STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-WEST DEPTFORD	550 JESSUP ROAD WEST DEPTFORD, NJ 08066

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ 562 Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to initiate or develop a care plan for 1 of 7 Residents (Resident #3) reviewed for comprehensive care plans. This deficient practice was evidenced by the following: According to the Progress Notes (PN), Resident #3 was admitted to the facility with [DIAGNOSES REDACTED]. A review of the Order Listing Report revealed an order, dated 02/02/2020, to Cleanse open area to sacrum with normal saline, apply wound gel, cover with bordered gauze every evening shift A review of a PN, dated 02/02/2020, revealed that a second day skin evaluation had been completed and included a 2 cm (centimeter) x 2 cm open area to the sacrum with pink and yellow tissue and a 3 cm x 3 cm dark purple discoloration of the open area's surrounding tissue. A review of Resident #3's care plan did not include a focus area for the sacral wound. During an interview on 08/12/2020 at 1:37 PM, with the Registered Nurse Unit Manager (RN/UM #2), the surveyor requested her to review the care plan for Resident #3. RN/UM #2 said I don't see one (care plan) myself for the sacral wound. RN/UM #2 added that there should have been a care plan for the sacral wound. During an interview on 08/13/2020 at 2:14 PM, the Director of Nursing (DON) said that on admission we start the care plan process and staff should put any skin findings on the care plan. The DON stated then the RN/UM would review the care plan the next day and add information to the care plan as needed. At 2:25 PM the DON said there should have been a care plan on admission as Resident #3 came into the facility with the wound. A review of a facility policy titled, Skin Practice Guide with an issue date of 01/2013, showed under the Phase 2: Plan, Comprehensive Care Plan section, based upon findings of . and other evaluations, the patient's initial plan of care is updated or a comprehensive care plan is developed . NJAC 8:39-27.1(a)
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ 624 Complaint #: NJ 442 Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to adequately manage pain for a resident who exhibited signs and symptoms of pain from an injury of unknown origin. This deficient practice was identified for Resident #1, 1 of 2 sampled residents reviewed for pain and was evidenced by the following: According to the Medical Practitioner Note, dated 10/29/19, Resident #1 was admitted to the facility with medical [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set (MDS), an assessment tool, dated 10/29/19, revealed Resident #1 had severe cognitive impairment and exhibited behaviors of inattention, disorganized thinking and delusions. The MDS further revealed that the resident required extensive assist with Activities of Daily Living and was non-ambulatory. Review of Resident #1's Care Plan with a closed date of 12/06/19, revealed the following: (1) A Focus that the resident has swollen left leg with an initiation date of 12/04/19. The Goal reflected Cause will be identified and resolved by review date with one intervention of Labs and diagnostic test per MD orders; (2) A Focus that the resident has Pain (joints) evidenced by verbal and nonverbal cues related to disease process ([MEDICAL CONDITION]), with an initiation date of 10/24/18. The Goal reflected Will express that pain management is within acceptable limits. Pain goal is no pain with interventions to Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc., Administer pain medication per physician orders, Encourage/Assist to reposition frequently to position of comfort, Implement non-pharmacological interventions (positioning) as needed and as tolerated, and observe for effectiveness, and Notify physician if pain frequency/intensity is worsening or if current [MEDICATION NAME] regimen has become ineffective. Review of the Order Summary Report for Active Orders as of 12/01/19 revealed an order dated 05/07/19 for [MEDICATION NAME] Arthritis Pain Tablet Extended Release 650 mg (milligrams) ([MEDICATION NAME] ER) one time a day for pain management and an ordered dated 04/01/19 for Tylenol Tablet ([MEDICATION NAME]) 650 mg by mouth every four hours as needed (PRN) for pain. The surveyor reviewed Progress Notes (PN) for Resident #1 as follows: Review of a Skilled Nursing PN dated 12/03/19 at 11:46 AM documented by Nurse Supervisor Licensed Practical Nurse #1 (LPN), revealed Resident #1 was calling out this am from (his/her) room for help. The PN reflected that the CNA (Certified Nursing Assistant) went to assist resident and resident complained of pain to (his/her) left leg. CNA noted that resident's left thigh appeared swollen. The PN revealed LPN #1 and the RN (registered nurse) went to assess the resident. LPN #1 documented, Some swelling noted from knee to groin. Skin warm but same as right thigh. No redness noted. The PN further revealed that the PA (physician assistant) was made aware, saw the resident and ordered an X-ray of the left knee, with two views for pain/swelling. The PN indicated that the family member was in and made aware. Resident remained in bed. Will continue to monitor. The PN did not