

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2020
NAME OF PROVIDER OR SUPPLIER BERGEN NEW BRIDGE MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 230 E RIDGEWOOD AVE PARAMUS, NJ 07652		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D 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#: NJ136800 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT VISIT. CENSUS: 393	F 000			
F 760 SS=G	SAMPLE SIZE: 3 Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: C#: NJ 136800 Based on interviews, review of medical records and review of other pertinent facility documentation, it was determined that the facility failed to maintain the accepted professional standards for medication administration by administering the wrong medication to the wrong resident (Resident #2). In addition, failed to follow their policies and procedure titled General Guidelines for the "Administration of Medication" and "Medication Incidents" when on 4/12/2020, during the 9 p.m. medication pass, the Licensed Practical Nurse(LPN) poured Resident #3's medication in a cup and gave it to the Assistant Director of Nursing (ADN) to administer it to	F 760	1. Resident #2 no longer resides at the facility. An investigation was completed for the medication incident and Resident #3 did receive all proper medication. All other residents on the unit of Resident #2 and #3 were reviewed, on the date of the medication error, to ensure there were no medication discrepancies with other residents. 2. All residents who receive medication have the potential to be affected by this practice.	6/18/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/01/2020

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 760	<p>Continued From page 1</p> <p>Resident #3. Instead the ADN administered Resident 3#'s medication which were poured by the LPN to Resident #2. At approximately 11:15 p.m., Resident #2 was found unconscious by the oncoming nurse on the 11 p.m. - 7 a.m. shift. This deficient practice was identified for 1 of 3 sampled residents reviewed for receiving the wrong medication, as evidenced by the following:</p> <p>A review of Electronic Medical Record (EMR) for Resident #2 revealed the following:</p> <p>The Admission sheet revealed Resident #2 was admitted to the facility on [REDACTED], with diagnoses which included but were not limited to: [REDACTED]</p> <p>The Physician's Renewal Order (PRO) in the EMR indicated the following medications were prescribed for Resident #2, by the physician were [REDACTED]. Give 2 tablets [REDACTED] at bedtime at 9:00 p.m.. for [REDACTED], dated 5/17/2017. [REDACTED]. Give 1 Tablet orally at 9:00 p.m., for [REDACTED]. (May cause drowsiness), dated 5/26/2017. [REDACTED] tab. Give 2 tablets ([REDACTED] orally daily at bedtime for [REDACTED], dated 4/23/2018.</p> <p>Review of the "Interdisciplinary Progress Notes (IPN)" dated 4/13/2020 at 1:27 a.m., written by the Registered Nurse (RN #1) who found Resident #2 unconscious while making her rounds revealed the "Resident was found unresponsive" at 11:15 p.m. The IPN also showed that Resident #2 was assessed and [REDACTED] was initiated via (by) a [REDACTED]. The Rapid Response Team</p>	F 760	<p>The Licensed Practical Nurse involved in the medication administration of Resident #2 was observed for medication pass to ensure all medication administration procedures were properly followed.</p> <p>The Registered Nurse/ADN involved in the medication administration was provided with medication pass observation to ensure proper medication administration procedures, particularly appropriate resident identifiers, were followed.</p> <p>3. Re-education was provided to all licensed nurses regarding proper medication administration procedures and policy, including the five rights of medication administration and three rights of proper documentation and appropriate resident identifiers.</p> <p>The licensed nurses involved with the medication administration of Resident #2 were provided with remedial education specific to medication administration, including the five rights of medication administration and three rights of proper documentation, prior to the complaint investigation.</p> <p>4. The Director of Nursing/designee will perform five random medication pass observations per month to ensure that all medication administration procedures are followed. The results of the audit will be reported to the Administrator monthly and the Quarterly Quality Assurance Performance Improvement Committee for a period of twelve months.</p>		

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F 760	<p>Continued From page 2</p> <p>(RRT) was called and arrived at 11:35 p.m. The LPN also revealed that an [REDACTED] was placed into Resident #2's [REDACTED], which was started on the unit. Resident #2 was then transferred to the ER (emergency room) at 12:00 a.m. for an evaluation.</p> <p>The surveyor requested the investigation, which was provided by the Director of Nursing (DON) on 6/12/2020, review of the incident report titled "Incidents: Modify Incident" report with an incident date of 4/12/2020, completed by the ADN, revealed that Resident #2 had a "Loss of Consciousness," and that the ADN "give the wrong meds, [REDACTED] tab to (Resident #2)..." Review of a facility document titled "Individual Statement Form (ISF)" dated 4/15/2020, written by the LPN revealed that on 4/12/2020 on the 3:00 P.M. to 11:00 p.m. shift, the LPN poured Resident #3's medication in a paper cup, and wrote the Resident's name and room number on a second cup for the ADN to administer the medications to Resident #3. The statement further explained that at 10:00 p.m., Resident #3 asked the LPN for his/her medications. The LPN then called the ADN and asked her who she gave Resident #2's medication to, and the ADN told the LPN that she gave Resident #3's medication to Resident #2, and it was a mistake.</p> <p>Review of a second "ISF" dated 4/25/2020, written by the ADN revealed that on 4/12/2020 at 9:30 p.m., "I was helping (the LPN) to administer medications. I administered the [REDACTED] to (Resident #2", when it should have been for (Resident #3)."</p>	F 760			

