STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Old Bridge	111 Route 516 Old Bridge, NJ 08857

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 40042 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to: a.) consistently follow a physician's order for the application of a bolster (cushion used for support) to the left arm rest of a wheelchair for a resident with decreased range of motion and mobility, b.) follow the residents individualized comprehensive care plan (ICCP), and c:) consistently document accountability for the placement of the device. The deficient practice was identified for 1 of 1 resident (Resident #10) reviewed for positioning and mobility. This deficient practice was evidenced by the following: On 10/01/24 at 11:40 AM, the surveyor observed Resident #10 in his/her wheelchair in the dayroom without a bolster applied to the left arm of the wheelchair. On 10/02/24 at 11:35 AM, the surveyor observed the Resident in his/her wheelchair in the dayroom without a bolster applied to the left arm of the wheelchair. The surveyor reviewed Resident #10's electronic Medical Record (eMR). A review of the resident's Admission Record revealed diagnoses that included but were not limited to: transient cerebral ischemic attack (a short period of symptoms similar to a stroke) and unspecified dementia. A review of the resident's Quarterly Minimum Data Set (MDS), a tool used to facilitate the management of care, dated 7/5/24, revealed a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated a severely impaired cognition. A review of the October 2024 Order Summary Report, revealed a physician's order (PO), dated 6/3/24, for Therapy: apply bolster to L (left) arm rest of w/c (wheelchair)individual daily morning. A review of the October 2024 Treatment Administration Record (TAR), did not reflect the above PO. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the ICCP, dated 8/8/24, revealed a care plan for .right and left upper extremities weakness. The goals revealed [name redacted] will maintain or improve ADL [activities of daily living] function over next quarter. Further review revealed the intervention Apply bolster to L arm rest of wheelchair . for positioning. A review of the Certified Nursing Assistant (CNA) Tasks revealed a Task: Apply bolster to left arm rest of wheelchair . for positioning when resident in wheelchair. Further review of the Tasks from the dates of 9/3/24 through 10/2/24, revealed no documented accountability for placement of this device for 13 out of 30 days reviewed. There was no documented accountability for device placement on 10/2/24. On 10/02/24 at 12:23 PM, the surveyor observed Resident #10 in the day room, awaiting lunch, in his/her wheelchair at a table without a bolster applied to the left arm of the wheelchair. The surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) and together observed the resident in his/her wheelchair. She acknowledged that there was no bolster applied to the left arm of the wheelchair. The LPN/UM stated that the purpose of the device was for positioning, and it was the responsibility of the CNA to apply the device when they transfer the resident to his/her wheelchair. She stated that she was not sure if it should be on the TAR for accountability. She further acknowledged that if the device was evidenced in the CNA Tasks, that it would have been the CNA's responsibility to document accountability that the device was in place. The surveyor and the LPN/UM reviewed the TASKs in the eMR, and she acknowledged that there were multiple omissions to account for CNA placement of the bolster device from dates 9/3/24 through 10/2/24, including 10/2/24. She also stated that it should have been both the nurse and therapists' responsibility to oversee this process. The surveyor and LPN/UM went to Resident #10's room which revealed the bolster (black in color) in the top of the resident's closet. In addition, she stated that the CNA assigned to the resident today was new and did not have access to the eMR and TASKs, and therefore he probably did not know the resident required the bolster. She further stated, we should have told him to apply the device. The LPN/UM stated that the staffing coordinator should have provided the CNA with access to the eMR and TASKs. On 10/02/24 at 1:45 PM, the surveyor interviewed the CNA who stated that he had worked at the facility one day in March 2024 and this was his first day back since then. He stated that he requested access to the eMR from the LPN/UM, who then requested the same from the staffing coordinator. He stated that up until this point he still had no access to the eMR. The CNA further acknowledged that he had