STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315488	A. BUILDING ______ B. WING ______	C 10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MADISON AVENUE	**151 MADISON AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT #NJ00146410, #NJ00148122, #NJ00145269, #NJ00146521 Census: 102 Sample Size: 6 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART483,SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all	F 755		10/19/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE

(X6) DATE: 10/14/2021

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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aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
C/O # NJ00148122

Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to account for and dispose of controlled medication in a manner that would decrease the possibility of loss or diversion. This was found with 1 of 1 nurse observed during medication pass.

The deficient practice was evidenced by the following:

1. On 10/1/21 at 10:28 AM, the surveyor observed a Licensed Practical Nurse #1(LPN #1) administer medication to Resident #5. Prior to placing a [redacted] on the resident's [redacted] LPN #1 removed a patch from the resident's [redacted] and placed it in an empty medicine cup. When LPN #1 completed medication administration with Resident #5 the surveyor and LPN #1 returned to the medication cart. The surveyor asked LPN #1 how she was going to discard the resident's used [redacted] patch that she removed from the resident's [redacted]

F 755

Resident #5 received the medication as ordered and was discharged home after a rehabilitative stay.

All residents receiving [redacted] patches have the potential to be affected.

Nurse #1 was provided one-on-one education related to [redacted] transdermal disposal and the process of witnessing waste for this class of medication as well as documentation related to the controlled drugs-count record (CDCR).

The Director of Nursing (DON) conducted an audit and investigation related to transdermal controlled medications.

Nursing staff were in-serviced related to [redacted] transdermal disposal and the process of witnessing waste for this class of medications.

The Director of Nursing or designee will audit 4 CDCR's weekly x 4 for one month, then twice monthly for two months.

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chest. LPN #1 said she already placed the [redacted] patch in the [redacted] (a liquid disposal system that is used to dissolve medication when being wasted by a licensed professional)." The surveyor did not observe LPN #1 dispose of the [redacted] patch in the [redacted] [redacted]. LPN #1 said that was the process she routinely used to dispose of the [redacted] patches.

On 10/1/21 at 11:45 AM, the surveyor asked the Unit Manager Registered Nurse (UM/RN) what the facility's policy was for disposing of [redacted] patches. The UM/RN said the nurse would place the patch in the [redacted] with a witness (a nurse or pharmacist) present. The witness would sign the "Controlled Drug Administration Record for Patches (CDARP)" where it said "Witness Signature." The surveyor reviewed the CDARP sheet for Resident #5 which indicated that a patch was removed from inventory with a date and time the patches were applied to the resident, 9/28/21 9:26 AM and 10/1/21 10:19 AM. Neither of those entries included an entry that an old patch was removed from the resident. There were no signatures for the nurse who removed the old patch or for the witness who observed the disposal of the old patch.

On 10/1/21 at 1:00 PM, the surveyor asked LPN #1 if she was aware that the facility's policy and procedure for disposing a [redacted] patch including having a witness observe the disposal and sign that they witnessed it. LPN #1 stated "No one ever brought it to my attention but now that I think about it, it's a controlled drug, so yeah, I guess so."

On 10/1/21 at 2:00 PM, the surveyor reviewed the facility's policy and procedure titled "Disposal of

F 755

The audit results will be presented to the Quality Assurance Performance Improvement (QAPI) committee monthly for a period of three months. Review of the audits will determine any changes in the plan or continued monitoring.

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F 755	Continued From page 3 Non Hazardous Medications" dated January 2011 and last revised 6/4/2014. Under the heading: "Documentation" it read "9. Documentation of drug destruction for controlled substances requiring decreasing inventory will include at least the following information or as required by state regulations: Name of resident, Name of medication, Strength of medication, Prescription number, Date removed from nursing unit, Controlled substance book and page numbers, Date destroyed, Signatures of individuals destroying and witnessing controlled drug destruction, If required by state, the individual pages of the narcotic destruction log will be sequentially numbered. Number 9.1 Both the destroying professional and the witnessing professional shall sign the completion/witnessing of the destruction on the declining inventory." 2. On 10/1/21 at 11:45 PM, the surveyor reviewed the controlled substance counting procedure with LPN #1. LPN #1 reported that at the beginning of the shift the outgoing nurse would count with the incoming nurse and both nurses would sign the "Controlled Drugs-Count Record (CDCR)." The surveyor reviewed the current CDCR. The [redacted] "Nurse On (7-3)" column was blank. The surveyor asked LPN #1 if she counted narcotics that morning. She said she did. The surveyor asked why she did not sign the CDCR. LPN #1 said "I don't know." The surveyor reviewed the CDCR for the month of [redacted]. For the 30 days in September there were nine missing signatures for the 11-7 shift, seven missing signatures for the 7-3 shift, and one missing signature for the 3-11 shift. On 10/1/21 at 2:00 PM, the surveyor reviewed the Facility's Policy and Procedure titled "Controlled	F 755		

