STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. Building B. Wing	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallsview Nursing and Rehabilitation Center	199 Powerville Road Boonton, NJ 07005

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 NJ00164623 Based on interviews, record review, and review of facility provided documents, it was determined that the facility failed to ensure that two (2) Licensed Practical Nurses (LPN #1 and #2) and one (1) Registered Nurse (RN) had Medication Pass Observation (MPO) competencies to provide nursing care for residents' needs. The deficient practice was evidenced by the following: A review of the facility provided Medication Error Incident Report ([NAME]) for 5/27/23 date of error showed that it was the RN who had a medication error of Klonopin (anti-anxiety medication) for Resident #390 and was given a written warning. In addition, the 5/29/23 and 5/30/23 dates of error in the [NAME] showed that it was LPN#1 who had a medication error of Klonopin for Resident #390 and was given a written warning. Further review of the 5/27/23, 5/29/23, and 5/30/23 dates of medication errors, included in the [NAME] revealed that on the explanation/reason medication error was made by the RN and LPN#1: Resident was previously receiving 0.25 mg (milligrams) tabs (tablets; 4 (four tabs) to equal 1 (one) mg) and new bingo card (Klonopin tabs have plastic bubbles for every day of the month. From the foil sealed to the back of the card, pills can be pushed through and taken) was delivered with 1 (one) mg tabs and nurse subsequently gave 4 (four) without confirming correct dose. The [NAME] for medication error dated 5/27/23, 5/29/23, and 5/30/23 action taken for both the RN and LPN#1 included written up and educated. A review of the provided copy of the typewritten Summary of Investigation for the date of the incident: 5/27/23, 5/29/23, and 5/30/23 showed follow up actions: Incident reports were completed for both separate incidents by each nurse for medication error reports and that the nurses were also educated about the five rights of medication pass and disciplinary action was taken due to the severity of the error and its potential consequences. Further review of the medical records and other facility provided documents revealed that no MPO competency was done to both LPN#1 and the RN before the incident of significant medication error and immediately after the incident was reported and investigated. (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/26/23 at 01:28 PM, the surveyor in the presence of the survey team interviewed the Director of Nursing (DON) about the 5/27/23, 5/29/23, and 5/30/23 [NAME]. The DON stated that it was the Consultant Pharmacist's (CP) responsibility to do MPO to all nurses. The DON was not sure how often MPO should be done to all nurses. She further stated that she did not ask nor call the CP to do MPO after the significant medication error incident happened. The DON confirmed that there was no follow up MPO competencies were done to both the RN and LPN#1 after the incident of significant medication error. On 7/28/23 at 8:18 AM, the DON provided a typewritten copy of Resident #390's Medication Errors summary that included that LPN#2 was the nurse who did the transcription error on 3/24/23 of the resident for the order of Klonopin wherein LPN#2 wrote for the medication to be dispensed as 1 (one) mg TID (3x/day) instead of 0.5 mg TID. Included as an attachment in Resident#390's Medication Errors summary was the [NAME] for the date of error 3/24/23 with a date of error discovery of 7/27/23 (after the surveyor's inquiry). On 7/27/23 at 8:52 AM, the surveyor reviewed the provided binder of Medication Pass Observation documents and revealed that LPN#1 and #2, and the RN did not have MPO competencies done at the facility prior to a significant medication error that happened on 5/27/23, 5/29/23, and 5/30/23 and immediately after the investigation reports were completed. On 7/28/23 at 11:59 AM, the survey team met with the Regional Chief Nurse Officer, DON, Licensed Nursing Home Administrator (LNHA), and were made aware of the above findings. The LNHA stated that the RN did not have a performance evaluation because the RN was hired on March 2023 and was not due. The LNHA further stated that LPN#1 was an agency nurse, and LPN#2 was hired on 10/31/22 and the performance evaluation was not due to complete. On that same date and time, the LNHA acknowledged and confirmed that there were no MPO competencies for 3 (three) nurses (LPN#1 and #2, and the RN) before the significant medication error and after the incident was investigated. The LNHA further stated according to the facility's protocol, MPO competency should be done upon hire and as needed or periodically. The LNHA acknowledged that the MPO competencies of the RN and LPN#2 and #2 should have been done. A review of the facility's provided Medication Pass Observation form that was provided by the LNHA with a Form 109 B revised date of 6/17 included a medication administration errors list #7 Correct drug, correct amount, correct dosage form administered and #9 Medication Administration: a. Medication checked against MAR (Medication Administration Record) before administering. NJAC 8:39-27.1(a)

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(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 - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Complaint # NJ00164623 Based on interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to ensure a) medication was accurately received, administered, and reconciled against the physician order prior to administration which contributed to a repeated administration of an incorrect dose to and proper disposal of Clonazepam (Klonopin; a hazardous, controlled substance/narcotic medication (med) to prevent and treat anxiety disorder), for Resident #390, b) accurate signing for a medication in the electronic medication administration record (eMAR), accurate accounting, dispensing, and administration of a controlled substance med, and med was administered according to physician orders and acceptable standards of practice, for Resident #78 and #47. This deficient practice was identified for three (3) of (3) residents (Resident #390, Resident #78, and Resident #47) reviewed for Clonazepam. 