STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation, interview and record review, it was determined that the facility failed to maintain clean and sanitary resident rooms for 2 of 23 rooms reviewed, (Residents #60 and #100). This deficient practice was evidenced by the following: During the initial tour of the facility on 03/03/20 at 11:07 AM, the surveyor observed Resident #60 lying in bed. The resident did not respond to the surveyor during this or on subsequent surveyor visits. The surveyor observed that the resident's oxygen concentrator had an accumulation of dust on its surface. Along the floor to wall juncture behind the head of the resident's bed, the surveyor observed a television remote control and packaging from a small piece of medical equipment. There was also a visible white powder along the area where the cove molding met the floor. On the pole and base of the resident's tube feeding pole, there were dried brown spills that were consistent with the color of the resident's tube feeding formula. The surveyor observed these same conditions on room visits on 03/04/20 at 12:32 PM and 03/05/20 at 9:28 AM. On 03/04/20 at 1:22 PM, the surveyor observed Resident #100 in bed. At that time, Resident #100 had two family members visiting, who stated that the resident was almost always in bed. The surveyor observed that the brown-colored laminate of the bed's footboard was torn off on one side. The particleboard on the footboard was exposed and there was black duct tape holding the rest of the laminate in place. The resident's headboard was slanted toward his/her head. The back surface of the headboard had a visible accumulation of dust on its surface. Underneath the resident's bed, near the head of the bed, there were small black disks on the floor. On 03/05/20 at 12:16 PM, the surveyor toured the unit with the Housekeeping Director (HD). At that time, the surveyor pointed out the dust on Resident 100's slanted headboard, which the HD could see and feel. The HD agreed that the headboard was dusty and said he would get housekeeping to take care of it. The surveyor showed the HD the delaminated footboard that was wrapped in duct tape. The HD stated that the condition of the footboard was such that it would not be easily cleanable. Finally, the surveyor pointed out the small black disks beneath the resident's bed. The HD stated that they tend to fall off when the head of the bed gets raised and lowered. The HD indicated that the facility was looking to replace some of the mattresses that shed the black rubber disks. On 03/05/20 at 12:26 PM, the surveyor showed the HD the room where Resident #60 was in bed. The resident's oxygen concentrator was visibly covered in dust. The HD stated that it was housekeeping's responsibility to clean the oxygen concentrators and that he would get someone to attend to it right away. The surveyor pointed out the area behind the bed, along the floor to wall juncture, where there had been a television remote control and a piece of trash for three days. At that time, the remote was placed on the resident's bedside table and the packaging for the medical equipment had been removed. The white powder that was observed along the floor to wall juncture was still visible. The HD stated that it should have been cleaned. The surveyor pointed out the brown, dried drips on the tube feeding pole. The HD stated that the dried spills could be cleaned during Carbolization (thorough cleaning) of the room. On 03/05/20 at 12:45 PM, the HD provided the surveyor with two in-services given to the housekeeping staff on 01/15/20. One described the cleaning of rooms for residents who were discharged and not expected to return to the facility. The other referred to infection control while cleaning rooms. The HD also stated that the rooms were Carbolized once a month. According to the instructions on the Carbolization Form, nursing was requested to have the residents in the room out of bed by 10:00 AM. The HD provided the surveyor with the Carbolization scheduled for February/(NAME)2020. According to this schedule, the room where Resident #60 had been in bed during three days of observations, was to be Carbolized on 03/05/20. On 03/05/20 at 1:45 PM, the surveyor interviewed the housekeeper who was responsible for cleaning Resident #60's room. The housekeeper stated that she Carbolized the resident's room earlier in the week but did not know which day she had cleaned it. On 03/05/20 at 1:48 PM, the HD brought a new tube feeding pole for Resident #60. The surveyor reported to the HD that the housekeeper had stated she Carbolized Resident #60's room earlier this week instead of on 03/05/20 when it was scheduled to be cleaned. The HD stated that he would bring the proof of Carbolization to the surveyor that day. The HD stated that he would speak to the housekeeper and that she should have cleaned the room in accordance with the schedule. On 03/05/20 at 2:12 PM, the HD stated that he did not see a Carbolization sheet for Resident #60's room. The HD stated that he would have Resident #60's room thoroughly cleaned. NJAC 8:39-31.4 (a)(f)
