STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315511	A. BUILDING _____ B. WING _____	10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT HANOVER TOWNSHIP	101 WHIPPANY ROAD WHIPPANY, NJ 07981

(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 STANDARD SURVEY: 10/10/19 CENSUS: 56 SAMPLE SIZE: 14 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to 1.) accurately depict the narcotic medication count for 2 of 3 medication carts reviewed; 2.) conduct safe smoking assessments for 1 of 1 residents reviewed for [redacted] (Resident #28), and 3.) supervise the administration of medication for 1 of 14 residents reviewed for medications (Resident # 55). This deficient practice was evidenced by the following: 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	F 658	1. 1. Residents were not affected by the omission of not signing the controlled drug administration record after medication administration. Declining sheets (controlled drug administration records) were compared with the electronic medical records and medications were administered and signed on the individual electronic medical record. 2. Residents with controlled medications have a potential to have the declining sheets not signed timely after administration of medication. Controlled drugs were counted and declining inventory sheets were reviewed for accuracy and no further discrepancy was noted.	11/5/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/19/2019

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F 658	Continued From page 1 treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes 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 case finding, 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." 1. On 10/03/19 at 11:07 AM, the surveyors reviewed the medication cart on [redacted] in the presence of the Registered Nurse Unit Manager (RN/UM). The surveyors reviewed a Controlled Drug Administration Record for [redacted] (mg). The count listed on the record revealed 23 pills left and that the last [redacted]t had last been administered on 10/02/19 at 9 PM. The [redacted] medication count revealed 22 pills left. The surveyors, in the presence of the RN/UM, reviewed another Controlled Drug Administration Record for [redacted] mg. The count listed on the record revealed 21 pills left and that the [redacted] had last been administered on 10/02/19 at 9 PM. The [redacted] medication count revealed	F 658	3. Licensed nurses will receive training on the medication administration policy with emphasis on complete, timely, and accurate documentation on the controlled drug administration record when administering controlled medication. Unit managers or designee will audit five controlled drug administration record weekly for 4 weeks then monthly for 2 months then quarterly x 2 Pharmacy consultant or ADON or designee will conduct medication observation that includes controlled drug record accuracy on at least 2 nurses per month. 4. Director of Nursing or designee will report findings to the quality assurance performance improvement committee on a quarterly basis for 2 quarters. 2. 1. Resident #28 was not affected. [redacted] evaluation was completed. 2. There were no other patients that smokes at the facility. 3. Licensed nurses will receive in-service education on the smoking policy regarding the frequency of completion of the [redacted] evaluation. Unit managers or designee will audit safe smoking evaluation completion every 3 months for a period of 4 quarters. 4. Director of Nursing or designee will report findings to the quality assurance performance improvement committee on a quarterly basis for 2 quarters.	

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F 658	Continued From page 2 20 pills left. The RN/UM acknowledged that both narcotic medication counts were inaccurate. Review of the Medication Administration Record (MAR) for the [redacted] revealed the medication had been administered 10/03/19 at 9 AM. The MAR for the [redacted] revealed the medication had been administered 10/03/19 at 9 AM. On 10/03/19 at 11:36 AM, the surveyors reviewed the medication cart on Unit 1, in the presence of the medication Licensed Practical Nurse (LPN). The surveyors reviewed a Controlled Drug Administration Record for [redacted] medication). The count listed on the record revealed 15 pills left. The [redacted] medication count revealed 14 pills left and that the [redacted] had last been administered on 10/02/19 at 9 PM. The surveyors, in the presence of the LPN, reviewed a second Controlled Drug Administration Record for Lorazep[redacted] mg. The count listed on the record revealed two pills left and that the [redacted] had last been administered on 10/02/19 at 9 PM. The [redacted] medication count revealed one pill left. The surveyors reviewed a third Controlled Drug Administration Record for [redacted] medication) [redacted]. The count listed on the record revealed 26 pills left and that the [redacted] had last been administered on 10/02/19 at 5 PM. The [redacted] medication count revealed 25 pills left. The LPN acknowledged all three counts were inaccurate. Review of the MAR for the [redacted] revealed that the medication had been administered 10/03/19 at 9 AM. The MAR for the	F 658	3. 1. Resident # 55 was not affected. The [redacted] was removed from the resident's bedside and discarded. MD was notified and new time administration was put in place. The patient was discharged home. 2. Residents receiving medications has potential to be affected. Resident rooms were checked for any medication left at the bedside or other areas in the resident'□s room. 3. Licensed nurses will be trained on administration of medication policy including refusal of medication or adjustment to administration time as per patient request or patient and family collaboration request. Additionally, licensed nurses will be educated on medication administration related to securing medication, not leaving medication at the bedside or in areas of the resident's room, and observing resident while medication is administered. Assistant Director of Nursing /Unit manager or designee will conduct weekly inspection of five resident rooms for presence of medication by the bedside or other areas in the resident□s room. The inspection will be conducted weekly for 4 weeks, twice monthly for 2 months then monthly thereafter for 6 months. 4. Director of Nursing or designee will report findings to the quality assurance performance improvement committee on a quarterly basis for 2 quarters.	

