STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315528	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JEWISH HOME FOR REHABILITATION AND NURSING, THE	1151 WEST MAIN STREET FREEHOLD, NJ 07728

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** Complaint NJ 5 Based on observation, interview, and record review, it was determined that the facility failed to: a.) document the administration of medications on the electronic Medication Administration Record (eMAR) and b.) document oxygen level saturations on the electronic Treatment Administration Record (eTAR) for 1 of 6 residents reviewed (Resident #6) for professional 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. According to the facility Admission Record, Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/15/19, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which showed an intact cognition. A review of the resident's individualized care plan, dated 10/09/19, indicated that the resident was alert and oriented and made care choices that may not always be in my best interest like refusing medications. Interventions included to educate the resident about possible outcomes of not complying with treatment care. A review of the December 2019 Order Summary Report (OSR) revealed the following physician's orders [REDACTED]. Hold if the systolic blood pressure was less than 100 units of millimeters of mercury (mm/Hg), dated 10/22/19; and [MEDICATION NAME] (a medication used to treat high blood pressure) 25 mg; give one tablet two times a day for high blood pressure. Hold for a systolic blood pressure less than 100 mm/Hg, dated 10/22/19. A review of the corresponding December 2019 electronic Medication Administration Record (eMAR) revealed blanks (not signed out as administered) for the 12/19/19 5:00 PM doses of [MEDICATION NAME] Fiber Packet, [MEDICATION NAME] plus D3, and [MEDICATION NAME]. The eMAR also revealed blanks for the corresponding blood pressures. Further review of the December 2019 OSR indicated a PO, dated 07/09/19, to check oxygen saturation levels every shift. The OSR also included a PO for a fall precaution to check bed in low position every shift. A review of the corresponding December 2019 electronic Treatment Administration Record (eTAR) revealed on 12/19/19 during the evening shift (3-11), that neither the bed was signed off that it was checked to be in the lowest position nor that oxygen saturation levels were recorded. A further review of the eTAR, indicated that during the 12/19/19 night shift (11-7), the resident's oxygen saturation levels were within normal level. A review of the December 2019 electronic Progress Notes (ePN), had not reflected that the resident was not in the facility or refused medications. During an interview with the surveyor on 08/13/2020 at 8:50 AM, the Licensed Practical Nurse (LPN) stated that during medication administration, the nurse first took any vital signs such as blood pressure that corresponded with any hold parameters of a medication. After the nurse administered the medications, the nurse signed in the eMAR that the medication was administered. If the medication was not administered, then the nurse signed and documented why the medication was not administered. During an interview with the surveyor on 08/13/2020 at 9:17 AM, the LPN/Unit Manager (UM), confirmed the LPN's medication administration procedure. The LPN/UM stated that a blank on the eMAR indicated that the resident had not received the medication or that the nurse forgot to sign that the medication was administered. The LPN/UM confirmed that there should be no blanks on the eMAR and that the nurse documented in the eMAR the reason why the medication was not administered, which automatically generated an ePN. During a telephone interview with the surveyor on 08/13/2020 at 9:49 AM, the Consultant Pharmacist (CP) stated that once a month, she reviewed each resident's eMAR to ensure that medication was timed appropriately, administered as ordered, and transcribed correctly. The CP stated that if there were blanks on the eMAR, she would report that to the facility. The CP further stated that blanks on the eMAR indicated that the medication was not administered or that the nurse forgot to sign. During an interview with the surveyor 08/13/2020 at 10:10 AM, the Director of Nursing (DON) stated that nurses signed the eMAR after they administered medications. If the resident refused a medication or had not received a medication, the nurse signed on the eMAR that the medication was not administered and the reason why was documented. The DON stated that an ePN was automatically generated from that. If during a review of the eMAR, a blank was noted, then she needed to speak with that nurse as to why there was a blank on the eMAR. The nurse would be educated on documentation or administration of medications. A blank on the eMAR meant either the medication was not administered or that the nurse forgot to sign. At that time the surveyor reviewed the December 2019 eMAR and eTAR with the DON. The DON acknowledged the blanks for 12/19/19. The DON stated that the nurse was no longer employed by the facility but she would look to see if there was any additional information. On 08/13/2020 at 12:53 PM, the DON, in the presence of the Administrator and the Regional Clinical Nurse, stated that there was no medication error investigation completed for 12/19/19 for Resident #6. The DON continued that there should not have been a blank on the eMAR and eTAR, and no adverse consequences occurred if the resident had not received the medication. A review of the facility's Administering Medications policy, dated revised 2012, included that medications must be administered in accordance with the PO, including any required time frame. The policy also included that the individual administering the medication must initial the resident's eMAR on the appropriate line after giving each medication and before administering the next ones. If a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the eMAR space provided for that drug and dose. NJAC 8:39-11.2(b)