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** Based on observation, interview and record review, it was determined that the facility failed to develop a comprehensive person-centered care plan for a resident who required incontinence care every two hours. This deficient practice was identified for Resident #73, 1 of 27 residents reviewed for comprehensive person-centered care plans, and was evidenced by the following: On 03/05/20 at 10:14 AM, the surveyor interviewed the Power of Attorney (POA) for Resident #73. At that time, the surveyor observed the resident asleep in a wheelchair. The POA stated that she visited the resident daily for six hours, as she wanted to ensure that Resident #73 was well-cared for. The POA further explained that Resident #73 had a physician's orders [REDACTED].#73 was often soaking wet. The POA stated that the resident was supposed to be changed every two hours. The surveyor asked the POA if Resident #73 had any skin breakdown. She stated that the resident's bottom was really bad. On 03/09/20 at 11:45 AM, the surveyor reviewed the Resident Concern Form (Concern Form) dated 02/06/20 filed by the POA for Resident #73. The Concern Form revealed the resident's Need for more frequent toileting, anticipation of needs and brief changes. 3-11 and 11-7 shift. The Resolution and Disposition portion of the Concern Form revealed to have staff provide two-hour checks for Resident #73. The Follow-up portion of the Concern Form, dated 02/07/20, indicated that the Social Worker and Unit Manager (UM) met with the POA to discuss the interventions and plan of care. The conclusion of the Follow-up indicated that the POA is happy with the plan and efforts. During a follow-up interview with the surveyor on 03/10/20 at 10:07 AM, the POA stated that she was here on Sunday for a total of six hours and the resident was not changed every two hours. The resident was not changed until around 5:50 PM. The POA stated, there was a puddle in the wheelchair the resident was sitting in. The POA further stated the urine-soaked through the two-inch cushion to the wheelchair seat and the resident's clothes were saturated. On 03/10/20 at 11:43 AM, the surveyor interviewed the Certified Nurse Aide (CNA) who usually cared for Resident #73. The CNA stated that she toileted or provided incontinence care for Resident #73 at least four times during her 7 AM- 3 PM shift. The surveyor inquired if there was a way that the CNA would document that the resident received incontinence care. She stated, there was a sheet for CNAs to document toileting before Resident #73 went to the hospital. The CNA did not know if the form was still being used. She stated that at least three out of five

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) days a week, she found that Resident #73 was really wet when she cared for the resident in the morning. On 03/10/20 at 11:50 AM, the Director of Nursing (DON) provided the surveyor with a folder that contained incontinence sheets for Resident #73. The forms were designed to be completed every two hours. The forms included columns for staff to check, which indicated if the resident was incontinent or dry and if the call light was in use. The forms were initiated on 02/06/20. They were completed accurately from 02/06/20 to 02/22/20 before the resident was sent to the hospital. Resident #73 was readmitted to the facility on [DATE]. After that date, there was a missing sheet from the folder for Saturday, 02/29/20, and the form from Sunday, 03/08/20, was incomplete. On 03/08/20, only four of the 12 daily checks were filled out by a staff member. There was no indication that Resident #73 had incontinence checks from 12:00 AM to 6:00 AM or from 4:00 PM to 10:00 PM. On 03/11/20 at 2:50 PM, the surveyor interviewed the Unit Manager (UM) regarding the missing and incomplete incontinence sheets for Resident #73. The UM stated that when she worked Monday through Friday, she would initiate the sheet and attach it to the 24-hour report. She stated that she didn't have a good answer for the incomplete and missing records. The surveyor reviewed the resident's medical record which revealed