STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR RIDGE REHABILITATION AND HEALTHCARE CENTER	261 TERHUNE DRIVE WAYNE, NJ 07470

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to: a) monitor the behavior of a resident on psychoactive medications for 2 of 5 residents (Resident #23 and 74); and, b) clarify a physician's order for ROM (Range of Motion) for 1 of 19 residents (Resident #74) reviewed for adherence to acceptable standards of nursing practice. This deficient practice 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 9/16/20 at 10:05 AM, the surveyor observed Resident #74 lying in bed. The resident could not remember how long they couldn't use their right leg, which was not something new to the resident. The resident stated that the therapist had told him/her that they were on the list to be seen. On 9/21/20 at 8:36 AM, the Certified Nursing Aide #1 (CNA#1) informed the surveyor that the resident was alert with some forgetfulness, and required extensive assistance with activities of daily living (ADLs), total assists with the transfer, and can feed themselves. CNA #1 stated that the resident had a bilateral (bil) foot drop, which was not something new, and was on active ROM (AROM) both upper extremities (ext). He further stated that the resident had hallucination episodes at sundown, which was not new. He also indicated that Resident #74 was often seen arguing with someone who was not present and referred to the other person as the resident's child. A review of the resident's Face Sheet, an admission summary, indicated that the resident had [DIAGNOSES REDACTED]. A review of the 8/7/20 Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate care management, revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated that the resident's cognition was intact. The CMDS noted that there was no behavior documented and with bil lower extremities limitations. A review of Resident #74 [MEDICAL CONDITION] medications Care Plan (CP), initiated 12/16/19, revealed that the CP Interventions indicated to monitor/record the occurrence of target behavior symptoms and monitor/document for side effects and effectiveness. A review of Resident #74's September 2020 Order Summary Report (OSR) showed an order dated 9/4/19 for [MEDICATION NAME] 0.5 milligram (mg) at night, [MEDICATION NAME] 0.25mg in the morning (am), dated 7/23/20 for [MEDICATION NAME] 0.75 mg at bedtime (hs) and [MEDICATION NAME] 1 mg in am. Also, orders dated 9/21/16 for Passive ROM (PROM) on bilateral lower ext daily and dated 12/10/19 PROM/AAROM on bil lower ext during care. The corresponding physician's orders were transcribed into the resident's September 2020 Medication Administration Record (MAR) and Treatment Administration Record (TAR) and signed by the nurses as administered each day. On 9/21/20 at 12:37 PM, the Registered Nurse/Desk Nurse (RN/DN) informed the surveyor that the facility doesn't use a behavior monitoring record for residents who were on Psychoactive meds, which included [MEDICATION NAME] (used to treat the symptoms of [MEDICAL CONDITION]), and [MEDICATION NAME]. The RN/DN stated that the nurse only documents the behavior when the resident is first prescribed psychoactive meds, which is to be documented for 14 days. On that same date at 12:46 PM, the Licensed Practical Nurse (LPN) assigned to Resident #74 informed the surveyor that the facility utilized a Behavior Monitoring Form (BMF) located in the MAR binder. The BMF of each resident contained psychoactive meds and targeted behavior for the specific medication. The BMF should be filled out by the nurse every shift to determine if the meds were effective for possible gradual drug reduction (GDR) when the Psychiatric doctor comes in every quarter. At that time, the LPN had no answer why Resident #74 had no BMF for September 2020. The LPN and the RN/DN checked the resident's medical records and could not locate the September 2020 BMF. The LPN was unable to state the targeted behaviors for Resident's #74 for the use of [MEDICATION NAME], and [MEDICATION NAME]. On 9/21/20 at 1:10 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Regional Registered Nurse (RRN) and discussed the above observations and concerns. On 9/22/20 at 9:09 AM, CNA#3 informed the surveyor that she was the regular aide of Resident #74. CNA#3 stated the resident was cognitively intact, on AROM, and that there was no decline in the resident's functional status. She further noted that there was no unusual behavior that the resident had exhibited. On 9/22/20 at 9:10 AM, the RN/DN informed the surveyor that it was the nurse's responsibility to document and sign the TAR for the resident's ROM, splinting ambulation for a restorative and functional maintenance program. On that same date and time, the RN/DN had no answer why there were two different orders for bil lower ext ROM and both signed by nurses for the whole month of September 2020 for Resident #74. The RN/DN indicated that the orders should have been clarified with the physician. On 9/22/20 at 10:02 AM, the Rehab Manager/Occupational Therapist (RM/OT) informed the surveyor that as facility practice, residents who were discharged (d/c) from Skilled Physical Therapy (PT) and OT would be transitioned to Restorative Nursing Program (RNP) or a Functional Maintenance Program (FMP). The RM/OT stated that the assigned nurse and CNA received educated and signed off on the recommendations for RNP and FMP. She further noted that the residents in the facility were being screened quarterly. She indicated that there was no decline in Resident #74's functional status. On that same date and time, the RM/OT stated that she was made aware by nursing that Resident #74 had two existing different orders for ROM for bil lower extremities that should have been clarified. She further stated that education would be provided to the rehab staff to ensure that previous rehab recommendations would be d/c'd and would re-evaluate, which rehab recommendations will be appropriate at this time. On 9/23/20 at 1:02 PM, the RRN informed the survey team in the presence of the LNHA, DON, and the Administrative Orientee, the facility was still figuring out the behavior monitoring form. She further stated that due to the pandemic, the facility's focus was on the care of each resident; That was why there were some missed documentation. Also, the RRN stated that the 9/21/16 and 12/10/19 orders for bil lower ext of Resident #74 were d/c'd and was picked up by PT to re-evaluate the status of the resident's ROM. On that same date and time, the DON stated that the September 2020 BMF was left in the August 2020 MAR binder; That was why there was no September 2020 BMF in the September 2020 MAR binder. 2. On 9/16/20 at 9:40 AM and 9/21/20 at 8:42 AM, the surveyor, observed Resident #23 in their room seated in a wheelchair, calm and quiet. On 9/21/20 at 8:42 AM, CNA#2 informed the surveyor that the resident was cognitively impaired and required extensive assistance with ADLs. CNA#2 further stated that the resident had no behavior, usually calm and quiet, and stays in their room. A review of the resident's Face Sheet disclosed that the resident had [DIAGNOSES REDACTED]. A review of the 6/28/20 Quarterly MDS (QMDS) indicated that the cognitive skills for daily decision making were severely impaired. The QMDS indicated that the resident had wandering behavior, and the mood was being short-tempered and easily annoyed. A review of Resident #23's September 2020 OSR showed an order dated 8/21/20 for [MEDICATION NAME] 125 mg give two capsules (caps) for a total of 250 mg one time a day for Mood Stabilizer, dated 8/18/20 for [MEDICATION NAME] 0.5 mg with 0.25 mg for a total of