no knowledge that the resident required a bolster to the left arm of the wheelchair and that no one told him. On 10/02/24 at 2:03 PM, the surveyor interviewed the staffing coordinator. She verified that it was the CNAs first day and that he should have received eMR access. She stated that she was mostly responsible to set up access for the CNA prior to the start date. The staffing coordinator stated that in the event it could not have been done timely, the Licensed Nursing Home Administrator (LNHA) had the ability to gain access as well. She further stated she was busy but that is no excuse. The staffing coordinator acknowledged the LPN/UM requested access for the CNA and that she had not done so yet. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/24 at 9:00 AM, the surveyor interviewed the Director of Rehabilitation. She stated that the bolster for the left arm of the wheelchair was for positioning and that the resident tends to lean due to a stroke. She stated that the device was trialed, and it was successful. She also stated that it was the responsibility of the CNA to apply the bolster and account for that in the TASKs section of the eMR. She further stated that nursing should oversee this process to ensure placement and accountability, and she was not sure if the PO should have also been on the TAR. She stated that the resident was discharged from therapy on 8/21/24. On 10/08/24 at 9:40 AM, the surveyor interviewed the Director of Nursing (DON) in presence of survey team as well as the LNHA and the Regional DON. She acknowledged that the bolster had not been in place as the surveyor observed and was not accounted for on the TAR. The LNHA acknowledged that the staffing coordinator should have gotten the CNA access to the eMR and provided it to nursing prior to the CNAs arrival. In addition, he stated that he also had the ability to acquire access. The DON stated that in the event eMR access was not available that nursing should have given the CNA a verbal report of the resident's needs. A review of the facility policy Activities of Daily Living (ADLs) dated February 2024, included The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. A review of the facility policy Assistive Devices and Equipment dated July 2024, included the following: Our facility maintains and supervises the use of assistive devices and equipment for residents. Certain devices and equipment that assist with resident mobility, safety and independence are provided for residents. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the residents care plan. Staff and volunteers are trained and demonstrate competency on the use of devices and equipment prior to assisting or supervising residents. A review of the facility policy Care Plans, Comprehensive Person-Centered dated July 2024, included A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. NJAC 8:39-27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 34033 Based on observation, interview, and record review, it was determined that the facility failed to provide care and services in accordance with professional standards by adjusting medication administration times to accommodate for a resident's dialysis scheduled times. The deficient practice was identified for one (1) of one (1) resident, (Resident #151) reviewed for dialysis services 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. On 10/2/24 at 1:00 PM, the surveyor interviewed Resident #151 in their room. The resident stated that they go to dialysis on Monday, Wednesday and Friday (MWF) and was usually picked up after 3 PM and would return to the facility around 9 PM. The resident stated that the nurses brought them their medication. The resident was unable to speak to which medications and what times they received their medications. The surveyor reviewed the medical record for Resident #151. A review of the resident's Admission Record revealed diagnoses which included but not limited to, end stage renal disease (a condition which the kidneys cannot filter waste from the blood) and dependence on renal dialysis (a mechanical process used to filter waste from the blood). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 9/9/24, reflected the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating that the resident had an intact cognition. A review of the resident's interdisciplinary care plan (IDCP) revealed as a focus that the resident received hemodialysis (same as dialysis and renal dialysis) due to renal failure. An intervention/task included but was not limited to, that the resident received dialysis MWF with a chair time of 4:15 PM and pick up time of 3:15 PM and to offer the resident a dinner tray upon returning from dialysis. The goal reflected that the resident would not have signs and symptoms of complications from dialysis. The IDCP had not indicated any interventions regarding medication times. