Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER Careone at Oradell		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Kinderkamack Road Oradell, NJ 07649	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48617 Complaint #: NJ00178451 Based on interviews, records review, and review of pertinent facility documents on 11/22/2024 and 11/25/2024, it was determined that the facility failed to ensure and provide the correct medication for a resident (Resident #1) according to the Physician's Order when the facility's providing pharmacy sent a different medication to the facility. This deficient practice was observed in 1 of 4 residents reviewed for medications and was evidenced by the following: According to the Admission Record (AR), Resident #1 was admitted to the facility with diagnoses which included but was not limited to Malignant Neoplasm of Left Breast, Cerebral Infarction, Altered Mental Status, Osteoarthritis, Muscle Weakness, and Anxiety Disorder. According to the Minimum Data Set (MDS), an assessment tool that provides a comprehensive assessment of a resident's functional capabilities, dated 09/30/2024, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 06, indicating the Resident's cognition was severely impaired. The MDS furthermore revealed in Section GG-Functional Abilities and Goals that Resident #1 was totally dependent on staff for the completion of her/his Activities of Daily Living (ADLs). According to the facility's document titled, Investigation, Summary, and Conclusion (ISC) for Reportable Event 06/12/24, . On 06/12/24, the RN [Registered Nurse] unit manager conducted a medication review and observed the medication Anagrelide 1 mg [anti-cancer medication] in the medication cart for [Resident #1's name]. Anagrelide 1 mg was administered approximately 8 times from February 10, 2024, through June 12, 2024. The resident representative and attending physician were notified. The APN [nurse practitioner] examined [Resident's name] on 6/12/24, and the MD [physician] examined [Resident] on 6/13/24 with no untoward findings .The unit manager, upon finding the discrepancy, immediately notified the pharmacy, as well as the NP [nurse practitioner] and the attending physician .After a thorough investigation, including review of the medical record, and staff statements and pharmacy audit, it has been concluded the Anagrelide 1 mg was inadvertently sent to the facility by the pharmacy, and nursing administered the capsule in the place of the medication Anastrozole . (continued on next page)

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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #1's Order Summary Report (OSR) dated 02/01/2024 to 10/31/2024 showed the following physician order: Anastrozole Oral Tablet 1 mg (Anastrozole) Give 1 tablet by mouth one time a day for Post breast CA [cancer] with Order Date of 02/09/2024. Resident #1's OSR revealed no indications of a physician's order of Anagrelide 1mg. A review of Resident #1's Medication Administration Record (MARs) dated 02/01/2024 to 10/31/2024 showed a medication order entry of Anastrozole Oral Tablet 1 mg (Anastrozole) Give 1 tablet by mouth one time a day for Post Breast CA [cancer] with Start Date of 02/10/2024 0900 [morning]. The MARs mentioned above further revealed Anastrozole Oral Tablet 1 mg was checked and initialed [administered] by nursing staff for the months of 02/2024, 03/2024, 04/2024, 05/2024,06/2024, and 07/2024. There were no indications or medication entries of Anagrelide 1 mg in the MARs mentioned above. On 11/22/2024 at 1:31 p.m. [afternoon], in an interview, Registered Nurse #1 stated he found the medication Anagrelide 1 mg in the bingo card and reported it to the previous DON (DON #2). He further stated the medications were round, white tablets in a bingo card (BC) and could not affirm the number of tablets remaining in the card to the Surveyor. He stated he looked at the name of the Resident on the card and told the Surveyor there were no other residents with the medication Anagrelide at that time. A review of the document titled Pharmacy Occurrence Report (POR) submitted by the providing pharmacy [pharmacy name] to the facility with date reported of 06/12/2024, under Description of Occurrence: Anastrozole 1mg tab entered incorrectly on 02/09/2024 as Anagrelide 1mg cap .; Corrective Action taken: pharmacy issued a pick up for RX[number] (Anagrelide 1 mg caps); pharmacy processed and shipped the correct medication (Anastrozole 1 mg tab); education was provided to the staff involved in the error; Measures Taken to Prevent Reoccurrence: double check data entry by coding technician; double check initial pharmacist review by the verifying pharmacist; OE [order entry] must type the 1st 6 letters of the drug and the full strength in the drug search field to make sure correct medication is picked .Root Cause Analysis [RCA]: Wrong medication and wrong strength was picked; RPH [registered pharmacist] failed to detect error; Resolution: double check data entry by coding technician; double check initial pharmacist review by the verifying pharmacist; order entry must type the 1st 6 letters of the drug and the full strength in the drug search field to make sure correct medication is picked . Further review of the ISC and the statements collected by DON #2 from the nurses indicated the medication Anastrozole 1 mg was given and signed by the nurses, not the Anagrelide medication. On 11/25/2024 at 9:58 a.m. [morning], the Surveyor requested a copy of the Anagrelide medications receipts delivered from 02/2024 to 06/2024 for Resident #1 from the pharmacy. The DON provided the following documents: 1. Long Term Care (LTC) Pharmacy Shipping Manifest (PSM), dated 03/05/2024 at 01:05 a.m. [morning] indicated Anagrelide 1 mg cap (Gen for: Agrylin) RX: [number] QTY: 30 ea [each] was delivered to Nursing Unit [name] for Resident #1 and signed by nurse [initials]. 2. LTC PSM, dated 03/24/2024 at 12:09 a.m. [morning], indicated Anagrelide 1 mg cap (Gen for: Agrylin) RX: [number] QTY: 30 ea [each] was delivered to Nursing Unit [name] for Resident #1 and signed by a nurse [initials]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. LTC PSM, dated 06/06/2024 at 1:26 p.m. [afternoon], indicated Anagrelide 1 mg cap (Gen for: Agrylin) RX: [number] QTY: 30 ea [each] was delivered to Nursing Unit [name] for Resident #1 and signed by a nurse [initials]. On 11/25/2025 at 10:30 a.m. [morning], in an interview of the Surveyor with the DON, the DON stated the pharmacy processed the wrong medication which was sent to the facility for Resident #1. When asked by the Surveyor regarding the receipts provided earlier showing nurses' initials, the DON affirmed the nurses receiving the medications from the pharmacy should have reconciled or checked the medications against the residents' concurrent medication orders. She further stated the nurses overlooked the process. On 11/25/2024 at 10:44 a.m. [morning], in an interview with Resident #1's AP, AP stated, I checked her [Resident #1] multiple times when I was informed, and there were no negative or adverse effects on [Resident #1's name]. A review of the facility's policy on MEDICATION ORDERING AND RECEIVING FROM PHARMACY, dated and effective February 2019 under Medication Packaging . its Policy: Medications are provided in packaging to facilitate accurate administration and accountability of the medication .; Medications Acquired or Brought to the Facility .B. A licensed nurse: 1) Receives medications delivered to the facility, and documents delivery of the medication on the appropriate form. 2) Verifies medications received and directions for use with the original medication order. 3) Assures medications are incorporated into the Resident's specific allocation/storage area. N.J.A.C. 8:39-29.2 (b)