STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALLENDALE NURSING HOME	85 HARRETON ROAD ALLENDALE, NJ 07401

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** - 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 observation, interview, and record review, it was determined that the facility failed to: a.) accurately document for the placement of a neck pillow and absorbent pad, b.) accurately follow a physician's orders [REDACTED].) document the re-assessment of a resident for a new elopement risk, in accordance with professional standards of nursing practice. This deficient practice was identified for 3 of 21 residents reviewed (Resident #36, #38, and #43). 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. The evidence was as follows: 1. The surveyor reviewed the medical record for Resident #36. A review of the Resident Information Sheet (an admission summary face sheet) reflected that the resident had [DIAGNOSES REDACTED]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/18/2020 indicated that the resident had a short and long-term memory problem with a severely impaired decision-making capacity. A review of the February 2020 physician's orders [REDACTED]. The POS also included a PO dated 7/25/19 to apply a medical absorbent pad underneath the left side of the neck once daily in the morning and remove it in the evening. On 2/27/2020 at 11:07 AM, the surveyor observed Resident #36 lying in bed with his/her eyes closed. The surveyor observed that the resident was not wearing a neck pillow and there was no evidence of an absorbent pad to the left side of the neck. The surveyor was unable to interview the resident. At 11:27 AM, the surveyor returned and continued to observe the resident in bed with his/her eyes closed, and there was no evidence of neck pillow or absorbent pad in place in accordance with the physician's orders [REDACTED].#36's vacant room. A neck pillow was resting on top of the resident's bed. At 9:54 AM, the surveyor observed the resident reclined in a geri-chair (a medical recliner) with his/her eyes closed in the sensory room. The resident was not wearing a neck pillow or absorbent pad underneath his/her neck. There was no evidence of moisture under the left side of the resident's neck, and the resident's head was positioned midline to his/her body. A review of the resident's Treatment Administration Record (TAR) for March 2020. The TAR reflected the corresponding physician's orders [REDACTED]. The TAR also reflected the physician's orders [REDACTED]. A review of the TAR reflected that the nurse signed for the proper application of the neck pillow and the absorbent pad at 9:00 AM on [DATE]. This did not correspond with what the surveyor observed. On the same day on [DATE] at 10:39 AM, the surveyor interviewed the Registered Nurse (RN) assigned to care for Resident #36. The RN agreed to enter the vacant room of Resident #36 with the surveyor. The surveyor and RN observed the neck pillow on top of the resident's bed. The RN stated that the neck pillow should not be on the bed, but that it should be worn by the resident. She added that the Certified Nursing Aide (CNA) was supposed to apply it after morning care. The RN stated that she signed in the TAR that the neck pillow was on place and confirmed that she did not put it on the resident. She acknowledged that it was therefore not accurately signed in the TAR. The RN stated that an absorbent pad was also placed under the resident's neck since the resident had a history of [REDACTED]. The RN stated that the night nurse usually placed the absorbent pad under the resident's neck. The RN stated that she usually changed the pad around noon. She acknowledged it was not in place. At this time, the surveyor reviewed the TAR for March 2020 with the RN who confirmed she signed for the application of the neck pillow and absorbent pad. The RN stated that she saw the absorbent pad on the resident earlier around 7:00 AM and that maybe the pad fallen off. The RN stated that the resident should have the neck pillow and absorbent pad in in place in accordance with the physician's orders [REDACTED].#36 back to his/her room. The surveyor observed that the skin underneath the resident's left neck was intact and had no signs of redness or moisture. At this time, the RN placed an absorbent pad underneath the resident's left neck fold and applied the neck pillow. The RN stated the pillow was for comfort purposes. At 10:54 AM, the surveyor interviewed the resident's CNA who stated that she placed the neck pillow on the resident and that she thought the resident used the neck pillow at all times. The CNA stated that the nurse was responsible for applying an absorbent pad underneath the resident's chin, and if the pad was missing then she was to inform the nurse. The CNA stated that this morning around 7:00 AM, she saw that the resident had an absorbent pad on. The CNA stated that she brought the resident to the sensory room today without the neck pillow because she noticed that the resident was not wearing the absorbent pad. The CNA stated that she informed the RN that the resident needed an absorbent pad this morning after morning care. At 12:44 PM, the RN informed the surveyor that she followed up with the resident's Medical Doctor (MD) who stated that the resident would benefit from the absorbent pad and the neck pillow. The MD changed the PO to reflect that the absorbent pad and neck pillow should be applied every shift and that the nurses should check the placement every shift. On 3/5/2020 at 10:54 PM, the in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, the Director of Nursing (DON) acknowledged that the CNA and RN both stated that the neck pillow and the absorbent pad were on during morning care around 7:00 AM that day. This did not correspond with the physician's orders [REDACTED]. The DON stated that the CNA was able to apply the neck pillow, but that they could not apply the absorbent pad. The DON acknowledged that there was no reason the neck pillow would need to be withheld if there was no absorbent pad. The DON acknowledged that the nurse should not have signed for the application of the neck pillow and absorbent pad if it had not yet been applied. 