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 treating human responses to actual and 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 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. Reference DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Disease Control and Prevention National Institute for Occupational Safety and Health (NIOSH) list of Antineoplastic and Other Hazardous Drugs in Healthcare settings, 2016. Table 3 Table 3 primarily meet the NIOSH criteria for reproductive hazards. They represent a potential occupational hazard to males or females who are actively trying to conceive, women who are pregnant or may become pregnant, and women who are breast feeding, as they may be present in breast milk. Unopened, intact tablets and capsules may not pose the same degree of occupational risk as injectable drugs that usually require extensive preparation. Cutting, crushing, or otherwise manipulating tablets and capsules will increase the risk of exposure to workers. The manufacturer's safe-handling guidance (MSHG) is typically in Section 16 of the DPI. See Table 5 for safe handling recommendations . Table 3 list included but were not limited to the following: Clonazepam, Increased risk of congenital abnormalities when taken in first trimester; FDA Pregnancy Category D (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 7/25/23 at 10:42 AM, the surveyor reviewed Resident #390's medical record. The Admission Record (AR; or face sheet; an admission summary) reflected the resident was admitted with diagnoses which included Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), unspecified dementia (loss of cognitive functioning), bipolar disorder (mental illness that causes unusual shifts in mood from extreme high to extreme low), dysphagia (difficulty swallowing), peripheral vascular disease (circulation disorder), major depressive disorder (persistent feeling of sadness and loss of interest) and generalized anxiety disorder. The most recent Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, dated 5/04/23, reflected that the resident had a brief interview for mental status (BIMS) score of 6 out of 15, which indicated the resident had a severely impaired cognition. Further review of the MDS section E Behavior indicated the resident was not delusional and section N Medications reflected the resident received antipsychotic and antianxiety medications. The resident's personalized care plan revised on 8/03/22, under the section Intervention/ Tasks, included review medications (meds) and record possible causes of cognitive deficit: new meds or dosage increases; anticholinergics, opioids, benzodiazepines, recent discontinuation, omission or decrease in dose of benzodiazepines, drug interactions, errors or adverse drug reactions, drug toxicity. A review of the Order Summary Report (OSR) dated 5/01/23 to 5/31/23, included an order for Clonazepam with a start date of 5/16/23, and reflected the following: Clonazepam ODT 1 (one) mg (milligram), Controlled Drug, give 1 tablet by mouth three times a day related to generalized anxiety disorder. A review of the Controlled Drug Record (CDR; a narcotic log/form used to inventory and document each dose of med administered or disposed) with a pharmacy provider label for Clonazepam ODT 0.25 mg, give 4 (four) tablets by mouth three times a day was signed received on 5/18/23, for 90 doses. Further review of the CDR revealed that the med was signed removed from inventory for administration by the nurses from 5/19/23 to 5/27/23 at 2:00 PM. A review of the electronic Medical Record (eMR) did not reflect a physician's order to correspond with the CDR for Clonazepam ODT 0.25 mg that was signed received on 5/18/23, signed removed for administration for 90 doses. A review of the Medication Error Incident Report ([NAME]) dated 5/29/23, revealed under Explanation/ Reason medication error was made reflected Resident was previously receiving 0.25 mg tabs [tablets] (4 to equal 1 mg) and the new bingo card was delivered with 1 (one) mg tabs and nurse subsequently gave 4 (four) without confirming the right dose. A review of the [NAME] dated 5/30/23, revealed under Explanation/ Reason med error was made reflected Resident was previously receiving 0.25 mg tabs [tablets] (4 to equal 1 mg) and the new bingo card was delivered with 1 (one) mg tabs and nurse subsequently gave 4 (four) without confirming the right dose. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the eMAR for Resident #390 reflected the following: -On 5/04/23 at 2:00 PM, the eMAR was signed absent from home without meds. -On 5/11/23 at 2:00 PM, the eMAR was signed absent from home without meds. -On 5/28/23 at 6:00 AM, the eMAR was signed refused. A review of the CDR for Resident #390 revealed the following: On 5/04/23 at 02:00 PM, one tablet of Clonazepam 1 (one) mg was removed from inventory for administration. No documentation of disposal was annotated on the CDR. On 5/11/23 at 02:00 PM, one tablet of Clonazepam 1 (one) mg was removed from inventory for administration. No documentation of disposal was annotated on the CDR. -On 5/28/23 at 6:00 AM, four tablets of Clonazepam 1 (one) mg were removed from inventory for administration. No documentation of disposal was annotated on the CDR. On 7/26/23 at 9:48 AM, during a telephonic interview with the surveyor, the provider pharmacist stated the physician or nurse enters the order into the eMR, electronically signs off and is transcribed into their system. On 7/27/23 at 10:14 AM, the survey team met with the Regional Director of Nursing (RDON), License Nursing Home Administrator (LNHA), and the Director of Nursing (DON) and were made aware of the above findings. At that time, the LNHA stated that she spoke with the provider pharmacy when the medication error occurred. The LNHA was concerned why the physician's order (PO) on the eMR did not match the med received. She was informed by the pharmacy that they are unable to see what is on the eMR. At that time, the LNHA informed the surveyor that in the event of a discrepancy between a PO and a med received, the nurses would call the pharmacy to rectify the discrepancy and get the correct order for the resident. On 7/27/23 at 12:52 PM, during a meeting with the survey team, the RDON, and LNHA, the DON acknowledged the PO should be followed. At that time, the RDON stated following a PO was based on accepted standard of professional practice to avoid negative outcomes for the resident. At that time, the LNHA informed the surveyor that in the event of a discrepancy between a PO and a med received the nurses would call the pharmacy to rectify the discrepancy and get the correct order for the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, the DON acknowledged the med received from the pharmacy should have been reconciled for accuracy against the PO. On that same date and time, during a meeting with the survey team, RDON, and LNHA, the DON informed the surveyor that she was aware the med was refused on 5/28/23 at 6:00 AM. The DON stated it did not cross her mind to in-service (provide education) regarding proper disposal of Clonazepam. 