

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35A3302</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/13/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TRADITIONS OF CROSS KEYS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3152 GLASSBORO CROSS KEYS ROAD</b> <b>GLASSBORO, NJ 08028</b>
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(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) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint and COVID-19 Focused Infection Control</p> <p>COMPLAINT #'s: NJ00153715, NJ00154709</p> <p>CENSUS: 60</p> <p>SAMPLE SIZE: 5</p> <p>The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p> <p>A COVID-19 Focused Infection Control Survey was conducted by the State Agency on 5/13/2022. The facility was found to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.</p>	A 000		
A 963	<p>8:36-11.5(f) Pharmaceutical Services</p> <p>(f) Medications shall be accurately administered</p>	A 963		

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

TITLE

(X6) DATE

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A 963	<p>Continued From page 1</p> <p>and documented by properly authorized individuals, in accordance with prescribed orders.</p> <p>This REQUIREMENT is not met as evidenced by: COMPLAINT #'s: NJ00153715, NJ00154709</p> <p>Based on interview and record review it was determined that the facility failed to ensure that medication was accurately documented as administered in accordance with prescriber's orders for 1 of 5 residents, Resident #4.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 5/13/22 at 11:20 a.m., the surveyor reviewed the closed medical record (MR) for Resident #4 which identified that Resident #4 had moved into the facility on [REDACTED] with diagnoses which included [REDACTED]. The resident was discharged on [REDACTED].</p> <p>The surveyor reviewed Resident #4's Medication Administration Record (MAR) for [REDACTED] and observed that Resident #4 received prescriber's orders for: [REDACTED] mg tablet take one tablet every eight hours as needed for [REDACTED] and [REDACTED] mg tablet take one tablet three times daily at 9:00 a.m., 1:00 p.m., and [REDACTED] 7:00 p.m. routinely for [REDACTED]. The surveyor observed that Resident #4 was administered [REDACTED] mg tablet on the</p>	A 963		

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A 963	<p>Continued From page 2</p> <p>following dates and times as indicated by staff initial on the MAR as follows:</p> <p>1. [REDACTED] mg tablet take one tablet by mouth three times daily for [REDACTED] was documented as administered to Resident #4 on 2/5/22 and 2/6/22 at 9:00 a.m., 1:00 p.m., and 7:00 p.m., and on 2/7/22 at 9:00 a.m. and 1:00 p.m.</p> <p>2. [REDACTED] mg tablet take one tablet every eight hours as needed for [REDACTED] was documented as administered on 2/5/22 at 2:42 p.m., on 2/6/22 at 11:15 a.m. and 2:11 p.m., and on 2/7/22 at 3:45 p.m.</p> <p>3. On 2/3/22 at 2:30 p.m. and on 2/4/22 at 2:00 p.m. the PRN (as needed) order for [REDACTED] mg tablet take one tablet every eight hours as needed for [REDACTED] with prescription number: [REDACTED] was documented as having been removed from inventory on the declining inventory record. However, the dose was not initialed or documented on Resident #4's MAR to indicate the dose was administered to the resident. On 5/13/22 at 3:00 p.m., the surveyor interviewed the LPN who explained that he was unable to recall if he had documented the removal of 2 doses of [REDACTED] mg. in error on the declining inventory sheet on 2/3/22 and 2/4/22 as these doses were not documented as having been administered to the resident on the MAR.</p> <p>During Resident #4's MAR review, the surveyor identified that on 2/5/22 Resident #4 was administered the routine dose of [REDACTED] mg at 1:00 p.m. and the as needed (PRN) [REDACTED] mg tablet at 2:42 p.m. This resulted in the two doses of [REDACTED] being administered one hour and forty-two minutes</p>	A 963		

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A 963	<p>Continued From page 3</p> <p>apart from the administered dose at 1:00 p.m.</p> <p>Additional review of the MAR identified that on 2/6/22, Resident #4 received routine doses of [REDACTED] mg at 9:00 a.m. and 1:00 p.m. and an as needed dose of [REDACTED] mg at 11:15 a.m. which was two hours and fifteen minutes post the 9:00 a.m. dose and one hour and forty-five minutes prior to the 1:00 p.m. dose. Also, Resident #4 was administered [REDACTED] mg as needed dose on 2/6/22 at 2:11 p.m. which was one hour and eleven minutes after the 1:00 p.m. dose.</p> <p>During further, review of Resident #4's MAR, the surveyor identified that on 2/7/22 Resident #4 was administered a routine dose of [REDACTED] mg at 1:00 p.m. and was administered an as needed dose of [REDACTED] mg at 3:45 p.m. which was two hours and forty-five minutes post the 1:00 p.m. dose.</p> <p>On 5/13/22 at 12:00 p.m., the surveyor interviewed the Health and Wellness Director (HWD) who explained that Resident #4 had been receiving [REDACTED] mg one tablet at bedtime which was increased to three times a day 9:00 a.m., 1:00 p.m., and 7:00 p.m. for [REDACTED] on 2/2/22. Further, the HWD informed the surveyor that Resident #4 also had a prescriber's order for [REDACTED] mg 1 tablet every eight hours as needed for [REDACTED] since [REDACTED]. The HWD further explained that neither the Licensed Practical Nurse nor the HWD had clarified the dosing interval of the PRN as needed [REDACTED] once the routine order had been increased to 3 times a day at 9 a.m., 1 p.m. and 7 p.m.</p> <p>The facility administered Resident #4's [REDACTED] mg one tablet three times a day at</p>	A 963		