F 0842 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint NJ 5 Based on observation, interview, and record review, it was determined that the facility failed to maintain medical records for a discharged resident who received Restorative Nursing Program (RNP) services while residing in the facility, in accordance with acceptable standards of practice for 1 of 5 discharged residents (Resident #6) reviewed. This deficient practice was evidenced by the following: According to the facility Admission Record, Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the the most recent Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/15/19, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated an intact cognition. Further review of the

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 0842 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	(continued... from page 1) MDS, reflected that the resident used a wheelchair to ambulate. The MDS reflected in Section O. Therapies, that the resident received no therapies and was not participating in a RNP. A comparison to the Admission MDS, dated [DATE], reflected in Section O, Therapies, that the resident received both Occupational Therapy (OT) and Physical Therapy (PT) which started on 07/09/19. A review of the resident's individualized care plan, dated 08/05/19, indicated that the resident has an activities of daily living self-care performance deficit with regards to impaired mobility. Interventions had not included any therapies or RNP. A review of the PT Treatment Encounter Note, dated 07/22/19, reflected that the resident would begin the RNP with the resident's Certified Nursing Aide (CNA) for ambulation using a rolling walker to continue strengthening and ambulation. The family brought in a rolling walker and it was kept in the resident's room. A review of the resident's RNP form, dated 07/22/19, reflected that the resident would ambulate twenty-five feet with a rolling walker daily as tolerated, to maintain ambulation distances and current level of function. The RNP form was signed off by the resident's CNA, CNA #1. Review of the CNA Task records dated July through December 2019, reflected the last documented day Resident #6 walked in the corridor was on 09/13/19. During an interview with the surveyor on 08/12/2020 at 12:58 PM, the Interim Rehab Director stated that she had only been at the facility since April or May of this year. The Rehab Director stated that last summer, the facility had switched rehabilitation companies. The Rehab Director stated there was no interruption of services, and that she was unfamiliar with the resident since he/she no longer resided in the facility. The Rehab Director stated that she would look into Resident #6. During an interview with the surveyor at 08/12/2020 at 2:53 PM, the Licensed Nursing Home Administrator (LNHA) stated that Resident #6 was receiving therapy from the previous rehabilitation company and that he was unable to determine at that time why Resident #6's therapy stopped. The LNHA stated that CNA #1 was no longer employed with the facility. During an interview with the surveyor on 08/13/2020 at 10:40 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that rehabilitation staff educated the resident's CNA on the RNP. The CNA signed off in the Task section of the electronic medical record (eMR) that they completed the therapy for that day. If the resident declined on the RNP, then a request for the resident to be screened by therapy was made. During an interview with the surveyor on 08/13/2020 at 11:10 AM, the resident's CNA, CNA #2 stated that she could not recall if the resident received RNP. The CNA stated that the RNP was documented in the Task section of eMR. During an interview with the surveyor on 08/13/2020 at 11:50 AM, the Regional Clinical Nurse stated that the resident had no decline in functional status so he/she was not screened again by therapy. During a follow-up interview on 08/13/2020 at 12:41 PM, the Interim Rehab Director informed the surveyor that RNP was usually performed with the resident three to five times a week based on the resident's tolerance. If the CNA saw a decline with the resident, the CNA would have communicated it to rehabilitation staff. The Rehab Director stated that rehabilitation staff did not usually put a stop date on the RNP. The RNP continued until the resident declined or refused, but the length was dependent on the resident. On 08/13/2020 at 12:53 PM, the LNHA in the presence of the surveyor and administration staff, stated that he could not provide the surveyor with any additional information regarding Resident #6's RNP services received after 09/13/19. The LNHA stated that the current management company and rehab company took over the facility on 08/19/19. A review of the facility's Restorative Nursing Services, dated revised March 2018, did not include when a resident stopped receiving restorative rehabilitation. NJAC 8:39-27.1(a)