48273 2. On 7/20/23 at 10:34 AM, the surveyor observed Resident #78 seated up on the bed awake, alert, and responded appropriately to the surveyor. The surveyor also observed the Certified Nursing Assistant (CNA) assisted the resident with breakfast. The surveyor reviewed Resident #78's medical record. The AR reflected that the resident was admitted to the facility which included diagnoses that included but were not limited to type 2 diabetes mellitus with hyperglycemia (abnormal blood glucose level), hypothyroidism (deficiency of thyroid hormones can disrupt such things as heart rate, body temperature, and all aspects of metabolism), hyperlipidemia (A condition in which there are high levels of fat particles (lipids) in the blood), Alzheimer's Disease, essential hypertension (elevated blood pressure), unspecified dementia, and anxiety disorder. A review of Resident #78's PO presented an order initiated on 5/05/23 for Alendronate Sodium (medication use to treat osteoporosis) Oral Tablet 70 mg, 1 (one) tablet by mouth weekly for osteoporosis (A condition in which bones become weak and brittle). The medication order was changed on 7/12/23 to Alendronate Sodium Oral Tablet 70 mg, 1 (one) tablet by mouth one time a day every Sunday for osteoporosis - give with 8 (eight) ounces of plain water, at least half hour before all other food, beverage, or med; do not lie down for half hour. The surveyor reviewed the eMAR for Resident #78 for the med administration of Alendronate Sodium Oral Tablet 70 mg, 1 (one) tablet by mouth weekly for osteoporosis, which revealed the following: For the month of May 2023, the nurses signed 23 out of 27 days that the med was administered. For the month of June 2023, the nurses signed 29 out of 30 days that the med was administered. For the month of July 2023, the nurses signed 11 out of 12 days that the med was administered. On 7/25/23 at 01:05 PM, the surveyor interviewed the DON regarding the above concerns for the Alendronate Sodium medication. The DON stated when the order was entered for Alendronate Sodium 70 mg give 1 (one) tablet by mouth weekly on 5/05/23, it was selected for the nurses to document daily instead of weekly. The CP identified the error in 7/08/23, and the DON initiated an investigation for the med documentation error. The DON further stated that the investigation concluded that the nurses were signing the eMAR daily and not administering the med, as the med was not available to be given every day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/26/23 at 11:59 AM, the surveyor interviewed LPN #2, who was assigned previously to Resident #78 and signed for the Alendronate Sodium medication in the eMAR. LPN #2 stated the Alendronate Sodium was to be given weekly and she observed the med was being signed daily. She stated she did not administer the med and documented a progress note dated 5/13/23 and 5/14/23 that she did not give the med because it was already given for the week. LPN #2 acknowledged that it was expected for the nurses to report a concern about a med order and that it should have been reported for follow up to the supervisor. 3. On 7/26/23 at 01:45 PM, the surveyor reviewed the CDR form for Resident #78 on the Magnolia unit med cart. The surveyor reviewed Resident #78's CDR form for Clonazepam 0.5 mg 1/2 (half) tablet (0.25 mg) by mouth every 12 hours as needed for Anxiety for 14 days, which revealed two entries on 7/16/23 at 11:20 AM. Indicating Resident #78 received Clonazepam 0.5 mg. The surveyor reviewed the PO for Resident #78 which revealed an order initiated on 6/09/23 for Clonazepam give 0.5 tablet by mouth every 12 hours as needed for anxiety for 30 days - 0.5 tablet = 0.25 mg, which was discontinued on 7/09/23. Further review of the PO revealed an order initiated on 7/14/23 for Clonazepam 0.5 mg 1 (one) tablet every 8 (eight) hours as needed for anxiety/agitation for 30 days. Further review of resident's CDR revealed the following: On 7/20, 7/21, 7/22, and 7/25 entries documented a single Clonazepam 0.5 mg 1/2 (half) tablet (0.25 mg) was signed out for each of these days. The surveyor reviewed July eMAR, which indicated on 7/20, 7/21,7/22, and 7/25 med Clonazepam 0.5 mg 1 (one) tablet was administered. On 7/26/23 at 02:00 PM, the surveyor interviewed LPN #3, who was the assigned nurse for Resident #78 and confirmed the count of the Clonazepam in the med cart. The surveyor reviewed with LPN #3 the CDR for the Clonazepam. LPN#3 stated that the nurses who were administering the med should have reviewed the directions of the med prior to administering the med. She further stated that when the new bingo card with the correct dose was received that the discontinued med should have been remove from the med cart. On 7/26/23 at 02:10 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) about the process for when a med order was changed. UM/LPN stated when a doctor changed the order that they will fax the new order to the pharmacy. When a new order is received from the pharmacy, the discontinued order will be remove from active med stock. The med nurse will give her the unit manager the discontinued med and that med will be destroyed in the presence of two nurses. On 7/27/23 at 12:52 PM, the surveyor informed the LNHA, DON, and RDON about the above concerns with the Alendronate Sodium med and the Clonazepam med for Resident #78. The DON acknowledged there was a med error, in which an investigation was completed. 46049 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The surveyor reviewed the hybrid (electronic and paper) medical records for Resident #47, which revealed the following: The resident's AR listed diagnoses that included but were not limited to, unspecified dementia, major depressive disorder, and anxiety disorder. A review of the July 2023 OSR and the July 2023 eMAR indicated that Resident #47 had a PO, dated 6/30/23 for Clonazepam 0.5 mg, give 1 (one) tablet by mouth two times a day for anxiety, which was discontinued on 7/11/23. A PO, dated 7/11/23, was started for Clonazepam 1 (one) mg, give 1 tablet by mouth three times a day for anxiety. On 7/26/23 at 02:09 PM, the surveyor interviewed the UM/LPN about the CDR. The UM/LPN stated upon completion of a CDR, it would be removed from the binder in the med cart, and that it would be given to the DON. The surveyor asked the UM/LPN what the expectations were for when a nurse wasted a controlled med. UM/LPN stated two nurses were to waste (destroy) a controlled med, to witness and co-sign the disposal of the med. The surveyor requested from the UM/LPN the Clonazepam drug records for Resident #47. On 7/27/23 at 10:01 AM, the surveyor interviewed the DON about CDR keeping. The DON stated she kept all original CDR forms for record keeping. The surveyor requested from the DON the Clonazepam 0.5 mg, CDR forms for Resident #47. On 7/28/23 at 10:10 AM, the DON provided the surveyor the Clonazepam 0.5 mg July 2023 CDR forms for Resident #47. A review of the July 2023 CDR forms for Clonazepam 0.5 mg revealed the following: For the entry dated and timed, 7/13 9 PM, LPN #4 signed out for Clonazepam 0.5 mg, 1 (one) tablet. The physician's order was for Clonazepam 1 (one) mg to be administered and LPN #2 signed on the eMAR that Clonazepam 1 (one) mg was administered on 7/13/23 at 9 PM. For the entries dated and timed, 7/14 9 AM, 2 PM and 9 PM, LPN #1 signed out Clonazepam 0.5 mg 1 (one) tablet at each of those times. The physician's order was for Clonazepam 1 (one) mg to be administered. LPN #1 signed on the eMAR that Clonazepam 1 (one) mg was administered on 7/14/23 at 9 AM, 2 PM, and 9 PM. For the entries dated and timed, 7/15 9 AM and 2 PM, LPN #1 signed out Clonazepam 0.5 mg, 1 (one) tablet. The physician's order was for Clonazepam 1 (one) mg to be administered. LPN #1 signed on the eMAR that Clonazepam 1 (one) mg was administered on 7/15/23 at 9 am and PM. For 7/17/23, there were no entries on the controlled drug records documenting Clonazepam being signed out for the 2 PM and 9 PM dose. LPN/UM signed on the eMAR that Clonazepam 1 (one) mg was administered on 7/17/23 at 2 PM and Registered Nurse (RN) #1 signed that Clonazepam 1 (one) mg was administered on 7/17/23 at 9 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For the entry dated and timed 7/18 9 AM, LPN #1 signed out two Clonazepam 