STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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 0553 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Allow resident to participate in the development and implementation of his or her person-centered plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint NJ 798 Based on interview and record review, it was determined that the facility failed to ensure that the resident was invited to participate in the resident's care conference meetings. This was cited at a level E as there was no documented evidence that the resident had been invited to the care conference meetings since 1/12/2019. This deficient practice was identified for 1 of 1 residents reviewed for participation in the care planning process, (Resident #7) and was evidenced by the following: The surveyor reviewed the 6/26/2020 quarterly review of the Resident Assessment Instrument (RAI), an assessment tool, and observed that the facility had identified Resident #7 as being alert and oriented. The surveyor reviewed the facility's policy for Care Planning which included The resident, the resident's family . are invited and encouraged to participate in the development of and revisions to the resident's care plan. An IDT (Interdisciplinary team) meeting V.3 note will be completed in the EHR (Electronic Health Record) after care plan meeting is complete. When interviewed on 8/18/2020 at 12:45 PM, the Director of Social Services (DSS)said prior to covid, around March, care conference days were Tuesdays and Wednesdays. The DSS said she would call the family regarding the date and time of the meeting and tell the resident. The DSS said she would then write a note in the social services section of the progress notes. On 8/19/2020 at 10:50 AM the DSS said residents and families were invited any time there was a careplan meeting which included a quarterly review, an annual review, or a significant change review of the RAI. When interviewed on 8/20/2020 at 1:59 PM, the surveyor asked the resident about attending care conference meetings. The resident said I don't remember going to any. The surveyor reviewed the medical record and observed the dates of the RAI reviews and documentation of resident participation were as follows: 10/12/18- RAI 5 day medicare assessment and subsequent care conference meeting. Documentation noted the resident was in attendance. 1/12/19- RAI quarterly review assessment and subsequent care conference meeting. Documentation noted the resident was in attendance. 4/14/19- RAI quarterly review assessment and subsequent care conference meeting. There was documentation of the care conference meeting but the resident was not noted as being present. 5/26/19- RAI significant change assessment and subsequent care conference meeting. There was documentation of the care conference meeting but the resident was not noted as being present. 8/26/29- RAI quarterly review assessment and subsequent care conference meeting. There was documentation of the care conference meeting but the resident was not noted as being present. The resident was discharged on [DATE] but returned to the facility as a new admission on 9/19/2019. 9/26/19- RAI admission assessment and subsequent care conference meeting. There was documentation of the care conference meeting but the resident was not noted as being present. 12/27/19- RAI quarterly review assessment and subsequent care conference meeting. There was documentation of the care conference meeting but the resident was not noted as being present. 3/27/2020- RAI quarterly review assessment and subsequent care conference meeting. There was documentation of the care conference meeting but the resident was not noted as being present. 6/26/2020- RAI quarterly review assessment and subsequent care conference meeting. There was documentation of the care conference meeting but the resident was not noted as being present. NJAC 8:39-13.2(a)
