STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Care at Dover	65 North Sussex Street Dover, NJ 07801

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 - 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** 48617 Complaint #: NJ00164594 Based on observations, interviews, and record review, as well as a review of pertinent facility documents on 03/21/24, it was determined that the facility failed to administer the medications in accordance with the acceptable standard of nursing practice and follow the facility policy on Medication Administration and Physician Services in 1 of 6 floors for 5 of 5 sampled residents, (Residents#1, #2, #3, #4, and #5). This deficient practice was evidenced by the following: On 03/21/24 at 10:12 am, the surveyor conducted a medication pass observation on the Nursing Unit with the Registered Nurse (RN #1). The surveyor observed a red color on the Electronic Medication Administration Record (EMAR) screen for Resident #2, #3, #4, and #5. RN#1 stated that the red color on the screen meant that the Residents' medications were due to be given at 9:00 am but were not given yet. The surveyor further observed that RN #1 prepared and administered medications to Resident #2, #3, #4, and #5. 1. According to the ADMISSION RECORD (AR), Resident #1 was admitted with diagnoses including but not limited to Diabetes Mellitus type 2, Atrial Fibrillation, Hypertension, Glaucoma, Depression, Heart Failure, and Neuromuscular Dysfunction of Bladder. A review of the Minimum Data Set (MDS), an assessment tool dated 11/17/23, showed that Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15, indicating that Resident #1 had intact cognition and required assistance with Activity of Daily Living (ADLs). A review of Resident #1's care plan (CP), dated 6/9/23, indicated that Resident #1 had hypertension, hyperlipidemia, atrial fibrillation, and congestive heart failure. The CP had an intervention which included but was not limited to give medication as ordered. A review of Resident #1's Order Summary Report (OSR) revealed an order for the following: On 2/26/23, Glimepiride Tab 2 mg (milligram), give 1 tablet orally two times a day related to type 2 Diabetes Mellitus 30 minutes before breakfast and dinner. On 4/4/23, Metformin HCl (hydrochloride) Oral Tablet Extended Release 24 Hour 500 mg (Metformin HCl), give 2 tablets by mouth two times a day for Type 2 Diabetes Mellitus to be given with food. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/24/23, Methenamine Hippurate Tab 1 gm (gram), give 1 tablet orally two times a day for UTI (Urinary Tract Infection) prophylaxis give with meals. On 9/19/23, Simbrinza Suspension 1-0.2%, instill 1 drop in both eyes two times a day for Glaucoma. A review of Resident #1's Medication Administration Report (MAR) for 01/2024 confirmed the abovementioned medications were scheduled and to be administered as follows: Glimepiride Tab 2 mg at 7:30 a.m. and 5:30 p.m. Metformin HCl ER 500 mg at 8:00 a.m. and 5:00 p.m. Methenamine Hippurate Tab 1 gm at 9:00 a.m. and 5:00 p.m. Simbrinza [NAME] 1-0.2% eye drops at 9:00 a.m. and 5:00 p.m. A review of Resident #1's Medication Admin Audit Report (MAAR) indicated that the abovementioned medications were not administered according to the scheduled time. The medications were administered as follows: Glimepiride Tab 2 mg was scheduled to be administered at 7:30 a.m. and 5:30 p.m., however, on the following days the medication was given late. 1/1/24 was administered at 10:59 a.m. 1/2/24 was administered at 10:42 a.m. 1/5/24 was administered at 10:31 a.m. 1/6/24 was administered at 11:29 a.m. and at 8:07 p.m. 1/7/24 was administered at 11:07 a.m. 1/8/24 was administered at 11:28 a.m. and at 7:37 p.m. 1/9/24 was administered at 12:43 p.m. 1/10/24 was administered at 11:32 a.m. 1/11/24 was administered at 11:18 a.m. 1/12/24 was administered at 11:43 a.m. 1/13/24 was administered at 1:11 p.m. 1/14/24 was administered at 11:45 a.m. 1/15/24 was administered at 2:01 p.m. and at 9:09 p.m. (continued on next page)

