

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Morris View Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 540 West Hanover Avenue Morristown, NJ 07960	

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)
<p>F 0756</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48617</p> <p>Complaint# NJ00174351</p> <p>Based on interview and record review of pertinent facility documents, it was determined that the facility's Consultant Pharmacist (CP) failed to identify and notify the facility of a medication irregularity for a resident. On 1/11/2024, a nurse documented a Physician order in the medical record for Resident #2 for Warfarin Sodium,(Coumadin) a blood thinner. This medication order was for another resident. Resident #2, was already on a Xarelto, a blood thinner. Resident #2 was administered the Coumadin for eighteen (18) doses from 1/12/2024 to 1/29/2024. On 1/15/2024, the CP conducted an on-site visit and had reviewed Resident #2 chart, however, there was no documented evidence for the recommendations for Coumadin and Xarelto in the report. The administration of both blood thinners caused Resident #2 to become symptomatic and decline in health. The resident eventually needed to be admitted to a acute care hospital.</p> <p>This deficient practice was identified in one (1) of four (4) residents reviewed for medication regimen review and was evidenced by the following:</p> <p>On 6/6/2024, the surveyor reviewed the hybrid medical record (paper and electronic) for Resident #2. According to the ADMISSION RECORD (AR), Resident #2 was admitted with diagnoses including but not limited to Chronic Kidney Disease, Paroxysmal Atrial Fibrillation, Neuromuscular dysfunction of Bladder, Hypertension, Congestive Heart Failure, and Atherosclerotic Heart Disease.</p> <p>A review of the Minimum Data Set (MDS), an assessment tool dated 03/28/24, showed that Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15, indicating that Resident had intact cognition. Resident #2's MDS further revealed he/she required assistance in Activities of Daily Living (ADL).</p> <p>A review of Resident #2 electronic Medication Administration Record (eMAR) from 1/1/2024 - 1/31/2024 reflected Xarelto Tablet 15MG (Rivaroxaban) Give 1 tablet by mouth one time a day for A Fib [atrial fibrillation] - Start Date- 12/29/2023 1700 -Hold Date from 01/30/2024 1008 to 02/01/2024 0000. The eMAR further showed that the above-mentioned medication was checked, initialed, and administered from 01/01/24 to 01/29/24 to Resident #2.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0756</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident #2's [DATE] eMAR revealed Warfarin Sodium Tablet Give 7 milligram by mouth at bedtime for treating/preventing blood clots - Start Date -01/12/2024 2100 and was-D/C [discontinued] Date-01/30/2024 1024. The eMAR indicated Warfarin Sodium was checked, initialed, and administered at 2100 on the following dates:</p> <p>01/12/2024; 01/13/2024; 01/14/2024; 01/15/2024; 01/16/2024; 01/17/2024; 01/18/2024; 01/19/2024; 01/20/2024; 01/21/2024; 01/22/2024; 01/23/2024; 01/24/2024; 01/25/2024; 01/26/2024; 01/27/2024; 01/28/2024, and 01/29/2024.</p> <p>A review of the report submitted by the CP to the facility between 1/1/2024 and 1/31/2024 revealed a Recommendation to Nursing Services - [DATE] under [Resident #2] name and as follows: clarify Mg [magnesium] order is it only on Tues, Thurs, Sat and Sunday. No parameters on [Carvedilol] no need to do BP/P [blood pressure/ pulse] prior to administration. The above report was a response dated 1/17/24 and signed by [Nurse].</p> <p>A review of the Progress Notes (PN) dated 02/5/2024 14:53 documented by Licensed Practical Nurse (LPN) #1, that at 11:15am [morning] Called into resident room upon rounds .stating he [Resident #2] feels too weak to go back to bed .Staff unable to transfer safely back to bed, slowly the resident [Resident #2] started to become more lethargic, unit manager is present with other staff members .MD [physician] notified and orders to send to [hospital] for eval [evaluation] and treat [treatment]. 911 called. 12pm [afternoon] Taken to [hospital] via stretcher .</p> <p>A further review of the PN dated 02/05/2024 16:54 documented by Nurse Unit Manager (NUM) revealed . resident has been admitted to [hospital]. Dx [diagnosis] Upper GI [gastrointestinal] bleed, Diarrhea.</p> <p>During the surveyor's interview with the CP via phone on 06/06/24 at 4:11 pm [afternoon], the CP stated she did drug regimen review once a month in the facility, kept a copy, and emailed it to the DON, Administrator, Assistant Director of Nursing (ADON), Nursing Supervisors (NS), and the Unit Managers (UM)s, on the day I did it and before I left the facility. CP further stated she would do the monthly review of residents' medications around the 15th until the 25th of the month. CP confirmed that she did Resident #2's January monthly drug review. The surveyor asked the CP if she saw the new medication order of Warfarin (Coumadin) for Resident #2. CP stated that she did see the new medication order. The CP stated I thought it was a short period of time; I did not ask nurses or confirm with the DON. When the facility notified me on 1/30/24 of what happened to Resident #2, I looked back on my notes, and I did not write any notes. I normally would order to stop it, but I did not.