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's dialysis book, that was kept on the unit, reflected that dialysis was scheduled for MWF 3:15 PM pick up time and chair time was 4:15 PM and treatment 4 hours. In addition, the dialysis book contained a Dialysis Communication Form for the dates of 9/27/24 and 10/2/24 that were completed indicating that the resident had received dialysis on those days. A review of the resident's Order Summary Report for active orders as of 9/27/24 revealed a physician's order (PO) dated 9/27/24 for the following: -Ascorbic Acid (Vitamin C, a supplement) Oral Tablet 500 milligrams (MG) (Ascorbic Acid) Give 1 tablet by mouth two times a day (BID) for supplement until 10/27/24 23:59 (11:59 PM) Give Ascorbic Acid 500 MG BID by mouth. -Insulin Lispro Injection solution (a rapid acting insulin medication used to lower blood sugar),100 units per milliliter, Inject 5 units (U) subcutaneously three times a day for Type 2 DM. -Calcium Acetate (Phos Binder) (a medication used to bind phosphates in food consumption) Oral Capsule 667 MG (Calcium Acetate (Phosphate Binder) Give 1 capsule by mouth three times a day for Hypophosphatemia. Administer with meals. -Prostat (sugar free)(SF) (a wound healing supplement) two times a day for supplement until 10/27/24 23:59 Give Prostat SF 30 ML BID by mouth. There were no PO indicating medications to be administered on dialysis days and non-dialysis days or changes in administration times on dialysis and non-dialysis days. A review of the September and October 2024 electronic medication administration record (eMAR) for the POs listed above indicated medication administration times that occurred during the time that the resident was out of the facility at dialysis on 9/27/24 and 10/2/24. The eMAR revealed the following: -on 9/27/24 the doses for Vitamin C 500 MG at 5 PM, Lispro 5 U at 5 PM, Prostat 30 ML at 5pm and Calcium Acetate at 5:30 PM, all indicated for administration the number 5 which corresponded to the code chart hold/see nurses notes. -on 10/2/24 the doses for Vitamin C 500 MG at 5 PM, Lispro 5 U at 5 PM, Prostat 30 ML at 5pm and Calcium Acetate at 5:30 PM, all indicated for administration the number 9 which corresponded to the code chart other/see nurses notes. A review of the resident's corresponding electronic progress notes (EPN) revealed the following: -on 9/27/24 an eMAR Administration Note for 21:25 (9:25 PM) indicated for Vitamin C, Insulin Lispro, Calcium Acetate and Prostat out to hemodialysis. -on 10/2/24 an eMAR Administration Note for 16:39 (4:39 PM) indicated for Vitamin C, Insulin Lispro, Calcium Acetate and Prostat out to dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/4/24 at 11:19 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who verified that Resident #151 on MWF was picked up from the facility at approximately 3:15 PM for dialysis. The LPN stated that she was able to administer all the resident's medications during her shift which was 7 AM to 3 PM. The LPN added that when the resident was out to dialysis then medications should not appear on the eMAR for administration. The LPN added that if a medication was on the eMAR when the resident was out to dialysis then the time of the medication should be changed. On 10/4/24 at 1:00 PM, the surveyor interviewed the Unit Manager/LPN (UM/LPN) who stated that medication times should be reviewed with the physician and adjusted to accommodate the resident being out of the facility at dialysis. The surveyor, with the UM/LPN reviewed the eMAR for Resident #151. The UM/LPN acknowledged that Vitamin C, Insulin Lispro, Calcium Acetate and Prostat had times of administration when the resident was out to dialysis. The UM/LPN stated that those medications should not have an administration time when the resident was at dialysis. The UM/LPN stated, I have to fix that. The UM/LPN added that Resident #151 was recently readmitted to the facility and the prior admission had the medication times adjusted. The UM/LPN explained that upon readmission the nurses should have compared the medication times and obtained a PO for those medications to accommodate when the resident was out to dialysis. On 10/7/24 at 11:50 PM, the surveyor interviewed the Director of Nursing (DON), who acknowledged that upon the resident's readmission the medications were not timed to accommodate when the resident went out to dialysis. The DON added that a chart review should have been completed to make sure the medications