0.5 tablets. LPN #1 did not sign eMAR for 7/18/23 at 9 AM, the eMAR was signed by LPN #5. LPN #1 worked on 7/19/23. There were no other entries on the CDR forms for the 7/18/23 9 AM, 2 PM, and 9 PM dose to document Clonazepam being signed out for administration to the resident. LPN #5 signed the eMAR on 7/18/23 for 9 AM and 2 PM that Clonazepam 1 (one) mg was administered to the resident. LPN #6 signed the eMAR for 7/18/23 at 9 PM that the med was administered. For the entries dated and timed 7/19 2 PM, LPN #1 signed out two Clonazepam 0.5 mg tablets. On the eMAR, LPN #1 signed, the chart code 5 for the Clonazepam 1 (one) mg to be administered on 7/19/23 at 2 PM. The chart code 5 indicated Hold/See Progress Notes. A review of the Administration note, LPN #1 documented awaiting order from pharmacy. There was no documentation to account if the two Clonazepam 0.5 mg tablets signed out by LPN #1 were wasted or administered to the resident. A review of the July 2023 CDR for Clonazepam 1 (one) mg which was currently in use for Resident #47 revealed the following: For the entry dated and timed 7/22 9 PM, LPN #6 signed their name and wrote wasted to indicate the Clonazepam 1 (one) mg tablet signed out was destroyed. There was no co-signature by another nurse on the entry to document that the wasting of the med was witnessed. On 7/28/23 at 10:25 AM, the surveyor informed the DON and LNHA of the above concerns. The DON stated it was expected for the nurses to follow the PO and if the dose of a med was not available the physician should be called, and the order clarified. The DON further stated it was expected for the nurses to have a second nurse to witness and co-sign on the controlled drug record when a controlled med was wasted (destroyed). The LNHA acknowledged the nurses were expected to follow the PO and administer med accurately. The DON and LNHA stated they would follow up and provide further information. On 7/28/23 at 11:59 AM, the survey team met with the LNHA, DON, and Regional Chief Nursing Officer. The DON confirmed the nurses could only provide the resident with Clonazepam from the resident's med supply in the med cart, that would require the nurses to sign and document on the CDR form. The DON stated there was no alternate access for the Clonazepam med and that there was no back up controlled med stock in the facility. The LNHA provided the surveyor with the controlled substances policy. A review of the facility provided policy; Accepting Delivery of Medications reviewed/revised 01/2023, included the following: Policy Statement 2. Any errors noted in receiving meds shall be brought to the attention of the Pharmacist and Director of Nursing Services. Policy Interpretation and Implementation 2. Before signing to accept the delivery, the Nurse must reconcile the meds in the package with the delivery ticket/order receipt. (continued on next page)

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Fallsview Nursing and Rehabilitation Center	199 Powerville Road Boonton, NJ 07005

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. If an error is identified when receiving meds from the pharmacy, the Nurse verifying the order shall: b. Return incorrect meds (e.g. wrong strength, form etc.) to the dispensing pharmacy and reorder the correct med. A review of the facility provided policy; Discarding and Destroying Medications reviewed/revised 1/2023 included the following: Policy Interpretation and Implementation 8. Any controlled substance that is considered hazardous waste will be managed in accordance with federal, state and local hazardous waste regulations as well as the Controlled Substance Act and DEA regulations. 10. The med disposition record will contain the following information: a. The resident's name b. Date med disposed e. quantity disposed f. method of disposition h. signature of witnesses A review of the facility provided policy; Controlled Substances dated 11/2022 included the following: Policy Interpretation and Implementation 9. The Director of Nursing services shall investigate any discrepancies in narcotic reconciliation to determine the cause and identify any responsibility parties, and shall give the Administrator a written report of such findings. A review of the facility's policy titled, Controlled substances, dated 12/2018, under policy statement read: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. The policy did not further address documentation by nurses at the time of medication being signed out and administered. The policy also did not address the procedure by nurses for destroying and documenting the wasting of a controlled medication. A review of the facility's policy titled Administering Medications, dated 11/2022, under Policy Statement read, Medications shall be administered in a safe and timely manner, and as prescribed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Under Policy Interpretation and Implementation, it read: 3. Medications must be administered in accordance with the orders .7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . On 7/28/23 at 01:11 PM, the facility had no further information to provide. NAACP 8:39-11.2 (b), 29.2 (d), 29.4(G)(I)(Mk), 29.7(ac)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Complaint # NJ00164623 Based on observation, interview, record review, and review of the facility provided documents, it was determined that the facility failed to identify medication irregularity during the monthly MRR (Medication Record Review) of the CP (Consultant Pharmacist) for two (2) of three (3) residents, (Resident #390 and Resident #78) reviewed for Clonazepam (or Klonopin; antianxiety medication). This deficient practice was evidenced by the following: A review of the manufacturer's specifications for Klonopin included the following: Geriatric Use, Clinical studies of Klonopin did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy. 1. On 7/25/23 at 10:42 AM, the surveyor reviewed Resident #390's medical record. The Admission Record (AR; or face sheet; an admission summary) reflected the resident was admitted with diagnoses which included Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), unspecified dementia (loss of cognitive functioning), bipolar disorder (mental illness that causes unusual shifts in mood from extreme high to extreme low), dysphagia (difficulty swallowing), peripheral vascular disease (circulation disorder), major depressive disorder (persistent feeling of sadness and loss of interest) and generalized anxiety disorder. The most recent Comprehensive Minimum Data Set, an assessment tool used to facilitate the management of care, dated 5/04/23, reflected that the resident had a brief interview for mental status (BIMS) score of 6 (six) out of 15, which indicated the resident had a severely impaired cognition. Further review of the MDS section E Behavior indicated the resident was not delusional and section N reflected the resident received Antipsychotic and Antianxiety medication. A review of the Psychiatric Progress Note (PN) dated 3/24/23, revealed recommendations that included but were not limited to a discontinuation of Klonopin PRN (administered as needed) and an increase of the routinely Klonopin from 0.5 milligram (mg) twice daily to Klonopin 0.5 mg every 8 