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F 755	Continued From page 4 Drugs Count Record (CDCR)/Controlled Drug Index (CDI)-New Jersey." It was dated 8/1/10. Under "Process." Number 1 read: "At the change of each shift and/or at any time in which the narcotic keys are surrendered to another responsible party, the outgoing responsible party will count drugs with the incoming responsible party." Number 2 read: "Accounting will be documented on the Controlled Drug Count Record (CDCR) form." Number 3 read: "Both responsible parties will count the number of bingo cards, packs/boxes, and bottles and document the count on the designated spaces. The outgoing responsible party fills out the fist column and the incoming responsible party completes the second column on each shift and signs on the designated line to acknowledge that the count was correct on the CDCR form." NJAC 8:39-29.7 (c)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: C/O # NJ 00148122 Based on observation, interview and record review, it was determined that the facility failed to administer medication with an error rate of less than 5%. The surveyor observed one nurse administer medications to two residents with 27 opportunities for error. There were five errors	F 759	Resident #6 received the prescribed medications as ordered. Resident #5 received their medications as ordered and was discharged. Resident #5 and #6 were monitored and had no adverse effects. LPN #1 was in-serviced on cautionary labels, medication times, and the process for medications not administered.	10/19/21

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F 759	Continued From page 5 resulting in an error rate of 18.5% as evidenced by the following: 1. On 10/1/21 at 9:35 AM, the surveyor observed a Licensed Practical Nurse (LPN#1) administer medication to Resident # 6. LPN #1 crushed the following medicine and placed it in a medication cup with other medicine: MG (Milligrams), a medication used to treat Certain Types of . The cautionary label on the blister pack that contained the medication read; "Do not crush, chew, or divide." When LPN #1 was about to walk into the resident's room to administer the medication the surveyor confirmed with her that the Tablet MG was one of the crushed pills in the medicine cup. LPN #1 and the surveyor looked at the cautionary on the blister pack. LPN #1 stated "[The resident] is on a pureed diet. What do I do?" The surveyor asked LPN #1 what she would normally do if she had a question. She said she would ask the Unit Manager/Registered Nurse (UM/RN). LPN #1 then asked the UM/RN what she should do with the medication that was not supposed to be crushed according to the cautionary on the blister pack but was crushed and in a cup with other medication. The UM/RN told LPN #1 to discard all of the medication and call the resident's doctor. LPN #1 did discard the medication and the UM/RN called the resident's doctor who said to hold the until the doctor saw the resident later that day. 2. The surveyor then observed the LPN #1 prepare medication for Resident #5. LPN #1 placed the following medication in a medicine cup; mg (a medication to), mg (a	F 759	All residents receiving medications have the potential to be affected. The Director of Nursing (DON) or designee provided education to nurses on all shifts related to the importance of following cautionary labels, medication administration times, and process for medications not administered. The Director of Nursing or designee will conduct 3 medication pass with various nurses on different shifts. Audits will be conducted weekly x4 weeks, for one month, then twice monthly for two months related to medication cautionary labels and administration times, and missing medications. Results of the audits will be presented at the monthly Quality Assurance Performance Improvement (QAPI)meeting x 3 months and changes to the plan will be made if necessary.	

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F 759	Continued From page 6	F 759		

medication to), 2 tablets, and (a medication to treat and) (mg.

The cautionary label on the blister pack that contained the read: "take with breakfast or first main meal."

The cautionary label on the blister pack that contained the read: "Take with or right after a meal." Additionally the cautionary on the Medication Administration Record (MAR) and the Physician's Order Sheet (POS) read: "Take with or immediately following meals."

The cautionary label on the blister pack that contained the read: "Give with meals." Additionally, the cautionary on the MAR and the POS read: "Give with meals."

