STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. Building B. Wing	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cranford Park Care	600 Lincoln Park East Cranford, NJ 07016

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 25225 Based on interview and record review, the facility failed to obtain physician ordered antidiabetic and/or antibiotic medications in a timely manner for two (Resident (R) 1 and R8) of four sampled residents whose medications were reviewed. This had the potential for R1 to have uncontrolled blood sugars and for R8 to have an untreated infection which could lead to serious medical complications for both residents. Findings include: 1. Review of a document provided by the Director of Nursing (DON) titled Admission Record indicated R1 was admitted with diagnoses that include type II diabetes mellitus. Review of R1's Physician Orders, dated 11/01/22 and located under the Orders tab of the electronic medical record (EMR), revealed Trulicity (an antidiabetic medication), 0.75 milligrams (mg)/0.5 milliliters (ml) subcutaneously every Wednesday, was ordered for R1 due to increased blood sugar levels. Review of R1's Medication Administration Records (MARS), dated 11/16/22 and located under the Orders tab of the EMR, revealed no documentation R1 received the ordered Trulicity. Review of R1's Orders - Administration Note, dated 11/16/22 at 8:08 AM and located under the Progress Notes tab of the EMR, indicated, . Trulicity . Waiting on the pharmacy . Review of R1's MARS, dated 11/23/22 and located under the Orders tab of the EMR, revealed no documentation R1 received the ordered Trulicity. Review of R1's Orders - Administration Note, dated 11/23/22 at 12:35 PM and located under the Progress Notes tab of the EMR, indicated, . Trulicity . Waiting on the pharmacy . Review of R1's MARS, dated 11/30/22 and located under the Orders tab of the EMR, revealed no documentation R1 received the ordered Trulicity. Review of R1's Orders - Administration Note, dated 11/30/22 at 10:35 AM and located under the Progress Notes tab of the EMR, indicated, . Trulicity . Waiting on the pharmacy . (continued on next page)

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.

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's MARS, dated 12/07/22 and located under the Orders tab of the EMR, revealed no documentation R1 received the ordered Trulicity. Review of R1's Orders - Administration Note, dated 12/07/22 at 12:17 PM and located under the Progress Notes tab of the EMR, indicated, . Trulicity . Waiting on the pharmacy . Review of R1's Physician Orders, dated 12/14/22 and located under the Orders tab of the EMR, revealed Trulicity 1.5mg/0.5ml was ordered for R1 due to his blood sugar levels remaining elevated. Review of R1's Orders - Administration Note, dated 12/14/22 at 12:25 PM and located under the Progress Notes tab of the EMR, indicated, . Trulicity . Waiting on the pharmacy . Review of R1's Medication Administration Records (MARS), dated 12/21/22 and located under the Orders tab of the EMR, revealed R1 received the ordered Trulicity. Review of R1's MARS dated 12/28/22 and located under the Orders tab of the EMR, revealed R1 received the ordered Trulicity. Review of R1's Progress Notes, dated 10/15/22 through 12/31/22 and located under the Progress Notes tab of the EMR revealed no documentation Nurse Practitioner (NP) 1 or the Medical Director had been notified R1 did not receive the ordered Trulicity on 11/16/22, 11/23/22, 11/30/22, 12/07/22, and 12/14/22. During an interview on 04/18/23 at 9:41 AM, Licensed Practical Nurse (LPN) 1 stated if a medication was not available for administration, the nurse should call the pharmacy and, if the medication could not be obtained quickly, then call the physician. LPN1 stated there were emergency medication kits available that contained often used medications and those medications could be used when ordered medications were not available. Continuing the interview on 04/18/23 at 9:50 AM, LPN1 reviewed the EMR for R1 and confirmed she could not find documentation noting why R1 had not received the ordered Trulicity or what the nurses had done at those times. During an interview on 04/18/23 at 3:36 PM, the Director of Nursing (DON) reviewed R1's clinical record and confirmed R1 did not receive the ordered Trulicity on 11/16/22, 11/23/22, 11/30/22, 12/07/22, and 12/14/22. The DON stated he had no idea why he had not been informed of these situations. The DON stated his expectation was staff would call the pharmacy if a medication was not available for administration and then call the physician and then contact him. During an interview on 04/19/23 at 9:00 AM, LPN3 stated R1 had received the Trulicity on 11/02/22 and 11/09/22 as ordered. LPN3 stated on 11/16/22, the Trulicity was not available for administration, so she had called the pharmacy and had been informed it was an insurance issue. LPN3 stated she had notified the NP1 and did not document the notification. LPN3 stated she did not remember if she had notified the DON. LPN3 stated the NP1 had been notified each time R1 did not receive the Trulicity but she had failed to document the notification. During an interview on 04/19/23 at 10:49 AM, the DON stated there was no documentation to show the facility received the Trulicity and that was documented as being given on 12/21/22 and 12/28/22. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/19/23 at 10:42 AM, the Medical Director stated his expectation for medications to be available for administration and for the physician to be notified if a medication was unavailable for a resident. The Medical Director stated he was not sure what had happened in this case unless it was an insurance issue, but the prescribing provider should have been informed. 2. Review of a document provided by the DON titled Admission Record indicated R8 was admitted to the facility with diagnoses that included type II diabetes mellitus and protein calorie malnutrition. Review of R8's Progress Note, dated 04/11/23 and located under the Progress tab of the EMR, revealed R8 was sent to the emergency room at 1:45 PM and returned to the facility at 10:38 PM. Review of R8's hospital After Visit Summary, dated 04/11/23 and provided by the administrator, revealed R8 had been diagnosed with COVID-19, metapneumovirus, and acute cystitis. It was documented R8 was to begin taking Keflex (an antibiotic), 500 mg by mouth three times daily for seven days. Review of a pharmacy Order Details form, dated 04/12/23 at 12:52 AM and provided by the DON, revealed the pharmacy had received the physician's order for Keflex for R8. Review of MARS, dated 04/12/23 and located under the Orders tab of the EMR, revealed R8 did not receive the first dose of Keflex until 04/12/23 at 2:00 PM. This was approximately 13 hours after the order had been received by the pharmacy. During an interview on 04/18/23 at 9:41 AM, Licensed Practical Nurse (LPN) 1 stated if a medication was not available for administration, the nurse should call the pharmacy and then the physician if the medication could not be obtained quickly. LPN1 stated there were emergency kits available with some medications used in the facility, including antibiotics. LPN1 stated the nurse on duty should have checked the emergency kit for the antibiotic. LPN1 confirmed it was over 15 hours before R8 received the first dose of Keflex after returning to the facility. During an interview on 04/18/23 at 3:21 PM, the DON stated if a resident returned to the facility with new medication orders, the nurse was to contact the physician, write the order, and that triggered the pharmacy to deliver the medication. The DON stated the facility's policy on medications was if the medication did not come in a timely manner, the nurse should look in the emergency kit to see if the medication was available, and if not, then call the pharmacy for an emergency delivery. The DON confirmed the first dose of Keflex was administered approximately 11 hours after the order was received by the pharmacy and over 15 hours after R8 returned to the facility. The DON stated that was not timely. The DON stated the nurse should have let him know, checked the emergency kit, and notified the pharmacy if necessary. During an interview on 04/19/23 at 10:42 AM, the Medical Director stated staff should have looked to see if the antibiotic was available in the emergency kit. The Medical Director stated the time interval for administering the antibiotic was too long. During an interview on 04/19/23 at 10:46 AM, the facility's Infectious Diseases physician stated R8 should have received the antibiotic within six hours of his return to the facility due to the pharmacological properties of the antibiotic. NJAC : 8:39-29.2 (d)