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # NJ 630, NJ 523, NJ 732, NJ 698 Based on interview and record review, it was determined that the facility failed to administer medications in a timely manner as per the facility's policy and professional standards of clinical practice with timing of medication administration for Residents #4, #5, #6, and #8, 4 of 4 residents reviewed for medication administration. In addition, the facility failed to maintain medication records that were complete with staff signatures for Resident #4. This deficient practice was identified for Residents #4, #5, #6 and #8 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 casefinding, 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 casefinding; 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. Resident #8 was a resident in the facility from 4/7/2020 to 4/27/2020 and had [DIAGNOSES REDACTED]. The surveyor reviewed the Order Summary Report and observed a physician order [REDACTED]. Inject as per sliding scale subcutaneously before meals and at bedtime for diabetic. The surveyor reviewed the electronic Medication Administration Record (eMAR) and observed the physician's orders [REDACTED]. The surveyor reviewed the facility's Medication Pass policy which included Medications ordered to be given at a specific time will be administered within one hour of that time (i.e., 8 am will be administered between 7am and 9 am). When interviewed on 8/18/2020 at 1:59 PM, the Director of Nursing (DON) confirmed the policy and stated if insulin is ordered at 9 PM, the resident should receive it anywhere between 8 and 10. When asked if the administered time on the eMAR was when the nurse administered the medication to the resident, the DON said yes. The surveyor also reviewed the section of the eMAR that identified the Scheduled Time and the Administered Time of the Insulin administration. The surveyor observed multiple administration times of the insulin that were given beyond the 1 hour window of administration time which was inconsistent with the facility's Medication Pass policy. The incorrect administration times are as follows: 4/10/20- scheduled 11:30, administered 13:33 (1 hour 3 mins late) 4/10/20- scheduled 16:30, administered 17:52 (22 mins late) 4/12/20- scheduled 11:30, administered 13:26 (1 hour 56 mins late) 4/15/20- scheduled 16:30, administered 18:40 (1 hour 10 mins late) 4/17/20- scheduled 11:30, administered 13:14 (1 hour 44 mins late) 4/17/20- scheduled 16:30, administered 19:18 (1 hour 48 mins late) 4/19/20- scheduled 11:30, administered 12:47 (17 mins late) 4/19/20- scheduled 16:30, administered 17:56 (26 mins late) 4/19/20- scheduled 21:00, administered 23:29 (1 hour 29 mins late) 4/27/20- scheduled 16:30, administered 19:32 (2 hours 2 mins late) There was no documented evidence in the medical record that Resident #8 experienced a negative reaction/harm from the late administration of the medications. 2. Resident #5 was a resident in the facility from 3/31/20 to 5/2/20 and had [DIAGNOSES REDACTED]. The surveyor reviewed the Order Summary Report and observed a physician order [REDACTED]. The surveyor reviewed the eMAR and observed the physician's orders [REDACTED]. The surveyor also reviewed the section of the eMAR that identified the Scheduled Time and the Administered Time of the [MEDICATION NAME] administration. The surveyor observed multiple administration times of the [MEDICATION NAME] that were given beyond the 1 hour window of administration time which was

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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	315174	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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** - Many	(continued... from page 1) inconsistent with the facility's Medication Pass policy. The incorrect administration times are as follows: 4/1/20- schedule 08:00, administered 09:58 (58 mins late) 4/2/20- scheduled 16:00, administered 17:15 (15 mins late) 4/3/20- scheduled 16:00, administered 17:20 (20 mins late) 4/3/20- scheduled 20:00, administered 21:12 (12 mins late) 4/6/20- scheduled 08:00, administered 10:33 (1 hour 33 mins late) 4/6/20- scheduled 12:00, administered 13:34 (34 mins late) 4/6/20- scheduled 16:00, administered 17:47 (47 mins late) 4/6/20- scheduled 20:00, administered 21:32 (32 mins