STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. BUILDING _____ B. WING _____	C 08/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CENTER	**625 STATE HIGHWAY 34 MATAWAN, NJ 07747**

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F 000	INITIAL COMMENTS COMPLAINT #: NJ 133633; NJ 136848; NJ 137110 CENSUS: 106 SAMPLE SIZE: 11 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.	F 000		
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: Complaint # NJ 136848 Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication pass on 08/17/2020, the surveyor observed two (2) nurses administer medications to eight (8) residents. There were 30 opportunities and two (2) errors observed which calculated to a medication administration error rate of 6%. This deficient practice was identified for 1 of 2 nurses and 2 of 8 residents (Resident #10 and	F 759	1. Resident #10 was assessed by RN with no ill effects noted. Physician was notified and a Medication Error Report completed. Resident #11 was assessed by RN with no ill effects noted. Physician was notified and a Medication Error Report was completed. Policy NSG305 Medication Administration was reviewed and reinforced with identified nurse. Proper medication pass technique was reviewed with emphasis on following Pharmacy cautionaries during administration.	8/25/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/25/2020

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 759	Continued From page 1 #11) and was evidenced by the following: 1. On 08/17/2020 at 10:10 AM to 10:25 AM, the surveyor observed the Registered Nurse (RN) administer medications to Resident #10. The surveyor observed the RN prepare three medications to be administered by mouth to the resident. The medications included two medications used as nutritional supplements, Exec Order 26 § 4b1 individual's health info [redacted] The precautionary statement printed on the medication administration card read, "Take this med with a meal." The RN did not address the resident's consumption of breakfast or food at the time the medications were administered. After the RN administered the medications to the resident, the surveyor interviewed Resident #10 in the presence of the RN and asked when he/she ate breakfast. The resident stated that it had to have been about an hour ago. There was no breakfast tray or food in the resident's room at the time of medication administration. The surveyor then stepped out of the resident's room and interviewed the RN at her medication cart. The RN stated that the Exec Order 26 § 4b1 individual's health info [redacted] should have been administered when the resident was eating a meal like breakfast in accordance with the individual manufacturer specifications. The RN further stated that the breakfast trays arrived on the unit around 9:00	F 759	2.DON/ Designee completed a comprehensive audit of Residents on Medications requiring a meal with administration to ensure the medications administered compliant with the Physician's orders and Pharmacy Cautionary. 3.DON/Designee completed Re-education with the Licensed Nursing Staff on the administration of medications compliant with the Physician's orders and Pharmacy Cautionaries in accordance to policy and procedure. 4.DON/Designee will perform 3 random medication passes weekly to ensure medications are administered compliant with the Physician's Orders and Pharmacy Cautionary weekly x 4 weeks and then monthly x 1 quarter. The information will be brought to QAPI committee for review. After completion of 4 months review of audit results, audits may be discontinued.	

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AM, that NJSA 47 1A-1 rea was the last to be served breakfast, and the resident had already eaten his/her breakfast meal. The RN acknowledged that the medications were given after 10 AM.

A review of Resident #10's August 2020 electronic Medication Administration Record (eMAR) reflected the following physician's orders (PO):

A PO dated 05/07/2018 for the medication, Exec Order 26 § 4b1 individual's health info give one capsule by mouth in the morning every other day. The medication was plotted to be administered at 9 AM every other day. There were no cautionary instructions on the eMAR that the medication needed to be administered in accordance with meals.

A review of the manufacturer specifications for the Exec Order 26 § 4b1 individual's health info indicated that the medication should be taken immediately after a meal or with a meal to prevent an upset stomach.

2. On 08/17/2020 at 10:46 AM to 11:13 AM, the surveyor observed the same Registered Nurse (RN) administer medications to Resident #11. The surveyor observed the RN prepare six medications to be administered by mouth to the resident and one medication to be applied to Exec Order 26 § 4b1 individual's he. The medications included Exec Order 26 § 4b1 ind, a medication used to reduce the production of Exec Order 26 § 4b1 individual's health info , Exec Order 26 § 4b1 individual's health info

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Exec Order 26 § 4b1 individual's health info [redacted] The precautionary statement printed on the medication administration card read, "Take this medication with a meal." This time the RN acknowledged the resident's order for Exec Order 26 § 4b1 in and the precautionary instructions and offered the resident graham crackers with his/her medications.

After the RN administered the medications to the resident, the surveyor interviewed Resident #11 in the presence of the RN and asked when he/she ate breakfast. The resident stated that it had been a while ago. There was no breakfast tray or food in the resident's room at the time of medication administration.

The surveyor then stepped out of the resident's room and interviewed the RN at her medication cart. The RN stated that the Exec Order 26 § 4b1 individual's health info [redacted] should have been administered when the resident was eating a meal like breakfast in accordance with the individual manufacturer specifications. The RN further stated she gave the graham crackers because she knew the resident had already eaten his/her breakfast meal. Upon additional questioning the RN acknowledged graham crackers were not a meal, and she should have offered a sandwich.

A review of Resident #11's August 2020 electronic Medication Administration Record (eMAR) reflected the following physician's orders (PO):

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A PO dated 09/06/2019 for the medication, Exec Order 26 § 4b1 individual's health info The medication was plotted to be administered at 9 AM every day. There were no cautionary warnings on the eMAR that the medication needed to be administered in accordance with meals.

A review of the manufacturer specifications for the Exec Order 26 § 4b1 individual's health info indicated that the medication should be taken immediately after a meal or with a meal to prevent an upset stomach.

A review of the facility's Medication Administration: General Policy and Procedure, revised 11/01/2019, indicated the purpose was to provide a safe, effective medication administration process and that "A licensed nurse, Med Tech, or medication aide, per state regulations, will administer medications to patients. Accepted standards of practice will be followed."

On 08/17/2020 at 4:30 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Assistant Director of Nursing (ADON) to discuss the medication administration process observation. The ADON stated the nurse should read the medication administration card before administrating a medication and follow any instructions. The ADON and the LNHA acknowledged the nurse should have administered the Exec Order 26 § 4b1 individual's health info to the residents with a meal.

NJAC 8:39-11.2(b), 29.2(d), 29.4(c)