STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315451	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Elms Rehab and Healthcare Center of Cranbury	61 Maplewood Avenue Cranbury, NJ 08512

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41858 Complaint NJ #161104 Based on record review, interviews and other facility documentation, it was determined that the facility failed to notify the Board of Nursing (BON) (evaluates license applications, issues licenses, renews licenses, and takes disciplinary action in response to professional misconduct) for a Licensed Practical Nurse/Supervisor (LPN/S #1) who was under investigation for misappropriation of Residents' narcotic medication. This deficient practice was identified for one of one investigation reviewed. This deficient practice was evidenced by the following: On 02/21/24 at 2:40 pm, the Director of Nursing (DON #1) provided the survey team with a file for an investigation dated 12/18/22. A review of the file revealed a Reportable event [Resident's name redacted] 12/18/22; Summary and Conclusion: On 12/18/22, the nurse assigned to [name redacted] went to administer his/her Oxycodone (an opioid pain medication-narcotic) around 9am. The nurse went to the declining inventory form (a record used to keep accurate count of controlled substances) for [name reacted] Oxycodone. The nurse observed three signatures timed 10a, 12p, and 2:20 p for 12/17/22. This nurse was also the nurse that worked this assignment on 12/17/22 7a-3p. The three signatures were not her signature. The nursing supervisor (LPN/S #2) notified the Director of Nursing (DON #2) and the Administrator. The signatures could not be identified. Further review of the investigation identified 2 other residents that had unidentified signatures on their declinining inventory sheets. Based upon the investigation and review of statements, the supervisor (LPN/S #1) who worked 3p-11p on 12/17/22 was the only nurse that had access to all three residents that had unidentifiable signatures on their declining inventory sheets .She was suspended pending investigation. Further review revealed that on 12/22/22, the Human Resource Director (HRD) reached out to the supervisor (LPN/S #1) to come in and meet with administration. A meeting was scheduled for 1/3/23. The supervisor (LPN/S #1) did not show up for the meeting. The HRD called her, but she did not answer. Further review of the investigation file revealed a certified letter dated 1/10/23 sent to the LPN/S #1, On Tuesday 01/03/23 at 1:30 pm you had a meeting scheduled at this facility with [name redacted] DON and me to discuss the outcome of an investigation. Since you did not attend this meeting, we are considering this a voluntary resignation. This letter was signed by the HRD. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional review of the investigation file revealed that the police and the DEA (Drug Enforcement Administration) were notified. It did not reveal evidence that the Board of Nursing had been notified. On 02/22/24 at 8:45 AM, in the presence of the survey team, the Regional Director of Clinical Services (RDCS), confirmed that the facility did not report the LPN/S to the Board of Nursing because they did not have concrete proof she took the medications, but she (the LPN/S) was the only one who had access to all of the carts (medication carts). She then stated that the DEA and the police were notified. On 02/22/24 at 10:48 AM, the RDCS, the Regional Director of Operations (RDO), DON#1 and the Licensed Nursing Home Administrator (LNHA) met with the survey team to review the above-mentioned investigation. The RDCS, who confirmed at the time of the incident she was the DON #2, acknowledged that the investigation was completed and reported to the Department of Health, the police, and the DEA. She stated that it is fair to say yes we believe that [name redacted] (the LPN/S #1) was the common denominator, she had access to all the carts but I did not send a report to the BON. The RDCS stated that the purpose of reporting to the BON was so that they are aware of a situation, something that that nurse did, so they could investigate it. The administrative team all acknowledged that the incident should have been reported. On 02/23/224 at 10:22 AM, the DON provided the survey team with the incident report, dated 12/18/22 at 12:00 PM. Review of the report, revealed Agencies/People Notified: State Agency (DEA), Office of Ombudsman, Department of Health, and Physician. On 2/22/24 at 1:50 PM the LNHA provided the survey team with copy of a report that the above incident was submitted to the BON, dated 2/22/24. A review of the facility's policy Incident and Accidents revised 7/17/23, revealed: Policy: It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Definitions: An incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. This can involve a visitor, vendor, or staff member. Policy Explanation: The purpose of incident reporting can include Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements; Meeting regulatory requirements for analysis and reporting incidents and accidents. Compliance Guidelines: 4. Incidents that rise to the level of abuse, misappropriation, or neglect, will be managed and reported according to the facility's abuse policy. 