late) 4/8/20- scheduled 12:00, administered 13:44 (44 mins late) 4/8/20- scheduled 16:00, administered 18:03 (1 hour 3 mins late) 4/9/20- scheduled 04:00, administered 06:24 (1 hour 24 mins late) 4/9/20- scheduled 16:00, administered 17:12 (12 mins late) 4/10/20- scheduled 04:00, administered 05:14 (14 mins late) 4/10/20- scheduled 12:00, administered 14:12 (1 hour 12 mins late) 4/10/20- scheduled 16:00, administered 18:56 (1 hour 56 mins late) 4/12/20- scheduled 04:00, administered 05:30 (30 mins late) 4/12/20- scheduled 08:00, administered 09:32 (32 mins late) 4/14/20- scheduled 00:00, administered 01:27 (27 mins late) 4/14/20- scheduled 08:00, administered 09:27 (27 mins late) 4/14/20- scheduled 16:00, administered 17:14 (14 mins late) 4/15/20- scheduled 08:00, administered 09:36 (36 mins late) 4/15/20- scheduled 12:00, administered 13:23 (23 mins late) 4/15/20- scheduled 16:00, administered 18:15 (1 hour 15 mins late) 4/15/20- scheduled 20:00, administered 21:47 (47 mins late) 4/16/20- scheduled 08:00, administered 10:06 (1 hour 6 mins late) 4/16/20- scheduled 12:00, administered 13:23 (23 mins late) 4/17/20- scheduled 12:00, administered 13:59 (59 mins late) 4/17/20- scheduled 20:00, administered 22:17 (1 hour 17 mins late) 4/18/20- scheduled 08:00, administered 10:07 (1 hour 7 mins late) 4/18/20- scheduled 16:00, administered 17:13 (13 mins late) 4/19/20- scheduled 20:00, administered 23:27 (2 hours 27 mins late) 4/20/20- scheduled 04:00, administered 05:58 (58 mins late) 4/20/20- scheduled 08:00, administered 12:30 (3 hours 30 mins) 4/20/20- scheduled 16:00, administered 17:33 (33 mins late) 4/21/20- scheduled 04:00, administered 05:43 (43 mins late) 4/21/20- scheduled 08:00, administered 10:50 (1 hour 50 mins late) 4/21/20- scheduled 16:00, administered 17:18 (18 mins late) 4/23/20- scheduled 00:00, administered 01:48 (48 mins late) 4/23/20- scheduled 08:00, administered 10:10 (1 hour 10 mins) 4/23/20- scheduled 12:00, administered 15:14 (2 hours 14 mins) 4/23/20- scheduled 20:00, administered 23:22 (2 hours 22 mins late) 4/24/20- scheduled 04:00, administered 05:47 (47 mins late) 4/24/20- scheduled 20:00, administered 21:23 (23 mins late) 4/25/20- scheduled 00:00, administered 01:34 (34 mins late) 4/25/20- scheduled 04:00, administered 05:40 (40 mins late) 4/25/20- scheduled 08:00, administered 09:36 (36 mins late) 4/26/20- scheduled 00:00, administered 03:28 (2 hours 28 mins late) 4/26/20- scheduled 04:00, administered 06:51 (1 hour 51 mins late) 4/26/20- scheduled 08:00, administered 09:49 (49 mins late) 4/26/20- scheduled 12:00, administered 14:09 (1 hour 9 mins late) 4/26/20- scheduled 16:00, administered 18:19 (1 hour 19 mins) 4/27/20- scheduled 00:00, administered 02:27 (1 hour 27 mins late) 4/27/20- scheduled 04:00, administered 07:19 (2 hours 19 mins late) 4/27/20- scheduled 08:00, administered 10:29 (1 hour 29 mins late) 4/27/20- scheduled 16:00, administered 19:06 (2 hours 6 mins late) 4/27/20- scheduled 20:00, administered 22:16 (1 hour 16 mins late) 4/28/20- scheduled 00:00, administered 01:19 (19 mins late) 4/28/20- scheduled 12:00, administered 13:42 (42 mins late) 4/29/20- scheduled 04:00, administered 05:32 (32 mins late) 4/29/20- scheduled 08:00, administered 11:03 (2 hours 3 mins late) 4/29/20- scheduled 12:00, administered 14:42 (1 hour 42 mins late) 4/30/20- scheduled 00:00, administered 01:12 (12 mins late) 4/30/20- scheduled 04:00, administered 06:06 (1 hour 6 mins late) 4/30/20- scheduled 20:00, administered 23:33 (2 hours 33 mins late) There was no documented evidence in the medical record that Resident #5 experienced a negative reaction/harm from the late administration of the medications. 