were timed correctly. On 10/8/24 at 12:25 PM, the surveyor interviewed the Consultant Pharmacist (CP), who stated that medication times need to be adjusted to accommodate dialysis times. The CP added that she would make that recommendation during her chart review. The CP also stated that her last chart review was 9/12/24 and the resident was readmitted just last week. A review of the facility policy updated July 2024 for Administering Medications provided by the DON, reflected that medications are to be administered in a timely manner as prescribed. Further review of the policy reflected, Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). A review of the facility policy dated as revised February 2023 for Hemodialysis provided by the DON, reflected that This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician's orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. In addition, the policy reflected that The facility will ensure that the physician's orders for dialysis include: .f. Any medication administration or withholding of specific medications prior to dialysis treatments. NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34033 COMPLAINT # NJ00169735, NJ00170064 and NJ00170351 Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards of practice by not ensuring that a.) medications were administered to a resident in a timely manner as ordered by a physician, (Resident #72). This was identified for one (1) of eight (8) residents, reviewed for medication management. and b.) a controlled drug (Oxycodone) was available for administration and accurately documented as per a physician's order in the electronic medication administration record (Resident #87). This was identified for one (1) of eight (8) residents, reviewed for medication management. The deficient practices were 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 10/1/24 at 10:32 AM, the surveyor interviewed Resident #72 in their room. The resident stated that they were blind but had all their faculties. The resident stated that they knew all their medications and what time they were due. The resident added that they had to make sure that they received their fast-acting insulin before they ate and that sometimes was late getting their medications. The resident added that they knew specifically in January 2024 they had received their medications late. On 10/2/24 at 8:27 AM, during the morning medication administration observation with the Licensed Practical Nurse (LPN), the surveyor observed Resident #72 at their room door in a wheelchair calling out to the LPN. The LPN stated that she would be giving medications to the resident next. The surveyor reviewed the medical record for Resident #72. A review of the resident's Admission Record revealed diagnoses which included but not limited to; blindness right eye category 3 (blindness), blindness left eye category 3, and type 2 Diabetes Mellitus (DM) (high blood sugars), glaucoma (a disease that damages the optic nerve), anemia (a condition of deficient red blood cells), peripheral vascular disease (a circulatory condition) and congestive heart failure (a condition where the heart does not pump blood as well as it should). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent annual comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 8/21/24, reflected the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating that the resident had an intact cognition. A review of the resident's interdisciplinary care plan (IDCP) revealed as a focus that the resident has DM and an intervention/task included but was not limited to, Diabetes medication as ordered by doctor. Additionally, another focus was that the resident has hypertension (high blood pressure) with an intervention/task to Give antihypertensive medications as ordered. A review of the resident's Medication Administration Audit Report (MAAR) revealed that on 1/10/24 and 1/11/24 Resident #72 had received their medications out of the allowed time range of one hour before or 1 hour after the time of administration as ordered by the physician. The report reflected the following for 1/10/24: -Zinc Gluconate (a supplement) had a scheduled time of 9 AM and had an administration time of 11:36 AM and a documented time of 11:41 AM. -Clonidine (a medication used to lower blood pressure (BP)) had a scheduled time of 2 PM and had an administration time of 3:52 PM and a documented time of 4:53 PM. -Brimonidine Tartrate Ophthalmic Solution 0.2 % (eyedrop used for glaucoma) had a scheduled time of 5:05 PM and had an administration time of 6:51 PM and a documented time of 6:51 PM. -Admelog SoloStar (Insulin Lispro)(a fast-acting insulin used to lower blood