STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315509	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROOSEVELT CARE CENTER AT OLD BRIDGE	1133 MARLBORO ROAD OLD BRIDGE, NJ 08857

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to properly prepare and administer medications as per physician orders [REDACTED]. This deficient practice was identified for 1 of 7 residents (Resident #64) reviewed for medication administration and was evidenced by the following: Reference: New Jersey Statutes, 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 regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference New Jersey Statutes, 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 task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 9/17/20 at 9:39 AM, the surveyor observed pills in two separate medication cups and one medication cup filled with applesauce and a spoon on Resident #64's overbed table. The medications consisted of one whole white oval pill and one white, oblong pill cut in half. The surveyor observed the resident self-administer the contents in the medication cups. Resident #64 verbalized that he/she did not know the medications received in the cups but took medicine by themselves, all the time. The surveyor observed that there were no other residents in the vicinity at this time. A review of the Minimum Data Set, an assessment tool used to facilitate care management, dated 6/30/2020, revealed that the resident's cognition was intact. A review of the Order Summary Report (OSR) revealed a physician's orders [REDACTED]. The OSR showed a physician's orders [REDACTED]. The OSR also showed an additional physician's orders [REDACTED]. Don't chew/crush. Take with plenty of water. Avoid lying down x 10 minutes after. May open/sprinkle on soft food. A review of the September 2020 Medication Administration Record [REDACTED]. A review of the Medication Administration Audit Report (MAAR) reflected the administration details of the Acidophilus and the Potassium Chloride. The MAAR indicated that the Potassium Chloride ER 10 mEq tablet and Potassium Chloride ER 20 mEq tablet were administered on 09/17/2020 at 09:15 AM and documented 09/17/2020 at 09:18 AM. The Acidophilus two capsules were documented as administered on 09/17/20 at 09:16 AM and documented on 09/17/2020 at 09:18 AM. The surveyor interviewed the Licensed Practical Nurse (LPN #1) assigned to the resident at 9:48 AM on 9/17/20. LPN #1 identified the pills in the medication cups as one whole Acidophilus capsule and one Potassium Chloride tablet cut in half. LPN #1 stated that she could not confirm if the potassium tablet in the medication cup was 10 mEq or 20 mEq. LPN #1 said she left the pills with Resident #64 because she had to go to the bathroom. LPN #1 also stated that the nurse was to remain with the resident during medication administration because it was the facility's policy. LPN #1 confirmed that she should not have left the medications with Resident #64. At 10:02 AM, the surveyor and LPN #1 went to the medication cart outside of Resident #64's room. The surveyor observed the computer screen located on the medication cart had a list of medications (Acidophilus 2 capsules, Potassium ER 20 mEq one tablet, and Potassium ER 10 mEq one tablet) that were highlighted in green with a checkmark. LPN #1 stated that a green highlight with a checkmark indicated that the medication was documented as given. LPN #1 confirmed that the physician order [REDACTED].#64 was to receive one Potassium Chloride 10 mEq tablet and one Potassium Chloride 20 mEq tablet for a total of Potassium Chloride 30 mEq and two Acidophilus capsules. When interviewed on 9/18/20 at 11:39 AM, the Clinical Coordinator stated that during the administration of medications, the nurse should not sign off the medications as given in the computer because the resident may refuse to take the medications. The Clinical Coordinator also confirmed that the nurse should not leave residents with medications unsupervised and that the facility policy reflected her statement. On 9/23/20 at 2:14 PM, the Director of Nursing (DON), Director of Clinical Services, and Administrator were interviewed in the survey team's presence. The DON also acknowledged that LPN #1 should not have left the medications with the resident unsupervised. On 9/24/20 at 12:07 PM, the Administrator, DON, and Director of Clinical Services, in the surveyor team's presence, provided copies of LPN #1's latest Medication Pass Observation Worksheet. The Administrator mentioned that medications must be taken in the presence of the nurse. The Director of Clinical Services stated that LPN #1 should not have left medications at the bedside and indicated that This is a standard of practice. The Director of Clinical Services reconfirmed and stated that it was a standard of practice for the nurse not to leave medications at the bedside. The DON indicated that any resident that can self-medicate without the nurse must have a physician order [REDACTED].#1 ' s nursing competency form titled, Medication Pass Observation Worksheet dated 11/18/2019, Section 9(c) indicated the following: The resident/patient was observed to ensure medication was swallowed. NJAC 8:39-11.2(b)
