STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315141	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ABINGDON CARE & REHABILITATION CENTER	**303 ROCK AVE GREEN BROOK, NJ 08812**

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** NJ 287 Based on interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to ensure appropriate documentation for a resident who was discharged against medical advice. This deficient practice was identified for 1 of 5 residents reviewed for discharge (Resident #3). 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: On 9/1/20, the surveyor reviewed the closed medical record for Resident #3. A review of the Move In Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The surveyor attempted to review the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, but Resident #3 was admitted to the facility for less than three days. A review of the electronic Physician's Progress Note (ePN) dated 4/3/20 reflected a medical assessment of the resident. A review of a Brief Interview for Mental Status (BIMS) cognitive evaluation signed by the Social Worker (SW) on 4/3/20 reflected that the resident had a BIMS score of 15 out of 15, indicating fully intact cognition. A further review of the progress notes did not reflect evidence of any further documentation regarding the resident after the BIMS score obtained on 4/3/20. A review of an electronic Medication Administration Record [REDACTED]. There were no additional progress notes documented regarding the condition of the resident upon the AMA discharge, how the resident was sent home, if any durable medical equipment or personal belongings were sent home with the resident. On 9/2/20 at 9:28 AM, the surveyor interviewed the Certified Nursing Aide (CNA) who stated that when residents are discharged from the facility, she would assist them in getting their belongings placed in bags to pack up, assist them in getting dressed and transfer them in a wheelchair to the transportation vehicle. She stated at process would be the same if it was a planned discharge or unplanned discharge such as a hospitalization or AMA. The CNA stated that she does not document the discharge in the medical record but that nurses do that. On 9/2/20 at 9:36 AM, the surveyor interviewed a Licensed Practical Nurse (LPN). The LPN stated that she was slightly familiar with Resident #3 but that she was not working the day the resident was discharged home AMA. She stated that upon discharge whether it was AMA or a planned discharge home, residents would still be provided discharge instructions and that the CNA would assist in getting the resident dressed and belongings would be packed and sent with the resident. The LPN stated that she would document the discharge in the medical record, including the resident's cognitive status, vital signs if the resident allowed, the reason for discharge, the equipment sent with the resident and belongings that may have been set as well. The LPN confirmed that the electronic progress notes were the only place that the nurses would document the discharge. At 9:42 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that she wasn't working at the facility at the time of the resident's admission. She stated that nurses are to be documenting the discharge in the electronic progress notes and that there was no other place it should be recorded. The surveyor and the RN/UM reviewed the resident's electronic progress notes together and the RN/UM acknowledged that there was no discharge note written by the nurse. The RN/UM provided the surveyor with the nurses name who worked on 4/4/20 at the time of resident discharge. At 9:47 AM, the surveyor attempted calling the nurse who discharged Resident #3 home with the spouse and the nurse did not respond to the surveyor's call. At 10:10 AM, the surveyor interviewed the Occupational Therapist/Rehab Director who stated that the resident was seen by therapy for one day and left AMA on 4/4/20. She stated that the Rehab Evaluation indicated that the resident had all DME at home and that he/she did not need any further equipment. At 12:50 PM, the surveyor reviewed the findings with the Director of Nursing (DON) and the DON acknowledged there was no clear discharge note from the nurse. The DON acknowledged she also tried to call the nurse this morning who discharged the resident AMA on 4/4/20 but that the nurse had not responded to her call yet either. The DON acknowledged there was no nursing progress note or nursing discharge note written on 4/4/20 to address the AMA discharge. A review of the facility's Discharge Planning Process Policy revised 12/2019 included in cases where the resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the interdisciplinary team will treat this situation similarly to refusal of care. Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location .Document any discussions related to the options presented. Document refusals or other options that could meet the resident's needs. At that time of discharge, follow policies regarding discharges against medical advice A review of the Transfer and Discharge (Including AMA) policy revised 1/2020, included under Discharges Against Medical Advice (AMA), Documentation of this notification should be entered in the nurse's notes by the nursing department. NJAC 8:39-11.2 (b)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** NJ 843 Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to: a.) administer a fever-reducing medication for a resident with a fever and b.) initiate respiratory comfort measures while awaiting Emergency Medical Transportation for the same resident who was experiencing an increased respiratory rate. This deficient practice was identified for 1 of 3 residents reviewed for hospitalization s (Resident #4). The evidence was as follows: On 9/2/2020 the surveyor reviewed the closed medical record for Resident #4. A review of the Move In Record face sheet (an admission summary) reflected that the resident was admitted to the facility with [DIAGNOSES REDACTED]. The surveyor attempted to review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, but the resident was admitted to the facility for less than 14 days. A review of the resident's individualized comprehensive care plan dated 4/30/20 included that Resident #4 was on antibiotic therapy for Pneumonia and was admitted to the facility with COVID-19. Interventions included to administer medications as ordered. A review of the Physician's Order Summary Report reflected a physician's order (PO) dated 4/28/20 to Evaluate for COVID-19 signs and symptoms every shift including a blood pressure, heart rate, respiratory rate, pulse oximetry and pain. A review

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) of the electronic Medication Administration Record (eMAR) for May 2020 reflected the corresponding PO dated 4/28/20 to evaluate for signs and symptoms of COVID-19. The eMAR reflected that on 5/3/20 during the night shift (11 PM to 7 AM) the resident's vital signs included a heart rate that was slightly elevated to 108 beats per minute (normal range is approximately 60-100 beats per minute at rest), and a respiratory rate of 20 breaths per minute (normal range is approximately 14 to 20 breaths per minute at rest). The resident was not experiencing a fever at that time. A review of the electronic Progress Notes (ePN) dated 5/3/20 at 9:16 PM reflected that at 5 PM the resident was in bed awake, alert, no respiratory distress or signs and symptoms of discomfort noted. Resident refused to eat and drink despite encouragement. Vital signs included a heart rate of 130 beats per minute and respiratory rate of 30 breaths per minute and the pulse oximetry reading was 94% on room air. The note indicated that the physician was notified of the resident's change in medical condition, and the physician provided orders. One hour later the resident's heart rate was 131 beats per minute, respiratory rate was 27 breaths per minute and pulse oximetry was 95% on room air. The resident was afebrile (without a fever). The note indicated that the attending physician was updated with the subsequent assessment and vital signs. The physician ordered laboratory work, nutrition supplements, and intravenous (IV) fluids. A review of the subsequent ePN dated 5/30/20 at 11:12 PM reflected that the resident representative was made aware of the poor appetite and refusing of a peripheral IV fluid line for hydration. The note indicated that fluids were encouraged but the resident refused and spit out the fluids. The physician was notified that the resident refused the IV fluids. A review of an ePN dated 5/4/20 at 11:23 AM, reflected that the resident spiked an new axillary (armpit) temperature of 102.5 degrees Fahrenheit, respirations were now 38 breaths per minute and the pulse oximetry was 95% on room air. Respirations noted labored and shallow. The note included that the resident was unable to take any medications and the Physician was notified and ordered for the resident to be transferred to the hospital. The electronic Progress Note dated 5/4/20 at 11:23 AM did not address respiratory comfort measures such as repositioning or the application of supplemental oxygen when the resident was experiencing labored breathing. In addition the ePN did not address the administration of a fever-reducing medication to treat the resident's elevated fever while awaiting medical transportation. A review of the physician's Order Summary Report for May 2020 did not include a physician's order for supplemental oxygen or a fever-reducing medication. A review of the eMAR for May 2020 did not reflect documented evidence of the administration of supplemental oxygen for comfort or evidence of administration of a fever-reducing medication when the resident spiked a fever of 102.5 degrees Fahrenheit. A review of the Universal Transfer Form (UTF) dated 5/4/20 reflected that the resident was full code and was transported to the hospital at 9:50 AM with a fever of 102.5, elevated heart rate and tachypnea (rapid breathing). There was no documented evidence that a fever-reducing