sugar) had a scheduled time of 5:15 PM and had an administration time of 6:51 PM and a documented time of 6:51 PM. -Metoprolol Tartrate (a beta-blocker medication used to lower BP) had a scheduled time of 5:30 PM and had an administration time of 6:51 PM and a documented time of 6:51 PM. Further review of the MAAR reflected the following for 1/11/24: -Admelog SoloStar (Insulin Lispro) had a scheduled time of 8:15 AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. -Accu check with freestyle Libre sensor (a sensor that shows the measurement of the blood sugar level) had a scheduled time of 8:15 AM and had an administration time of 11:14 AM and a documented time of 11:14 AM. -Metoprolol Tartrate had a scheduled time of 8:30 AM and had an administration time of 11:13 AM and a documented time of 11:13 AM. -Magnesium Oxide (a supplement) had a scheduled administration time of 9 AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. -Dorzolamide HCl Ophthalmic Solution 2 % (eye drop used to treat glaucoma) had a scheduled time of 9AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Aspirin 81 MG had a scheduled time of 9 AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. -Zinc Gluconate had a scheduled time of 9 AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. -Fluticasone Propionate Nasal Suspension (a steroid nose spray) had a scheduled time of 9 AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. -Ferrous Sulfate (an iron supplement) had a scheduled time of 9am and had an administration time of 11:12 AM and a documented time of 11:13 AM. -Claritin (an antihistamine) had a scheduled time of administration for 9 AM and had an administration time of 11:12 and a documented time of 11:13 AM. -Paxlovid (a medication used to treat mild to moderate coronavirus) had a scheduled time of 9 AM and had an administration time of 11:12 AM and a documented time of 11:13 AM. -Polyethylene Glycol 3350 Powder (a medication used to treat constipation) had a scheduled time of 9 AM and had an administration time of 11:14 AM and a documented time of 11:14 AM. -Dorzolamide HCl Ophthalmic Solution 2 % had a scheduled time of 5 PM and had an administration time of 10:46 PM and a documented time of 10:47 PM. -Fish Oil (a supplement) had a scheduled time of 7 PM and had an administration time of 9:16 PM and a documented time of 9:48 PM. -Latanoprost Ophthalmic Solution 0.005 % (an eyedrop used to treat glaucoma) had a scheduled time of 9:05 PM and had an administration time of 10:47 PM and a documented time of 10:47 PM. A review of the January 2024 electronic medication administration record (eMAR) revealed nurse's initials that signified that the above medications were administered at their scheduled times. This contradicted the above administration times. A review of the electronic progress notes (ePN) had not revealed that there was any indication of a need for the above medications to be administered outside of the time of administration that was ordered by the physician. On 10/4/24 at 3:12 PM, the survey team met with the Director of Nursing (DON) and the Regional Director of Nursing (RDON) and reviewed the above concern regarding late medication administration for Resident #72 on 1/10/24 and 1/11/24. The DON stated that she would have to review. The DON was unable to speak to whether audits were reviewed to ensure and identify accurate medication administration times documented on the eMAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/24 at 11:50 AM, the surveyor interviewed the DON who stated that Resident #72 had been on contact precautions for COVID (Coronavirus disease) in January. The DON added that the nurses should be signing the eMAR after the medication was administered and should not be administering or documenting late. The DON acknowledged that according to the MAAR the above medications were administered late. A review of the facility policy updated July 2024 for Administering Medications provided by the DON, reflected that medications are to be administered in a timely manner as prescribed. Further review of the policy reflected, Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). In addition, the policy reflected, If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. 