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** Based on interview and review of facility documents, it was determined that the facility failed to ensure that all Drug Enforcement Administration (DEA) 222 forms were completed with sufficient detail to enable accurate accountability and reconciliation for controlled medications for 7 of 8 DEA 222 forms provided. This deficient practice was evidenced by the following: On 9/24/2020 at 10:54 AM, the surveyor reviewed all DEA 222 forms from a binder provided by the Director of Nursing (DON) for the last six months. The surveyor reviewed the documents and noted the following: 1. A DEA 222 form dated 04/14/2020, under Part 1: To Be Filled In By The Purchaser, the last line under Item was left blank and Part 5: To Be Filled In By Purchaser had the date received as 4/16/20 with an attached Packing Slip signed by a Registered Nurse (RN) dated 4/17/20. 2. A DEA 222 form dated 05/15/2020, under Part 5 had the date received as 5/18/20 with an attached Packing Slip signed by an RN and dated 5/19/20. 3. A DEA 222 form dated 06/26/20, under Part 5 column, Number Received, there was the number one circled and the Date Received column had 7/1/20 written. Both of these were written above the Item line. Also, under Part 1, Item 1, there was one (1) package of [MEDICATION NAME] (an opioid medication used to treat pain) Patch 50 mcg (micrograms) written, and under Part 5, the date received was not written on the Item line. Under Part 1, Item 2, there was one (1) package of [MEDICATION NAME] Patch 25 mcg and Part 5 column Number Received and Date Received were left blank. The attached Packing Slip indicated that both of the above medications had been received as noted by a signature and dated 7/1/20. 4. A DEA 222 form dated 7/20/20, under Part 1, Item 1 was documented as [MEDICATION NAME] (an opioid medication used to treat pain) 10 mg (milligrams) Tab (tablet) and Under Part 5 revealed Number Received as 30 and Date Received was 7/21/20. Part 1 also listed Item 2 as [MEDICATION NAME] (a narcotic medication used to treat pain) 2 mg tab. Under Part 5, Item 2, did not have the Number Received and Date Received documented. It was blank. The attached Packing Slip indicated that both medications had been signed as received by an RN and Licensed Practical Nurse (LPN) and was dated

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.

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) 7/22/20. 5. A DEA 222 form dated 07/22/2020 had no numbers entered for the Supplier DEA Number # on the top right of the form. It was left blank. Also, under Part 1, revealed the Item [MEDICATION NAME] Patch 25 mcg was noted with Date Received under Part 5 was 7/24/20. The attached Packing Slip indicated that the [MEDICATION NAME] 25 mcg was received on 7/25/20 and signed by an RN. 6. A DEA 222 form dated August 27, 2020 revealed that Item 1 was [MEDICATION NAME] IR (an immediate-release medication used to treat pain) 5 mg tab and under Part 5 had the Date Received as 8/28. Then for Item 2 was documented as, [MEDICATION NAME]/APAP ([MEDICATION NAME]) 5/325 mg tab and under Part 5 the Date Received was 8/28. The attached Packing Slip was signed as received by an LPN and RN on 8/29/20. 7. A DEA 222 form dated 9/4/2020 revealed under Part 1, Item 1 had the number of packages ordered was 1, with the size of the package written was 15 for [MEDICATION NAME] 10 mg/0.5 ml syringe and under Part 5, the Number Received for Item 1 was blank and the Date Received was documented as 9/7. Also, Item 2 had the number of packages noted as 1, with the package size of 30 for [MEDICATION NAME] 10 mg tablet and under Part 5, Item 2 line under Number Received was blank and the Date Received documented was 9/7. The attached Packing Slip revealed that both of the medications ordered had been signed by a nurse as received on 9/7/20. On 9/24/2020 at 11:06 AM, the surveyor interviewed the Facility's DON who stated it was her responsibility to maintain the DEA 222 form. The DON said that the facility did not have their own policy related to receiving narcotics and completing the DEA 222 form but used the policy from their contacted Pharmacy. The DON confirmed that the medications ordered on the DEA 222 forms were for the back up supply of medications stored in the automated pharmacy machine on the third floor. The surveyor then reviewed the (Pharmacy) Policy and Procedure titled, Controlled Dangerous Substance Inventory Back Up Box and Emergency Kits with a revised date of April 2018 which read under Policy, (Pharmacy) and the facility will properly distribute, maintain, and dispense controlled substances that are stored within the back up box or emergency kit. All controlled dangerous substances (CDS) are dispensed and handled in accordance with state and federal regulations. The policy continued under Procedure A. CDS (Controlled Dangerous Substances) in Back-Up Supply - Schedule II CDS: 1. A DEA Form 222 must be completed to obtain the par level quantity of Schedule II CDS in back up supply. Upon signature of the Medical Director or his/her designee, the