2. On 2/27/2020 at 11:42 AM, the surveyor observed Resident #43 sitting on the edge of the bed smiling. The surveyor observed an oxygen concentrator next to the resident's bed turned to the on position, and running at 2 liters/minute. The concentrator was connected to an empty humidification bottle dated 2/17/20 and the nasal cannula was not connected to the resident. The nasal cannula had a piece of tape on it that was dated 2/26/20. At that time, the resident agreed to be interviewed. The resident told the surveyor that he/she would use the oxygen via nasal cannula if he/she needed it. The resident stated that he/she would sometimes put it on at night just for comfort, but that the oxygen wasn't a necessity anymore. The resident stated that he/she did not touch the concentrator and that only the nurses would adjust the concentrator. The resident stated that he/she would put the nasal cannula on and off independently. At that time, the resident applied the nasal cannula in the presence of the surveyor and then removed it. The resident denied shortness of breath. On 2/28/2020 at 12:00 PM, the surveyor observed the resident sitting on the edge of the bed awaiting lunch service. The surveyor observed that the oxygen concentrator was turned on, and the empty humidification bottle dated 2/17/20 was still attached to the concentrator. The concentrator was running at 2 Liters per minute, but the resident was not wearing

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

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) the nasal cannula. The resident stated he/she did not need the oxygen. At 12:02 PM, the surveyor interviewed the resident's assigned Licensed Practical Nurse (LPN). The LPN stated that she would float between the units, but was somewhat familiar with Resident #43. The LPN stated that the resident was alert and oriented to person, place and time, and that he/she had an order for [REDACTED]. The surveyor asked the LPN about the oxygen concentrator. The LPN stated that if a resident was not using the oxygen, that the concentrator should be turned off. The LPN also stated that the tubing and humidification bottle got changed weekly. At approximately 12:05 PM, Resident #43 allowed the LPN and surveyor to enter the room. After performing hand hygiene and cleaning the equipment, the LPN obtained a pulse oxygenation status on the resident. The LPN and surveyor confirmed a reading of 98% on room air. At that time, the LPN confirmed that the oxygen concentrator was running and turned it off. She confirmed it should have been turned off. She stated she did not turn it on because the resident did not need the oxygen this morning. She then removed the nasal cannula and discarded it. The LPN confirmed that the humidification bottle was empty and was dated [DATE]. The surveyor reviewed the medical record for Resident #43. A review of the Resident Information Sheet reflected that the resident was recently admitted to the facility with [DIAGNOSES REDACTED]. A review of the admission MDS dated [DATE], included that the resident had a BIMS of 13 out of 15, indicating the resident had an intact cognition with mild forgetfulness. It further reflected that the resident was on oxygen therapy. A review of the physician's orders [REDACTED]. A review of the Treatment Administration Record (TAR) for February 2020 reflected a physician's orders [REDACTED]. The TAR was signed to reflect that the humidification and oxygen tubing was changed on 2/17 and 2/24. At 12:12 PM, the surveyor and the LPN reviewed the TAR for February 2020 together. The LPN acknowledged that the nurse signed that the humidification bottle was replaced on 2/24 at 6 AM. The LPN acknowledged that it wasn't changed because the humidification bottle was dated 2/17. She confirmed the order had two steps to it, to change the oxygen tubing and humidifier. She stated that maybe the nurse missed the second part to the order to change the humidifier. The LPN confirmed the humidifier bottle was empty. On 3/5/2020 at 10:57 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team. The DON stated that Resident #43 was capable of taking the oxygen on and off independently and that the resident was educated on how to store the oxygen tubing. The DON acknowledged that the concentrator should have been turned off, and that the resident should have told the nurse when the nasal cannula was removed. The DON acknowledged that the MAR indicated [REDACTED]. The DON stated that the physician's orders [REDACTED]. The DON acknowledged that the nurse signed that the humidification bottle was changed on 2/24, when it had not been done. She confirmed that when a nurse signs for the accountability for an order, he or she signs after the order is completed in accordance with professional standards of nursing practice. A review of the facility's undated Oxygen policy included, place humidifier bottle. Change bottle weekly . Label humidifier bottle with date and nurse's initials. 3. On [DATE] at 9:55 AM, the surveyor observed Resident #38 sitting on the edge of the bed. The Registered Nurse (RN) assisted the resident to bed for a nap. After the RN completed assisting the resident, the resident agreed to be interviewed. At that time, the resident stated his/her name and that he/she was doing well. The resident stated a concern that his/her spouse was in another building and that he/she wanted to see the spouse. The surveyor attempted to ask clarifying questions with the resident, but the resident's responses were not appropriate. The surveyor reviewed the medical record for Resident #38. A review of the Resident Information Sheet reflected that the resident had [DIAGNOSES REDACTED]. A review of the most recent annual MDS dated [DATE] reflected that the resident had a BIMS score of 6 out of 15, indicating a moderately impaired cognition. The assessment further reflected that the resident had no wandering behaviors in the last seven day look-back period. A review of the Nursing Admission assessment dated [DATE] reflected an Elopement Risk assessment was performed. The assessment reflected that the resident had a