hours for anxiety. The Social Services Note dated 3/28/23 indicated, Klonopin PRN was dc'd [discontinued]. Klonopin was increased to 0.5 mg every 8 hours (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Order Audit Report ([NAME]) revealed the order for Clonazepam Oral Disintegrating Tablet (ODT) 1 (one) mg, give one tablet (tab) three times a day related to (r/t) generalized anxiety disorder was created by the LPN and signed by the physician on 3/24/23. A review of the electronic Medication Administration Record (eMAR) with an order range date of 3/01/23 to 3/31/23 included the following physician orders (PO): -Clonazepam ODT 1 (one) mg, give one tab three times a day r/t generalized anxiety with a start date of 3/24/23 and discontinued on 3/27/23. -Clonazepam ODT 1 (one) mg, give one tab three times a day for give 2 (two) tablets of 0.5 mg = 1 (one) mg r/t generalized anxiety with a start date of 3/27/23. A review of the CP monthly report from 3/2023 through 5/2023, did not identify or inform the prescriber of the irregularity between Psychiatric Nurse Practitioner (PNP) dosing recommendation of Clonazepam 0.5 mg every 8 hours dated 3/24/23, against the executed PO of Clonazepam ODT 1 (one) mg every 8 hours, dated 3/24/23. On 7/26/23 at 10:38 AM, during a telephonic interview with the surveyor, the CP stated he did not make any recommendations regarding the executed PO dose increase for Clonazepam on 3/24/23 or thereafter. On 7/26/23 at 11:39 AM, during a telephonic interview with the surveyor, the Medical Doctor (MD) stated he did not recall if the order changes were communicated to him. The Physician also stated that the Psychiatry had prescribing privileges in the facility. On 7/26/23 at 02:21 PM, during an interview with the surveyor, the PNP explained that after a resident encounter her recommendations were documented into a psychiatric progress note. The PNP stated she made a copy and gave it to the nurse on duty. The PNP informed the surveyor that if the physician disagreed with her recommendation, she documented the information and wrote the reason on her psychiatric progress note. At that time, the surveyor asked the PNP if she was aware that her recommendation on 3/24/23 for Clonazepam 0.5 mg every 8 hours was implemented as 1 (one) mg every 8 hours instead. The PNP stated maybe I was not aware of it. On 7/27/23 at 10:14 AM, the survey team met with the Regional Director of Nursing (RDON), License Nursing Home Administrator (LNHA), and the DON and were made aware of the concern regarding the doubled Clonazepam dose in which the CP did not identify or notify the MD and the facility of the irregularity. At that time, the LNHA stated she had discussed and questioned the CP as to the reason why the irregularity was not identified. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/28/23 at 11:40 AM, during a meeting with the survey team, the DON stated that the LPN was written up yesterday (7/27/23), for the medication (med) error [transcription error] of placing an order for the Clonazepam as 1 (one) mg as opposed to the intended 0.5 mg recommended by the PNP on 3/24/23. The DON acknowledged and stated that the CP should have identified the transcription error as well. The DON further stated that the transcription error was identified after the surveyor's inquiry. No further information was provided. 48273 2. On 7/20/23 at 10:34 AM, the surveyor observed Resident #78 seated up on the bed awake, alert, and responded appropriately to the surveyor. The surveyor also observed the Certified Nursing Assistant (CNA) assisted the resident with breakfast. The surveyor reviewed Resident #78's medical record. The AR reflected that the resident was admitted to the facility that included diagnosis which included but was not limited to type two diabetes mellitus with hyperglycemia (abnormal blood glucose level), hypothyroidism (deficiency of thyroid hormones can disrupt such things as heart rate, body temperature, and all aspects of metabolism), hyperlipidemia (A condition in which there are high levels of fat particles (lipids) in the blood), Alzheimer's Disease, essential hypertension (elevated blood pressure), unspecified dementia, and anxiety disorder. A review of Resident #78's PO presented an order initiated on 5/05/23 for Alendronate Sodium Oral Tablet 70 mg, 1 (one) tab by mouth weekly for osteoporosis (A condition in which bones become weak and brittle). The med was changed on 7/12/23 to Alendronate Sodium Oral Tablet 70 mg, 1 (one) tab by mouth one time a day every Sunday for osteoporosis - give with 8 (eight) ounces of plain water, at least half hour before all other food, beverage, or med; do not lie down for half hour. Review of the eMAR documented the med Alendronate Sodium Oral Tablet 70 mg, 1 (one) tab by mouth weekly for osteoporosis initiated on 5/05/23 and the order was changed on 7/12/23; revealed the following: The month of May 2023, 23 out of 27 days the nurses signed for the med indicating it was administered. The month of June 2023, 29 out of 30 days the nurses signed for the med indicating it was administered. The month of July 2023, 11 out of 12 days the nurses signed for the med indicating it was administered. A review of the CP Monthly Report revealed that the CP visited and documented comments monthly, with the last documented visit and comment on 7/05/23. A review of the recommendations for Resident #78 dated 6/8/23 did not document recommendations related to the med Alendronate Sodium. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/26/23 at 10:39 AM, the surveyor interviewed the CP who stated that he reviews all resident's meds once a month. The CP further stated that he reviews a lot of things when he reviews a resident's med, which includes eMAR and PO. The surveyor notified the CP of the above concerns related to the med Alendronate Sodium. During the interview with the CP about the med Alendronate Sodium order and eMAR, the CP stated, It was possible I overlooked it since I did not make any recommendations for the month of June regarding that med. On 7/27/23 at 12:52 PM, the survey team met with the LNHA, DON, and Regional DON regarding CP not having recommendation about the med Alendronate Sodium for the month of June 2023. LNHA stated, the pharmacy consultant should have picked up the error. A review of the facility provided; Pharmacy Consultant Policy and Procedure reviewed 01/2023, included the following: Objectives: 1. To facilitate the administration of med with regard to safety, federal and state requirement and to ensure the accurate acquiring, receiving, dispensing and administration of all drugs and biologicals to meet the need of each resident. 5. to have the drug regimen reviewed by the pharmacist and ensure compliance with the drug regime [regimen] requirements. 