2. On 10/3/24 at 11:56 AM, the surveyor interviewed Resident #87 in their room. The resident stated they felt that the nurses frequently ran out of their medication, Oxycodone. The resident also stated that they were supposed to receive the Oxycodone every four (4) hours. The resident added that the nurses would tell them that they were waiting for the pharmacy to deliver the medication. The resident then stated this past weekend there was a problem on Sunday and Monday with getting the Oxycodone. The resident stated, On Monday morning at 9 AM and 1 PM the nurse did not have any Oxycodone, so I did not receive any until 5 PM. The resident further stated that I was okay because I have a 20 milligram (MG) dose I can take in between, and I took that at 11 AM. The resident also stated that they thought it was odd that the nurse could not get the Oxycodone because usually the nurses would tell them that they had to go to the backup when they did not have the Oxycodone in the medication cart. The surveyor reviewed the medical record for Resident #87. A review of the resident's Admission Record revealed diagnoses which included but not limited to; pain in unspecified hip, stress fracture, left foot, personal history (healed) traumatic fracture and opioid abuse. A review of the most recent quarterly comprehensive MDS, dated [DATE], reflected the resident had a BIMS score of 15 out of 15, indicating that the resident had an intact cognition. A review of the electronic Order Summary Report revealed a physician's order (PO) dated 6/4/24 for Oxycodone HCl(hydrochloride) oral tablet 15 MG (Oxycodone HCl) Give 1 tablet by mouth every 4 hours for pain management. A review of the September 2024 eMAR revealed the above PO with administration times of 1 AM, 5 AM, 9 AM, 1 PM, 5 PM and 9 PM. In addition, the eMAR revealed that on 9/29/24 at 9 AM and 1 PM, the nurse entered the number 9 for administration which corresponded with the chart code Other/see nurses notes. A review of the ePN dated 9/29/24 at 9:00, titled eMAR Medication Administration Note for Oxycodone indicated medication not given notified MD medication pending delivery from pharmacy. In addition, another eMAR Medication Administration Note dated 9/29/24 at 23:02 (11:02 PM) for Oxycodone indicated pharmacy notified, pending delivery. MD notified. (continued on next page)

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	315381	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Old Bridge	111 Route 516 Old Bridge, NJ 08857

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Control/Narc Backup Box Medications Contents list provided by the DON revealed that Oxycodone 5 MG tablets and 10 MG tablets were available. A review of the removals from the controlled drug backup box revealed the House Stock Control Countdown Sheet (HSCCS) for Oxycodone IR (immediate release) 5 MG tablets reflected that there was removal of one (1) tablet from inventory on 8/19/24 at 12:30 AM, 5 AM, 9 AM, 1:48 PM, 5 PM and 9 PM. In addition, one (1) tablet was removed on 8/20/24 at 1 AM and on 9/29/24 at 1 AM and 6 AM. A review of the HSCCS for Oxycodone IR 10 MG tablets reflected that there was removal of one (1) tablet from inventory on 8/19/24 at 12:30 AM, 5 AM, 9 AM, 1:48 PM, 5 PM and 9 PM. In addition, one (1) tablet was removed on 8/20/24 at 1 AM and on 9/29/24 at 1 AM and 6 AM. A review of the September and October 2024 eMAR revealed the above PO and indicated that Oxycodone was administered as a 15 MG tablet for the same dates and times listed above on the HSCCS. A review of the ePN for the same dates and times as the HSCCS had not indicated that one (1) 5 MG tablet and one (1) 10 MG tablet was administered or that a PO was obtained. There was no documentation that there was a PO obtained allowing the administration of one (1) 5 MG and one (1) 10 MG tablet for a total dose of 15 MG for the dates and times indicated on the HSCCS. On 10/4/24 at 11:52 AM, the surveyor interviewed the Registered Nurse (RN), who stated that she was responsible for the medications for Resident #87 and worked at the facility on a regular basis. The RN verified that the resident had a PO for Oxycodone to be administered every four (4) hours. The RN explained that the procedure was to order the Oxycodone or any medication for refill before running out. The RN stated that the Nurse Practitioner (NP) was available every Tuesday and Thursday and if a new prescription was needed then the NP would write one. The RN added that Oxycodone was also in the facility backup supply but she tried not to use that because the Oxycodone was a routine PO and should be available. On 10/4/24 at 3:12 PM, the survey team met with the DON and RDON and reviewed the above concern of Oxycodone not being available on 9/29/24 and the use of the backup supply of Oxycodone. The DON stated that she would have to review. On 10/7/24 at 11:50 AM, the surveyor interviewed the DON, who acknowledged that the Oxycodone was not administered on 9/29/24 at 9 AM and 1 PM. The DON further acknowledged that Oxycodone 5 Mg and 10 MG tablets were available in the backup supply and