

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315457	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Lutheran Social Ministries Cranes Mill		STREET ADDRESS, CITY, STATE, ZIP CODE 459 Passaic Avenue West Caldwell, NJ 07006	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>19106</p> <p>Based on observation, interview, and record review it was determined the facility failed to provide physical privacy during a pressure ulcer treatment for 1 (Resident #21) of 9 residents reviewed for privacy and dignity. The deficient practice was evidenced by the following.</p> <p>On 3/7/25 at 10:42 AM the surveyor observed Resident #21 awake and alert in bed. The resident had a private duty companion seated at the bedside.</p> <p>A review of the electronic medical record revealed the following information.</p> <p>The 1/27/25 Admission Minimum Data Set (MDS) assessment tool indicated the resident had moderate cognitive impairment and was admitted with a full thickness sacral pressure ulcer.</p> <p>The Resident Medical Profile included a 2/14/25 physician's order for nursing to cleanse the right sacrum with normal saline solution, pack with Iodoform packing strips, cover with dry gauze and foam dressing once daily.</p> <p>The surveyor approached Resident #21's room on 3/11/25 at 1:08 PM to observe the resident's pressure ulcer treatment which had been prearranged with the Licensed Practical Nurse (LPN) who would perform the treatment. The surveyor knocked on the closed door. The LPN came out and left the door open. The resident was visible from the doorway. The resident was positioned on their left side facing the window. The resident's slacks were pulled down past their knees exposing their incontinence brief.</p> <p>The LPN prepared for the pressure ulcer treatment for 10 minutes while the resident remained exposed and visible from the hallway. At 1:19 PM the LPN approached the resident's bedside to begin the treatment. At that time the surveyor asked the LPN to speak with her near the doorway. The surveyor asked the LPN if privacy should be afforded to the resident and the LPN replied privacy should be provided and pulled the privacy curtain.</p> <p>The surveyor spoke with the Administrator and the Director of Nursing on 3/11/25 at 2:00 PM regarding the LPN's failure to provide the resident with physical privacy during the pressure ulcer treatment.</p> <p>The surveyor reviewed the 4/6/17 policy and procedure for providing a clean dressing change. The second step of the procedure, after identifying the resident, was to provide privacy.</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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-4.1(a)16		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>45449</p> <p>Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure a.) stored narcotic medication was maintained with the safety tamper resistant seal (Resident #4), identified for 1 of 1 medication cart inspected, b.) ensure an accurate ordering and receiving of narcotic medications on the required Federal narcotic acquisition forms (DEA Form-222) were completed with sufficient detail to enable accurate reconciliation, identified for 7 of 9 provided DEA Form-222, and c.) medication was properly disposed after falling onto the bed, observed during medication pass observation.</p> <p>The deficient practice was evidenced by the following:</p> <p>1.) On 3/11/25 at 9:29 AM, the surveyor and the Licensed Practical Nurse (LPN) began the narcotic medication inspection, which was stored in a mounted, double locked portion of the medication cart (narcotic box), assigned to the 2500 hall.</p> <p>At 9:32 AM, in the presence of LPN, the surveyor reviewed the accountability record (a shift-to-shift log; count/sign in sheet, used to account for the narcotic medications within the medication cart) was signed daily until the day shift of 3/11/25. The LPN stated that there were no discrepancies found that day.</p> <p>At 9:35 AM, the surveyor and the LPN reviewed the controlled medication utilization record (CMUR; a narcotic medication log that details the following: when the narcotic was received, starting quantity, the date, time, the dose removed from inventory, nurse administering, quantity remaining, wasted amount when pertinent and who checked the log) of Resident #4's Morphine Sulfate 100 milligram/ 5 milliliter (mg/ml; narcotic medication indicated for pain). The CMUR did not reflect the medication was used from the time it was received on 1/31/25.</p> <p>At that time, the surveyor and the LPN observed the safety tamper resistant seal (provides visual evidence of any attempt to open or manipulate the packaged medication) was missing for Resident # 4's Morphine Sulfate 100 mg/ 5 ml bottle. The Morphine had a pharmacy label dated 1/31/25, and the contents reflected approximately 30 ml.</p> <p>At that time, the LPN #1 stated she did not break the seal for Resident #4's Morphine Sulfate 100 mg/ 5 ml and that she had received the Morphine that way from the beginning of her shift that day. The LPN stated she did not inform the Director of Nursing about the missing tamper resistant seal.</p> <p>At 10:19 AM, the surveyor informed the DON of the concern regarding the missing tamper resistant seal for Resident #4's Morphine 100 mg/ 5 ml.</p> <p>At 10:40 AM, during a follow-up meeting with the surveyor, the DON acknowledged that all nurses on duty were responsible to ensure that bottled narcotic medications delivered from the pharmacy, had the tamper resistant seal and was stored in a manner that the tamper resistant seal was kept intact.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2.) On 3/11/25 at 11:50 AM, the surveyor and the DON reviewed the facility's DEA Form-222 which revealed that the facility did not complete Part 5, the number of packages received or the date the medication was received as instructed to on the reverse of the DEA Form-222. The insufficient details were as follows:</p> <p>Order Form:</p> <p>#231101679, No number received, no date received.