LPN #1 administered the medication to the resident at 10:28 AM. At that time the surveyor asked the resident, who was alert and oriented, what time [the resident] ate. The resident said 8:00 AM. The surveyor asked LPN #1 about the 3 medications that were administered to Resident #5 that had cautionaries to be given with food. LPN #1 stated "I thought with food was right after eating." The surveyor asked LPN #1 how long after eating was it ok to administer medicine that was to be given with food. LPN #1 said she didn't know. The surveyor asked the UM/RN what time the breakfast trays arrived on the unit. The UM/RN said 8:20 AM to 8:40 AM. The surveyor asked the UM/RN how long after the resident ate was it ok to give a medicine that was to be given with food. The UM/RN said 15 to 30 minutes after

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F 759	Continued From page 7 the resident ate, any longer than that LPN #1 should have given the resident a sandwich or a yogurt. 3. On 10/1/21 at 12:30 PM the surveyor reconciled medication administration observations with the physician's orders. The surveyor observed physician's orders that read [redacted] (a supplement) Tablet [redacted] MG, Give 1 tablet by mouth in the morning for risk of [redacted]" and [redacted] give [redacted] units by mouth one time a day for a [redacted] [redacted]." The surveyor had not observed LPN #1 give those medications during the medication pass observation that morning. On 10/1/21 at 12:45 PM the surveyor asked LPN #1 why she had not given the [redacted] [redacted] or the [redacted] that morning during medication pass. LPN #1 said they weren't in the medication cart, she said the UM/RN retrieved those medications from another floor and gave them to the resident. On 10/1/21 at 2:45 PM, the surveyor asked the UM/RN if she gave the [redacted] and the [redacted] that day to Resident #5. The UM/RN said she gave the resident the [redacted] but not the [redacted]. She said that the [redacted] was on the medication cart and LPN #1 should have given it to the resident. The surveyor asked the UM/RN if she noticed the nurses were not giving medication that was ordered. She said for months that had been an issue that she had been addressing with the nurses, particularly the agency nurses (LPN #1 that the surveyor	F 759		

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F 759	Continued From page 8 observed that day was an agency nurse). The UM/RN further stated that she had found that the agency nurses didn't take the next step when there was a missing medication. The UM/RN stated the nurse should call the pharmacy, call the doctor, re-order the medicine when they saw it was getting low. The surveyor asked the UM/RN what LPN #1 should have done when she couldn't find the [redacted]. The UM/RN said "she should have told me and she did not." On 10/1/21 at 2:00 PM the surveyor reviewed the facilities Policy and Procedure titled "General Guidelines for the Administration of Medication." The policy had an effective date of January 2015. The policy didn't address the issue of following the cautionaries. NJAC 8:39-29.2 (d)	F 759		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		10/19/21

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F 812 Continued From page 9

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
C/O # NJ00145269

Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) failed to sanitize and air dry steam table pans in a manner to prevent cross contamination of microbial growth; b.) failed to maintain the kitchen environment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness and c.) failed to utilize appropriate hand hygiene practices and techniques. This deficient practice was evidenced by the following:

On 10/1/21 at 9:42 AM, in the presence of the Director of Culinary Services (DCS), the surveyor observed the following:

1. In the dishwashing area directly next to the clean side of dish washing machine, the surveyor observed a hand washing sink with no barrier separating the sink and the dish washing machine, to prevent splashing or cross contamination while an employee is washing their hands.

2. Above the cook top area the surveyor observed three of four red sprinkler rubber caps soiled with black and tan colored substances.

3. On a shelf in the dishwashing area, the surveyor observed two 2-inch ¼ sized steam

F 812

The pans were re-sanitized and then air dried. The red rubber sprinkler caps above the cook top area were cleaned and a splash guard was also immediately installed to the hand wash sink.

All residents receiving meals from the kitchen have the potential to be affected.

Additional racks have been put into place for items that require the air dry process.

The Director of Culinary Services(DCS) provided Kitchen staff on both shifts re-education regarding sanitation guidance which included wet nesting, cleaning checklist, and handwashing (with return demonstration including competency).

The Director of Culinary or designee will conduct daily rounds and document a weekly observation of pans and the air dry process and audit the cleaning checklist. These observations and audits will be documented for four weeks, then twice monthly for an additional two months.

Results of these audits will be reported to the Administrator at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a period of 3 months. Any changes in process based on the

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F 812	Continued From page 10 table pans stacked with water between them. The DCS stated that these steam table pans should not have been stacked with water between them and they should have been air dried before stacking them. During an interview on 10/1/21 at 3:30 PM, the surveyor brought the above concerns to the attention of the Administrator and Director of Nursing. The facility did not provide the surveyor with a policy or procedure for the above concerns. NJAC 8:39-17.2(g)	F 812	results of the audit will be reviewed at the time and the plan adjusted.	