</p> <p>During the surveyor's exit conference with the DON and Administrator on 6/6/24 at 5:18 pm, DON and Administrator were made aware of CP statements about Resident #2 review of medications during visit at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy titled, ADVERSE CONSEQUENCES AND MEDICATION ERRORS, under Policy Interpretation and Implementation 1. Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. 2. An adverse consequence is defined as an unpleasant symptom or event that is due to or associated with a medication, such as .or decline in an individual's mental or physical condition or functional or psychosocial status. 4. The staff and practitioner shall strive to minimize adverse consequences by: .c. Determining that the resident: . (2) Is not taking other medications .that would be incompatible with the prescribed medication. 7. The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis. 8. When a resident receives a new medication, the medication order is evaluated for the following: .e. The resident is not taking other medications . that would be incompatible with the prescribed medication.</p> <p>NJAC 8:39-29.3 (a)1</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48617</p> <p>Complaint# NJ00174351</p> <p>Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident (Resident #2) who was currently being administered daily Xarelto, a blood thinner, was incorrectly transcribed a new medication Coumadin (Warfarin Sodium), another blood thinner by Registered Nurse #1 (RN). The Coumadin medication was prescribed by a Physician for another resident (Resident #1). Resident #2 remained on prescribed daily dose of Xarelto and also received daily doses of the Coumadin from 1/12/2024 to 1/29/2024 for 18 days for a total of eighteen (18) doses . This resulted in Resident #2 to become symptomatic and decline in health. The resident eventually needed acute inpatient hospitalization . This deficient practice was identified in one (1) Resident #2 of four (4) residents reviewed for medication order transcription and administration, and was evidenced by the following:</p> <p>According to the ADMISSION RECORD (AR), Resident #2 was admitted with diagnoses including but not limited to Chronic Kidney Disease, Paroxysmal Atrial Fibrillation, Neuromuscular dysfunction of Bladder, Hypertension, Congestive Heart Failure, and Atherosclerotic Heart Disease.</p> <p>A review of the Minimum Data Set (MDS), an assessment tool dated 03/28/24, showed that Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15, indicating that Resident had intact cognition. Resident #2's MDS further revealed he/she required assistance in Activities of Daily Living (ADL).</p> <p>A review of the Progress Notes (PN) dated 02/5/2024 14:53 documented by Licensed Practical Nurse (LPN) #1, that at 11:15am [morning] Called into resident room upon rounds .stating he [Resident #2] feels too weak to go back to bed .Staff unable to transfer safely back to bed, slowly the resident [Resident #2] started to become more lethargic, unit manager is present with other staff members .MD [physician] notified and orders to send to [hospital] for eval [evaluation] and treat [treatment]. 911 called. 12pm [afternoon] Taken to [hospital] via stretcher .</p> <p>A further review of the PN dated 02/05/2024 16:54 documented by Nurse Unit Manager (NUM) revealed . resident has been admitted to [hospital]. Dx [diagnosis] Upper GI [gastrointestinal] bleed, Diarrhea. The resident was discharged from the hospital and back to the facility on [DATE].</p> <p>A review of Resident #2 electronic Medication Administration Record (eMAR) from 1/1/2024 - 1/31/2024 reflected Xarelto Tablet 15MG (Rivaroxaban) Give 1 tablet by mouth one time a day for A Fib [atrial fibrillation] - Start Date- 12/29/2023 1700 [5 pm] -Hold Date from 01/30/2024 1008 to 02/01/2024 0000 and Warfarin Sodium Tablet Give 7 milligram by mouth at bedtime for treating/preventing blood clots - Start Date -01/12/2024 2100 [9 pm] and was-D/C [discontinued] Date- 01/30/2024 1024. The eMAR further indicated the abovementioned medications were checked, initialed, and administered at the following administration times and dates:</p> <p>01/12/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7mg at 9 pm - checked, initialed, and administered by LPN #2</p> <p>(continued on next page)</p>		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	<p>01/13/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by LPN #3</p> <p>01/14/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by LPN #4</p> <p>01/15/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by LPN #4</p> <p>01/16/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by LPN #4</p> <p>01/17/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by RN #1</p> <p>01/18/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by RN #1</p> <p>01/19/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by LPN #5</p> <p>01/20/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by LPN #6</p> <p>01/21/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by RN #1</p> <p>01/22/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by LPN #7</p> <p>01/23/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by RN #1</p> <p>01/24/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by RN #1</p> <p>01/25/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by RN #1</p> <p>01/26/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by RN #1</p> <p>01/27/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by LPN #3</p> <p>01/28/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by LPN #6, and</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>01/29/2024 Xarelto 15 mg at 5 pm and Warfarin Sodium 7 mg at 9 pm - checked, initialed, and administered by LPN #4</p> <p>A review of Resident #1's [DATE] eMAR revealed Warfarin Sodium Tablet Give 7 milligram by mouth at bedtime for treating/preventing blood clots -Start Date- 01/11/2024 2100 -D/C Date- 01/17/2024 1647. The eMAR indicated Warfarin Sodium was checked, initialed, and administered at 2100 [9 pm] as ordered on 01/11/2024.