6. To have the pharmacist find and identify apparent irregularities or potential drug therapy problems . The attending physicians are not required to agree with the pharmacist's report, nor are they required to provide a rationale for their acceptance or rejection of the report. They must, however, act upon the report. This may be accomplished by indicating acceptance or rejection of the report and signing their name. A review of the facility's document pharmacy agreement [name of pharmacy company] the agreement under Duties of Consultant, subsection iii states, Performing a monthly onsite review of the drug regimen of each patient on the Facility's unit census on date(s) of visit. Reports of any irregularities shall be provided on the nurse in charge and/or the attending physician, and the administrator. NJAC 8:39- 29.1(b), 29.3 (a)(1)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Complaint # NJ00164623 Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident was free of significant medication errors regarding the administration of anti-anxiety medication in accordance with the physician's order to prevent an adverse outcome for Resident #390. The facility failed to ensure that nurses administered medication to Resident #390 in accordance with professional standards of nursing practice. The significant medication errors were administered by two different nurses on three different days on 5/27/23, 5/29/23, and 5/30/23 when the anti-anxiety medication Klonopin was administered more than quadruple the prescribed medication dosage on each day to Resident #390 that resulted in the resident experiencing serious adverse effects of low blood pressure (less than 90/60 mmHg [milliliters of mercury]), increased congestion, pale, and hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions) resulting in an acute change of condition with a sudden clinically deviation from the resident's baseline. This deficient practice was identified for 1 of 3 residents reviewed who were on Clonazepam (Klonopin), and was evidenced as follows: A review of the manufacturer's specifications for Klonopin included the following: WARNING: RISKS FROM CONCOMITANT USE WITH OPIOIDS; ABUSE, MISUSE, AND ADDICTION; and DEPENDENCE AND WITHDRAWAL REACTIONS Concomitant use of benzodiazepines (depressant drugs) and opioids (controlled substances used to treat moderate to severe pain) may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing of these drugs for patients for whom alternative treatment options are inadequate. Limit dosages and durations to the minimum required. Follow patients for signs and symptoms of respiratory depression and sedation (see WARNINGS and PRECAUTIONS). Geriatric Use . In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy . Sedating drugs may cause confusion and over-sedation in the elderly; elderly patients generally should be started on low doses of Klonopin and observed closely. Precautions; General, Psychiatric and Paradoxical reactions (an effect of a chemical substance, such as a medical drug, that is opposite to what would usually be expected), such as agitation, irritability, aggression, anxiety, anger, nightmares, hallucinations, and psychoses are known to occur when using benzodiazepines . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	Paradoxical reactions are more likely to occur in children and the elderly. Overdose Management Treatment includes monitoring of respiration, pulse, and blood pressure, general supportive measures . On 7/25/23 at 10:42 AM, the surveyor reviewed the closed medical record of Resident # 390. The Admission Record (admission summary) reflected that the resident was admitted with diagnoses that included Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), unspecified dementia (loss of cognitive functioning), bipolar disorder (mental illness that causes unusual shifts in mood from extreme high to extreme low), dysphagia (difficulty swallowing), peripheral vascular disease (circulation disorder), major depressive disorder (persistent feeling of sadness and loss of interest) and generalized anxiety disorder. A review of the most recent Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, dated 5/04/23, reflected that the resident had a brief interview for mental status (BIMS) score of six (6) out of 15, which indicated the resident had a moderate to severely impaired cognition. Further review of the CMDS section E for Behavior revealed that the resident was not delusional and section N for Medications reflected the resident received antipsychotic and anti-anxiety medications during the look-back period. The resident's individualized care plan with a revised date of 8/03/22, under the section for intervention/tasks included to review medications and record possible causes of cognitive deficit: new medications or dosage increases; anticholinergics (medication that blocks a type of neurotransmitter), opioids (addictive medications typically used for pain), benzodiazepines (depressants) recent discontinuation, omission or decrease in the dose of benzodiazepines, drug interactions, errors or adverse drug reactions, drug toxicity. A review of the Psychiatric Progress Note (PN) dated 3/24/23 revealed recommendations that included but were not limited to the discontinuation of an order for an as needed (PRN) dose of Klonopin PRN and an increase in the frequency of the routine Klonopin from 0.5 milligrams (mg) twice daily to Klonopin 0.5 mg three times daily (every eight hours) for anxiety. The Social Services Note dated 3/28/23 indicated that the order for the as needed Klonopin was discontinued, and the routine standing order for the Klonopin was increased (in frequency) to 0.5 mg every eight hours. The Physician Monthly PN dated 4/06/23, under Assessment and Plan, included the following: Alzheimer's dementia with behavior disturbance -gets agitated at times due to anxiety and yells out but improved now with med [medication] changes by psych (psychiatrist), followed by psych, monitor depression/anxiety improved with med changes by psych, psych f/u [follow-up] monitor -stable with meds . A review of the Order Recap Report (ORR) for 5/2023, included the following physician orders: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	-Clonazepam (Klonopin) Oral Disintegrating tablet (ODT) 1 (one) mg dated 3/27/23. The order indicated to give one tablet by mouth three times a day. It further specified to give two tablets (tabs) of 0.5 mg to total the 1 mg dose related to generalized anxiety disorder. The order summary report indicated that this physician order was discontinued on 5/16/23. The ORR for 5/2023 reflected a new physician order for Klonopin dated 5/16/23 to administer Clonazepam (Klonopin) ODT 1 mg, give one tab by mouth three times a day, related to generalized anxiety. The surveyor reviewed a Controlled Drug Record (CDR; a declining inventory log used for the accountability for controlled drugs) which revealed a pharmacy provider label for, Clonazepam ODT 0.25 mg, give four tablets by mouth three times a day for Resident #390. The CDR was signed by a nurse indicating that 90 tablets of 0.25 mg were delivered on 5/18/23. A review of a second Controlled Drug Record revealed a pharmacy provider label for Clonazepam ODT 1 (one) mg. The CDR revealed that the Pharmacy Provider now delivered 1 mg tablets instead of 0.25 mg tablets. The label indicated to give 1 mg tablet by mouth three times a day and was signed as received on 5/27/23 by LPN #3 for 60 doses. Further review of the second CDR reflected the following: -5/27/23 at 9:00 PM, 4 (four) tablets [total of 4 mg, instead of 1 mg per order] of Klonopin were removed from the inventory for administration by LPN #1. -5/28/23 at 6:00 AM, 4 (four) tablets [total of 4 mg, instead of 1 mg per order] of Klonopin were removed from the inventory for administration by LPN #1. There were no tablets of Klonopin signed as wasted. The electronic Medication Administration Record (eMAR) for May 2023 revealed the following: -5/27/23 at 9:00 PM was signed as administered by LPN #1. -5/28/23 at 6:00 AM was signed by LPN#1 as the drug was refused. 