the following: The Face Sheet (an Admission Summary) reflected that Resident #73 was admitted to the facility with [DIAGNOSES REDACTED]. The Face Sheet further revealed the resident was hospitalized in February 2020 with a [DIAGNOSES REDACTED]. The MDS also revealed that the resident required extensive assistance for most activities of daily living including toileting, transferring and personal hygiene. The MDS reflected that Resident #73 was completely incontinent of bowel and bladder. The most recent physician's orders [REDACTED]. The Wound Care Assessment Sheet, dated 03/09/20, reflected that the resident had a moist, deep tissue injury to the sacrum/right buttock. The wound was treated with Zinc Oxide twice a day and was healing. The on-going Interdisciplinary Care Plan revealed an intervention for toileting listed under Potential for falls. The intervention, initiated on 04/12/19, reflected offer toileting frequently, before or after meals, activities, sleep. The Care Plan did not reveal an intervention for incontinence care. The Care Plan did not include the interventions that were discussed with the POA on 02/07/20 regarding checking the resident for incontinence every two hours. On 03/12/20 at 11:08 AM, the surveyor interviewed the DON regarding Resident #73's care plan which did not include every two-hour incontinence care. She stated that the care plan does include the intervention to reposition every two hours. The DON then stated, I guess they didn't spell it out. The surveyor reviewed the facility's policy Care Plans-Comprehensive, updated on 11/17/19. The policy revealed, Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. NJAC 8:39-11.2 (e)
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to a.) follow acceptable standards of nursing practice by administering the wrong medication to a resident and b.) consistently document the administration of an as-needed (PRN) medication in the electronic Medication Administration Record [REDACTED]. This deficient practice was identified for Resident #45, 1 of 27 residents reviewed for medication 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 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. According to the Admission Record, Resident #45 was admitted to the facility with [DIAGNOSES REDACTED]. The Admission Record further revealed that the resident was allergic to [MEDICATION NAME] (a form of narcotic medication used to treat pain). According to the Quarterly Minimum Data Set (MDS), an assessment tool dated 12/24/19, Resident #45 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A review of Resident #45's (NAME)2020 Order Summary Report (OSR) revealed a physician order, dated 02/17/20, for [MEDICATION NAME] 5-325 mg (milligram) two tablets orally every four hours PRN for severe pain. A review of Resident #45's (NAME)2020 eMAR indicated the resident was administered two [MEDICATION NAME] tablets on 03/07/20 at 1:33 PM. A review of Resident #45's Progress Notes revealed a Nurse Note (NN), dated 03/07/20, that the resident was given two tablets of Tylenol with [MEDICATION NAME] instead of two tablets of [MEDICATION NAME] 5-325 mg and that the resident was allergic to [MEDICATION NAME]. The NN further revealed Resident #45's physician was notified and ordered for the resident to be monitored. Resident #45's progress notes also revealed that the resident was monitored per the physician order [REDACTED]. The surveyor reviewed the Medication Administration Error form (Report), provided by the Director of Nursing (DON), which confirmed that the Licensed Practical Nurse (LPN #1) administered two tablets of Tylenol with [MEDICATION NAME] instead of two tablets of [MEDICATION NAME] 5-325 mg. The Report revealed that LPN #1 did not correctly check medication bingo card (a card that holds individual doses of a medication). The Report further revealed that Resident #45 had no adverse reactions to the Tylenol with [MEDICATION NAME]. The surveyor reviewed Resident #9's (an unsampled resident) Individual Patient's Controlled Drug Record form (narcotic declining inventory sheet) which reflected that two tablets of Tylenol with [MEDICATION NAME] were removed for Resident #45 on 03/07/20 at 1:30 PM. During an interview with the DON on 03/11/20 at 11:49 PM, the DON stated she was called by LPN #1 and informed of the medication error on 03/07/20. The DON further stated that LPN #1 pulled the wrong medication bingo card by mistake and realized she gave the wrong medication during the change of shift narcotic count. During a follow-up interview with the DON on 03/11/20 at 2:04 PM, the DON stated she expected the nurses to check the medication bingo card against the physician's orders [REDACTED]. 