indicate that Resident #1 had been assessed for pain. Review of the 12/2019 Electronic Medication Administration Record (eMAR) revealed that the PRN Tylenol was not documented as having been administered on 12/03/19. Review of the Medical Practitioner Note dated 12/03/19 at 8:55 PM documented by a Physician's Assistant (PA), revealed Chief Complaint/Nature of Presenting Problem: Left knee pain. The Medical Practitioner Note reflected Nursing requests I see the patient today for evaluation of left knee pain. Nursing reports patient started complaining of pain this morning. No recent trauma noted and patient confirms (his/her) knee is bothering (him/her). Tells me that (he/she) can't move it. The Medical Practitioner Note reflected Plan: Left knee pain with decreased ROM (range of motion): check X ray of the left knee. Cont (continue) with Tylenol for pain and monitor. The Medical Practitioner Note was documented at 8:55 PM and did not reveal the time when Resident #1 was assessed for left knee pain Review of the electronic Clinical Physician order [REDACTED]. Review of the Radiology Results Report dated 12/03/19 timed at 3:56 PM for the left knee, revealed Results: the knee joint is in alignment, but there is narrowing of the joint space due to modest [MEDICAL CONDITION] changes. There is modest [MEDICAL CONDITION] spurring. No fracture or dislocation is seen. No joint effusion is seen. Conclusion: modest [MEDICAL CONDITION] of the left knee. Review of a Skilled Nursing PN dated 12/04/19 at 15:11 (3:11 PM) signed by LPN #1, Swelling continues to left thigh. No redness in temperature noted. No complaints of pain noted all shift. Review of a General PN dated 12/05/19 at 07:25 AM documented by LPN #2, revealed patient c/o (complained of) left thigh pain during diaper change. while assessing left leg noticed, red/purple bruising in pelvic area and [MEDICAL CONDITION] left thigh down to knee. PRN Tylenol given at 6:45 AM. Report given to next shift Nurse. Review of the 12/2019 eMAR revealed the PRN Tylenol was not documented as administered on 12/05/19 at 6:45 AM. The PN did not include a follow up assessment of Resident #1's pain level. LPN #2 recently resigned from the facility and was unavailable for interview. Review of a General PN dated at 12/05/19 12:27 PM, documented by RN #1, revealed Resident noted with bruise at his/her pubic bone, extending to his/her left thigh. Rt (resident) denies pain to the site at this time. (His/her) left thigh has been swollen and (he/she) c/o knee pain yesterday (12/4/19). X-ray was negative yesterday (12/04/19). Bruise measured. It is purple and yellow in appearance. MD and family informed. The surveyor reviewed an undated Skin Alteration Record for Resident #1 completed by RN #1, which revealed Type of Alteration: Other Bruise, Date: (blank), Measurements: Length 8 cm

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 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Width: 16 cm, Description of Alteration: Intact skin, color purple, green, yellow, Skin Surrounding Alteration: [MEDICAL CONDITION] - swelling, and Pain at site: No. The surveyor reviewed a Pain/Pain Assessment in Advanced Dementia (PAINAD) Evaluation - V2 (Pain Evaluation) dated 12/05/19 at 12:05 PM completed by RN #1. The Pain Evaluation revealed the Scale Used was a verbal descriptor and the Most Recent Pain Level provided by patient was 0. RN #1 no longer works at the facility and was unavailable for interview. Review of a Skilled Nursing PN dated 12/05/19 at 2:57 PM documented by LPN #1, revealed Notified by 11-7 nurse that resident had bruising noted to (his/her) pubic area. This nurse & unit manager examined resident & noted purple & yellow-green bruising to (his/her) pubic area & upper thigh with increased swelling. No change in temperature noted. PA notified and saw resident. STAT x-rays ordered for left femur, pelvis/hip, 2 views. Family member in & made aware. The Skilled Nursing PN did not indicate if Resident #1 was assessed for pain. Review of the handwritten Physician/Prescriber Orders, documented by the PA, revealed an order dated 12/05/19 at 12:50 PM for a STAT x-ray with two views of the left hip/pelvis and femur. Review of the Radiology Results Report dated 12/05/19 timed at 4:52 PM for the left hip/pelvis reflected the Reason for Study was for pain in left hip and pain in left thigh. The Radiology Results Report revealed, Results: Acute, mildly displaced intertrochanteric [MEDICAL CONDITION] femur. Severe [MEDICAL CONDITION] of the hip, no foreign body. Conclusion: Intertrochanteric [MEDICAL CONDITION] femur as described. The Radiology Results reflected an Addendum: Comminuted impacted [MEDICAL CONDITION] LEFT femoral neck and trochanteric region again noted. There is diffuse bone demineralization. The Radiology Results further revealed Results: Acute, mildly displaced intertrochanteric [MEDICAL CONDITION] femur. Severe [MEDICAL CONDITION] of the hip, no foreign body, moderate [MEDICAL CONDITION] of the knee. Conclusion: Intertrochanteric [MEDICAL CONDITION] femur as described. Review of a Medical Practitioner Note dated 12/05/19 at 9:32 PM completed by the PA, revealed Chief Complaint/Nature of Presenting Problem: Left thigh swelling, bruising, and pain. The Medical Practitioner