1. A review of Resident #390's Medication Error Incident Report ([NAME]) dated 5/29/23 signed by the Director of Nursing (DON) included the following: Date of Error: 5/27/23 at 9:00 PM Date of Error Discovery: 5/29/23 at 8:36 AM Medication/Treatment involved: Klonopin Type of Error: Incorrect dose Explanation/Reason medication error was made, reflected Resident was previously receiving 0.25 mg tabs [tablets] (4 to equal 1 mg) and the new bingo card was delivered with 1 (one) mg tabs and nurse subsequently gave 4 (four) without confirming the right dose. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	Actions Taken: Resident assessed. Medical Doctor (MD) made aware. The family was made aware. Nurse written up and educated. The [NAME] also revealed that on 5/27/23, Licensed Practical Nurse#1 (LPN #1) administered the incorrect dose to the resident because the dosage of the tabs had changed, and the nurse failed to perform a dose check prior to administration. LPN #1 was informed via telephone by the DON on 5/30/23. No employee comment was annotated. A review of the Incident Report (IR) dated 5/29/23 at 9:40 AM, revealed the following: Incident Description: On 5/27/23 around 9:00 PM, the resident was given 4 (four) mg of Klonopin instead of 1 (one) mg as prescribed. The resident previously had a plastic bag of 0.25 mg disintegrating tabs therefore the nurses were giving 4 (four) tabs to equal 1 (one) mg. However, a new bag of tabs had been delivered 1 (one) mg tabs and the nurse failed to complete the five rights of medication pass, subsequently administering 4 (four) tabs of the 1 (one) mg tab for a total of 4 (four) mg, instead of total 1 (one) mg. Because they are disintegrating tabs, they do not come in a bingo card and are delivered in blister packs in a small plastic bag so the nurse should have checked the back of the blister pack for the correct dosage. The IR included that the resident unable to give a description. Further review of the IR, under Immediate Action Taken, revealed: Resident did suffer some adverse effects although this was not recognized until hindsight as the error was committed on 5/27 and was subsequently identified on 5/29. However, on 5/28, resident was pale with increased congestion, as well as hypotensive (lowered blood pressure) and hypoxic. Resident was lethargic most of the day with lack of appetite. MD was made aware at this time with no new orders as resident is on hospice. HOB (head-of-bed) was elevated, 02 at 1.5 L (liters) via NC (nasal cannula) was applied, resident suctioned. Resident later stabilized. MD and family were made aware of Klonopin mistake on 5/29/23 with no new orders from MD. A review of Resident #390's PN included the following: On 5/28/21 at 5:21 AM, LPN #1 documented that Resident #390 was noted to be pale, cool to touch, crying out, O2 (oxygen) sat [saturation] 78% placed on 1.5 L (liters) of oxygen for comfort, BP [blood pressure] 78/42, pulse 94. Resident #390 is a DNR (do not resuscitate; does not want other life-saving measures in the event of cardiac arrest)/DNI (does not want to be placed on a ventilator), on hospice. Attempted to give 6:00 AM dose of Klonopin but resident refused. Repositioned for comfort and covered with extra blankets. Will continue to monitor. On 5/28/23 at 7:34 AM, LPN #2 documented that Placed a call to [name redacted] hospice, updated nurse regarding a change in condition (deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains) from the previous shift. Comfort orders received, Levsin [an anti-tremor medication] 0. 125 mg, 1 (one) tab sl (sublingually) q 4 h (every 4 hours), secretion. Morphine Sulfate (a narcotic medication also known as an opioid) 100 mg/5 ml (milliliter), give 0.25 ml q 2 h (every 2 hours) for pain or shortness of breath. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallsview Nursing and Rehabilitation Center	199 Powerville Road Boonton, NJ 07005

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F 0760 Level of Harm - Actual harm Residents Affected - Some	On 5/28/23 at 8:42 AM, LPN #2 documented: Place a call to MD [medical doctor] made aware of change in condition, increase congestion and secretion, hospice made aware and will contact family. On 5/29/23 at 8:18 AM, (reflected late entry) LPN #2 documented: Medication error noted on 5/27 in reference to Klonopin. Dr [Name Redacted] made aware and no new orders at this time, and POA [Power of Attorney] made aware. On 5/29/23 at 3:15 PM, Registered Nurse #1 (RN #1) documented: Patient did not eat for breakfast, lunch only drank orange juice, [brand redacted] protein supplement, PRN sublingual Levsin, SO2 93% via NC (nasal cannula) T (temperature 97.3) . A review of the Licensed Nurse Competency Checklist for LPN #1 did not include a Medication Pass Observation. A review of the facility In-Service (education); The five rights of medication pass, dated 5/29/23 did not include LPN #1. A review of the undated, facility provided In-Service; The five rights of medication pass included LPN #1. A review of the facility-provided scheduled list did not reflect LPN #1 was in the facility from 5/27/23 to 5/31/23. 2. A review of Resident #390's [NAME] dated 5/30/23, signed by the DON included the following: Date of Error: 5/29/23 at 9:00 PM and 5/30/23 at 6:00 AM Date of Error Discovery: 5/30/23 at 9:00 AM Medication/Treatment involved: Klonopin Type of Error: Incorrect dose Explanation/Reason medication error was made: Resident was previously receiving 0.25 mg tabs (4 to equal 1 mg) and the new bingo card was delivered with 1 (one) mg tab and the nurse subsequently gave 4 (four) without confirming the right dose. Actions Taken: Resident assessed. MD was made aware. Family was made aware. Nurse written up and educated. The [NAME] also revealed that on 5/29/23 and 5/30/23, LPN #3 administered the incorrect dose to the resident because the dosage of the tabs had changed, and the nurse failed to perform a dose check prior to administration. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	LPN #3 signed the acknowledgment of the incident communication on 5/31/23. Under employee comments, LPN #3 wrote, Resident was previously receiving 0.25 mg and I popped the usual 4 (four) tabs Resident always receives. Seeing that the previous nurses gave and sign the same, I assumed still the same usual dose. Forgetting that pharmacy delivered a new blister card of 1 (one) mg instead of 0.25 mg. I admit my error .Med was crushed patient took a sip and the rest was discarded. A review of the IR dated 5/30/23, under Immediate Action Taken, revealed Resident was assessed, BP was 99/50, 76 (pulse rate), 98.1 (temp), O2 saturation variable in the 80s-90s on 2 (two) L (liters) of O2 via NC. MD was made aware with no new orders. Resident is DNR/DNI on hospice. Family made aware. Resident continues to be observed and doses for 2 PM and 9 PM have been scheduled to be held for today. A review of the Order Audit Report revealed on 5/30/23 at 11:34 AM, a hold order was created by the DON, ordered by the MD; the reason was a medication error, and the resident received additional doses. On 5/30/2023 at 11:27 AM, LPN #2 documented: Medication error noted, Klonopin on evening of 5/29 and morning of 5/30. Resident assessed, VS (Vital Signs): 99/50, 76, 98.1, 16, O2 sat variable in the 80's-90's on 2 LPM (liters per minute). MD made aware with no new orders. Resident is on hospice DNR/DNI. Will continue to observe resident for any changes. UM (Unit Manager) to call family and make them aware. A review of the Order Summary Report for May 2023 indicated that the Clonazepam (Klonopin) ODT 1 (one) mg, give one tab by mouth three times a day, related to generalized anxiety with a start date of 5/16/23 was placed on a hold from 5/30/23 at 11:34 AM to 5/31/23 at 5:59 PM. On 5/31/23 at 6:06 AM, LPN #3 documented, Medication on hold for low blood pressure. A review of the vital signs revealed the resident's O2 saturation levels from baseline had changed on 5/28/23 to 6/02/23 and required administration of supplemental oxygen by way of nasal cannula (NC). The vital signs reviewed included the following: Oxygen saturation 6/02/2023 11:40 PM 95.0 % Oxygen via NC 6/02/2023 10:50 AM 95.0 % Room Air 6/01/2023 7:42 PM 97.0 % Room Air 6/01/2023 10:51 AM 96.0 % Room Air 5/31/2023 10:15 AM 96.0 % Room Air 5/31/2023 10:16 AM 94.0 % Oxygen via NC 5/30/2023 10:41 PM 95.0 % Oxygen via NC (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	5/30/2023 09:36 AM 96.0 % Oxygen via NC 5/29/2023 11:11 PM 95.0 % Room Air 5/29/2023 10:27 AM 93.0 % Oxygen via NC 5/28/2023 8:00 PM 93.0 % Room Air 5/28/2023 02:27 PM 92.0 % Oxygen via NC 5/27/2023 8:07 PM 98.0 % Room Air 5/27/2023 10:39 AM 95.0 % Room Air 5/27/2023 10:39 AM 95.0 % Room Air 5/26/2023 10:42 AM 95.0 % Room Air 5/26/2023 06:14 AM 97.0 % Room Air 5/24/2023 8:05 PM 98.0 % Room Air 5/24/2023 09:26 AM 97.0 % Room Air 5/23/2023 7:22 PM 98.0 % Room Air 5/23/2023 10:58 AM 95.0 % Room Air 5/23/2023 01:14 AM 95.0 % Room Air 5/22/2023 10:19 AM 95.0 % Room Air 5/21/2023 8:09 PM 98.0 % Room Air 5/21/2023 09:34 AM 96.0 % Room Air 5/20/2023 10:42 AM 94.0 % Room Air 5/19/2023 11:34 PM 96.0 % Room Air 5/19/2023 12:03 PM 96.0 % Room Air 5/18/2023 8:31 PM 98.0 % Room Air 5/18/2023 11:19 AM 95.0 % Room Air 5/18/2023 00:42 AM 96.0 % Room Air (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	5/17/2023 02:33 PM 95.0 % Room Air 5/16/2023 11:43 PM 95.0 % Room Air 5/16/2023 10:33 AM 95.0 % Room Air 5/16/2023 01:40 AM 96.0 % Room Air 5/15/2023 10:42 AM 95.0 % Room Air Review of the Blood Pressure 6/09/2023 02:05 PM 101/67 mmHg Sitting r/arm (right/arm) 5/09/2023 02:36 PM 105 /65 mmHg Sitting l/arm (left/arm) 5/02/2023 06:21 AM 122 /64 mmHg Lying l/arm Review of the Pulse 6/09/2023 02:05 PM 78 bpm (beats per minute) Regular 5/09/2023 02:36 PM 78 bpm Regular 5/02/2023 06:21 AM 68 bpm Regular Review of the Respirations 6/09/2023 02:05 PM 78 bpm Regular 5/09/2023 02:36 PM 78 bpm Regular 5/02/2023 06:21 AM 68 bpm Regular Further review of the vital signs from May 2023 through June 9, 2023, revealed that the resident was not monitored for blood pressure, pulse, and respirations on 5/27/23, 5/28/23, 5/29/23, 5/30/23, and 5/31/23 when the resident had adverse effects from medication errors identified which included a change in condition as evidenced in the PN, RI and [NAME]. A review of the Licensed Nurse Competency Checklist dated 4/26/23 for LPN #3 did not include a Medication Pass Observation. A review of the facility In-Service (education); The five rights of medication pass, dated 5/29/23 did not include LPN #3. On 7/26/23 at 10:38 AM, the surveyor interviewed the Consultant Pharmacist (CP). The CP confirmed that he had not provided an in-service regarding the Clonazepam. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	On 7/26/23 at 11:02 AM, during an interview with the surveyor, LPN #1 informed the surveyor that during the medication pass on 5/29/23, she noticed the medication card (a multi-dose card containing individually packaged medications) for Clonazepam 1 (one) mg and compared it to the eMAR and I wondered why the other nurses gave 4 (four) tablets. LPN#1 further stated that I then called hospice, the physician, the family and told my supervisor. On 7/26/23 at 11:39 AM, the surveyor interviewed the physician of the resident. The physician stated that I do not recall if that was communicated to me, with regard to the 3/24/23 recommendation of the psychiatrist for Clonazepam 0.5 mg tab three times a day and was transcribed as 1 mg three times a day. The physician further stated that the psych (psychiatrist) has prescribing privileges. On 7/26/23 at 01:28 PM, the surveyor interviewed the DON in the presence of the survey team. The DON stated, Once a medication error occurred, we fix it right away and let the MD and family know. The DON further stated, I completed the IR and a medication error report. The DON also stated that at that time Resident #390 appeared to have declined but I can't correlate that it is from the error. At that same time, the DON stated that Resident #390 was lethargic and calling out when the resident received Klonopin more than what was prescribed. She further stated that We educated some of the nurses on the 5 (five) rights of medication administration. Furthermore, the DON stated, I held the medication because of the medication administration error. On 7/27/23 at 12:52 PM, the survey team met with the Regional Director of Nursing (RDON), the License Nursing Home Administrator (LNHA), and the DON. The DON acknowledged the physician's order should be followed. At that time, the RDON stated following a physician's order was based on accepted standards of professional practice to avoid negative outcomes for the resident. At that time, the LNHA confirmed the significant medication error for Klonopin and that the resident received more than the prescribed order. On 7/28/23 at 11:40 AM, during a meeting with the survey team, the DON stated that LPN #2 was written up yesterday (7/27/23), for the medication error [transcription error] of placing an order for the Clonazepam as 1 (one) mg as opposed to the intended 0.5 mg recommended by the PNP on 3/24/23; identified after surveyor inquiry. The DON confirmed that LPN#2 did not have a medication pass observation and was scheduled for a medication pass observation on that day. A review of the provided facility policy; Medication Errors included the following. Policy Statement: In the event of a medication error, the facility will act promptly to assess for adverse consequences, notify the physician, carry out follow-up orders as directed by the physician, and address the route cause of the error. Policy Interpretation: 3. In the event of a significant medication-related error or adverse consequence, immediate action is taken, as necessary, to protect the resident's safety and welfare. Significant is defined as: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	a. Requiring medication discontinuation or dose modification. d. Requiring treatment with prescription medication. NJAC 23.2(a); 27.1(a); 29.2(d)