2. A review of Resident #45's declining inventory sheet for [MEDICATION NAME] revealed the following: 1. [MEDICATION NAME] was documented as administered on 03/07/20 at 6:00 PM. A review of Resident #45's eMAR reflected that there was no documentation of the 03/07/20 at 6:00 PM administration. 2. [MEDICATION NAME] was documented as administered on 03/08/20 at 8:45 AM. A review of Resident #45's eMAR reflected that there was no documentation of the 03/08/20 at 8:45 AM administration. 3. [MEDICATION NAME] was documented as administered on 03/08/20 at 2:00 PM. A review of Resident #45's eMAR reflected that there was no documentation of the 03/08/20 at 2:00 PM administration. 4. [MEDICATION NAME] was documented as administered on 03/08/20 at 6:00 PM. A review of Resident #45's eMAR reflected that [MEDICATION NAME] was administered on 03/08/20 at 4:40 PM. During an interview with the DON on 03/11/20 at 12:09 PM, the DON confirmed that the nurse did not sign the eMAR on 03/07/20 at 6:00 PM, 03/08/20 at 8:45 AM, and 03/08/20 at 2:00 PM as documented on the narcotic declining inventory sheet. The DON further stated that the nurse documented the [MEDICATION NAME] administration in the Progress Notes on 03/07/20 for the 6:00 PM administration and on 03/08/20 for the 8:45 AM administration. At which time, the DON stated the nurse did not make a notation in the Progress Notes for the 2:00 PM administration of [MEDICATION NAME] on 03/08/20. The DON stated she expected the nurse to check the physician order [REDACTED]. The nurse would administer the medication to the resident and then return to the medication cart to sign the eMAR. A review of Resident #45's Progress Notes revealed a NN, with the effective date of 03/07/20 at 9:11 PM, which indicated that [MEDICATION NAME] 5-325 mg was administered at 6:00 PM. The Progress Notes also reflected a NN, with the effective date of 03/08/20 at 12:26 PM, which indicated that [MEDICATION NAME] 5-325 mg was administered at 9:00 AM. During a follow-up interview with the surveyor on 03/11/20 at 4:04 PM, the DON stated it was not a practice for the nurse to write a NN instead of signing the eMAR. The DON further stated that the nurses were supposed to sign the eMAR after the medication was administered to the resident. On 03/12/20 at 9:35 AM, the surveyor interviewed LPN #1, who did not sign the eMAR on 03/08/20 at 8:45 AM and 2 PM and who also administered the wrong medication to Resident #45 on 03/07/20. LPN #1 stated she would check the physician's orders [REDACTED]. LPN #1 further stated she would then remove the medication from the medication bingo card and sign the narcotic declining inventory sheet right away. LPN #1 stated she would also check the resident's armband to ensure it was the right resident and then administer the medication. LPN #1 stated she would return to the medication cart and sign the eMAR after administering the medication to the resident. When questioned about not signing the eMAR, LPN #1 stated it was human error. LPN#1 further stated that she self-reported the medication administration error to the shift supervisor, DON, and Medical Director on 03/07/20. During an interview with the surveyor on 03/12/20 at 2:07 PM, Resident #45 confirmed he/she was given the wrong medication but did not have any adverse reactions. The surveyor reviewed the facility's Administering Medications policy, dated February 2019, provided by the DON. The policy revealed that the individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. The policy also revealed that allergies [REDACTED]. The policy further revealed that the individual administering the medication must initial the resident's eMAR to document administration after giving the medication. NJAC 8:39-11.2 (b); 27.1(a)

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2)
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to act on or respond to comments made by the Consultant Pharmacist promptly. This deficient practice was identified for 2 of 27 residents reviewed for physician orders [REDACTED].