3. Resident #6 was a resident of the facility from 4/15/20 to 5/9/20 and had [DIAGNOSES REDACTED]. The surveyor reviewed the Order Summary Report and observed physician's orders [REDACTED]. The surveyor reviewed the eMAR and observed the physician's orders [REDACTED]. The surveyor also reviewed the section of the eMAR that identified the Scheduled Time and the Administered Time of the [MEDICATION NAME] administration. The surveyor observed multiple administration times of the [MEDICATION NAME] that were given beyond the 1 hour window of administration time which was inconsistent with the facility's Medication Pass policy. The incorrect administration times are as follows: Breakfast time 5/2/20- scheduled 07:30, administered 09:11 (41 mins late) 5/3/20- scheduled 07:30, administered 10:18 (1 hour 48 minutes late) 5/5/20- scheduled 07:30, administered 14:27 (5 hours 57 mins late) 5/6/20- scheduled 07:30, administered 09:51 (1 hour 21 mins late) Lunch time 5/4/20- scheduled 11:30, administered 13:31 (1 hour 1 min late) 5/5/20- scheduled 11:30, administered 14:27 (1 hour 57 mins late) 5/6/20- scheduled 11:30, administered 13:31 (1 hour 1 min late) On 5/5/20 the administered time for the 07:30 (breakfast) time and the 11:30 (lunch) time were the same; both administered at 14:27. When asked if that meant the breakfast dose had been missed and then signed for with the lunch dose, the Assistant Director of Nursing could not provide an explanation. Dinner time 5/2/20- scheduled 16:30, administered 17:54 (24 mins late) 5/3/20- scheduled 16:30, administered 17:45 (15 mins late) The Order Summary Report included a physician's orders [REDACTED]. On 4/23/20 the physician's orders [REDACTED]. The surveyor reviewed the eMAR and observed the physician's orders [REDACTED]. The surveyor reviewed the section of the eMAR that identified the Scheduled Time and the Administered Time of the [MEDICATION NAME] administration. The surveyor observed multiple administration times of the antibiotic that were inconsistent with the facility's Medication Pass policy as follows: 4/19/20- scheduled 21:00, administered 23:25 (1 hour 25 mins late) 4/24/20- scheduled 21:00, administered 23:33 (1 hour 33 mins late) 4/25/20- scheduled 21:00, administered 23:21 (1 hour 21 mins late) The Order Summary Report included a physician's orders [REDACTED]. (The physician's orders [REDACTED].) The surveyor also reviewed the section of the eMAR that identified the Scheduled Time and the Administered Time of the [MEDICATION NAME] administration. The surveyor observed multiple administration times of the [MEDICATION NAME] that were given beyond the 1 hour window of administration time which was inconsistent with the facility's Medication Pass policy. The incorrect administration times are as follows 4/18/20- scheduled 08:00, administered 11:29 (1 hour 29 mins late) 4/19/20- scheduled 08:00, administered 09:58 (58 mins late) 4/19/20- scheduled 17:00, administered 18:20 (20 mins late) 4/20/20- scheduled 12:00, administered 13:51 (51 mins late) 4/21/20- scheduled 08:00, administered 10:22 (1 hour 22 mins late) 4/22/20- scheduled 07:30, administered 08:56 (26 mins late) 4/22/20- scheduled 11:30, administered 13:09 (39 mins late) 4/23/20- scheduled 07:30, administered 08:45 (15 mins late) 4/23/20- scheduled 11:30, administered 15:13 (2 hours 43 mins late) 4/23/20- scheduled 21:00, administered 00:14 (2 hours 14 mins late) 4/24/20- scheduled 07:30, administered 09:03 (33 mins late) 4/24/20- scheduled 21:00, administered 23:30 (1 hour 30 mins late) 4/25/20- scheduled 07:30, administered 09:37 (1 hour 7 mins late) 4/26/20- scheduled 07:30, administered 11:16 (2 hours 46 mins late) 4/26/20- scheduled 11:30, administered 13:00 (30 mins late) 4/27/20- scheduled 07:30, administered 09:22 (52 mins late) 4/27/20- scheduled 16:30, administered 18:16 (46 mins late) 4/28/20- scheduled 07:30, administered 09:48 (1 hour 28 mins late) 4/28/20- scheduled 11:30, administered 14:22 (1 hour 52 mins late) There was no documented evidence in the medical record that Resident #6 experienced a negative reaction/harm from the late administration of the medications. 