</p> <p>#231101681, No number received, no date received.</p> <p>#231101682, No number received, no date received.</p> <p>#231101683, No number received, no date received.</p> <p>#231101684, No number received, no date received.</p> <p>#231101686, No number received, no date received.</p> <p>#231101687, No number received, no date received.</p> <p>Additionally, the surveyor observed the DEA Form-222 did not have the associated invoice to show that upon receipt of the narcotic, the items received were reconciled against the DEA Form-222 as evidenced by the missing documentation on Part 5.</p> <p>On 3/11/25 at 1:22 PM, during a meeting with two surveyors, the DON acknowledged that the process for receiving narcotics, and the reconciliation process could be streamlined. The DON stated that she would retrieve the invoices from the nurses or the pharmacy.</p> <p>On 3/12/25 at 8:58 AM, during a follow-up meeting with the surveyor, the DON stated that they were unable to determine when the tamper resistant seal went missing. The DON also stated that the policy would be updated to include verification of the tamper resistant seal was intact along with the accuracy of the inventory count, this was to ensure the integrity of the medication.</p> <p>A review of the provided facility policy, Controlled Substances, dated 4/30/19, revision undated, included under record keeping did not include a process to ensure narcotic medications with tamper resistant seal were received, maintained and tracked.</p> <p>A review of the provided facility policy, Storage of Medications, dated 6/8/15, revision undated, included that the facility shall store all drugs and biologicals in a safe, secure and orderly manner.</p> <p>A review of the instructions for DEA Form-222 under Part 5, Controlled Substance Receipt included the following:</p> <ol style="list-style-type: none"> 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item . <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>19106</p> <p>3. The surveyor observed the LPN administer medications to an unsampled resident on 3/11/25 at 8:16 AM. While administering the medications one pill dropped on to the resident's bed. The medication was Metoprolol Succinate 25 mg., an antihypertensive medication. The LPN disposed of the pill in the open trash receptacle affixed to the side of the medication cart located in the unit hallway.</p> <p>When questioned by the surveyor, LPN stated she should have used the Drug Buster, a receptacle used for the safe disposal of medications.</p> <p>The surveyor interviewed the Administrator and the DON on 3/11/25 at 2:00 PM. The DON stated the nurse should have used the Drug Buster which is located in each medication cart.</p> <p>NJAC 8:39- 29.2(a)(d); 29.4(i)(k); 29.7(c)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>19106</p> <p>Based on observation, interview, and record review it was determined the facility failed to follow appropriate infection control practices to prevent or reduce the spread of infection during a pressure ulcer treatment for 1 (Resident #21) of 2 residents reviewed for pressure ulcers. The deficient practice was evidenced by the following.</p> <p>The surveyor observed Resident #21 awake and alert in bed on 3/7/25 at 10:42 AM . The resident had a private duty companion seated at the bedside.</p> <p>A review of the electronic medical record revealed the following information.</p> <p>The 1/27/25 Admission Minimum Data Set (MDS) assessment tool indicated the resident had moderate cognitive impairment and was admitted with a full thickness sacral pressure ulcer.</p> <p>The Resident Medical Profile included a 2/14/25 physician's order for nursing to cleanse the right sacrum with normal saline solution, pack with Iodoform packing strips, cover with dry gauze and foam dressing once daily.</p> <p>The surveyor observed the resident's pressure ulcer treatment on 3/11/25 at 1:08 PM. The Licensed Practical Nurse (LPN) sanitized the over bed table, applied a clean disposable drape cloth to the table, and assembled the needed supplies for the treatment. A glass jar of Iodoform packing strips was taken from the treatment cart. The entire jar was brought into the resident's room and placed on the over bed table at the resident's bedside.</p> <p>At the completion of the treatment at 1:36 PM the LPN returned the jar to the drawer of the treatment cart without sanitizing it. When questioned by the surveyor, the LPN stated she should have sanitized the jar first.</p> <p>At that same time, the surveyor asked the LPN if she was done with the treatment pass. She replied she was. The surveyor noted the trash containing the soiled packing strip and the cover dressings were left in the room at the resident's bedside in the resident's trash can. The LPN stated she would remove the trash from the resident's room to the dirty utility room.</p> <p>The surveyor spoke with the Administrator and the Director of Nursing (DON) on 3/11/25 at 2:00 PM regarding the LPN's failure to follow standard infection control. The DON confirmed the jar should not have been replaced into the treatment cart without sanitizing it. The DON stated soiled dressings are to be removed from the resident's room upon completion of the treatment.</p> <p>The surveyor reviewed the 4/6/17 policy and procedure for providing a clean dressing change. The third step of the procedure was to place a plastic bag on the over bed table or in close proximity of the resident.</p> <p>The policy and procedure did not address removing trash from the room or returning unsanitized items back into the treatment cart.</p> <p>(continued on next page)</p>		

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