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

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.

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 0.75 mg at hs, and [MEDICATION NAME] 0.5 mg one time a day in the morning for Anxiety Disorder. The corresponding physician's orders were transcribed into the resident's September 2020 MAR and signed by the nurses as administered each day. Further review of the resident's medical record revealed [REDACTED].#23. On 9/21/20 at 12:37 PM, the RN/DN informed the surveyor that the facility doesn't use a behavior monitoring record for residents on Psychoactive meds, including [MEDICATION NAME] and [MEDICATION NAME]. The RN/DN stated that the nurse documented the behavior when the resident was on new psychoactive meds for 14 days. On that same date at 12:46 PM, the LPN assigned to Resident #23 informed the surveyor that the facility utilized a BMF located in the MAR binder. The BMF of each resident contained a list of psychoactive meds and targeted behavior for the specific medication that the nurse should fill out every shift to determine if the meds were effective for possible GDR when the Psychiatric doctor comes in every quarter. At that time, the LPN had no answer why Resident #23 had no BMF for September 2020. The LPN and the RN/DN checked the resident's medical records and could not locate the September 2020 BMF. The LPN was unable to state the targeted behaviors for Resident's #23 for the use of [MEDICATION NAME] and the [MEDICATION NAME]. On 9/21/20 at 1:10 PM, the survey team met with the LNHA, DON, and the RRN and discussed the above observations and concerns. On 9/23/20 at 1:02 PM, the RRN informed the survey team in the presence of the LNHA, DON, and the Administrative Orientee, that the facility was still on the process of figuring out the behavior monitoring form. She further stated that due to the pandemic, the facility's focus was on the care of each resident. That was why there were some missed documentations. On that same date and time, the DON stated that the September 2020 BMF was left in the August 2020 MAR binder. That was why there was no September 2020 BMF in the September 2020 MAR binder. A review of the facility's policy for Medication and Treatment Orders provided by the RRN with a revised date of May 2017, reflected that: Orders for medications and treatments will be consistent with principles of safe and effective order writing. The RRN stated that there was no specific policy with regards to clarification of orders. A review of the facility policy and procedure on Behavioral Assessment, Intervention and Monitoring provided by the DON with a revised date of May 2019 indicated: Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment, If the resident is being treated for [REDACTED]. NJAC 8:39-11.2 (b)
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate services to a resident with limited mobility for a total of two quarters. This deficient practice was identified for 1 of 3 residents (Resident #24) reviewed for a limited range of motion (ROM). This deficient practice was evidenced by: On 9/16/20 at 9:42 AM, the surveyor observed Resident #24 lying in bed with left upper extremity (LUE) limitation. There was no splint in use at that time. The resident stated that they used to have a left-hand splint a long time ago that was taken away with no explanation, and that they hadn't refused its use. The resident was unable to remember the person, and when the splint was taken away. The resident further stated that the left-hand contracture was not new and they didn't feel it had worsened. On 9/21/20 at 8:22 AM, the surveyor observed the resident lying in a Geri-chair with no splint in use at that time. On 9/21/20 at 8:45 AM, the Certified Nursing Aide (CNA) informed the surveyor that she's been working in the facility for over ten years. The CNA stated that Resident #24 was alert with some forgetfulness, able to make needs known, could answer questions, required extensive to total assists with activities of daily living (ADLs), and had a limitation on their left side of the body. The surveyor asked the CNA if resident #24 utilized an assistive device or splints. The CNA stated, I can't answer that. A review of the resident's Face Sheet (an admission summary) reflected that the resident was admitted to the facility with [DIAGNOSES REDACTED]. A review of the Quarterly Minimum Data Set (QMDS), an assessment tool, dated 6/28/20, reflected a brief interview for mental status (BIMs) score of 13, which indicated that the resident was cognitively intact. The QMDS reflected that Resident #24 had bilateral upper and lower extremities limitations. A review of the resident's medical records showed a Rehab Referral to Functional Maintenance Program (RR/FMP) dated 10/23/18 for ROM both extremities and left upper extremity (LUE) grip splint with finger separators x 6 hours (hrs) daily that was signed by the therapist and a nurse. Further review of Resident #24's medical records showed an RR/FMP dated 5/8/19 for ROM and to continue the previous Functional Maintenance Program (FMP) that was signed by the nurse, an aide, and therapist. There was no Rehab documentation that the resident was seen for routine screening concerning LUE limitation/contractures after 5/8/19. A review of the resident's physician's orders [REDACTED]. There was an order in the physician's orders [REDACTED].