| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315353 | A. BUILDING _____ B. WING _____ | 09/01/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **CRANBURY CENTER** | **292 APPLEGARTH ROAD MONROE TOWNSHIP, NJ 08831** |

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

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| F 0658<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Complaint #: NJ 607 Complaint #: NJ 944 Based on interview, review of the medical record, and other facility documentation, it was determined that the facility failed to provide acceptable clinical practice standards related to verifying and transcribing admission medications orders. The deficient practice was identified for 2 of 7 residents reviewed for medication, Residents #2 and Resident #3, and 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 or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 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. 1) According to the Admission Record, Resident #2 was admitted with medical [DIAGNOSES REDACTED]. A review of the Admission Minimum Data Set (MDS), an assessment tool, dated 6/29/20, revealed Resident #2 had surgical wounds and required extensive assist with Activities of Daily Living. A review of Resident #2's 6/23/20 hospital discharge records revealed a 6/21/20 Resident Progress Note-Plastic Surgery (surgeon notes) that included a recommendation for [MEDICATION NAME] (antibiotic cream used to prevent and treat wound infections) over areas of eschar (dead tissue) and the remainder of care per primary. The surgeon notes further instructed to be contacted for any change in exam or questions. A review of the Discharge Reconciliation Document (DRD) revealed a 6/23/20 physician order [REDACTED]. The DRD further revealed a 6/23/20 PO for Silver [MEDICATION NAME] topical cream ([MEDICATION NAME]) to be applied to areas with eschar on the left upper thigh and then covered with gauze and paper tape daily. A review of Resident #2's 6/23/20 New Jersey Universal Form reflected under Outpatient Medications a 6/23/20 medication order for Santyl topical ointment daily. The outpatient medication list further revealed a 6/23/20 medication order for [MEDICATION NAME] topical cream daily. A review of Resident #2's 6/23/20 hospital Interfacility Transfer Document (discharge instructions) reflected under the Discharge Medications section to continue Santyl topical ointment daily with a start date of 6/23/20. The discharge instructions further instructed to continue [MEDICATION NAME] topical cream daily with a start date of 6/23/20. Under the discharge medications list, the surveyor also noted that a question mark was documented next to the Santyl topical ointment and the [MEDICATION NAME] cream medication orders. A review of a 6/24/20 Nursing Documentation notes (admission note) indicated the medication list had been reconciled and verified with the provider. A review of the 6/23/20 Order Summary Report (OSR) did not include MEDICATION ORDERS FOR [REDACTED]. During an interview with Licensed Practical Nurse (LPN #1) on 9/1/20 at 10:44 AM, LPN #1 stated he would complete the body assessment, check vital signs, and interview the resident on admission. LPN #1 said he would contact the hospital if a medication order needed clarification and document any change of medications in the resident's medical record. LPN #1 further stated the supervisor on duty was responsible for reviewing the discharge medication list. On 9/1/20 at 11:01 AM, the surveyor interviewed the Registered Nurse/ Supervisor (RN supervisor), who reviewed Resident #2's 6/23/20 discharge instructions. The RN supervisor stated she would receive the discharge instructions and inform the physician of the admission. The RN supervisor further said she documents a check next to the medication order on the discharge instruction sheet as she inputs the physician orders [REDACTED]. The RN supervisor stated she documents a question mark when she is unsure of the medication order and would endorse to the next shift to follow up. The RN supervisor stated the Unit Manager (UM) would also review the resident's chart for completeness. The RN supervisor confirmed the Santyl and [MEDICATION NAME] medication orders with the question mark documented next to them were not inputted into the electronic medical record for administration. The RN supervisor stated she could not remember if she reviewed the Santyl and [MEDICATION NAME] medication orders with the physician on admission. The RN supervisor further stated that she did not know if the Santyl and [MEDICATION NAME] medication orders had been followed up. During an interview with the Director of Nursing (DON) on 9/1/20 at 12:24 PM, the DON said she had a call out to the wound team to clarify the Santyl and [MEDICATION NAME] medication orders. The DON stated that the Assistant Director of Nursing (ADON) was responsible for following up with the surgeon. The DON said there should be a nurse's note that the surgeon had been contacted and the medication orders clarified. The DON stated she could not locate any documentation in Resident #2's medical record that the surgeon had been called for clarification of the Santyl and [MEDICATION NAME] medication orders. During a telephone interview with the ADON on 9/1/20 at 12:56 PM, the ADON stated she contacted Resident #2's surgeon the following day, 6/24/20, to clarify the medication orders. The ADON further said that she believed Santyl was ordered and that it should be documented in the 6/24/20 progress note. The ADON stated she would contact the surgeon who ordered the medication for clarification, and any call out to a consultant physician should be documented in the resident's progress note. During a follow-up interview with the DON on 9/1/20 at 1:04 PM, the DON stated Resident #2's Santyl ointment order was initiated on 7/6/20, and the [MEDICATION NAME] cream order was initiated on 7/7/20. The DON further said she could not find documentation that the surgeon had been contacted. 2) According to the Admission Record, Resident #3 was admitted with medical [DIAGNOSES REDACTED]. A review of Resident #3's 12/11/19 hospital Patient Discharge Instructions (medication list) revealed under the Continued Medications section to continue [MEDICATION NAME] ([MEDICATION NAME]-Release tablet) (MS Contin) 115 milligram (mg) mouth every 12 hours for pain. The surveyor further reviewed under the Continued Medications list section that the [MEDICATION NAME] the only medication that did not have a checkmark next to the medication order. A review of the admission physician orders [REDACTED]. A review of a Nursing Documentation Note (NDN) with the effective date of 12/11/19 at 6:06 PM revealed Resident #3 had no signs of distress on admission. The NDN further revealed that the medication list had been reconciled, verified with the provider and that no issues were identified. A review of a physician History and Physical (H&P) with the effective date of 12/12/19 at 12:00 PM indicated the resident presented as comfortable, denied pain at the time, and was currently on [MEDICATION NAME] (nerve pain medication.) The H&P further revealed the medication list documented as reviewed by the physician did not include the medication order for [MEDICATION NAME] mg every 12 hours for pain. A review of the physician's Follow Up note with the effective date of 12/13/19 at 12:00 PM indicated the resident was comfortable and was restarted back on [MEDICATION NAME] hospital records after wife's reports of the same. During an interview with the Licensed Practical Nurse (LPN #1) on 8/28/20 at 12:06 PM, LPN #1 stated that she reviews the medication list with the physician and then inputs the orders onto the electronic medical record (EMR). LPN #1 further stated that she would inform the resident and document in the EMR if there were any changes with the admission medication list. During an interview on 08/28/20 at 12:36 PM, with the Registered Nurse/ Assistant Director of Nursing (RN/ADON) covering the A-wing Unit, the RN/ADON stated that she would read off the medications on the medication list to the |