two copies are sent to the pharmacist in charge at (Pharmacy). The purchaser's copy is kept on file and maintained at the facility. The surveyor then reviewed the instructions for DEA Form 222 which read under Part 5. Controlled Substance Receipt: 1. The Purchaser fills out each section on its copy of the original order form. 2. Enter the number of packages received and the date received on each item. 3. Purchaser must keep its copy of each executed order form and all copies of unaccepted or defective forms and any attached statements or other related documents available for inspection for a period of two years. On the same day at 11:52 AM, the surveyor interviewed the retiring DON and Training DON (TDON), who stated that (Pharmacy) delivers the narcotics at varying times and that the 11:00 PM - 7:00 AM Supervisor signed and dated the form when the medication was received. The DON then stated that the DEA 222 form does not go to the nursing units. That it stays with the DON and that the Packing Slip was attached to the medication that was entered into the automated pharmacy machine. At 12:55 PM, the surveyor interviewed the Retiring DON, the TDON, Consultant Pharmacist (CP) and the Director of Clinical Services (DCS). The DCS stated that the dates were different because the pharmacy delivered the medication before midnight. The retiring DON then said that she would put the Number Received and Date Received that she took from the date on the top left of the packing slip, not always the date that the staff had signed as received. The TDON, Retiring DON, CP and DCS confirmed that the date on the DEA 222 form should be the same date as the date received and signed for on the Packing Slip. The CP, in the presence of the TDON, Retiring DON and DCS, confirmed that the DEA 222 forms should be accurate and completed in its entirety. N.J.A.C. 8:39 - 29.7(c)
F 0806 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to a) honor a resident's food preferences; and, b) ensure a meal did not contain beef, which the resident had listed as a preference of no beef on the meal ticket. This deficient practice was identified for 1 of 6 residents reviewed for nutrition (Resident #139) and was evidenced by the following: On 9/16/20 at 10:56 AM, the surveyor interviewed Resident #139 in their room. The resident informed the surveyor that they disliked the food at the facility and found that the food received was, potluck. The resident stated that they had received eggs that contained peppers one day, which made the resident vomit, so after that, the resident said that he/she requested no more eggs at meals. The resident complained that every morning he/she still received eggs. The resident stated that they had expressed their concerns about receiving eggs to both the nursing and kitchen staff. The surveyor then reviewed the medical record of Resident #139. A review of the Admission Record reflected that the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated 8/19/20, reflected that the resident had a brief interview for mental status (BIMS) score of 15 out of 15, which indicated a fully intact cognition. A review of the Admission Nutrition assessment dated effective 8/14/20, included a nutrition intervention for dietary to provide extra protein for meals in essence (i.e.) eggs and peanut butter. A further review of the assessment had not reflected any dietary preferences. A review of the electronic Progress Notes (ePN) did not included any Dietary/Nutrition Notes. On 9/17/20 at 8:10 AM, the surveyor observed Resident #139 in their room eating breakfast. The tray contained untouched scrambled eggs, pancakes, and cereal. The resident reported eating the toast. The resident was unhappy that they had received scrambled eggs and happy that they were being discharged from the facility the next day. At 9:44 AM, the surveyor interviewed the Food Service Director (FSD), who stated that the Registered Dietitian (RD) interviewed the resident regarding food preferences. If there were any changes to the resident's preferences after that, the resident could speak with a Certified Nursing Aide (CNA) or nurse to make dietary changes. The nursing staff would then inform the kitchen of dietary changes. Dietary staff then inputted the resident's preferences into a computer system that removed any items the resident disliked from their meal ticket. The resident would not receive an item that was listed on their meal ticket as no. At 10:04 AM, the surveyor interviewed the resident's CNA, who stated that the resident was alert and able to tell you what they wanted. The CNA stated that the resident disliked eggs and did not want them. The CNA stated that the resident would say, I do not want these eggs, and the nurse called down to the kitchen for a different food item. At 10:13 AM, the surveyor interviewed the resident's Licensed Practical Nurse #2 (LPN #2), who stated that the RD interviewed the resident upon admission for their food likes and dislikes. If a preference changed, the nurse would call the kitchen to let them know to send something different to the resident. The nurse also filled out a dietary requisition form to