheimer's Disease, hypertension (high blood pressure), and cerebral infarction (stroke). (continued on next page)

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

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 3/5/24, revealed that the resident had had a Brief Interview for Mental Status (BIMS) score of three (3) out of 15, indicating a severely impaired cognition. A review of the monthly physician's orders revealed that the resident's primary care physician had not signed the resident's monthly orders for the months of December 2023 through May 2024. 5. On 5/30/24 at 10:52 AM, the surveyor observed Resident #65 in a bed in their room. The resident stated that he/she went for dialysis every Monday, Wednesday and Friday. The surveyor reviewed the hybrid medical records (paper and electronic) for Resident #65. A review of the resident's Admission Record revealed diagnoses that included Diabetes (high blood sugar levels in the blood), heart failure and chronic kidney disease. A review of the quarterly MDS (QMDS), dated [DATE], revealed that the resident had a BIMS score of 13 out of 15, indicating an intact cognition. A review of the monthly physician's orders revealed that the resident's primary care physician had not signed the resident's monthly orders for the months of December 2023 through May 2024. 6. On 5/30/24 at 10:36 AM, the surveyor observed Resident #121 in a wheelchair in their room. The resident stated that he/she was waiting for his/her aide who then walked into the room. The surveyor reviewed the hybrid medical records (paper and electronic) for Resident #121. A review of the resident's Admission Record revealed diagnoses that included Diabetes, dysphagia (a swallowing disorder) following cerebral infarction and hypertension. A review of the QMDS dated [DATE], revealed that the resident had a BIMS score of 12 out of 15, indicating an intact cognition. A review of the monthly physician's orders revealed that the resident's primary care physician had not signed the resident's monthly orders for the months of December 2023 through May 2024. 34421 7. A review of the hybrid medical record for Resident #97 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2023, January 2024, or February 2024. There were no physician or NPP progress notes entered into the record for January 2024, or February 2024. 8. A review of the hybrid medical record for Resident #116 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2023, January 2024, February 2024, March 2024, April 2024, or May 2024. There were no physician or NPP progress notes entered into the record for January 2024, February 2024, or May 2024. 46889 (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Resident #53's hybrid medical record review revealed no monthly physician-signed or electronically signed monthly orders for December 2023, January 2024, February 2024, March 2024, April 2024, and May 2024. 10. Resident #10's hybrid medical record review revealed that the physician electronically signed the monthly physician orders for December 2023, March 2024, and May 2024. There were no other signed monthly physician orders for January 2024, February 2024, and April 2024. Additionally, no monthly physician progress notes were written by the physician in January 2024, March 2024, and May 2024. 11. Resident #101's hybrid medical record review revealed that the physician electronically signed the April 2024 monthly physician orders. No other signed monthly physician orders for December 2023, January 2024, February 2024, March 2024, and May 2024. 12. Resident #11's hybrid medical record review revealed no monthly physician-signed or electronically signed monthly orders for December 2023, January 2024, February 2024, March 2024, April 2024, and May 2024. 13. Resident #2's hybrid medical record review revealed no monthly physician-signed or electronically signed monthly orders for December 2023, January 2024, February 2024, March 2024, April 2024, and May 2024. 14. Resident #69's hybrid medical record review revealed no monthly physician-signed or electronically signed orders for December 2023, January 2024, February 2024, March 2024, April 2024, and May 2024. 49078 15. Resident #33's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2023, January 2024, February 2024, March 2024, April 2024, and May 2024. 16. Resident #80's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2023, January 2024, February 2024, March 2024, April 2024, and May 2024. 17. Resident #138's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for February 2024, March 2024, April 2024, and May 2024. 48781 18. Resident #75's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for the months of December 2023 through March 2024 and May 2024. 19. Resident #118's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for the months of December 2023 through May 2024. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 11:02 AM, the surveyor interviewed the Unit Manager (UM), License Practical Nurse (LPN), on the 1st floor North Wing, who has been working in the facility for four years. She stated, The doctors mostly document in the Electronic Health Records (EHR) and the monthly orders are signed electronically. On 6/5/24 at 10:37 AM, interviewed the UM, Registered Nurse (RN), on the second floor North Wing, who has been working in the facility for [AGE] years. The RN stated, The physicians document in the EHR and some have a hard copy in the chart. Doctor [Name Redacted] still documents in the chart. The physicians sign their monthly orders electronically. On 6/5/24 at 12:14 PM, the survey team met with the administration: License Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant DON, two Assistant LNHAs and the Administrator in Training (AIT), regarding concerns with the completion of physician visits and monthly signage of physician orders. On 6/6/24 at 9:37 AM, the survey team met with the DON who acknowledged no improvements on the current concerns regarding physician visits, progress notes completion and monthly signage of physician orders. A review of the most current facility policies and procedures titled, Physician's Orders, and Physician Services stated, The attending physician must certify physician's orders monthly and Physician visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and facility policy. NJAC 8:39-23.2 (b), (d)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49078 Based on interview and record review, it was determined that the Consultant Pharmacist (CP) failed to report irregularities found in the medical records to the facility. This deficient practice was observed for the following resident. On [DATE] at 12:21 PM, the surveyor reviewed the hybrid medical record (paper and electronic) for Resident #83. The resident's Admission Record (AR) reflected that the resident was admitted with diagnoses including but not limited to Hypertension (elevated blood pressure) and Gastrostomy (G-tube) (an opening into the stomach from the abdomen, for the introduction of food or medications). A review of the resident's Medicare 5 Day Minimum Data Set (MDS) (a standardized assessment tool that measures health status in nursing home residents) dated [DATE], which reflected that the resident had a Brief Interview for Mental Status (BIMS) (a tool used to screen and identify the cognitive condition) Score of three (3) which reflects severe cognitive impairment. The surveyor reviewed the May and [DATE] electronic medication administration record (eMAR) and the current Physician's Order sheet which reflected orders for Sucralfate (a medication used to treat stomach ulcers) 1gm tablet by G-tube four (4) times a day, Nexium (a medication used to reduce stomach acid production) 40mg packet, 1 packet by G-Tube in the morning, Levothyroxine (a medication used to treat an underactive thyroid) 175mcg by G-tube once a day, and an order for enteral feeding (food given by G-tube) Jevity 1.5 (a liquid food product) bolus feed (given a one time) five (5) times per day. The eMAR reflected the administration times of the Sucralfate as 6 AM, 1 PM, 3 PM and 8 PM, the Nexium as 6 AM, the Levothyroxine at 6 AM, and the feeding as 12 midnight, 6 AM, 12 PM, and 9 PM. The Surveyor reviewed the manufacturer package information sheet for Sucralfate which reflected that the medication should be given on an empty stomach and that there was a potential for a drug interaction between the Sucralfate and the Levothyroxine which could be avoided by giving the Levothyroxine two (2) hours before the Sucralfate. The Surveyor reviewed the manufacturer package information sheet for Nexium which reflected that the medication should be given at least 1 hour before meals. The surveyor reviewed the Consultant Pharmacist Review sheet (CPR) for the resident. The CP's responsibility was to review all resident's medication monthly for discrepancies, continued monitoring and correct dose of medications. The CPE sheet did not reflect any comment related to timing of medications and the tube feeding. The Surveyor reviewed the Consultant Pharmacist's Monthly Report (CPMR) for [DATE] and [DATE]. The CPMR reflected that the CP had made recommendations on other unrelated irregularities for the resident during those months but did not make a recommendation on the potential drug interaction or the timing of Nexium or Carafate. On [DATE] at 11:58 AM, The surveyor interviewed the CP by telephone. The surveyor asked the CP if he was aware of the manufacturer dosing recommendations for Sucralfate and Nexium with food and interactions with Sucralfate and Levothyroxine. The CP stated that Sucralfate and Nexium should be given sixty (60) minutes before a meal and Levothyroxine should be separated by two (2) hours from Sucralfate. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:56 PM, the surveyor interviewed the Unit Manager LPN (UM) and the medication nurse on duty on the unit where Resident #83 resides. The medication nurse stated that she gives medications to residents as they are ordered in the eMAR. The UM stated that the CP had just called him to have medication times changed for Resident #83. On [DATE] at 2:15 PM, the surveyor in the presence of the survey team informed the facility administrative team of the concern with Resident #83's medication timing and the failure of the CP to report the irregularity. NJAC 8:,d+[DATE].3(a)(1)