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F 658	Continued From page 3 [redacted] revealed that the medication had been administered 10/03/19 at 9 AM. The MAR for the [redacted]P revealed that the medication had been administered 10/03/19. During an interview with the surveyors on 10/03/19 at 11:19 AM, the RN/UM stated the process was to sign out the narcotic medication "immediately when popped into the medication cup." The RN/UM stated the purpose was to have an accurate narcotic medication count, and to be sure the right dose was administered at the right time to the correct resident. During an interview with the surveyor on 10/03/19 at 11:44 AM, the medication LPN on [redacted] stated the process was to pull the medication, sign the sheet before administering it to the resident to make sure it was given and that the count was accurate. The [redacted] medication LPN stated, "I know the process, I just forgot to sign and I know I should have." During an interview with the surveyor on 10/03/19 at 11:47 AM, the medication LPN on [redacted] stated she had been "distracted so I didn't sign for the narcotic." The [redacted] medication LPN stated the process was to sign right away when a narcotic is administered so the nurse knows they gave the resident their medication. During an interview with the surveyor on 10/08/19 at 11:33 AM, the Director of Nursing (DON) stated the process of narcotic administration was to check the MAR, check the orders, go to the narcotic medication box and pull out the medication, match the pill count with the (Controlled Drug Administration Record) count sheet, sign that the nurse removed the	F 658		

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F 658	Continued From page 4	F 658		

medication on the Controlled Drug Administration Record, administer the medication and sign it out on the MAR. The DON stated the decline sheet (Controlled Drug Administration Record) was important to ensure the narcotic medication was administered and that there was no diversion of narcotic medications.

Review of the facility "General Guidelines for the Administration of Medications" policy, dated 01/15, revealed "administration of any controlled dangerous substance is also recorded on the declining inventory form" (Controlled Drug Administration Record).

Review of the facility "Controlled Substances" policy, dated 05/19, revealed "upon administration the nurse administering the medication is responsible for recording...quantity of the medication remaining; and signature of nurse administering medication."

2. During an interview with the surveyor on 10/07/19 at 11:42 AM, Resident #28 stated he/she [redacted] outside and showed the surveyor the [redacted] area, through the resident's room window. There was an [redacted] observed in the [redacted] area. Resident #28 stated the activities staff takes him/her to [redacted] after breakfast, after lunch and about 5 PM. Resident #28 stated he/she signed the [redacted] rules upon admission and that the staff holds the [redacted] and [redacted]. Resident #28 stated he/she had recently been re-admitted to the facility from the hospital.

According to the Admission Record, Resident #28 was admitted to the facility on [redacted] and re-admitted on [redacted] with diagnoses that included but were not limited to [redacted]

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F 658	Continued From page 5 [redacted] .	F 658		

Review of the facility [redacted] Rules," dated [redacted] and signed by Resident #28, revealed "b. Your ability to [redacted] and level of independence will be re-evaluated regularly."

Review of the "Resident Evaluation Readmission," dated [redacted], revealed "current [redacted] "

Review of the electronic medical record for Resident #28 revealed the last "Safe [redacted] Evaluation - quarterly," had been done on [redacted]

During an interview on 10/07/19 at 11:45 AM, the [redacted] LPN/UM stated Resident #28 was the only [redacted] in the facility and goes out to [redacted] with the activities staff take four times a day. The [redacted] t [redacted] LPN/UM stated the [redacted] assessments are done by the primary nurse quarterly and the assessments are located in the electronic medical record under "forms."