#205) and was evidenced by the following: 1. According to the Pharmacist's Drug Regimen Review (Pharmacist DRR) progress note, dated 02/14/20, the Pharmacist Consultant (PC) made a recommendation for Resident #16 PRN (as needed) [MEDICATION NAME] used routinely. A review of Resident #16's Order Summary Report (Summary Report) for Active Orders as of 02/01/20 revealed an order, dated 01/21/20, for [MEDICATION NAME] 5-325 mg ([MEDICATION NAME]-[MEDICATION NAME]) every eight hours as needed for pain. A review of the January 2020 Electronic Medication Administration Record [REDACTED]. A review of the February 2020 eMAR revealed Resident #16 received the medication on 02/01/20 at 11:57 AM, 02/03/20 at 8:46 AM and 4:53 PM, 02/04/20 at 8:38 AM and 4:50 PM, 02/05/20 at 9:03 am, 02/07/20 at 8:52 AM, 02/08/20 at 9:08 AM, 02/09/20 at 9:11 AM, 02/10/20 at 9:27 AM, 02/11/20 at 9:12 AM and 5:38 PM, 02/12/20 at 9:12 AM and 5:15 PM, 02/13/20 at 9:16 AM and 6:41 PM, 02/14/20 at 9:23 AM, 02/15/20 at 5:13 PM, 02/16/20 at 8:20 AM and 5:02 PM, 02/17/20 at 9:16 AM, 02/18/20 at 9:24 AM, 02/19/20 at 9:27 AM, 02/20/20 at 8:54 AM and 5:00 PM, 8/21/20 at 8:56 AM and 5:22 PM, 02/22/20 at 8:51 AM, 02/23/20 at 9:21 AM and 6:01 PM, 0[DATE] at 9:43 AM, 02/25/20 at 9:13 AM and 4:44 PM, 02/26/20 at 8:57 AM and 5:03 PM, 02/27/20 at 9:09 AM, 02/28/20 at 8:58 AM and 5:06 PM, and 02/29/20 at 11:58 AM and 8:02 PM. A review of the (NAME)2020 eMAR revealed Resident #16 received the medication on 03/01/20 at 8:11 AM and 4:30 PM, 03/02/20 at 2:09 PM, 03/03/20 at 9:37 AM and 5:50 PM, 03/04/20 at 8:00 AM and 5:06 PM, 03/05/20 at 8:43 AM and 4:42 PM, 03/06/20 at 8:21 AM and 4:22 PM, 03/07/20 at 8:50 AM, 03/08/20 at 8:40 AM and 5:57 PM, 03/09/20 at 9:43 AM, and 03/10/20 at 8:59 AM. A review of the Physicians Progress Note, dated 02/20/20 at 12:43 PM, revealed that the physician did not address the recommendation of the PC. During an interview with the surveyor on 03/10/20 at 11:07 AM, the Unit Manager (UM) and surveyor reviewed the PC recommendation dated 02/14/20. The UM stated that she normally reviewed the PC recommendations with the physician to see if he agreed or disagreed with the recommendation. The UM further stated that she was behind and did not address the PC's 02/14/20 recommendation with the physician. During an interview with the surveyor on 03/11/20 at 10:21 AM, the Director of Nursing (DON) confirmed that Resident #16 had a PRN order for [MEDICATION NAME] during January, February and (NAME)2020 and the medication was used routinely. The DON reviewed the Physicians Note, dated 02/20/20, with the surveyor and confirmed that the physician did not address the PC recommendation. 2. According to the Pharmacist DRR progress note dated 12/20/19, the PC made a recommendation for Resident #205 PRN [MEDICATION NAME] used routinely. Please re-evaluate psych meds. A review of the Summary Report for Active Orders as of 10/01/19 to 03/31/20 revealed that Resident #205 had an order, dated [DATE], for [MEDICATION NAME] 0.25 mg every 12 hours as needed for anxiety and an order, dated 01/03/20, for [MEDICATION NAME] 0.25 mg every 12 hours as needed for anxiety. A review of the October 2019 eMAR revealed Resident #205 did not receive the PRN [MEDICATION NAME]. A review of the November 2019 eMAR revealed Resident #205 received the medication on 11/12/19 at 9:04 PM, 11/15/19 at 10:35 PM, 11/20/19 at 2:01 AM, 11/21/20 at 6:45 PM, 11/23/19 at 6:06 PM, 11/25/19 at 1:06 AM, 11/26/19 at 2:30 AM and 11:30 PM, 11/28/20 at 12:37 AM, 11/29/19 at 12:51 PM, and 11/30/19 at 2:51 AM. A review of the December 2019 eMAR revealed Resident #205 received the medication on 12/01/19 at 12:46 AM, 12/02/19 at 1:59 AM, 12/03/19 at 1:54 AM, 12/04/19 at 1:48 AM, 12/05/19 at 12:51 AM, 12/06/19 at 2:24 AM, 12/07/19 at 3:10 AM, 12/08/19 at 2:58 AM and 5:25 PM, 12/09/19 at 11:52 PM, 12/11/19 at 12:45 AM, 12/12/19 at 1:07 AM, 12/13/19 at 12:19 AM, 12/14/20 at 12:35 AM, 12/15/19 at 12:06 AM, 12/16/19 at 12:34 AM and 10:19 PM, 12/18/19 at 3:00 AM, 12/19/19 at 2:51 AM and 7:41 PM, 12/22/19 at 1:19 AM, 12/23/19 at 12:43 AM and 11:07 PM, 12/25/19 at 2:02 AM, 12/26/19 at 2:28 AM, [DATE] at 2:07 AM and 11:48 PM, 12/28/19 at 11:50 PM, 12/30/19 at 12:49 AM, and 12/31/19 at 1:30 AM. The December 2019 MAR further revealed that the medication was discontinued on 01/02/20. A review of the January 2020 eMAR revealed Resident #205 received the medication on 01/04/20 at 2:27 AM, 01/05/20 at 2:05 AM, 01/06/20 at midnight, 01/07/20 at 1:28 AM, 01/08/20 at 12:01 AM, 01/09/20 at 2:00 AM and 11:29 PM, 01/11/20 at 4:25 AM, 01/12/20 at 2:37 AM, 01/14/20 at 12:40 AM, 01/15/20 at 12:51 AM and 8:20 PM, 01/16/20 at 11:32 PM, 01/18/20 at 1:57 AM, and 4:28 PM. The January 2020 MAR further revealed that the medication was discontinued on 01/21/20. During an interview with the surveyor on 03/10/20 at 8:20 AM, the Unit Manager (UM) stated that the PC reviewed each resident's medications monthly and made recommendations. The UM stated she reviewed the PC's recommendations and addressed each recommendation with the physician as soon as she could. The UM, in the presence of the