Note reflected, Request I see the patient today for evaluation of left thigh swelling and bruising. They state the patient just noted to have bruising to the let (sic) thigh with swelling and bruising noted to the puibic (sic) area. No new fall or injury noted but patient complains of pain to the left leg, pointing to the thigh . These symptoms of swelling to the left thigh started two days ago but bruising was only noted this morning. The Medical Practitioner Note did not indicate the time Resident #1 was assessed for left thigh swelling, bruising and pain. The note further indicated patient complains of pain to the left leg, pointing to the thigh. Review of the 12/19 eMAR revealed that the PRN Tylenol was not documented as having been administered on 12/05/19. During an interview with the surveyor on 08/13/20 at 10:58 AM, LPN #1 stated she was familiar with Resident #1. LPN #1 stated that the resident could tell you if he/she had pain. The surveyor inquired, who was the RN who completed the assessment on 12/03/19 at 11:46 AM. LPN #1 stated that it was probably RN #1 Unit Manager who no longer works here. LPN #1 stated that the resident's assessment, including pain, would have been documented in the progress notes by RN #1 and RN #1 would have notified the physician for further orders. LPN #1 stated that either RN #1 Unit Manager or I could have given pain medication to the resident. The surveyor inquired, was Resident #1's pain ever addressed. LPN #1 told the surveyor, I don't remember. LPN #1 further stated that when assessing a resident's pain, she would use the pain scale or face scale if the resident was confused. She would then administer the pain medication to the resident, document in the eMAR the time the medication was given and the pain score. LPN #1 stated, I would reevaluate the resident to see if the medication was effective and document the medication's effectiveness and the new pain score in the eMAR. RN #1 no longer works at the facility and was unavailable for interview. During an interview with surveyor on 08/13/20 at 11:32 AM, the surveyor and PA reviewed the 12/05/19 Medical Practitioner Note. The PA stated that staff called her in the AM and told her that Resident #1 had left thigh bruising and swelling. The PA stated she evaluated the resident immediately because she was worried. The PA went on to say that the resident had bruising and swelling in the pubic area and had no falls and the bruising started that morning The PA stated that the swelling was noted two days earlier when she saw Resident #1 on 12/03/19. The PA stated, I'm trying to remember, no bruising noted on 12/03/19. The resident couldn't move the left leg at all at the hip (on 12/05/19). The PA went on to say, because of the swelling/bruising of the thigh and pelvis, I ordered a STAT x-ray. The PA stated that Resident #1 was not horrifically in pain but in pain. The resident had a Tylenol order, so I ordered Tylenol to be given. The resident had definite swelling, but the resident was not in pain. The PA stated that she assumed Tylenol had been given, but I'm not sure if it was given. I'd have to look at the MAR. She stated that the family was not there when she saw the resident and that the family came in later. The facility provided the surveyor with a copy of an Incident Report - Patient Involved (Incident Report) dated 12/06/19 for Resident #1. The Incident Report revealed Date of Incident: 12/5/19 at 4:52 PM, Center Action: Patient's Care. Was patient taken to a hospital? Yes. If yes, Date: 12/5/19 5:30 PM. The surveyor reviewed the Statements of staff interviewed on 12/05/19 by RN #1 in the 12/06/19 Incident Report, which revealed the following: interviewed Resident #1. Resident stated that he/she was not currently in pain. CNA #3: On Tuesday 12/3/19, the resident's leg was swollen and the resident complained of the knee hurting. LPN #1: I was resident's nurse on 12/4 and 12/5. Resident said the knee was hurting. RN #1 (Interview completed by LPN #1): The resident denies pain on 12/5 but did complain of left knee pain the other day and the x-ray was negative. The surveyor reviewed the Statements of staff interviewed by RN #1 on 12/06/19 regarding the 12/06/19 Incident Report, which revealed the following: CNA #3: On 12/03/19 resident complained of knee pain in the morning and the nurses knew about it. CNA #1: I told LPN #1 that on Wednesday (12/04/19) resident was having leg swelling and pain when turning resident during care. Resident did not complain of pain with transfers, but did complain of left leg pain during care when turned in bed. On 12/05/19 resident remained in bed because the leg was more swollen and had a bruise there. CNA#2: Resident complained of pain on 12/04/19 while sitting in the wheelchair. Resident did not want a shower just wanted to go to bed. CNA #4: On Wednesday (12/04/19) during 11-7 shift, resident complained of pain with turns during care. I informed LPN #2 and LPN#2 stated that an x-ray of the knee was negative and maybe they need to get an x-ray of the pelvis too. LPN #1: I helped to roll resident yesterday (12/05/19) for resident's last change and the resident winced a little and kept apologizing. I told the resident not to apologize for it hurting. Resident never yelled out