score of 1 out of 11, indicating the resident was NOT AT RISK to elope at this time and placement on the Elopement Risk Protocol is NOT indicated. A review of the Nurse's Notes dated 9/27/2019 at 11:00 AM reflected that Resident #38 was noted by the main entrance attempting to follow a family/visitors. The note indicated that the resident was immediately intercepted by staff and redirected back to the nurse's station and that the family of the resident was notified. The note further included that a picture was placed at the front desk so that the resident could be easily identified by front desk staff. A review of the Nurse's Notes dated 10/14/19 and and physician's orders [REDACTED]. The surveyor attempted to review an Elopement Risk re-assessment for the resident after the resident attempted to elope, but there was no assessment in the resident's medical record. On 3/3/2020 at 10:55 AM, the surveyor interviewed the front desk Receptionist who stated that she works at the facility full time from 8 AM to 4:30 PM, and that another shift comes from 4:30 PM to 8 PM. She stated that after the 8 PM shift leaves for the day, the front door gets locked. She stated that the main lobby was always supervised by the Receptionist staff and that there were administrative offices near the door as well. The Receptionist stated that no resident's have ever exited the doors when they were not supposed to. She stated that the front entrance was the only entrance that was open and available for visitors. The Receptionist showed the surveyor a large picture of Resident #38 that was at the reception desk. The Receptionist stated that she was told that the resident was not allowed to go near the exit and that if he/she attempted then she would need to request assistance and intervene. She stated that the resident had a wander guard bracelet that would send a high frequency alarm sound throughout the area to alert staff that Resident #38 was close to the exit. She further stated that a key was needed to turn the alarm sound off. At 11:15 AM, the surveyor interviewed the RN who stated that Resident #38 had dementia and was confused. She stated that the resident would ambulate around the building, and would sometimes go near the exit but that he/she would wear a wander-guard bracelet that would alarm if the resident got close to the exit. She stated that the resident never got out of the building unsupervised. She stated that she heard there was one time when the resident got to the door but the staff were right there and redirected the resident back. The RN stated that was why the resident now had the wander-guard alarm, and that it had helped to keep the resident safe. She stated every shift the nurse checks for the placement of the wander-guard and the function would be checked weekly and it would be documented in the Treatment Administration Record. The RN showed the surveyor the resident's wander-guard bracelet and followed the process for checking functioning appropriately. At that time, the surveyor requested information about an assessment for the Elopement Risk. The RN confirmed there was no re-assessment in the chart and that she was not aware of an Elopement Risk assessment form, other than what was done on admission. She stated that the resident had to have been re-assessed in some capacity because the resident got a wander-guard alarm system because we determined the resident was at an increased risk of elopement. The RN could not speak to when it was done or where it was documented. On 3/3/2020 at 11:27 AM, the DON approached the surveyor who stated that the facility did not document Elopement Risk Assessments other than when the resident was initially admitted . The surveyor asked what the process was if a resident attempted to elope, and the DON stated that they would put a picture at the front desk, implement a care plan to keep the resident re-directed and distracted, and get a wander-guard alarm bracelet if needed. The DON stated that the wander-guard system was a new system and the system had recently been installed in October 2019. She stated that the resident had never eloped, but only attempted to exit once when the resident had to be intercepted by staff. She confirmed the facility had no elopement re-assessment screenings documented, but that she had noticed in January 2020 during chart audits that it was something that needed to be done. She stated they were in the process of finding an assessment form to implement and educate the nurses on. She stated it had not been implemented yet. She confirmed the resident was assessed for elopement but that it was not documented in accordance with professional standards of nursing practice. At 12:31 PM, the surveyor interviewed the CNA who stated that Resident #38 was confused. She continued that she had never seen the resident's spouse and could not speak to it, but that the resident had a family representative that came to visit often. The CNA denied that the resident had ever attempted to elope. She stated that the resident was always in a supervised line of sight when out of bed and that he/she had a wander-guard alarm bracelet that would sound if he/she got close to the front door. She stated that if she heard the alarm, she would respond immediately and re-direct the resident to activities, the nurses station for a snack, or other method to keep the resident distracted. NJAC 8:39-3.2 (a)
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to: a.) ensure an anti-anxiety medication was administered prior to going to the [MEDICAL TREATMENT] center in accordance with the physician's orders [REDACTED].) address a recommendation within the [MEDICAL TREATMENT] communication record for approximately one month. This deficient practice was identified for 1 of 1 residents reviewed for [MEDICAL TREATMENT] services and management (Resident #48). The evidence was as follows: On 3/4/2020 at 10:04 AM, the surveyor observed Resident #48 sitting in a wheelchair. The resident had a flat affect. At that time a Certified Nursing

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F 0698

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 2)