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 0658<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>physician. The RN/ADON further said she would follow up with the resident or resident's family if the physician questioned a medication on the medication list. The RN/ADON stated she would document on the admission record and generate a progress note (PN) to enter the reason for discontinuing a medication. The RN/ADON reviewed Resident #3's medication list in the surveyors' presence and confirmed it was her handwriting on the resident's 12/11/19 hospital Patient Discharge Instructions. The surveyor questioned the missing checkmark and why the [MEDICATION NAME] was not addressed. The RN/ADON<br>stated that she would have documented if a medication was discontinued. The RN/ADON further stated she could not remember why the [MEDICATION NAME] not been addressed during the admission process. During an interview with the Director of Nursing (DON) on 8/28/20 at 1:48 PM, the DON stated she expected the admitting nurse to review the hospital medication list with the physician. The DON said that if a physician did not want to continue a medication, she expected the admitting nurse to inform and discuss any medication changes with the resident or resident's family and document in the PNs. Review of Resident #3's 12/11/19 and 12/12/20 PNs revealed no documentation of the [MEDICATION NAME] order being addressed with the physician, resident, or resident's family. A review of the facility's NSG236 Skin Integrity Management policy with the revision date of 1/31/20 revealed that the surgeon's specific orders should be followed for surgical wounds. The facility failed to provide a policy and procedure for nursing admission medication list verification with the physician. NJAC 8:39-11.2(b) |