STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315332	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN OCEAN CENTER	1361 ROUTE 72 WEST MANAHAWKIN, NJ 08050

(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 # NJ 127942 CENSUS: 121 SAMPLE SIZE: 3	F 000		
F 658 SS=D	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: COMPLAINT # NJ 127942 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 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 regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title	F 658	#1 Resident #2 was identified to have received her roommate□s morning medications on 9/5/19. Resident experienced an [redacted] episode. Resident was receiving [redacted] mg and [redacted] mg for [redacted]. She received her roommate□s medicine [redacted] mg, [redacted] mg, [redacted] mg, and [redacted]. MD and family made aware. NP assessed patient immediately. [redacted] was applied, [redacted] were started, and resident was placed in bed with feet and head elevated. Nurse in question was removed from the floor immediately and sent home pending investigation and later asked not to return to facility, she did not pass any other medications in the facility. 2nd nurse involved was competencied on medication pass and in serviced on 7 rights of medication administration immediately.	10/30/19

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

Electronically Signed | 10/25/2019

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 658	Continued From page 1 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 with in 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." Based on interviews, Medical Record (MR) review, and review of other pertinent facility documents on 9/19/2019, it was determined that the facility staff failed to ensure medication was administered correctly to a resident, according to the Physician's orders, and according to the acceptable standards of clinical practice in accordance with the New Jersey Board of Nursing Statutes, for 1 of 3 sampled residents (Resident #2). In addition, the nursing staff failed to follow their own policies titled "Medication Administration: General" and "The Seven Rights of Medication Administration." This deficient practice is evidence by the following: 1. According to the "Admission Record (AR)," Resident #2 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted],	F 658	Resident #2 went to the hospital for and evaluation and went to another facility. #2 Due to the risk of other resident□s being affected by this, Director of Nursing audited current patients with [redacted] medications for order accuracy to ensure they are receiving the correct medications and dosage and free from significant medication error on that med pass. #3 Licensed staff were reeducated on medication administration policy immediately starting 9/5/19 and completed 9/9/19. Medication pass audits were done on licensed staff immediately and will continue randomly weekly for 3 months. Nurse Practice Educator/ designee will complete medication pass competencies on all orientees prior to their release to a medication nurse. #4 Results of audits will be reviewed by Director of Nursing/ designee monthly for 3 months in QAPI for compliance and then quarterly for a year there after.	

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F 658	Continued From page 2 [redacted].	F 658		

According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that Resident #2 had [redacted] impairment. The MDS also indicated Resident #2 required extensive assist with Activities of Daily Living (ADLs).

Review of the "Medication Review Report" for medication orders "on or after date [redacted]" revealed Resident #2 was prescribed the following medications:
[redacted] tablet [redacted] 24-hour [redacted] mg (milligrams) one tablet once a day for [redacted],
[redacted] mg capsule one capsule once a day for [redacted],
[redacted] tablet [redacted] mcg (micrograms) one tablet once a day for [redacted], [redacted] tablet [redacted] mg one tablet once a day for [redacted],
[redacted] ml (milliliters), give 10 ml once a day for [redacted]
[redacted] tablet [redacted] mg one tablet 2 times a day for [redacted],
[redacted] tablet [redacted] (milliequivalent), give one tablet with meals for [redacted].

Review of the Facility Reportable Event (FRE) dated [redacted], revealed a "Medication Error Record/Report" with an event date and time of [redacted] at 9:00 a.m. Under "Narrative" it showed the following: "Resident was given [redacted] roommates morning [redacted]) medications in error and experienced an

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F 658	Continued From page 3	F 658		

[redacted] [sic] episode. MD (Medical Doctor) and family made aware. NP (Nurse Practitioner) saw patient immediately."

Review of the investigation "Summary and Conclusion" dated [redacted], documented by the Director of Nursing (DON) revealed the following: Resident #2 received [redacted] mg and [redacted] mg which he/she is not on. He/she also received [redacted] mg which he/she is on and [redacted] mg which he/she is on at [redacted] mg." These medications were prescribed for Resident #2's roommate, however Resident #2 received the medications by nursing error.

During an interview on 9/19/2019 at 12:40 p.m., with the Licensed Practical Nurse (LPN #1) who was the nurse preceptor for the Registered Nurse (RN #1) reported the following: Both residents had on their name bracelets. Both residents knew their names and were able to answer to their names. They both looked totally different and their pictures were on the Medication Administration Record (MAR). In addition, LPN #1 reported "I said to her (RN #1), we are going right now to tell the Unit Manager (UM) and the Assistant Director of Nursing (ADON). She said you got to tell? I said yes. What if something happens to the resident? That's what is important the resident. This really upset me."

According to the "New Jersey Universal Transfer Form" it showed Resident #2 was transferred to the hospital on [redacted] at 9:00 p.m., for an evaluation.