Aide (CNA) was assisting the resident to his/her room by propelling the wheelchair down the hallway. The CNA told the surveyor the resident was alert and oriented to person, place and time, and could be interviewed. At 10:13 AM, the resident agreed to be interviewed by the surveyor in a private room behind the nurse's station. The resident was able to state their name and answer basic questions from the surveyor. The resident confirmed he/she went to the center for [MEDICAL TREATMENT] (a process of removing excess water, solutes and toxins from the blood due to kidney failure) on Tuesdays, Thursdays and Saturdays, and that he/she left the facility between 8:00 AM and 8:30 AM. The surveyor asked the resident if he/she took medications before going to the [MEDICAL TREATMENT] center, and the resident stated that he/she took a pill for nerves before going to the center and the resident agreed that the pill helped to keep him/her calm. The resident confirmed with a yes that he/she always got the anti-anxiety medication before going to the [MEDICAL TREATMENT] center. The resident stated that he/she would eat some food at the [MEDICAL TREATMENT] center. The resident was unable to elaborate what happens at the [MEDICAL TREATMENT] center, but the resident confirmed the process made him/her tired. The surveyor reviewed the medical record for Resident #42. A review of the Resident Information Sheet (an admission summary face sheet) reflected that the resident was admitted to the facility 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 1/26/2020 reflected that the resident had a brief interview for mental status (BIMS) score of 9 out of 15, indicating a moderately impaired cognition. The assessment further included that the resident had impaired kidney functioning and received [MEDICAL TREATMENT] services while a resident at the facility. A review of the resident's individualized, comprehensive care plan initiated on 12/5/19 included that the resident went to the [MEDICAL TREATMENT] center due to impaired kidney functioning. The care plan indicated that the resident was at risk for conditions including an electrolyte imbalance and infection. Pre-printed interventions documented in the care plan included to Review (the) [MEDICAL TREATMENT] communication book upon return (from the [MEDICAL TREATMENT] center) for recommendations and new orders. The care plan did not specify the resident's [MEDICAL TREATMENT] schedule including the [MEDICAL TREATMENT] pick-up time or estimated return time, information regarding medications to be taken prior to [MEDICAL TREATMENT], or any food items that were to be sent with the resident on [MEDICAL TREATMENT] days. A review of the physician's orders [REDACTED]. The order specified to administer the [MEDICATION NAME] 0.25 mg three times a week on [MEDICAL TREATMENT] days (Tuesday, Thursday, Saturday) one (1) hour prior to [MEDICAL TREATMENT]. A review of the Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. However, the MAR indicated [REDACTED]. Further review of the MAR for February 2020 reflected that on 2/11/2020 the nurse responsible to administer medications signed that the [MEDICATION NAME] 0.25 mg was administered at 8 AM. A review of the Controlled Substance Record (a declining inventory record used for the accountability of controlled substances) for the [MEDICATION NAME] 0.25 mg did reflected that 13 tablets of [MEDICATION NAME] 0.25 mg was delivered on 2/7/2020. The record indicated on 2/11/2020 at 8 AM there was no evidence it was removed from active inventory for administration to the resident as reflected on the MAR. On 3/4/2020 at approximately 10:35 AM, the surveyor interviewed the resident's assigned Certified Nursing Aide (CNA) who stated that the resident was very alert and was able to make her needs known. The CNA stated that the resident liked to eat and would often ask for a snack or a cookie. The CNA stated that the resident went to the [MEDICAL TREATMENT] center three days a week on Tuesday, Thursday and Saturday's and the CNA stated that she believed the resident left the facility around 7:30 AM. She stated that the resident was independent with ambulation and toileting, but liked to keep a wheelchair nearby. At 10:39 AM, the surveyor interviewed the Registered Nurse (RN) assigned to care for Resident #48. The RN stated that she worked at the facility full time during the day shift (7 AM to 3 PM) and that the resident was alert and oriented to person, place and time. The RN further stated that Resident #48 went to the [MEDICAL TREATMENT] center on Tuesdays Thursdays and Saturdays around 8 AM. She stated that the resident had a history of [REDACTED]. She stated that the resident's target behaviors had improved, but the resident's kidney function had declined and needed to be started on [MEDICAL TREATMENT]. She stated that the [MEDICAL TREATMENT] center had communicated that the resident was restless during [MEDICAL TREATMENT] and sometimes it would cause the resident to not be able to finish the entire sit time because the resident would try to get up from the chair or pull at equipment. The RN stated that the doctor had been notified and ordered a [MEDICATION NAME] 0.25 mg to be given one hour prior to [MEDICAL TREATMENT] beginning on 2/5/2020. She stated that the medication was plotted to be administered during the 7 AM to 3 PM shift. The surveyor and the RN reviewed the resident's MAR for February 2020 and the Controlled Substance Record sheet for the [MEDICATION NAME] 0.25 mg. The RN confirmed that she gave the medication at 8 AM right before the resident leaves for [MEDICAL TREATMENT] because she believed the resident's start time was 9 AM, and that would count as one hour. She confirmed the MAR indicated [REDACTED]. The surveyor then showed the RN the MAR indicated [REDACTED]. The RN confirmed the surveyor's findings and stated that maybe the [MEDICATION NAME] was removed from a back up supply, but the RN stated that she wouldn't know why it would be removed from a back up supply if the resident had the medication available on 2/7/2020. She stated she would have to look into that. She confirmed the nursing progress notes on 2/11/2020 did not