During an interview on 10/08/19 at 10:07 AM, the [redacted] LPN/UM stated he had been the UM since January 2018 and that he should have followed up that the [redacted] assessments were done. The [redacted] LPN/UM stated it was important to evaluate if the resident is able to [redacted] safely and if the staff needed to implement any interventions. The [redacted] LPN/UM stated when the resident came back from the hospital in [redacted], Resident #28 was [redacted] again and that the nursing staff should have done a [redacted] assessment at that time and he should

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F 658	Continued From page 6 have followed up that a [redacted] assessment had been done. During an interview with the surveyor on 10/08/19 at 10:19 AM, the Director of Activities stated he was the one who took Resident #28 out to [redacted] and that he had asked the [redacted] LPN/UM if Resident #28 was ok to go out to [redacted] again upon re-admission from the hospital. The Director of Activities stated it was important to check with nursing to be sure the resident was safe to [redacted] and if he needed to do anything for the resident. During an interview with the surveyor on 10/08/19 at 11:40 AM, the DON stated the [redacted] assessments were done quarterly and if a resident returned from the hospital a safe [redacted] reassessment would need to be done again. The DON stated it was the UM's responsibility to follow up that the safe [redacted] reassessments were completed. Review of the facility [redacted] Policy; Residents" policy, dated 09/13, revealed "complete the safe smoking evaluation for resident who are [redacted] at the time of their admission, quarterly, annually and with each significant change in condition to determine whether the resident may [redacted], what type and level of supervision is indicated, and what protective or adaptive equipment is indicated." 3. On 10/07/19 at 10:16 AM, the surveyor observed the resident lying in bed asleep with his/her breakfast tray at the bedside. On the breakfast tray, there was a medicine cup with 30 mL of a red liquid inside.	F 658		

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F 658	Continued From page 7 During an interview with the surveyor at the resident's bedside on 10/07/19 at 10:19 AM, the Registered Nurse (RN) for Resident #55 identified the red liquid as [redacted]. The RN further stated that he brought the [redacted] into the resident's room around 8:40 AM, but the resident refused and requested to take the supplement with breakfast when his/her spouse arrived. The RN then explained that he was not supposed to leave the [redacted] at the bedside unattended. He also stated that he should have discarded the [redacted] and offered it when the resident was ready. The RN acknowledged that the [redacted] was scheduled for 9:00 AM and could not be administered after 10:00 AM due to the time frame with a physician's order. The RN then removed the medicine cup from the tray and discarded it into a [redacted] in the presence of another nurse. During an interview with the surveyor on 10/07/19 at 10:49 AM, the Unit Manager (UM) explained the medication administration process which included identifying the resident, checking the medication, administering the medication, and documenting on the MAR. The UM also stated that medication should never be left in the room because the nurse must stay with the resident to ensure the medication was taken. If a resident refuses the medication, it must be destroyed and offered later. The UM added that if the resident wants the medication outside of the administration time frame, the physician must provide an order to administer it late. The UM further stated that Resident #55's [redacted] should not have been left at the bedside. During an interview with the surveyor on 10/08/19 at 12:07 PM, the Director of Nursing (DON)	F 658		

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explained the medication administration process which included identifying the resident, assessing the resident, checking the medications against the MAR, explaining the medications to the resident, witnessing the resident swallow the medications, and documenting on the MAR. The DON further stated that if a resident refused medication, the nurse should dispose of the medication and re-attempt later. If the resident wants the medication outside of the administration time frame, the physician must order for the medication to be administered at a different time.

During an interview with the surveyor on 10/10/19 at 9:20 AM, the Administrator stated that the RN should have not left the [redacted] at the resident's bedside, and should have discarded it.

According to the Admission Record, Resident #55 was admitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted]

Review of the resident's Quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted] reflected the resident had a Brief Interview for Mental Status of [redacted] which indicated the resident's cognition was intact.

Review of the resident's Order Summary Report, dated [redacted], revealed a physician's order for [redacted] to be given twice a day for a diagnosis of [redacted]

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F 658	Continued From page 9 Review of the resident's MAR, dated [redacted] indicated the administration times for [redacted] were at 9:00 AM and 6:00 PM. Review of the resident's Care Plan dated [redacted] included a focus for nutritional status related to [redacted] and an intervention to "provide [redacted] per orders: [redacted] Review of the facility's General Guidelines for the Administration of Medications policy, dated 01/2015, revealed, "Nurse will remain in the presence of the resident while the resident takes the medication." NJAC 8:39-11.2 (i); 27.1(a); 29.2 (d); 29.7(c)	F 658		