surveyor, reviewed the PC's recommendation dated 12/20/19. The UM stated that she was behind and did not address the PC's recommendations. During an interview with the surveyor on 03/10/20 at 8:55 AM, the DON stated that the PC came in monthly to review the resident's medications. The PC would print out his recommendations when he was in the facility and give them to the UM, DON, and the Assistant DON. The UM was responsible for completing and reviewing the PC's recommendations with the physician and it was expected that the recommendations would be reviewed and completed by the UM within a day or two of receipt of the recommendations. During a follow-up interview with the surveyor on 03/11/20 at 10:34 AM, the DON reviewed the Physicians Progress Note completed by the Nurse Practioner (NP) dated 01/14/20. The DON confirmed that the NP did not address the PC's recommendation. During an interview with the surveyor on 03/12/20 at 9:35 AM, the NP stated that she usually addressed the PC's recommendations in her progress notes and that sometimes she and the UM would go through them. The NP stated that she usually ordered a medication for 14 days at a low dosage and then re-evaluated the medication. At 10:19 AM, in the presence of the surveyor, the NP reviewed the Physicians Progress Note dated 01/14/20. The NP confirmed that she did not discuss the risk versus benefit of the medication in the progress note. A review of the facility's Medication Regimen Review policy, revised in (NAME)2007, revealed, The Consultant Pharmacist will provide the Director of Nursing Services and Medical Director with a written, signed and dated copy of the report, listing the irregularities found and recommendations for their solutions. Upon receipt of the report, the facility shall address recommendations with a reasonable time frame. NJAC 8:39-29.3
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 ensure that medications were stored in a safe and sanitary manner and were maintained with appropriate labeling and dating. This deficient practice was identified in 3 of 4 medication carts and 1 of 2 medication storage rooms inspected on 2 of 3 units (Harbor Unit and Mallard Unit) and was evidenced by the following: On 03/11/20 at 2:44 PM, in the presence of the Registered Nurse (RN), the surveyor inspected the Little Cart on the Harbor Unit. The surveyor observed a [MED] [MED], an injectable diabetes medication, ([MED] Pen #1) stored directly in a drawer on the medication cart. The surveyor also observed a [MEDICATION NAME] Pen, an injectable diabetes medication, ([MED] Pen #2) stored directly in a drawer on the medication cart. The surveyor observed that [MED] Pen #1 and [MED] Pen #2 were stored in the same compartment in the medication cart and not in their individual plastic bags. The surveyor also observed the individual plastic bags for [MED] Pen #1 and [MED] Pen #2 stored on the medication cart were not in use. When interviewed, the RN confirmed the surveyor's findings and stated [MED] Pen #1 and [MED] Pen #2 should be stored in their individual plastic bags and were not supposed to be stored directly in the medication cart. On 03/11/20 at 2:49 PM, in the presence of the Licensed Practical Nurse (LPN #1), the surveyor inspected the High Cart on the Mallard Unit. The surveyor observed an open and undated foil packet of [MEDICATION NAME] inhalation suspension (a medication used to relax muscles in the airway and increases air flow to the lungs). The foil packet contained five vials of inhalation suspension. When interviewed, LPN #1 stated the foil packet should be dated when opened. On 03/11/20 at 3:08 PM, in the presence of LPN #2, the surveyor inspected the Low Cart on the Mallard Unit. The surveyor observed an open and undated foil packet of [MEDICATION NAME]-[MEDICATION NAME] inhalation suspension (a medication used to relax muscles in the airway and increases air flow to the lungs). The foil packet contained one vial of inhalation suspension. When interviewed, LPN #2 stated the foil packet should be dated when opened. On 03/11/20 at 3:12 PM, in the presence of LPN #2, the surveyor inspected the Mallard Unit medication room refrigerator. The surveyor observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MYSTIC MEADOWS REHAB & NURSING CENTER	151 NINTH AVENUE LITTLE EGG HARBOR TW, NJ 08087