address the [MEDICATION NAME] 0.25 mg. The surveyor continued to review the [MEDICAL TREATMENT] communication book for Resident #48. A review of a lab dated [DATE] reflected a vitamin D level of 20.8 (a vitamin D insufficiency was listed as a level of 10-30 nanograms/milliliter). A review of the [MEDICAL TREATMENT] Communication Form dated [DATE]20 reflected a comment with an asterisk to See MD (Medical Doctor) order -- start Vitamin D3 1000 units PO (by mouth) daily. A review of the physician's orders [REDACTED]. On 3/4/2020 at 11:14 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who reviewed the [MEDICAL TREATMENT] Communication Form and Physician orders [REDACTED]. He confirmed it was addressed yesterday. The ADON stated that the nurses are responsible to review the [MEDICAL TREATMENT] Communication Forms with the [MEDICAL TREATMENT] center upon return to the facility. He was not sure if there was an accountability that communication forms were checked. At 11:30 AM, the surveyor interviewed the RN a second time. The RN stated that she worked yesterday and the [MEDICAL TREATMENT] center called her yesterday to request the order for the Vitamin D3, so she got a telephone order from the physician to start it. The surveyor showed the RN the [MEDICAL TREATMENT] Communication Form dated [DATE]20 and the RN confirmed it did not seem as though it was addressed because the resident would have had a physician's orders [REDACTED]. The RN confirmed the nurse was supposed to review the forms when the resident returns from the [MEDICAL TREATMENT] center. The RN stated there was no accountability for checking the [MEDICAL TREATMENT] communication record to verify it was done or to review possible recommendations or orders. The RN and ADON were unable to provide documented evidence within the nursing notes or physician's progress notes to address the Vitamin D level or the recommended order to start the Vitamin D3 medication. At 12:12 PM, the surveyor conducted a phone interview with the covering Consultant Pharmacist (CP) who stated that the consultant pharmacists try to review the [MEDICAL TREATMENT] Communication Forms, but if the book was at the [MEDICAL TREATMENT] center with the resident during the CP visits, it wouldn't be available for review. The CP indicated that the nurses should review it when the resident comes back from the center. On 3/4/2020 at 2:24 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team. The DON stated that the [MEDICATION NAME] 0.25 mg did not come from the back up box supply, and that she was going to look into where the nurse got the [MEDICATION NAME] from to administer it on 2/11/2020 at 8 AM. On 3/5/2020 at 11:01 AM, the surveyor interviewed the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team. The DON stated that the resident's care plan should include that the resident gets [MEDICATION NAME] before going to the [MEDICAL TREATMENT] center (adding that they were responsible to administer medications and not the [MEDICAL TREATMENT] center). She stated that the care plan should have also included that the resident got served a breakfast before going to [MEDICAL TREATMENT], a packed snack would be sent with him/her on [MEDICAL TREATMENT] days, and the resident's [MEDICAL TREATMENT] schedule should also have been on there. The DON confirmed the care plan had not been specific. She stated that the care plans were an interdisciplinary team approach and that all staff were responsible to update the care plan, as necessary. The DON continued to add that the resident's Vitamin D level was done on [DATE] and was sub-therapeutic. She stated that the Registered Dietician at the [MEDICAL TREATMENT] center addressed the lab in February 2020, and that it was not picked up in the communication book from the [MEDICAL TREATMENT] center. The DON acknowledged that there was no record of where the [MEDICATION NAME] 0.25 mg came from on 2/11/2020 when the nurse signed for it. The DON indicated that on 2/11/2020, there was no documented evidence the resident did not complete a therapeutic treatment on that day at the [MEDICAL TREATMENT] center. The DON stated that the physician was looking into ordering a different medication instead of the [MEDICATION NAME], as they feel as though it might be dialyzed out of the resident's system before it begins working anyway. The DON stated that she further spoke with the nurse and the nurse could not recall the day in question. The DON confirmed it was signed as administered but could not verify where the dose came from if it was no removed from the declining inventory controlled drug record. The DON was unable to provide documented evidence in the medical record to address the [MEDICATION NAME] 0.25 mg, or to address the [MEDICAL TREATMENT] Communication Form dated [DATE]20 to start the

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F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) Vitamin D3 1000 units daily. The DON acknowledged the surveyor's findings. A review of the facility's undated [MEDICAL TREATMENT] Policy included, A communication book will be sent with the resident to [MEDICAL TREATMENT]. Upon return from [MEDICAL TREATMENT], the nurse will review and take note of any recommendations Notify Dietary of scheduled day for [MEDICAL TREATMENT] to ensure a meal goes with resident. The policy did not address medication management related to a resident's individual [MEDICAL TREATMENT] schedule. NJAC 8:39-2.9; 2.10