or cried out even when palpating the area. Other than that, the only thing resident said was hurting was the knee on 12/03/19 and we got an x-ray for it. LPN #2: Received report from 3-11 nurse that knee x-ray was negative and that the leg was still swollen. I told the CNA to get me at some point during the shift when the resident was changed to assess the resident. At 6:45 AM, I assessed resident's bruising and swelling. I palpated the area and asked if it hurt. The resident said no, just the knee. (12/05/19) PA: On 12/05/19, I palpated the bruised and swollen area and the resident did not exhibit any signs/symptoms (s/s) of pain or distress. I ordered STAT x-rays of the left hip. I wanted to evaluate the resident in-house rather than send them to the ER, where it could cause a resident with dementia, anxiety and stress while in an unfamiliar place and being cared for by strangers. The surveyor reviewed the PNs for Resident #1 from 12/01/19 through 12/05/19. The PNs did not reveal any non-pharmacological interventions the staff tried with Resident #1 prior to the administration of a pain medication. Review of the 12/2019 eMAR revealed that the PRN Tylenol was not documented as having been administered from 12/01/19 through 12/05/19. A further review of the 12/2019 eMAR revealed that Resident #1's pain level was evaluated every eight hours (at 6:00 AM, 12:00 PM and 10:00 PM) from 12/01/19 through 12/05/19. The surveyor noted that each nurse documented 0 (no pain) for 14/15 entries. On 12/05/19 at 10:00 PM, the nurse documented 3. The surveyor reviewed the 12/2019 electronic Treatment Administration Record (eTAR) which revealed that Resident #1 received a body audit every evening shift for skin observation from 12/01/19 through 12/05/19. The surveyor noted that each nurse documented a check mark character. On 12/05/19 during the evening shift, the nurse documented a 3. During an interview with the surveyor on 08/13/20 at 1:25 PM, the RN Unit Manager #2 stated that when a resident exhibits signs and symptoms of pain, the nurse should offer non-pharmacological interventions like repositioning. The nurse would document resident's pain in the progress notes together with the non-pharmacological interventions offered to the resident and if a pain medication was administered. The RN Unit Manager #2 stated that when a pain medication was administered, the nurse will document the administration of the medication together with pain scale in the eMAR and follow up to ensure that the pain medication was effective. During an interview with the surveyor on 08/13/20 at 2:15 PM, the Director of Nursing (DON) stated that she expected the nurses to document anything that was out of the norm for a resident in the PNs. During a post survey telephone interview with the surveyor on 08/18/20 at 1:30 PM, the DON stated LPN #2 recently resigned from the facility and RN #1 left on medical leave and did not return. The DON stated that she expected the nurses and PA to document an approximate time in their progress notes when a resident assessment was completed. The DON said she expected that the nurses would offer non-pharmacological interventions such as repositioning, prior to administering a pain medication. The DON said she expected that the non-pharmacological interventions would be documented in the PN and if ineffective, that a pain medication was administered. The DON further stated that she expected the nurses to document in the eMAR when a pain medication was administered with the pain level or non-verbal expressions such as grimacing and moaning and expected the

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F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) nurse to follow up after a pain medication was administered to reassess the resident's level of pain and determine if the pain medication was effective. Review of the facility's Medication and Treatment Administration Guidelines policy, updated 03/2018, revealed Medications and treatments administered are documented immediately following administration or per state specific standards, Administration of PRN medications include the specific reason for the medication, any non-pharmacological interventions utilized, and the medication effectiveness, and The licensed nurse is responsible for validating documentation is completed for any medication administered during the shift. Review of the facility's Documentation policy, updated 07/2017, revealed the Purpose was To provide general guidelines regarding the documentation of care provided by nursing personnel. The Guidelines revealed Patient clinical records include handwritten documentation as well as data entered into an electronic health record (EHR). Review of the facility's Pain Practice Guide, issued 11/2011, revealed Individual pain rating scales are completed as part of the admission screen and pain evaluations, and findings are documented daily on the Medication Administration Record (MAR), including identification of the type of scale used and Patients are evaluated daily for evidence of pain. Pain evaluation is also completed before and after PRN pain medication administration. The patient's pain scale and score is recorded on the Medication Administration Record (MAR). N.J.A.C. 8:39 - 27.1 (a)