4. The surveyor interviewed Resident #4 on 8/19/2020 at 9:24 AM. Resident #4 expressed concern regarding getting medications late and not receiving wound care. The surveyor reviewed the 6/1/2020 Resident Assessment Instrument, an assessment tool, and observed that the facility had identified Resident #4 as cognitively intact with a wound infection and acquired absence of the left leg above knee. On 8/19/2020 at 11:00 AM the surveyor reviewed the February, March, and April 2020 MAR for Resident #4. When medications are ordered by the physician, the order is placed on the MAR. When administered by the nurses, the nurse will sign their initials on the MAR indicating that they have given the medication. The surveyor noted a 2/20/2020 physician's orders [REDACTED]. The surveyor observed a blank, there were no nurse's initials indicating administration on 2/21/2020 at 2200. The surveyor observed another antibiotic order, [MEDICATION NAME] ordered on [DATE] 300 mg give 1 capsule by mouth every 8 hours for 14 days for abscess on left stump . This medication also had blanks on 3/21/2020 and 3/22/2020 at 2200. The surveyor observed another antibiotic [MEDICATION NAME] HCL Solution Reconstituted 1.5GM use 1500 milligram intravenously every 12 hours for osteo[DIAGNOSES REDACTED] for 7 days which was ordered on [DATE]. There were blanks on 4/25/2020 at 0600 and 1800. There was also a medication [MEDICATION NAME] Capsule 300mg give 3 capsules 3 times a day for phantom pain with an order date 2/11/2020. There was a blank on 4/21/2020 at 1300. During an interview on 8/21/2020 at 8:30 AM, the Nurse Manager stated that if a medication or treatment is not documented it was not done. On 8/21/2020 at 11:00 AM the surveyor reviewed the June and August 2020 Treatment Administration Records for Resident #4. The surveyor observed an antibiotic ointment [MEDICATION NAME] to be applied to the right hip twice a day which was ordered on [DATE]. There were blanks for 6/1/2020 at 7a- and August 2, 5, 15,and 16 at 7a-. The surveyor observed an order for [REDACTED]. The surveyor observed an order for [REDACTED]. There were blanks for 6/1/2020 at 7a- and 8/2/2020, 8/5/2020, and 8/13/2020 at 7a-. There was a physician's orders [REDACTED]. There were blanks for 8/2/2020, 8/5/2020, 8/15/ , and 8/16/2020 at 7a-. The surveyor noted Resident #4 had an order for [REDACTED]. The time of application was listed as 9:15 am. The surveyor also reviewed the section of the eMAR that identified the Scheduled Time and the Administered Time of

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) the Nicotin patch. The surveyor observed multiple administration times of the patch that were given beyond the 1 hour window of administration time which was inconsistent with the facility's Medication Pass policy. The incorrect administration times are as follows: 2/1/2020 administered 11:42 (1 hour 27 minutes late) 2/2/2020 administered 12:08 (1 hour 43 minutes late) 2/3/2020 administered 10:26 (11 minutes late) 2/4/2020 administered 10:29 (14 minutes late) 2/5/2020 administered 11:07 (52 minutes late) 2/9/2020 administered 10:34 (19 minutes late) 2/11/2020 administered 12:11 (1 hour an 56 minutes late) 2/12/2020 administered 10:54 (39 minutes late) 2/13/2020 administered 10:44 (29 minutes late) 2/14/2020 administered 10:41 (26 minutes late) 2/15/2020 administered 10:38 (23 minutes late) 2/16/2020 administered 14:42 (4 hours 27 minutes late) 2/20/2020 administered 12:30 (2 hours 15 minutes late) 2/21/2020 administered 10:40 (25 minutes late) 2/23/2020 administered 11:05 (50 minutes late) 2/25/2020 administered 10:48 (33 minutes late) 2/29/2020 administered 12:39 (2 hours and 24 minutes late) 3/1/2020 administered 15:52 (5 hours 37 minutes late) 3/2/2020 administered 10:39 (24 minutes late) 3/3/2020 administered 11:06 (51 minutes late) 3/4/2020 administered 11:43(28 minutes late) 3/5/2020 administered 11:26 (1 hour 11 minutes late) 3/6/2020 administered 10:55 (40 minutes late) 3/7/2020 administered 11:30 (1 hour 24 minutes late) 3/8/2020 administered 11:21 (1 hour 6 minutes late) 3/9/2020 administered 11:36 (1 hour 21 minutes late) 3/10/2020 administered 10:26 (11 minutes late) 3/12/2020 administered 10 :51 (36 minutes late) 3/16/2020 administered 12:04 (1 hour 49 minutes late) 3/17/2020 administered 10:44 (29 minutes late) 3/19/2020 administered 13:37 (3 hours 22 minutes late) 3/20/20 administered 10:41 (26 minutes late) 3/21/2020 administered 10:57 (42 minutes late) 3/22/2020 administered 10:35 (20 minutes late) 3/23/2020 administered 10:31 (16 minutes late) 3/25/2020 administered 10:37 (22 minutes late) 3/26/2020 administered 10:50 (35 minutes late) 3/28/2020 administered 11:03 (48 minutes late) 3/29/2020 administered 10:57 (42 minutes late). 