was unable to speak to why the nurse had not used the backup supply. In addition, the DON stated that according to the HSCCS, the removal of one (1) 5 MG tablet and one (1) 10 MG tablet accounted for all the doses documented as administered on the eMAR for the same dates and times. The DON added that the correct dose was administered. The DON acknowledged that the PO was for Oxycodone 15 MG tablets and that according to the eMAR a 15 MG tablet was documented as administered for the same dates and times as the HSCCS indicated removals from the backup inventory for Oxycodone 5 MG and 10 MG tablets. The DON was unable to speak to the documentation on the eMAR not matching what the physician ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/24 at 12:25 PM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that the dose of any medication as ordered by the physician had to match the dose being administered. The CP also stated that if the PO was for a 15 MG tablet, then a new PO was needed to administer one (1) five (5) MG tablet plus one (1) ten (10) MG tablet to make the total dose of 15 MG. The CP added that the eMAR must be signed for the actual doses being administered as ordered. A review of the facility policy titled Medication and Treatment Orders provided by the DON dated July 2024 reflected that Drugs and biologicals that are required to be refilled should be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. In addition, the policy reflected that Orders for medications must include: a. name and strength of the drug; A review of the facility policy titled Backup Medications and Controlled Medications in Long-Term Care Setting provided by the DON and updated 10-24 which reflected that The facility will maintain a system for the secure management of backup and controlled medications to ensure availability while minimizing risks of misuse or diversion. In addition, for Administration: Ensure that all staff are trained on the protocols for accessing and administering backup medications. Document administration in the resident's medical record. And 4. Documentation: Ensure administration of controlled medications are documented accurately in the resident's medical record and in a controlled substance log. The policy also revealed for Administration: Ensure that all staff are trained on the protocols for accessing and administering backup medications. Document administration in the resident's medical record. And 4. Documentation: Ensure administration of controlled medications are documented accurately in the resident's medical record and in a controlled substance log. NJAC 8:39-11.2(b), 29.2 (a)(d), 29.4(k), 29.7(c)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34033 Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation on 10/2/24, the surveyor observed two (2) nurses administer medications to five (5) residents. There were 31 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 6.45 %. This deficient practice was identified for one (1) of five (5) residents, (Resident #72), that were administered medications by one (1) of two (2) nurses. The deficient practice was evidenced as follows: On 10/2/24 at 8:27 AM, the surveyor observed the Licensed Practical Nurse (LPN) preparing to administer 12 medications to Resident #72, which included two (2) different insulin pen injectors, Basaglar (a long-acting insulin (a medication used to lower blood sugar)) and Fiasp (a rapid-acting insulin), according to the electronic medication administration record (eMAR). The LPN removed the Basaglar and Fiasp pen-injectors from the medication cart, removed the pen caps and attached a needle to each pen-injector. At that time, the LPN explained that Resident #72 had poor eyesight, was alert and oriented x 3 (meaning that the resident had an intact cognition), was able to administer the pen injectors themself and was very involved and aware of their medications. On 10/2/24 at 8:52 AM, the surveyor observed the LPN give the Basaglar pen-injector to the resident who self-administered a dose of four (4) units (U) and then the surveyor observed the LPN give the resident the Fiasp pen-injector who then self-administered a dose of 16 U. The surveyor had not observed the LPN prime either the Basaglar or the Fiasp pen-injectors before administration. (ERROR #1 and #2) The surveyor reviewed the medical records for Resident #72. A review of the resident's Admission Record reflected that the resident had diagnoses which included but not limited to, type 2 Diabetes Mellitus (DM) with unspecified complications (high blood sugar). A review of the resident's Order Summary Report reflected the following: - a physician's order (PO) with an order date of 8/1/24 for Basaglar KwikPen Subcutaneous (SC) Solution Pen-Injector 100 U/milliliter (ML) (Insulin Glargine), inject 4 units subcutaneously in the morning for DM supervised self-administration Rotate Sites. - a PO with an order date of 8/19/24 for Fiasp Flextouch SC Solution Pen-Injector 100 U/ML (Insulin Aspart(with Niacinamide)), Inject 4 unit subcutaneously in the morning related to Type 2 DM with unspecified complications supervised self-administration refrigerate until opening, store at room temp after opening, rotate sites. