STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. BUILDING _____ B. WING _____	**08/17/2020**

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

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 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # NJ 8 Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication pass on 08/17/2020, the surveyor observed two (2) nurses administer medications to eight (8) residents. There were 30 opportunities and two (2) errors observed which calculated to a medication administration error rate of 6%. This deficient practice was identified for 1 of 2 nurses and 2 of 8 residents (Resident #10 and #11) and was evidenced by the following: 1. On 08/17/2020 at 10:10 AM to 10:25 AM, the surveyor observed the Registered Nurse (RN) administer medications to Resident #10. The surveyor observed the RN prepare three medications to be administered by mouth to the resident. The medications included two medications used as nutritional supplements, [MEDICATION NAME] Acid 250 milligrams (mg) and Beta Carotine 25,000 units; and a supplement to treat low potassium levels in the blood, Potassium Chloride ER (extended release) 10 milliequivalents (Meq). The order for the Potassium Chloride ER specified to administer one (1) capsule by mouth in the morning every other day for supplement. The precautionary statement printed on the medication administration card read, Take this med with a meal. The RN did not address the resident's consumption of breakfast or food at the time the medications were administered. After the RN administered the medications to the resident, the surveyor interviewed Resident #10 in the presence of the RN and asked when he/she ate breakfast. The resident stated that it had to have been about an hour ago. There was no breakfast tray or food in the resident's room at the time of medication administration. The surveyor then stepped out of the resident's room and interviewed the RN at her medication cart. The RN stated that the Potassium Chloride ER should have been administered when the resident was eating a meal like breakfast in accordance with the individual manufacturer specifications. The RN further stated that the breakfast trays arrived on the unit around 9:00 AM, that C-Wing was the last to be served breakfast, and the resident had already eaten his/her breakfast meal. The RN acknowledged that the medications were given after 10 AM. A review of Resident #10's August 2020 electronic Medication Administration Record [REDACTED]. The medication was plotted to be administered at 9 AM every other day. There were no cautionary instructions on the eMAR that the medication needed to be administered in accordance with meals. A review of the manufacturer specifications for the Potassium Chloride indicated that the medication should be taken immediately after a meal or with a meal to prevent an upset stomach. 2. On 08/17/2020 at 10:46 AM to 11:13 AM, the surveyor observed the same Registered Nurse (RN) administer medications to Resident #11. The surveyor observed the RN prepare six medications to be administered by mouth to the resident and one medication to be applied to resident's scalp. The medications included [MEDICATION NAME], a medication used to reduce the production of uric acid in the body; aspirin used as an anti-[MEDICAL CONDITION] medication; [MEDICATION NAME], a medication used to treat [MEDICAL CONDITION]; [MEDICATION NAME], a medication used to treat high blood pressure and fluid retention; [MEDICATION NAME], a medication to treat mental/mood disorders; [MEDICATION NAME] cream, a topical steroid; and a supplement to treat low potassium levels in the blood, Potassium Chloride 20 Meq. The order for the Potassium specified to give 20 Meq by mouth one time a day for [DIAGNOSES REDACTED] (low potassium levels). The precautionary statement printed on the medication administration card read, Take this medication with a meal. This time the RN acknowledged the resident's order for potassium and the precautionary instructions and offered the resident graham crackers with his/her medications. After the RN administered the medications to the resident, the surveyor interviewed Resident #11 in the presence of the RN and asked when he/she ate breakfast. The resident stated that it had been a while ago. There was no breakfast tray or food in the resident's room at the time of medication administration. The surveyor then stepped out of the resident's room and interviewed the RN at her medication cart. The RN stated that the Potassium Chloride ER should have been administered when the resident was eating a meal like breakfast in accordance with the individual manufacturer specifications. The RN further stated she gave the graham crackers because she knew the resident had already eaten his/her breakfast meal. Upon additional questioning the RN acknowledged graham crackers were not a meal, and she should have offered a sandwich. A review of Resident #11's August 2020 electronic Medication Administration Record [REDACTED]. The medication was plotted to be administered at 9 AM every day. There were no cautionary warnings on the eMAR that the medication needed to be administered in accordance with meals. A review of the manufacturer specifications for the Potassium Chloride indicated that the medication should be taken immediately after a meal or with a meal to prevent an upset stomach. A review of the facility's Medication Administration: General Policy and Procedure, revised 11/01/2019, indicated the purpose was to provide a safe, effective medication administration process and that A licensed nurse, Med Tech, or medication aide, per state regulations, will administer medications to patients. Accepted standards of practice will be followed. On 08/17/2020 at 4:30 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Assistant Director of Nursing (ADON) to discuss the medication administration process observation. The ADON stated the nurse should read the medication administration card before administrating a medication and follow any instructions. The ADON and the LNHA acknowledged the nurse should have administered the Potassium Chloride ER to the residents with a meal. NJAC 8:39-11.2(b), 29.2(d), 29.4(c)

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

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.