4/1/2020 administered 10:30 (1 hour 15 minutes late) 4/2/2020 administered 10:48 (33 minutes late) 4/4/2020 administered 12:53 (2 hours 38 minutes late) 4/5/2020 administered 11:26 (1 hour and 11 minutes late) 4/6/2020 administered 10:55 (40 minutes late) 4/7/2020 administered 10:48 (33 minutes late) 4/8/2020 administered 11:13 (58 minutes late) 4/9/2020 administered 11:23 (1 hour and 8 minutes late) 4/10/2020 administered 10:27 (12 minutes late) 4/13/2020 administered 10:46 (31 minutes late) 4/14/2020 administered 11:40 (1 hour 25 minutes late) 4/15/2020 administered 11:37 (1 hour 22 minutes late) 4/17/2020 administered 12:28 (2 hours 13 minutes late) 4/18/2020 administered 12:17 (2 hours 2 minutes 4/18/2020 administered 12:17 (2 hours 2 minutes late) 4/19/2020 administered 12:28 (2 hours 13 minutes late) 4/20/2020 administered 11:32 (1 hour 17 minutes late) 4/21/2020 administered 13:20 (3 hours and 5 minutes late) 4/22/2020 administered 13:30 (3 hours 15 minutes late) 4/23/2020 administered 15:59 (5 hours 44 minutes late) 4/24/2020 administered 11:25 (1 hour 10 minutes late) 4/25/2020 administered 13:42 (3 hours 27 minutes late) 4/27/2020 administered 14:34 (4 hours 19 minutes late) 4/28/2020 administered 14:41 (4 hours 26 minutes late) 4/29/2020 administered 11:16 (1 hour 1 minute late) 4/30/2020 administered 13:21 (3 hour 6 minutes late) The surveyor noted a physician order [REDACTED]. The times of adinistration are 0900 and 2100 hours. The medication was administered beyond the 1 hour window of administration time which was inconsistent with the facility's Medication Pass policy. The incorrect administration times are as follows: 2/1/2020 administered 11:42 (1 hour 42 minutes late) 2/2/2020 administered 12:08 (2 hours 8 minutes late) 2/3/2020 and 2/4/2020 administered 10:26 (26 minutes late) 2/5/2020 administered 11:07 (1 hour 7 minutes late) 2/8/2020 administered 10:23 (23 minutes late) 2/9/2020 administered 10:34 (34 minutes late) 2/10/2020 administered 10:24 (24 minutes late) 2/10/2020 administered 22:56 (56 minutes late) 2/11/2020 administered 12:10 (2 hours 10 minutes late) 2/12/2020 administered 10:12 (12 minutes late) 2/13/2020 administered 10:44 (44 minutes late) 2/14/2020 administered 10:40 (40 minutes late) 2/15/2020 administered 10:38 (38 minutes late) 2/16/2020 administered 14:41 (4 hours 41 minutes late) 2/17/2020 administered 10:20 (20 minutes late) 2/18/2020 administered 10:21 (21 minutes late). 4/1/2020 administered 10:30 (1 hour 15 minutes late) 4/2/2020 administered 10:48 (33 minutes late) 4/4/2020 administered 12:53 (2 hours 38 minutes late) 4/5/2020 administered 11:26 (1 hour and 11 minutes late) 4/6/2020 administered 10:55 (40 minutes late) 4/7/2020 administered 10:48 (33 minutes late) 4/8/2020 administered 11:13 (58 minutes late) 4/9/2020 administered 11:23 (1 hour and 8 minutes late) 4/10/2020 administered 10:27 (12 minutes late) 4/13/2020 administered 10:46 (31 minutes late) 4/14/2020 administered 11:40 (1 hour 25 minutes late) 4/15/2020 administered 11:37 (1 hour 22 minutes late) 4/17/2020 administered 12:28 (2 hours 13 minutes late) 4/18/2020 administered 12:17 (2 hours 2 minutes 4/18/2020 administered 12:17 (2 hours 2 minutes late) 4/19/2020 administered 12:28 (2 hours 13 minutes late) 4/20/2020 administered 11:32 (1 hour 17 minutes late) 4/21/2020 administered 13:20 (3 hours and 5 minutes late) 4/22/2020 administered 13:30 (3 hours 15 minutes late) 4/23/2020 administered 15:59 (5 hours 44 minutes late) 4/24/2020 administered 11:25 (1 hour 10 minutes late) 4/25/2020 administered 13:42 (3 hours 27 minutes late) 4/27/2020 administered 14:34 (4 hours 19 minutes late) 4/28/2020 administered 14:41 (4 hours 26 minutes late) 4/29/2020 administered 11:16 (1 hour 1 minute late) 4/30/2020 administered 13:21 (3 hour 6 minutes late). There was no documented evidence in the medical record that Resident #4 experienced a negative reaction/harm from the late administration of the medications. NJAC 