8. The supervisor or other designee will be notified of the incident/accident. If necessary, law enforcement may be contacted for specific events. A review of the facility's policy Abuse, Neglect and Exploitation revised 7/2023, revealed: VII. Reporting/Response: A. the facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, .all other required agencies. B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy Controlled Substance Administration & Accountability revised 5/20/23, revealed Policy: It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. 9. Discrepancy Resolution: e. Any discrepancies which cannot be resolved must be reported immediately as follows: iii. The DON, charge nurse, or designee must also report any loss of controlled substances where theft is suspected to the appropriate authorities. NJAC 8:39-13.4(c)(2)(v)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49173 Based on observation, interview, record review and review of pertinent facility documents it was determined that the facility failed to complete and submit a Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with the federal guidelines of the MDS 3.0 Resident Assessment Instrument (RAI) for 1(Resident #33) of 1 resident reviewed for hospitalization s. This deficient practice was evidenced by the following: On 02/14/24 at 11:30 AM, the surveyor observed Resident #33 in his/her room lying in bed. Resident #33 was alert and verbally responsive, the resident was observed wearing oxygen via nasal cannula (a medical device which provides supplemental oxygen therapy). The surveyor interviewed Resident #33, in reference to his/her hospitalization s. Resident #33 stated that he/she was admitted to [NAME] Medical Center three months ago, however he/she was unable to recall how many times or why he/she was admitted and readmitted from the hospital since admission to the facility. The surveyor reviewed the medical record of Resident #33. Review of the Admission Record (an admission summary) reflected that Resident #33 was admitted to the facility with diagnoses which included but are not limited to: chronic systolic heart failure (a chronic condition that occurs when the left ventricle cannot pump blood efficiently), acute and chronic respiratory failure with hypoxia (occurs when there is not enough oxygen in your blood), and chronic kidney disease stage 3 (mild to moderate damage, which they are less able to filter waste and fluid out of your blood). A review of the electronic medical record (EMR) under the section titled census, revealed that Resident #33 was admitted to the hospital on 10/18/23, readmitted to the facility on [DATE] and sent back to the hospital again on 11/24/23. A review of the MDS tracking records (a record which documented the resident's entry and discharge into and out of the facility) which revealed the following: 10/18 2023(Discharge Return Anticipated); 12/2/2023(Entry); 12/12/2023(Discharge Return Anticipated) and 12/19/2023(Entry). A review of the EMR progress notes revealed the following: 11/24/2023 14:2 Nursing Note Text: patient arrived from PMC ([NAME] Medical Center), respiratory distress noted VS (vital signs) 160/80 HR (heart rate)128, o2 (oxygen) 85% on 3L (liters), SOB (shortness of breath) using abd (abdominal) accessory muscles, MD notified, nebulizer treatment given, continue to monitor, call bell within reach. 11/24/2023 17:04 Nursing Note Text: oncoming nurse rounded on resident noticed he was in respiratory distress, reported to UM (unit manager), upon arrival to room resident noted to be SOB, utilizing accessory muscles, VS 145/58 HR 136, 97.7 Temp, 79% O2 on 3L, MD contacted order to send back to PMC for evaluation. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	11/25/2023 08:37 Nursing Note Text: Resident was admitted to PMC with dx (diagnosis): chronic respiratory failure. On 02/20/24 at 10:16 AM, the surveyor interviewed the MDS Coordinator, who explained to the surveyor that she was informed of the facility admissions and discharges through morning meetings, utilization review meetings (review of subacute resident's discharge status), emails, and the discharge calendar. She stated that she completed the entry tracking and discharge records the day the resident was admitted , readmitted , or discharged if she was in the building or the next day. She further stated that if there was an admission, re-admission, or discharge on the weekend, that she completed the tracking assessment on Monday. The MDS coordinator reviewed Resident #33's MDS tracking record in the presence of the surveyor. The MDS Coordinator acknowledged that she did not see the entry and discharge tracking record for the date of 11/24/23. She stated, I will look into why the entry and discharge tracking were not completed for 11/24/23. On 02/20/24 at 11:08 AM, the MDS Coordinator acknowledged that the above mentioned MDS records were not completed for 11/24/23. She informed the surveyor that she completed and submitted the MDS entry/discharge tracking record after surveyor inquiry. A review of the facility policy titled MDS 3.0 Completion, date reviewed/revised 9/18/23 included the following: a. Entry Tracking i. Complete and submit with every entry into the facility no later than entry date + 7 calendar days. F. Discharge Assessment-completed using the discharge date as the Assessment Reference Date (ARD). Must be completed within 14 days of the discharge date /ARD. NJAC 8:39-11.2 (3)(i)

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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. 48423 Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure the medication error rates were not 5% or greater. During the morning medication administration observation on 2/20/24, the surveyor observed two (2) nurses administer medications to four (4) residents. There were 37 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 5.41%. This deficient practice was identified for one (1) of four (4) residents, Resident# 83, that was administered medications by one (1) of the two (2) nurses that were observed. The deficient practice was evidenced by the following: On 2/20/2024 from 9:23 AM to 9:40 AM, during the medication administration, the surveyor observed the Licensed Practical Nurse (LPN) prepare and administer medications to Resident # 83 which included: (i) Icosapent Ethyl (a medication used along with a proper diet to help lower fats [triglycerides] in the blood.) oral capsule one (1) gram (GM) (ii) Darolutamide (an oral tablet for prostate cancer that has not spread to other parts of your body) oral tablet 300 milligrams (MG). The surveyor asked the LPN if the resident had breakfast and the LPN stated, the resident has not eaten yet. The LPN opened up resident's room door to show the surveyor that his/her breakfast tray was on the tray table, which was positioned away from the resident's bed and further stated, the resident is waiting for [his/her] wife to bring [him/her] breakfast from home. At 10:00 AM, the surveyor reviewed Resident #83's Electronic Medication Administration Records (eMARs), which included special directions for these medications: (i) Icosapent Ethyl- Give 1 capsule by mouth two times a day for HLD (hyperlipidemia [high lipids]). Give with meals. (ii) Darolutamide Oral tablet 300 MG- Give 2 tablet by mouth two times a day for prostate cancer. Please ensure given 12 hrs. (hours) apart and with food in the stomach and also with food. At 1:25 PM, the surveyor asked the LPN when the resident ate last and the LPN stated, the resident had food last night. At that time the surveyor requested the LPN to review the eMARs and read the directions for the above medications, Give with meals and Please ensure given 12 hrs. apart and with food in the stomach and also with food. After reviewing the directions, the LPN stated, I should've HOLD the medications. A review of facility's policy, Medication Administration, revised on 5/30/23, included the following: 14. Administration medication as ordered in accordance with manufacturer specifications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Provide appropriate amount of food and fluids. A review of an undated policy titled PharmACCURATE Medication Pass, which was provided by the Director of Nursing on 2/23/24, included the following instructions under the subsection titles, Medication Timing: -Medication ordered with food may be administered up to 15 minutes after a meal or given with 4 ounces of milk and 2 graham crackers (or similar items). -Applesauce is not food. -Medication ordered with meals should be given with the meal (i.e., Metoprolol). -Milk and crackers do not constitute a meal. N.J.A.C 8:39-29.2 (d)