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F 760	<p>Continued From page 3</p> <p>A review of the EMR for Resident #3's revealed the following:</p> <p>The Admission Sheet revealed the resident was admitted to the facility on [REDACTED] with diagnoses which included but were not limited to: [REDACTED].</p> <p>The MDS dated [REDACTED], revealed that Resident #3 had a BIMS score of [REDACTED].</p> <p>The PRO in the EMR indicated the following medications were prescribed, by the physician for Resident #3: [REDACTED], 1 tab orally daily at 9:00 p.m. for [REDACTED], dated 3/27/2018. [REDACTED] orally at 6:00 A.M., 2:00 p.m., and 10:00 p.m. for pain management, dated 6/12/2018.</p> <p>During a telephone interview on 6/11/2020 at 10:53 a.m., RN #1 stated she found Resident #2 unresponsive lying in bed, during her rounds. RN #1 also indicated she told LPN #1 that Resident #2 was unresponsive. LPN #1 explained to RN #1 that Resident #2 was given Resident #3's medication, and she told the LPN to call the RRT. RN #1 also indicated that she took the crash cart to Resident #2's room and placed the [REDACTED] [REDACTED] on the Resident, however; the Resident was not responding. RN #1 further explained at this time the RRT arrived in Resident 2's room and took over caring for the resident.</p> <p>During an interview on 6/11/2020 at 11:15 a.m., LPN #1 stated that around 9:00 p.m., the ADN was assisting her with administering the medication, she wrote Resident #3's name and</p>	F 760			

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F 760	<p>Continued From page 4</p> <p>room number on the cup and gave the cup to the ADN to administer the medication to the resident and then signed off on the Medication Administration Record. LPN #1 indicated that Resident #3 came to her around 9:30 p.m. and asked for [REDACTED] medication. The LPN explained she then called the ADN and asked her who she gave Resident #3 medication to, and the ADN indicated she gave the medication to Resident #2. In addition, LPN #1 stated "when giving medication the policy is to check the (resident's) hand band which has the Resident's name.</p> <p>During a telephone interview on 6/11/2020 at 1:17 p.m., the RRT Physician stated that she was told that Resident #2 was given [REDACTED]. The RRT Physician also indicated, when she arrived at the scene the Resident #2 was lethargic, and the Resident's [REDACTED] were fluctuating. The RRT Physician also indicated Resident #2 was placed on a 100 % non-rebreather O2 and Narcan was administered. In addition, the Physician stated that Resident #2 responded to the [REDACTED] and was stable.</p> <p>During an interview on 6/11/2020 at 11:52 a.m., with the with the DON, in the presence of the ADN, the DON indicated the ADN should have checked Resident #2's hand band prior to administering the medication.</p> <p>During an interview on 6/12/20 at 9:39 a.m., the ADN stated she was helping the LPN to administer the 9 p.m., medication. The LPN prepared Resident #3's medication and indicated the medication was for Resident #3 and gave her the medication to administer to Resident #3. However, the ADN indicated she did not look to see if it was a male or female resident and she administered Resident #3's medication to the</p>	F 760			

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F 760	<p>Continued From page 5</p> <p>wrong resident, Resident #2. The ADN also indicated that prior to administering the medication to Resident #2, she failed to check the Physician's order, Medication Administration Record, and follow the 5 rights, the right patient, the right medication, the right dosage, the right route and the right time. In addition, the ADN stated she failed to check Resident#2's name wrist band and she was not supposed to administer medications she did not prepare.</p> <p>Review of the facility policy titled, "General Guidelines for the Administration", dated 1/2019, under "Procedure" #3, included the following: ... The nurse observes the five rights in administering each medication: a). The right resident b). The right time c). The right medication d). The right dose Under #5. Nurse identifies resident by name and by the facility identification system in place (ID bracelet, photo, etc.).</p> <p>Review of a second facility's policy titled "Medication Incidents", dated 1/19, included under "Definitions: Medication Incident: Any preventable event that may cause or lead to inappropriate medication use or patient harm, while the medication is in the control of the health professional" Under "Severity of Event" included "Incident Harm, Category L4. An incident occurred that resulted in the need for treatment or intervention and caused temporary patient harm.</p> <p>N.J.A.C:8:39-29.2(d)</p>	F 760			