medication was administered. The section for Respiratory Needs for the documentation for supplemental oxygen was blank. The surveyor conducted interviews with facility staff which revealed the following: On 9/2/20 at 9:15 AM, the surveyor interviewed the Registered Nurse (RN) who was caring for Resident #4 on 5/4/20 during the day shift and wrote the ePN. The RN stated that she was also the Unit Manager on the floor. The RN stated that if any resident presents with shallow or labored breathing, she would try to reposition the resident and initiate supplemental oxygen at 2 liters per minute via a nasal cannula. She added that supplemental oxygen at 2 liters per minute was a nursing intervention and that she didn't need a physician's order to apply oxygen at that flow rate, adding that it was because it was a respiratory comfort measure. She stated that she could later inform the physician that she applied the supplemental oxygen. The surveyor asked that if a resident had a fever of 102.5 degrees Fahrenheit what she would do, and the RN stated that she would look to see if there was a physician's order for a fever reducing medication such as Tylenol, and administer the prescribed dose to the resident. The surveyor asked, what if there was no physician's order? The RN stated that she would call the physician and get an order for [REDACTED]. She confirmed that Tylenol came in oral form or rectal suppository form and if a resident was refusing oral medications, they could administer the medication via a rectal suppository route. The RN showed the surveyor the facility's house stock of Tylenol rectal suppositories. The RN confirmed they had enough supply of the suppositories. The surveyor asked the RN if the resident had a fever of 102.5 Fahrenheit and was awaiting Emergency Medical Transport (EMT), would the nurse be responsible to obtain an order from the physician to treat the fever, or would they wait for the EMT or receiving hospital to address it? The RN stated that she would have to address the fever unless the physician gave order's otherwise. She stated that she would get a physician's order for Tylenol suppository, administer the medication and document it in the eMAR and document the administration of the fever reducing drug on the UTF form as a means of communication to the receiving facility/ higher level of care. She stated that it should all be documented in the resident's medical record. The surveyor reviewed the resident's medical record together including the ePN and the eMAR and the RN acknowledged that there was no evidence of documentation regarding respiratory comfort measures such as repositioning or supplemental oxygen, and there was no evidence of administration of a fever-reducing medication. The RN stated that she thought she recalled this day and stated I think I gave (Resident #4) a non-rebreather mask but she stated that if she did it she would have documented it. The RN confirmed she did not recall, but she stated because the resident's pulse oximetry was reading within a normal range, that may be why she didn't document about applying oxygen. The RN stated that if a resident's respiratory rate was labored for an extended period of time, it could eventually affect the pulse oximetry reading. The RN further acknowledged there was no physician's order for Tylenol, and therefore there was no evidence it was given. She stated that she would not have given the Tylenol if it was not ordered by the physician. She stated that she could not recall obtaining a physician's order and administering Tylenol to the resident. On 9/2/20 at 12:48 PM, the surveyor interviewed the Director of Nursing (DON) and the DON acknowledged that while the resident's pulse oximetry was being closely monitored and within normal range, the nurse should have applied supplemental oxygen at 2 Liters/minute for respiratory comfort measures due to the resident's increased respiratory rate. She also acknowledged that the RN should have obtained a physician's order for the Tylenol, and that there should have been no delay in administering the suppository to treat the fever prior to sending the resident to the hospital. She acknowledged there was no PO for a fever-reducing medication in the resident's medical record. The DON was unable to provide additional documentation to refute the surveyor's findings. A review of the facility's Change In Condition policy revised 10/2019, included that The licensed nurse will evaluate and/or assess these reported changes in condition and appropriate referrals will be made .(to) physician, as needed. Changes in condition will be communicated to Attending Physician, resident and/or resident representative .Care plan and medical records will be updated, as needed. A review of the Oxygen Safety policy revised 1/2020 did not address when staff should implement the use of supplemental oxygen. At 1:15 PM, the surveyor reviewed the findings with the Licensed Nursing Home Administrator (LNHA), Assistant LNHA, and the DON. There were no additional policies provided. NJAC 8:39-27.1