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) five [MEDICATION NAME] Flextouch pens ([MED] medication used to treat diabetes) bound together with a rubber band and stored directly on the refrigerator shelf. The surveyor observed that the five [MEDICATION NAME] Flextouch pens were unlabeled. When interviewed, LPN #2 stated she did not know which resident the five [MEDICATION NAME] Flextouch pens belonged too and would have to follow-up with the surveyor. LPN #2 further stated that the five [MEDICATION NAME] Flextouch pens were not supposed to be stored directly on the refrigerator shelf. During an interview with the surveyor on 03/11/20 at 3:37 PM, the Unit Manager (UM) stated the five [MEDICATION NAME] Flextouch pens belonged to a resident who had been discharged on [DATE]. The UM further stated that the resident's family brought the five [MEDICATION NAME] Flextouch pens from home and the nurse should not have received them. The UM stated the 11 PM-7 AM nurse was responsible for inspecting the medication room refrigerator nightly. The UM further stated she did not have the key to open the medication room when that resident was being discharged and forgot to return the five [MEDICATION NAME] Flextouch pens back to the resident. During an interview with the surveyor on 03/12/20 at 9:20 AM, the Director of Nursing (DON) stated that resident's [MED] pens were to be stored in individual plastic bags for infection control purposes. The DON further stated that [MED] pens should not be stored directly in the medication cart. The DON stated that nurses were supposed to date the inhalation suspension foil packets when opened for expiration monitoring. The DON stated the five [MEDICATION NAME] Flextouch pens should not have been stored in the medication room refrigerator without a label and that they should have been labeled with the resident's name. The DON further stated that the resident's family should have been called to see if they still wanted the five [MEDICATION NAME] Flextouch pens and if they did not; the medications should have been discarded. A review of the facility's Storage of Medications policy, updated February 2019, provided by the DON revealed that drugs and biologicals should be stored in the packaging in which they were received. The policy further revealed that the nursing staff were responsible for maintaining storage in a clean, safe, and sanitary manner. A review of the facility's Labeling of Medication policy, updated February 2019, provided by the DON revealed that all medications maintained in the facility should be properly labeled in accordance with current state and federal regulations. The policy further revealed that labels for individual drug containers should include all necessary information, such as the resident and prescribing physician's names; the name, strength, and quantity of the drug; the prescription number; the issuing pharmacy's information; the date the medication was dispensed; and the direction for use. NJAC 8:39-29.4(a)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **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 follow proper infection control practices for handwashing to address the risk of infection transmission during wound treatments. This deficient practice was identified for 1 of 2 nurses observed during the wound treatment observation on 1 of 3 units (Mallard Unit). On 03/09/20 at 11:11 AM, the surveyor observed the Licensed Practical Nurse (LPN), with the assistance of the Unit Manager (UM), provide wound care to Resident 8's left lateral foot, right lateral foot, left ischium, and right ischium (the lower and back part of the hip bone). During the wound treatment observation, the surveyor observed that the LPN washed her hands multiple times as follows: the LPN tapped on the motion sensor red light on the motion sensor towel dispenser to dispense a towel, turned on the faucet, applied soap to her hands, applied friction to all hand surfaces, pulled the paper towel down from the motion sensor towel dispenser, tore off the paper towel, and dried her hands. The surveyor further observed the LPN then tap the motion sensor red light on the motion sensor towel dispenser to dispense a second paper towel, tore off the towel, and turned off the faucet. The surveyor then observed the LPN don (apply) gloves and prepare the clean field. The LPN repositioned the overbed table, located next to the resident's bed, closer to the treatment cart and placed a clean covering on the overbed table. The surveyor did not observe the LPN clean the overbed table before establishing the clean field. The surveyor observed the wound treatment for [REDACTED].#8. The LPN donned gloves, removed the dressing, removed gloves, washed her hands, and donned gloves. The LPN then cleansed the wound with saline three times, applied the physician ordered [MEDICATION NAME] treatment (an antiseptic used for skin disinfection) to the wound and then covered the wound with a dressing. The surveyor further observed the LPN remove her gloves and wash her hands. The surveyor observed the wound treatment for [REDACTED].