</p> <p>During the surveyor's interview with Resident #2 at 10:37 am (morning) on 06/06/24, Resident stated I went to hospital on February 5, 2024, ER emergency it was 911; what they discovered while I was waiting for the ambulance before sending me out, I was on Xarelto and on January 12 a doctor called in a prescription for Coumadin for another resident and a nurse put it in my record. My blood pressure was low, and I was bleeding all over.</p> <p>During the surveyor's interview with the DON and facility's Administrator at 1:49 pm on 06/06/24, the DON stated she did an investigation on the incident. DON affirmed that a medication transcription error with the medication Coumadin (Warfarin Sodium) occurred and was transcribed by Registered Nurse (RN) #1 on 01/11/24 in Resident #2 chart in error. DON stated Resident #2 was on Xarelto and that the transcription error was found out on 01/30/24. DON further stated upon investigation she asked RN #1 regarding the Warfarin Sodium transcription error and DON stated RN #1 was not able to recall the specific incident and was not able to provide an explanation about the medication error.</p> <p>A review of the Investigation Summary (IS) provided by the facility on 06/06/24, completed and signed by the Director of Nursing (DON) and the Administrator on 1/30/24, under Description of event: On Tuesday, January 30th, 2024 at approximately 8:25 am [morning], [Resident #2] was observed with bleeding from suprapubic catheter site and dark liquid stools [feces]. He [Resident #2] complained of feeling lightheaded; under Involved resident's pertinent medical data: Medications include [but not limited to]: .Xarelto, Morphine Sulfate, Detrol .; under Investigation/chart review: >1/11/24: New order- Coumadin [warfarin sodium] 7 mg [milligram] po [by mouth] at bedtime to start 1/12/24. (Received a total of 18 doses - 1/12 to 1/29); >1/15/24 pharmacist note: see nursing report. Report recommendations: consider gdr [kidney filtration rate] [medication], reeval [reevaluation] need both [Detrol/Mybetriq- bladder medications] duplicate tx [treatment], . clarify Mg[magnesium] order is it only on Tue, Thur, Sat, and Sun and no parameters on Coreg [heart medication]- no need to do bp [blood pressure] prior to administration; >1/30/24 Nurses note: At 8:25 AM [morning], resident was noted to have large amount of [NAME] [fresh] bleeding from his SP [suprapubic] tube site .Call placed to Optum NP [nurse practitioner] who came in to see resident. Orders received .; >1/30/24 Optum note: Pt [Resident #2] seen in AM [morning] after nurse called to report he [Resident#2] had a large amount of bleeding from his SPC [suprapubic catheter] as well as hypotension [low blood pressure] and dark liquid stool .Upon chart review, it was found that an order for warfarin 7 mg was entered on 1/12/24 in error and he [Resident #2] is also on Xarelto 15 mg daily . Conclusion: On January 11th, 2024, [RN#1] ordered Coumadin 7 mg po at bedtime to start on 1/12/24 for [Resident #2]. Order was intended for another resident on the unit. [Resident #2] had a current order for Xarelto (a blood thinner) .Further assessment indicated hypotension and c/o [complaint of] feeling lightheaded .He [Resident #2] refused to be transferred to [hospital] ER [emergency room] for evaluation but agreed to some in house treatments such as labs and medications.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During the survey on 06/06/2024 at 5:11 pm, the surveyor placed a phone call to RN #1 who transcribed the medication in error into Resident #2's medical record. RN #1 did not answer nor return surveyor's phone call. The other nurses who signed off on the medication error for Resident #2 LPNs #2, #4, #5, #6, and #7 no longer work in the facility.</p> <p>A review of the facility's policy titled, ADVERSE CONSEQUENCES AND MEDICATION ERRORS, under Policy Interpretation and Implementation 1. Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. 2. An adverse consequence is defined as an unpleasant symptom or event that is due to or associated with a medication, such as .or decline in an individual's mental or physical condition or functional or psychosocial status. 4. The staff and practitioner shall strive to minimize adverse consequences by: .c. Determining that the resident: . (2) Is not taking other medications .that would be incompatible with the prescribed medication. 5. A medication error is defined as thee preparation or administration of drugs .which is not in accordance with physician's orders . or accepted professional standards and principles of the professional (s) providing services. 8. When a resident receives a new medication, the medication order is evaluated for the following: .e. The resident is not taking other medications . that would be incompatible with the prescribed medication.</p> <p>NJAC 8:39-29.2(d)</p>		