communicate with the kitchen any preference changes. The nurse stated that Resident #139 did not want eggs but stated that the resident might want eggs one day, so she did not send a form to the kitchen. The LPN #2 stated that she checked on the resident daily to see if their breakfast was okay or if the resident wanted something else. The LPN #2 reported that she had not checked on the resident's breakfast today. At 10:35 AM, the surveyor conducted a follow-up interview with the resident's CNA, who confirmed that the resident never ate their eggs. The CNA stated that the resident complained right away when they received eggs. The CNA reported that she had not lifted the resident's lid on their breakfast tray today, so she was unaware what was served to the resident. At 12:08 PM, the surveyor observed Resident #139 in their room eating lunch. The surveyor observed untouched beef pepper steak on the resident's plate. The resident stated that they did not want beef and had told the kitchen this already. The surveyor observed the resident's meal ticket, which reflected no beef. At 12:10 PM, the Registered Nurse/Unit Manager (RN/UM) accompanied the surveyor into the resident's room. The RN/UM compared the resident's meal ticket with the resident's meal received. The RN/UM confirmed that the resident should not have received beef steak for lunch. At this time, the resident stated that receiving beef was just like how he/she received eggs in the morning. The resident expressed that they were thankful that they were not allergic to these items. The surveyor continued to interview the RN/UM in private, who stated that the resident disliked eggs. The RN/UM noted that sometimes the resident made a big deal about the eggs. The resident liked pancakes and french toast. The RN/UM stated that she had called the kitchen and told them not to send the resident eggs, but said she never filled out a dietary requisition form with this request. The RN/UM stated that she spoke with someone in the kitchen, but it was not the FSD. The RN/UM confirmed that the resident did not like eggs, the staff was aware of this dislike, and the resident should not receive eggs. At 12:17 PM, the surveyor interviewed the RD, who stated that she screened all residents upon admission, quarterly, annually, and for any significant changes. The RD reported receiving the resident's dietary preferences upon admission and would inform the dietary staff. The RD stated that she documented resident preferences in her Dietary/Nutrition Notes in the ePN and the

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F 0806 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) care plan; The kitchen was notified of any preference changes. The RD confirmed that if a resident disliked a particular food, the resident should not be served that food. The RD stated that the resident was relatively new and was speaking with dietary regarding their preferences. The RD noted that the care plan reflected i.e., extra eggs. At 12:31 PM, the surveyor interviewed the Food Clerk, who stated that she was in charge of the meal tickets. She inputted dietary preferences and types of diets on the meal ticket. The Food Clerk noted that she received her information from the nurse or the RD. The Food Clerk stated that the resident had received western scrambled eggs and did not want those eggs, so she had put that on his/her meal ticket, no western egg scramble. The Food Clerk reviewed the activity log with the surveyor, which indicated on 8/28/20 that the resident disliked western scrambled eggs. The Food Clerk stated that she was unaware the resident disliked all eggs and that on 9/4/2020, someone changed in the computer system to add double eggs to the resident's meal. The Food Clerk stated in regards to the no beef, that the resident was not allergic to beef, but it was a preference. The resident ate beef because sometimes he/she asked for a hamburger. The preferences on the meal ticket were just used as guidance. On 9/18/2020 at 8:07 AM, the surveyor observed the resident eating breakfast. The resident stated that they were happy that they had not received eggs today. The resident said that they spoke with the FSD yesterday about their meal preferences and stated that the FSD was very persistent that the resident should receive hard-boiled eggs. The resident expressed being happy that they were being discharged that day. At 9:49 AM, the FSD, in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, stated that the resident's preferences had changed. The FSD noted that the resident was not allergic to beef, but it was a preference. The FSD reported that if a ticket reflected that a resident had preferred not to have an item, the resident should not receive that item unless the resident requested it. At this time, the LNHA confirmed that the resident was alert and oriented with no confusion and made their needs known. A review of the facility's policy titled, Dining and Food Preferences and revised 9/17, included that the individual tray assembly ticket will identify all food items appropriate for the resident based on diet order and allergies [REDACTED]. N.J.A.C. 8:39-17.4(a)1