F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure: a.) the appropriate ordered dose of an anti-[MEDICAL CONDITION] medication ([MEDICATION NAME]) matched the label packaging in storage, b.) the timeliness of administration of an anti-[MEDICAL CONDITION] medication [MEDICATION NAME], and c.) the accurate accountability for the anti-[MEDICAL CONDITION] medication ([MEDICATION NAME]) for 2 of 7 residents reviewed for medication management (Resident #32 and #62) and on 1 of 2 medication carts reviewed. The evidence was as follows: 1. On 2/27/2020 at 10:40 AM, the surveyor attempted to observe Resident #62. The resident's door was closed and there was a stop sign posted on the door that indicated to please see the nurse before entering the room. The surveyor also observed a clear plastic bin outside the resident's room with personal protective equipment (PPE) including yellow disposable gowns, gloves and face masks. At that time, the surveyor went to the resident's assigned Licensed Practical Nurse (LPN). On 2/27/2020 at 10:43 AM, the surveyor interviewed the resident's LPN who stated that she was the full time nurse assigned to care for Resident #62. The LPN stated that Resident #62 had developed the flu and was on transmission-based precautions to prevent the spread of infection. The LPN stated that the resident was on the anti-[MEDICAL CONDITION] medication, [MEDICATION NAME]. The LPN stated to the surveyor that Resident #62 was taking [MEDICATION NAME] 75 milligrams (mg) daily, and after the resident got the seventh dose of a 14-day [MEDICATION NAME] treatment, the resident tested positive for the flu. At that time, approximately 10:45 AM, the surveyor requested to observe the resident's supply of the [MEDICAL CONDITION] medication, [MEDICATION NAME] from the medication cart. The LPN showed the surveyor a clear plastic bag with the name of Resident #62. The pharmacy provider's printed label indicated that 14 capsules of the drug [MEDICATION NAME] 75 mg were delivered on [DATE]. The clear plastic bag contained only one capsule of [MEDICATION NAME] 75 mg remaining in the bag. The surveyor asked if the resident had any additional bags of [MEDICATION NAME] 75 mg in the cart assigned to Resident #62. The LPN searched the medication cart twice and was unable to find any other labeled bags for [MEDICATION NAME] assigned to Resident #62. The LPN confirmed there was only one capsule of [MEDICATION NAME] 75 mg remaining for Resident #62. The LPN stated that she had not yet given Resident #62 his/her dose this morning and was saving that room for last. She could not speak further as to why the 9 AM dose had not yet been given as of 10:43 AM, when the surveyor first approached her. The surveyor reviewed the medical record for Resident #62. A review of the Resident Information Sheet (an admission summary face sheet) reflected that the resident was admitted to the facility 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 2/12/2020 reflected that the resident had a brief interview for mental status score of 11 out of 15 indicating the resident had a intact cognition with some forgetfulness. A review of the physician's orders [REDACTED]. A review of the Medication Administration Record (MAR) for February 2020 reflected the corresponding PO dated [DATE] for the [MEDICATION NAME] 75 mg daily. The order was plotted for the medication to be administered at 9 AM daily. Further review reflected that the first dose was signed by the nurse as administered on 2/19/2020 at 9 AM. The MAR further reflected that the nurse signed for the administration of the [MEDICATION NAME] 75 mg daily at 9 AM from 2/19/2020 through 2/25/2020 for a total of seven (7) doses. The MAR reflected that the daily dose of [MEDICATION NAME] was discontinued on 2/25/2020. A review of the physician's orders [REDACTED]. A review of the MAR for February 2020 reflected the corresponding PO dated 2/25/2020 to administer [MEDICATION NAME] 75 mg by mouth twice a day for five days. The MAR reflected that the dosages were to be administered at 9 AM and 5 PM daily. The MAR was signed to reflect the resident received a dose on 2/26/2020 at 9 AM and 5 PM, and had not yet received the dose on 2/27/2020 at 9 AM. The MAR for February 2020 reflected that the nurses signed for the administration of nine (9) doses of [MEDICATION NAME] 75 mg from 2/19/2020 through 2/26/2020 in accordance with the physician orders [REDACTED]. On 2/27/2020 at 10:46 AM, the surveyor continued to interview the LPN. The LPN confirmed that the label for Resident #62's [MEDICATION NAME] from the pharmacy provider indicated that 14 capsules of [MEDICATION NAME] 75 mg were sent on [DATE], and that only one capsule remained. The LPN and the surveyor reviewed the MAR for February 2020 together. The LPN confirmed that a total of nine (9) doses were signed as administered, which reflected that there should have been five (5) capsules of [MEDICATION NAME] 75 mg remaining in the resident's inventory, and not one capsule. She confirmed there were four (4) capsules that were missing from the resident's inventory. The LPN could not speak to how this could happen. The surveyor asked her process for administering medications, and the LPN stated that she reads the orders, and makes sure she was giving the right drug, the right dose at the right time to the right resident. She stated that she pulls out the individually labeled packaging for each resident and confirms she was removing the drug labeled for that individual resident. She stated she would never borrow a medication labeled for a different resident. She also denied that she had to destroy a dose of [MEDICATION NAME] dose for this resident that she could recall. At that time, in the presence of the surveyor, the LPN then removed a bag labeled for another resident (Resident #32) for [MEDICATION NAME] 75 mg. Inside the bag were four (4) capsules of [MEDICATION NAME] 75 mg, commingling with nine (9) capsules of [MEDICATION NAME] 30 mg. The LPN removed the four (4) capsules of [MEDICATION NAME] 75 mg from the bag designated for Resident #32, and put it into the bag labeled for [MEDICATION NAME] 75 mg and designated for Resident #62. The LPN stated that she thought the four missing capsules got placed in the wrong resident's bag. She could not speak to why she was removing capsules designated for another resident labeled for [MEDICATION NAME] 75 mg and placing them in a bag for Resident #62 labeled for [MEDICATION NAME] 75 mg. On 2/27/2020 at 11:04 AM, the surveyor interviewed the Assistant Director of Nursing (ADON). The surveyor and ADON reviewed the discrepancy between the [MEDICATION NAME] 75 mg, which included that 14 capsules of [MEDICATION NAME] were delivered on [DATE], and nine (9) capsules were signed as administered in the MAR and only one capsule remained in the inventory. The ADON acknowledged there were four capsules