8:39-27.1(a)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #NJ 394 Based on interview and record review, it was determined that the facility failed to transfer a resident in a timely manner after the resident requested a hospital transfer for right hip pain. This deficient practice was identified for 1 of 1 residents reviewed for a fall (Resident #1) and was evidenced by the following: Resident #1 was admitted to the facility on [DATE] with muscle weakness, difficulty in walking, diabetes with [MEDICAL CONDITION] and a [MEDICAL CONDITION] in place. The resident's 3/10/2020 Resident Assessment Instrument, an assessment tool, identified the resident as having moderate cognitive impairment, requiring extensive of 1 person assistance for transfers and ambulation, and no impairments with upper/lower extremities. The surveyor reviewed Progress Notes in the medical record and observed that on 4/17/2020 at 3:30 PM the resident had an unwitnessed fall in his/her room while trying to self-transfer to the wheelchair from the bed. The Certified Nursing Assistant (CNA) found the resident on the floor next to the wheelchair and notified the Licensed Practical Nurse (LPN). The LPN assessed the resident and the CNA and LPN placed the resident back in bed. At that time, the resident complained of right hip pain and requested to go to the hospital. After placing the resident back in bed, the LPN told the resident she would return and left the room. There was no documented evidence that she returned to the resident's room. When interviewed on 8/18/2020 at 12:15 PM, the surveyor asked the LPN why she did not return to the resident's room. The LPN said I can't remember what happened and we were in the middle of a shift change when this happened. The LPN further stated she informed the Advanced Practice Nurse (APN), the Registered Nurse (RN) and the resident's family of the fall. The LPN stated she filled out the Incident report and left the facility. The surveyor reviewed the incident report and observed the LPN noted no injuries noted but also wrote on the Initial Event Documentation form that the resident was complaining of hip pain and wanted to go to the hospital. The surveyor reviewed an RN Narrative assessment dated [DATE] at 5:12 PM that noted Resident wanted to go to the hospital for hip pain - did not want to have x-ray done here - family called the police - resident sent to (name of hospital) at his/her family request. On 8/18/2020 at 12:35 PM the surveyor interviewed the Director of Nursing (DON) and asked why the resident was not transferred when the fall occurred at 3:30 PM. The DON stated, We were waiting for the transport service to pick the resident up. There was no documentation that the facility had either called for a transport or that they were planning on transferring the resident to the hospital after the resident's fall. The surveyor reviewed the facility policy Falls Management and Prevention which included 8. If injury, severe pain or abnormal assessments observed, call 9-1-1 for transfer. The surveyor reviewed the facility policy Accident - Incidents dated 8/2019 and observed under 4. Medical Management, sub part 4.4. If the injury appears serious or questionable, the individual will be sent to the hospital via ambulance or 911 as needed. The surveyor reviewed the facility policy Discharge - Transfer/Discharge Process which indicated 3. A resident's physician will determine if a transfer to the hospital is required for an urgent medical need, and 7. Should a resident be transferred or discharged for any reason, the receiving facility or provider will be provided with all needed information to ensure a safe and effective transition of care, including but not limited to emergency contact information, advance directive information, pertinent lab result, medication regimen, and other information regarding the residents current medical/physical/psychosocial condition. The surveyor was unable to find a transfer form and when asked for a copy of the transfer form, the facility was unable to produce one. After being sent to the hospital, the resident did not return to the facility. NJAC 8:39 27.1(a)