#8. The LPN donned gloves, removed the dressing and cleansed the wound with saline three times. The LPN then removed her gloves and washed her hands. The surveyor did not observe the LPN perform handwashing and glove change after she removed the dressing on the wound. The surveyor observed the UM remove the items from the overbed table, remove her gloves, wash her hands, and remove the trash from the room. The surveyor did not observe the UM or the LPN clean the overbed table. During an interview with the surveyor on 03/09/20 at 11:53 AM, the LPN stated that she did not know that she hit the motion sensor on the towel dispenser. The LPN further stated that sometimes the towel dispenser did not work. At that time, the surveyor tested the motion sensor towel dispenser. The dispenser worked properly with the hand motion to dispense a paper towel. During a follow-up interview with the surveyor on 03/09/20 at 1:47 PM, the LPN stated that the overbed table was wiped before entering Resident #8's room and that the UM came back to the room after we left and wiped the table. The LPN stated that she washed her hands after cleansing the resident's wound and before applying the [MEDICATION NAME] to Resident #8's right lateral foot. The LPN further stated that she washed her hands after she removed the dressing from the resident's right ischium and before cleansing the wound. The LPN stated that she washed her hands so much they hurt and they were very dry. On 03/09/20 at 2:12 PM, the surveyor tested the motion sensor towel dispenser. The dispenser worked properly with the hand motion to dispense a paper towel. During an interview with the surveyor on 03/09/20 at 2:19 PM, the UM stated that the procedure to complete a dressing change was to wash hands, don gloves, remove the dressing, remove gloves and wash hands, cleanse the wound, wash hands, apply the treatment and dressing, and wash hands. The UM confirmed that there was no need to touch the motion sensor on the towel dispenser. The UM further confirmed that the LPN completed the right lateral foot incorrectly and could not remember if she completed the right ischium correctly. The UM further stated she expected the nurse to wipe the overbed table with a sanitized wipe before setting up the clean field and could not remember if she did that. The UM confirmed that she removed the trash from the overbed table but did not sanitize the overbed table. The UM stated she thought the LPN would clean the table. During an interview with the surveyor on 03/09/20 at 3:16 PM, the Director of Nursing (DON) stated she expected her nurses to wash their hands properly. The DON confirmed the nurse should clean the overbed table with a bleach wipe before establishing a clean field and after the trash was removed. The DON further confirmed that the nurse should remove gloves and wash hands when a nurse removes the dressing, cleans the wound, and before applying treatment to the wound. During an interview with the surveyor on 03/10/20 at 9:00 AM, the Assistant Director of Nursing (ADON) stated that she completed the nurse competencies. The ADON stated that wound rounds were completed on Mondays and that she picked a nurse to follow during the wound rounds. The ADON told the surveyor that she educated the nurses to wash hands, don gloves, sanitize the overbed table, remove gloves, wash hands, don gloves, establish a clean field, and gather supplies. The nurse would then remove gloves and wash hands, don glove and remove the dressing, remove gloves, and wash hands. The nurse would then don gloves, apply the physician ordered treatment and dressing, remove gloves and wash hands. The ADON stated that she observed the LPN during wound treatment in November and she did fine. A review of the facility's Handwashing/Hand Hygiene policy, revised (NAME)2015, revealed, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The policy further revealed to wash hands with soap after handling used dressings. A review of the facility's Wound Care policy, updated February 2019, revealed the following: the working area (overbed table) should be cleansed before establishing a clean field; the nurse would don gloves, remove the dressing, remove the gloves and perform hand hygiene; and the nurse would don gloves, cleanse the wound, perform hand hygiene, don gloves and apply the treatment as ordered. The policy further revealed to clean the working area after the treatment was completed. NJAC 8:39-19.4