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-a PO with an order date of 8/19/24 for Fiasp Flextouch SC Solution Pen-Injector 100 U/ML (Insulin Aspart(with Niacinamide)), Inject as per sliding scale: if 0-100 = 0 units; 101-150 =1 units; 151-200 = 2 u; 201-250=3 units; 251-300=4 units; Call MD if greater than 300 , subcutaneously four times a day related to Type 2 DM with unspecified complications supervised self-administration Give 15 minutes prior to a meal or snack, refrigerate until opened. A review of the eMAR reflected the above POs. On 10/3/24 at 8:30 AM, the surveyor interviewed the LPN who stated that she only performed a test on the insulin pen- injectors when they were fresh out of the refrigerator. The LPN explained that the insulin pens were stored in the refrigerator until it was time to use the pen-injector and then it remained stored in the medication cart until it was finished. The LPN further explained that the test was done on the pen-injector by dialing two (2) U and then seeing that the insulin liquid comes out of the needle. The LPN stated that she had not tested the insulin pens before each injection because she thought that would be wasting the insulin. The LPN acknowledged that the test she had described was the same as priming the insulin pen injector but was unaware that the pen injector needed to be primed before each dose. The LPN stated that she had been working at the facility for six (6) months and was unsure if there had been an inservice regarding insulin pen injector technique. The LPN also stated that she would have to do the priming of the insulin pen-injector for Resident #72 because the resident had poor vision. On 10/3/24 at 9:10 AM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone. The CP stated that the insulin pens were required to be primed before each injection. The CP added that she had done training in the past but not recently. The CP also stated that there had been a handout regarding Insulin pen-injector technique that was posted in the medication room at one time. A review of an information sheet for Insulin Pens & Administration provided by the CP revealed for Administration Techniques 2. Priming the Pen (airshot) a. Dial the specified amount of units. B. Orient the pen properly (point up-vertically-unless otherwise specified) and tap cartridge holder to collect air at the top c. Push the dose knob in until it stops. D. Priming is complete when a drop of insulin appears at the needle tip. E. If a drop of insulin does not appear, repeat priming steps; if no results, change the needle. On 10/3/24 at 1:27 PM, the survey team met with the Director of Nursing (DON) and the Regional Director of Nursing (RDON). The DON acknowledged that the insulin pens were to be primed prior to each injection and by not following the manufacturer's specifications for priming an insulin pen-injector could affect the dosage of the insulin. (ERROR #1 and #2) On 10/4/24 at 3:12 PM, the surveyor team met with the DON and RDON. The DON stated that instructions for priming the insulin pen-injector prior to each injection was added to the eMAR. A review of the facility policy for Insulin Pen, dated as accessed April 2024, provided by the DON reflected for 11. Procedure: h. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the manufacturer specifications for Instructions for Use for Basaglar KwikPen revealed People who are blind or have vision problems should not use the Pen without help from a person trained to use the Basaglar prefilled pen. In addition, the instructions reflected Prime before each injection. Priming means removing the air from the Needle and Cartridge that may collect during normal use. It is important to prime your Pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin. A review of the manufacturer specifications for Instructions for Use for Fiasp PenFill revealed Check the insulin flow Step 5: Small amounts of air may collect in the cartridge during normal use. You must do an airshot before each injection to avoid injecting air and to make sure you receive the prescribed dose of your medicine. NJAC 8:39-11.2(b), 29.2(d)