#24 to the hospital. On 9/22/20 at 10:02 AM, the Rehab Manager/Occupational Therapist (RM/OT) informed the surveyor that as facility practice, residents who were discharged (d/c) from Skilled Physical Therapy (PT) and OT will be transitioned to Restorative Nursing Program (RNP) or FMP. The RM/OT stated that the assigned nurse and CNA would be educated and signs the recommendations for RNP and FMP. She further noted that the residents in the facility were being screened quarterly. She indicated no decline in Resident #24's functional status, and the LUE contracture was the same. She further stated that she would get back to the surveyor regarding the resident's quarterly screen by rehab. On that same day at 11:03 AM, the RM/OT informed the surveyor that the last time Resident #24 was screened by rehab was in February 2020, according to Therapy Screening Tracking Log. The RM/OT stated that she was responsible for scheduling residents to be seen quarterly by rehab, and I don't know why I missed it. On 9/22/20 at 1:07 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Registered Nurse (RRN), and the Administration Orientee, who were made aware of the above concerns. On 9/23/20 at 1:02 PM, the RRN informed the survey team in the presence of the LNHA, DON, and the Administrative Orientee that they were not aware that Resident #24 was not screened quarterly and that the last screen by rehab was in February 2020. The RRN further stated that the resident should have been screened quarterly. A review of the facility's policy for Restorative Nursing Services provided by the RN Supervisor with a revised date of July 2017, reflected that: Resident will be monitored, and if the decline is observed, the resident will be referred back to therapy for screen and or evaluation. NJAC 8:39-27.1(a), 27.2(m)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to: a) properly store and dispose of medications in 2 of 4 medication carts inspected; and b) failed to properly secure narcotic storage boxes in 1 of 2 medication refrigerators inspected. This deficient practice was evidenced by the following: On [DATE] at 9:50 AM, the surveyor inspected the first-floor medication room refrigerator in the presence of a Registered Nurse (RN). The surveyor observed a narcotic box that was secured to the refrigerator but was unlocked. The narcotic box contained four bags of [MEDICATION NAME] gel. The surveyor interviewed the RN, who stated that the narcotic box should have been locked. On [DATE] at 10:00 AM, the surveyor inspected the memory unit medication cart in the presence of RN #2. The surveyor observed an opened Basaglar insulin pen and an opened [MEDICATION NAME]vial that was not dated. The surveyor also observed an unidentifiable tablet sitting on top of the medication cart; There were no residents observed near the medication cart. The surveyor interviewed RN #2, who stated that she didn't see the unidentifiable tablet, and she didn't know how it ended up on top of the cart. RN #2 said that the unidentifiable tablet should have been destroyed in a drug buster (drug disposable system). RN #2 also stated that an opened Basaglar insulin pen and an opened [MEDICATION NAME] vial should have been dated. On [DATE] at 10:15 AM, the surveyor inspected the 2 North medication cart in the presence of a Licensed Practical Nurse (LPN). The surveyor observed an opened [MEDICATION NAME]vial that was not dated and an opened [MEDICATION NAME]vial with an opened date of [DATE] that was expired. The surveyor interviewed LPN #1, who stated that a [MEDICATION NAME]vial should have been dated once opened and that the [MEDICATION NAME]vial with an opened date of [DATE] was expired and should have been removed from the medication cart. A review of the Manufacturer's Specifications for the above medications indicated the following: 1. [MEDICATION NAME] Insulin vials, once opened, had an expiration date of 28-days 2. Basaglar Insulin pen, once opened, had an expiration date of 28-days A review of the facility's policy titled Controlled Substances indicated the following under number 5. Controlled substances must be stored under double lock, separate from containers for any

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) non-controlled medications. Controlled substances must remain locked at all times, except when it is accessed to obtain medications for residents. A review of the facility's policy titled Storage of Medications indicated the following under number 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. NJAC: 8:,[DATE].4 (a) (h) (d)