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A 963	Continued From page 4  9:00 a.m., 1:00 p.m., and 7:00 p.m. in conjunction with Resident #4's as needed [REDACTED] mg one tablet every [REDACTED] as needed for anxiety less than two hours apart on 2/5/22, 2/6/22, and on 2/7/22 less than three hours apart which was in contradiction to the physician's order for lorazepam to be administered every eight hours.	A 963		
A1011	8:36-11.7(k) Pharmaceutical Services  (k) Controlled dangerous substances shall be stored, and records shall be maintained, in accordance with the Controlled Dangerous Substances Acts, N.J.S.A. 24:21-1 et seq. and all other Federal and State laws and regulations concerning the procurement, storage, dispensation, administration, and disposition of same.  This REQUIREMENT is not met as evidenced by: COMPLAINT #'s: NJ00153715, NJ00154709  Based on interview and record review it was determined that the facility failed to: ensure that Controlled Substance Medications were documented as being administered on the Medication Administration Record (MAR) after recording removal of the dose from the declining inventory controlled substance record for 1 of 5 residents, Resident #4 and failed to ensure that shift to shift narcotic counts were consistently documented as performed in order to ensure accountability of Controlled Substance inventory.	A1011		

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A1011	<p>Continued From page 5</p> <p>This deficient practice was evidenced by the following:</p> <p>On 5/13/22 at 11:20 a.m., the surveyor reviewed the closed medical record (MR) for Resident #4 which identified that Resident #4 moved into the facility on 11/3/21 with diagnoses which included dementia (cognitive memory loss) and high blood pressure. The MR indicated that the resident was discharged on 2/15/22.</p> <p>During review of Resident #4's "Controlled Drug Record" (CDR) declining inventory sheet in Resident #4's MR, the surveyor observed that [REDACTED] mg tablet every eight hours was signed out and dated for removal from inventory by the Licensed Practical Nurse (LPN) on 2/3 at 2:30 p.m. and 2/4 at 2:00 p.m. The surveyor then reviewed Resident #4's MAR for February 2022 and observed blank spaces under 2/3/22 and 2/4/22 failing to confirm that the dose removed from inventory had in fact been administered to Resident #4.</p> <p>On 5/13/22 at 12:30 p.m., the surveyor reviewed the facility January and February 2022 "Controlled Drug Count Sheets (CDS)" and identified that there were no documented signatures on the Narcotic Controlled substance inventory counts for the following dates 1/2/22, 1/18/22, 1/20/22, 1/25/22, 1/27/22, and 2/4/22. The shift to shift signatures on the CDS ensures that the incoming and outgoing medication personal counted the controlled drug inventory to ensure accuracy and accountability of the inventory.</p> <p>On 5/13/22 at 3:00 p.m., the surveyor interviewed the LPN who explained that Controlled Substance inventory counts were conducted daily at the start</p>	A1011		

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A1011	<p>Continued From page 6</p> <p>and end of twelve hour shifts and sometimes in the middle of the shift to confirm accuracy. Further, the surveyor inquired about the LPN's signature on Resident #4's CDR for removal of [REDACTED] mg tablet every eight hours as needed for [REDACTED] from Resident #4's inventory on "2/3 at 4:30 p.m., and 2/4 at 2:00 p.m." The LPN stated that he could not recall the events of 2/3/22 and 2/4/22 but he may have documented in error.</p> <p>On 5/13/22 at 3:20 p.m., the surveyor reviewed the facility policy and procedure titled, "Controlled Substances" and listed under " ...Procedure ...6. If an error is made, never erase, or use white-out. Correct the error by drawing a single line through the error, make the notation "ERROR" and sign or initial ....1. Schedule Four documentation .... Shift Count."</p> <p>The facility failed to ensure and maintain consistent documentation on the shift to shift counts of the Controlled Substance inventory. The facility also failed to identify and correct a discrepancy identifying the removal of [REDACTED] mg. from Resident #4's CDR declining inventory sheet and the MAR thereby diminishing the integrity of the accountability of the controlled substances.</p>	A1011		