missing from the resident's inventory, because there was only one capsule available. The ADON stated that nurses are to read the label and ensure they are removing the right drug, the right dose for the right resident as labeled on his/her active inventory. He stated that nurses were not to be borrowing medications designated for other residents, and that if a medication was not available there was a back up supply of drugs available. The ADON was not sure if the [MEDICAL CONDITION] drug, [MEDICATION NAME] was available in the back up supply. The ADON stated that he would have to look into it further as to why there was a discrepancy, and where the four (4) missing capsules went. At 11:29 AM, the surveyor donned a gown, gloves and facial mask, and knocked and entered the room of Resident #62. The surveyor observed Resident #62 sitting on the edge of the bed. The resident agreed to be briefly interviewed at that time, and stated that he/she had the flu and had not been feeling well. The resident stated that he/she had been taking [MEDICATION NAME] everyday, but still got the flu. The resident could not recall how long he/she had been on the medication but stated it was maybe a week ago. The resident denied refusing the [MEDICATION NAME], and that he/she took the medication when the nurse brings it in. The resident further stated that he/she didn't think the nurse brought the [MEDICATION NAME] in yet this morning. On 2/27/2020 at 12:07 PM, the surveyor reviewed the discrepancy with the covering Consultant Pharmacist (CP). The CP stated that she would review it. The CP acknowledged that nurses should not borrow medications designated for other residents, but that she wasn't sure at that point if that was what happened to cause the discrepancy. On 3/3/2020 at 2:20 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team. The DON acknowledged the discrepancy observed on 2/27/2020, and stated that they reviewed all the [MEDICATION NAME] inventory for each resident on the identified medication cart. The DON added that because all the residents in the building were being administered [MEDICATION NAME] as a precaution, there were a lot of bags of [MEDICATION NAME] in the medication cart. She further stated that the nurses do not borrow medications from other residents, but that the nurses may have been confused and inadvertently removed a dose from the wrong resident's bag. She stated that she interviewed all the nurses that work on that cart, and that all the nurses stated that all the residents received the [MEDICATION NAME] in accordance with the physician order. A review of the facility's undated policy for Proper Medication Pass Techniques included, Routinely scheduled medications have a two (2) hour window of administration. Example: A daily 9:00 AM medication must be given between 8:00 AM and 10:00 AM. 2. On

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALLENDALE NURSING HOME	85 HARRETON ROAD ALLENDALE, NJ 07401

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 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) 2/27/2020 at 10:41 AM, the surveyor donned a gown, gloves and a facial mask. The surveyor knocked and entered the room of Resident #32. The surveyor observed Resident #32 sitting upright in a wheelchair, awake and smiling. The resident was able to tell the surveyor his/her name and that he/she was feeling good. The surveyor attempted to continue to interview Resident #32 by asking how long he/she had been at the facility, if he/she had recently changed rooms, but the resident just shrugged his/her shoulders, and the surveyor was unable to continue the interview. On 2/27/2020 at 10:43 AM, the surveyor interviewed the resident's LPN who stated that she was the full time nurse assigned to care for Resident #32. The LPN stated that Resident #32 was on transmission-based precautions to prevent the spread of the flu. The LPN stated that the resident was on the anti-[MEDICAL CONDITION] medication, [MEDICATION NAME]. The surveyor reviewed the medical record for Resident #32. A review of the Resident Information Sheet (an admission summary face sheet) reflected that the resident was admitted with [DIAGNOSES REDACTED]. A review of the admission MDS dated [DATE] reflected that the resident had a BIMS score of 6 out of 15, indicating the resident had a moderately impaired cognitive deficit. A review of the physician's orders [REDACTED]. Further review of the physician's orders [REDACTED]. A review of the resident's MAR for February 2020 reflected the corresponding PO dated [DATE] to administer [MEDICATION NAME] 75 mg by mouth daily for 14 days. The MAR was signed to reflect the [MEDICATION NAME] 75 mg was administered one time on 2/19/2020 at 9 AM. The MAR reflected the order was discontinued on 2/19/2020 and the new order for [MEDICATION NAME] 30 mg was started. Further review of the MAR for February 2020 reflected the PO dated 2/19/2020 for the [MEDICATION NAME] 30 mg by mouth daily for 14 days. The MAR was signed to reflect the [MEDICATION NAME] 30 mg was administered at 9 AM on 2/20/2020 through 2/27/2020, for a total of eight (8) doses administered. On 2/27/2020 at approximately 10:45 PM, the surveyor continued to interview the resident's assigned LPN. The surveyor requested to see the resident's supply of [MEDICATION NAME] from the medication cart. The LPN removed a bag labeled for Resident #32, and the bag was labeled for [MEDICATION NAME] 75 mg capsules, and it had a delivery date of [DATE] from the pharmacy provider. Inside the bag labeled with [MEDICATION NAME] 75 mg, were four (4) capsules of [MEDICATION NAME] 75 mg, commingling with nine (9) capsules of [MEDICATION NAME] 30 mg. The surveyor asked the LPN why there were two different dosages of [MEDICATION NAME] inside a bag labeled for Resident #32. The LPN stated that she did not know. At that time she pulled up the resident's MAR for February 2020 and stated that the resident was currently on [MEDICATION NAME] 30 mg. She stated that the resident was initially on [MEDICATION NAME] 75 mg, but the dose had to be lowered to 30 mg due to the resident's recent lab results. At that time, in the presence of the surveyor, the