Review of the facility policy titled "Medication Administration: General" with an effective date of

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F 658	Continued From page 4 01/01/04, and a revision date of 07/01/19, revealed the following under "Policy:" ..."Accepted standards of practice will be followed." Under "Purpose:" "To provide a safe, effective medication administration process." Review of the facility policy titled "The Seven Rights of Medication Administration." undated, established the following: "The Seven Rights of Medication Administrations: 1. Right Patient 2. Right Drug 3. Right Time 4. Right Route 5. Right Dose 6. Right Reason 7. Right Documentation. N.J.A.C. 8:39-11.2(b)	F 658		
F 760 SS=G	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: COMPLAINT # NJ 127942 Based on interviews, Medical Records (MR) review, and review of other pertinent facility documents on 9/19/2019, it was determined that the facility staff failed to administer medication correctly, according to the Physician's orders, for 1 of 3 sampled residents (Resident #2). The wrong medication was administered to a resident on [redacted], which resulted in a [redacted] episode and treatment requiring hospitalization. In addition, the facility staff failed to follow their own policy titled "The Seven Rights of Medication Administration" for 1 of 3 sampled residents (Resident #2). This deficient practice is evidence	F 760	#1 Resident #2 was identified to have received her roommate's morning medications on [redacted]. Resident experienced an [redacted] episode. Resident was receiving [redacted] mg and [redacted] for [redacted]. [redacted] received [redacted] roommate's medicine [redacted] and [redacted] 4mg. MD and family made aware. NP assessed patient immediately. [redacted] was applied, [redacted] were started, and resident was placed in bed with feet and head elevated. Nurse in question was removed from the floor	10/30/19

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F 760	Continued From page 5 by the following: 1. According to the "Admission Record (AR)," Resident #2 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that Resident #2 was [redacted] impaired. The MDS also indicated Resident #2 was extensive assist for Activities of Daily Living (ADLs). Review of the "Medication Review Report" for medication orders "On or After Date [redacted]," revealed Resident #2 was on the following medications: [redacted]) tablet [redacted] 24 hour [redacted] mg (milligrams) one tablet once a day for [redacted], [redacted] mg capsule one capsule once a day for [redacted], [redacted] tablet [redacted] (micrograms) one tablet once a day for [redacted] tablet [redacted] mg one tablet once a day for [redacted], [redacted] (milliliters), give [redacted] once a day for [redacted] mg one tablet 2 times a day for [redacted] tablet [redacted] meq (milliequivalent), give one tablet with meals for	F 760	immediately and sent home pending investigation and later asked not to return to facility, she did not pass any other medications in the facility. 2nd nurse involved was competencied on medication pass and in serviced on 7 rights of medication administration immediately. Resident #2 went to the hospital for and evaluation and went to another facility. #2 Due to the risk of other resident's being affected by this, Director of Nursing audited current patients with [redacted] medications for order accuracy to ensure they are receiving the correct medications and dosage and free from significant medication error on that med pass. #3 Licensed staff were reeducated on medication administration policy immediately starting 9/5/19 and completed 9/9/19. Medication pass audits were done on licensed staff immediately and will continue randomly weekly for 3 months. Nurse Practice Educator/ designee will complete medication pass competencies on all orientees prior to their release to a medication nurse. #4 Results of audits will be reviewed by Director of Nursing/ designee monthly for 3 months in QAPI for compliance and then quarterly for a year there after.	

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F 760	Continued From page 6 [redacted]. Review of the Facility Reportable Event (FRE) dated [redacted], revealed a medication error report with an event date and time of [redacted] at 9:00 a.m. Under "Narrative" it showed the following: Resident was given [redacted] roommates morning [redacted]) medications in error and experienced an [redacted] episode. Medical Doctor and family made aware. Nurse Practitioner (NP) saw patient immediately. Further review of the FRE revealed the following under interventions implemented: "Resident's vital signs being monitored q (every) 15 minutes x (times) 24 hours, [redacted], in bed with feet and head elevated. [redacted] administered." Review of the investigation "Summary and Conclusion" dated [redacted] documented by the Director of Nursing (DON) revealed the following: Resident #2 received [redacted] mg and [redacted] mg which he/she is not on. He/she also received [redacted] mg which he/she is on, and [redacted] mg which he/she is on at [redacted] mg." An [redacted] episode resulted. The resident was seen by the NP who was in the building. Treatment was administered and the resident was later sent out to the hospital. In addition, the DON documented the following: ...while sitting in her wheelchair he/she experienced an orthostatic episode. He/she was responsive at this time, but confused, [redacted] and [redacted] (an estimate of the amount of [redacted]) were low. NP was called and came to assess resident immediately.	F 760		

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F 760	Continued From page 7	F 760		

[redacted] applied, [redacted] started, and resident was placed in bed with feet and head elevated.

During an interview on 9/19/2019 at 12:40 p.m., with the Licensed Practical Nurse (LPN #1) who was the nurse preceptor for the Registered Nurse (RN #1), reported she watched RN #1 pour the medications then put them in applesauce. At that time, the resident across the hall called for attention. LPN #1 stated to RN #1 "just stay here I'll be right back." LPN #1 left RN #1 standing at the med cart and went across the hall to check on the resident. When LPN #1 came out of the other resident's room she noticed RN #1 was not standing at the med cart, she was in the resident's room. When LPN #1 went into the room RN #1 was on [redacted] of the room. LPN #1 stated "Please tell me you did not give those medications to [redacted] RN #1 responded "yes I gave the meds to [redacted]." LPN #1 said "No they were for [redacted]

During an interview on 9/19/2019 at 10:56 a.m., the DON reported, RN #1 said she did not check the resident's name bracelet. In addition, the DON stated RN #1 was taken off the floor immediately. She did not administer any medications to any other residents after the medication error. "I spoke to her than I asked her to leave. I told her not to report the next day and HR (Human Resources) later called her and told her not to return."

According to "New Jersey Universal Transfer Form" it showed Resident #2 was transferred to the hospital on [redacted] at 9:00 p.m., with a pulse of [redacted] and a [redacted]

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F 760	Continued From page 8 According to the facility staff Resident #2 did not return to the facility. Review of the facility policy titled "The Seven Rights of Medication Administration." undated, established the following: "The Seven Rights of Medication Administrations: 1. Right Patient 2. Right Drug 3. Right Time 4. Right Route 5. Right Dose 6. Right Reason 7. Right Documentation. N.J.A.C. 8:39-29.2(d)	F 760		