LPN removed the four (4) capsules of [MEDICATION NAME] 75 mg, and put it into the bag labeled for [MEDICATION NAME] 75 mg and designated for Resident #62. The LPN stated that four capsules of the [MEDICATION NAME] 75 mg might have been accidentally placed in the active inventory for Resident #32. The surveyor then asked where the remaining 13 capsules of [MEDICATION NAME] 75 mg were for Resident #32, if 14 capsules were delivered on [DATE] and the resident only received one (1) capsule on 2/19/2020 at 9 AM. The LPN could not speak to it. The LPN also acknowledged that if a medication was discontinued, the bag and all the medications in the bag would be sent back to the pharmacy. The surveyor asked the LPN to continue looking into her medication cart to see if there was a bag labeled for Resident #32 for [MEDICATION NAME] 30 mg. The LPN was unable to find a bag labeled for Resident #32 for [MEDICATION NAME] 30 mg. The LPN could not speak to how [MEDICATION NAME] 30 mg ended up in a bag labeled for 75 mg. The LPN stated that she gives the resident 30 mg and that before she gives the resident the medication, she reads the individually packaged [MEDICATION NAME] medication to verify for accuracy of the 30 mg. She acknowledged it should not have been commingling in the same package. The LPN stated that Resident #32 had not refused the [MEDICATION NAME] 30 mg. On 2/27/2020 at 11:04 AM, the surveyor interviewed the ADON who stated that Resident #32 was originally on [MEDICATION NAME] 75 mg and that he/she had not had recent labs. Lab studies were obtained and based on those results the determination was made by the physician to lower the dose to [MEDICATION NAME] 30 mg daily. The surveyor reviewed the bag labeled with [MEDICATION NAME] 75 mg, but inside the bag had nine (9) capsules of [MEDICATION NAME] 30 mg and designated for Resident #32. The ADON acknowledged that [MEDICATION NAME] 30 mg should not be in a bag labeled as 75 mg, and that two different dosages ([MEDICATION NAME] 75 mg and [MEDICATION NAME] 30 mg) should not be commingling inside the same bag labeled as [MEDICATION NAME] 75 mg. He acknowledged that could put a resident at risk for receiving the wrong dose. He stated that the nurses should however be reviewing each individually packaged pill which indicates the dose right on it, and verify it with the physician's orders [REDACTED]. The ADON could not speak to where the resident's 13 remaining capsules of [MEDICATION NAME] 75 mg were, when 14 capsules were delivered and only one capsule administered. He indicated that it likely went back to the pharmacy, but stated that the pharmacy provider would take the bag labeled as [MEDICATION NAME] 75 mg, and he acknowledged the facility still had the bag labeled with the 75 mg. The ADON acknowledged the surveyor's findings and stated he would have to investigate the issue further. At 11:38 AM, the ADON provided the surveyor a copy of the pharmacy delivery receipt which reflected that on 2/19/2020, 14 capsules of [MEDICATION NAME] 30 mg was received for Resident #32. At that time, the surveyor asked the ADON about the discrepancy of what was available for the resident in the inventory. The ADON acknowledged there 14 capsules were delivered on 2/19/2020 and there were nine (9) capsules of [MEDICATION NAME] 30 mg remaining in the resident's inventory. The surveyor and the ADON reviewed the MAR for February 2020 together and acknowledged that the nurses signed for the administration of [MEDICATION NAME] 30 mg for eight (8) daily doses from 2/20/2020 through 2/27/2020 without refusals or missed doses. The ADON acknowledged that the numbers do not reflect an accurate account of the [MEDICATION NAME] 30 mg. He stated that if 14 capsules were sent, and the resident received eight (8) capsules in accordance with physician order [REDACTED]. He could not speak to the three extra dosages available. The surveyor asked the ADON did the resident get those three dosages that were signed as administered but are still available in inventory? The ADON acknowledged the surveyor's question and stated that he would have to further investigate. The ADON stated that nurses are not supposed to be borrowing medications, but stated that based on the surveyor's findings from Resident #32 and #62, he stated that it was going to be investigated as a possibility. On 2/28/2020 at 10:19 AM, the surveyor interviewed the covering CP who stated that they have been looking into the concern and believe that when the 14 capsules of the [MEDICATION NAME] 30 mg were delivered on 2/19/2020, the individually packaged [MEDICATION NAME] capsules were removed from the bag, and inadvertently placed in the bag labeled for [MEDICATION NAME] 75 mg. She stated that they were still looking for the resident's bag labeled with [MEDICATION NAME] 30 mg with the delivery date of 2/19/2020. On 3/3/2020 at 2:20 PM, the surveyor interviewed the DON in the presence of the survey team. The DON acknowledged the surveyor's findings on 2/27/2020, and stated that they reviewed all the [MEDICATION NAME] inventory for each resident on the identified medication cart. The DON added that because all the residents in the building were being administered [MEDICATION NAME] as a precaution, there were a lot of bags of [MEDICATION NAME] in the medication cart. She further stated that the nurses do not borrow medications from other residents, but that the nurses may have been confused and inadvertently removed a dose from the wrong resident's bag. She stated that Resident #32 received the [MEDICATION NAME] 30 mg every day in accordance with the physician's orders [REDACTED]. She confirmed two different dosages of medication should not be commingling in the same bag. The DON was unable to provide documented evidence that the resident had refused [MEDICATION NAME] 30 mg during his/her course of treatment. A review of the facility's undated policy for Proper Medication Pass Techniques included, to identify the resident and make sure they are ready to receive medication prior to pouring the medication. The policy did not address how medications labeled for individual residents should be handled. NJAC 8:39-29.1