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(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 - Some	1/16/24 was administered at 10:42 a.m. and at 8:25 p.m. 1/17/24 was administered at 8:02 p.m. 1/18/24 was administered at 11:12 a.m. 1/19/24 was administered at 1:57 p.m. 1/24/24 was administered at 11:35 a.m. 1/25/24 was administered at 8:19 p.m. 1/26/24 was administered at 12:42 p.m. Metformin HCl 500 mg was scheduled to be administered at 8:00 a.m. and 5:00 p.m., however, on the following days the medication was given late. 1/1/24 was administered at 10:59 a.m. 1/2/24 was administered at 10:43 a.m. 1/3/24 was administered at 8:02 p.m. 1/4/24 was administered at 7:10 p.m. 1/6/24 was administered at 11:29 a.m. and at 8:07 p.m. 1/7/24 was administered at 11:07 a.m. 1/8/24 was administered at 11:28 a.m. and at 7:36 p.m. 1/9/24 was administered at 12:43 p.m. 1/10/24 was administered at 11:32 a.m. 1/11/24 was administered at 11:19 a.m. and at 7:20 p.m. 1/12/24 was administered at 11:43 a.m. 1/13/24 was administered at 1:11 p.m. 1/14/24 was administered at 11:45 a.m. 1/15/24 was administered at 2:01 p.m. and at 9:09 p.m. 1/16/24 was administered at 10:42 a.m. and at 8:25 p.m. 1/17/24 was administered at 7:14 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/18/24 was administered at 11:13 a.m. 1/19/24 was administered at 1:57 p.m. 1/20/24 was administered at 10:44 a.m. 1/21/24 was administered at 10:56 a.m. 1/22/24 was administered at 10:54 a.m. 1/23/24 was administered at 11:42 a.m. 1/24/24 was administered at 11:35 a.m. and at 7:04 p.m. 1/25/24 was administered at 8:18 p.m. 1/26/24 was administered at 1:56 p.m. Methenamine Hippurate 1 gm was scheduled to be administered at 9:00 a.m. and 5:00 p.m., however, on the following days the medication was given late. 1/1/24 was administered at 11:01 a.m. 1/3/24 was administered at 8:02 p.m. 1/4/24 was administered at 7:10 p.m. 1/6/24 was administered at 11:31 a.m. and at 8:07 p.m. 1/7/24 was administered at 11:08 a.m. 1/8/24 was administered at 11:29 a.m. and at 7:37 p.m. 1/9/24 was administered at 1:06 p.m. 1/10/24 was administered at 11:34 a.m. 1/11/24 was administered at 11:28 a.m. and at 7:20 p.m. 1/12/24 was administered at 11:45 a.m. 1/13/24 was administered at 1:11 p.m. 1/14/24 was administered at 11:45 a.m. 1/15/24 was administered at 2:01 p.m. and at 9:09 p.m. 1/16/24 was administered at 8:25 p.m. (continued on next page)

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(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 - Some	1/17/24 was administered at 7:14 p.m. 1/18/24 was administered at 12:55 p.m. 1/19/24 was administered at 2:02 p.m. 1/23/24 was administered at 11:43 a.m. 1/24/24 was administered at 11:36 a.m. and at 7:04 p.m. 1/25/24 was administered at 8:18 p.m. 1/26/24 was administered at 3:59 p.m. Simbrinza 1-0.2% eye drops was scheduled to be administered at 9:00 a.m. and 5:00 p.m., however, on the following days the medication was given late. 1/1/24 was administered at 11:03 a.m. 1/3/24 was administered at 8:02 p.m. 1/4/24 was administered at 7:10 p.m. 1/6/24 was administered at 11:32 a.m. and at 8:07 p.m. 1/7/24 was administered at 11:09 a.m. and at 7:51 p.m. 1/8/24 was administered at 11:30 a.m. and at 7:37 p.m. 1/9/24 was administered at 1:06 p.m. 1/10/24 was administered at 11:34 a.m. 1/11/24 was administered at 11:29 a.m. and at 7:21 p.m. 1/12/24 was administered at 11:46 a.m. 1/13/24 was administered at 1:11 p.m. 1/14/24 was administered at 11:46 a.m. 1/15/24 was administered at 2:01 p.m. and at 9:09 p.m. 1/16/24 was administered at 8:25 p.m. 1/17/24 was administered at 7:14 p.m. 1/18/24 was administered at 12:55 p.m. (continued on next page)

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(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 - Some	1/19/24 was administered at 2:05 p.m. 1/23/24 was administered at 11:45 a.m. 1/24/24 was administered at 11:37 a.m. and at 7:04 p.m. 1/25/24 was administered at 8:18 p.m. A review of Resident #1's progress notes (PN) from 1/1/24 to 1/26/24, there was no indication in the PN that the Resident's Primary Care Physician (PCP) was notified that the aforementioned medications were not administered according to the scheduled time.Also, there was no documented evidence of harm to the resident from the late administration of medications. 2. According to the AR, Resident #2 was admitted with diagnoses including but not limited to Hypertension, Pain in Knee, Type 2 Diabetes Mellitus, Dementia, and Alzheimer's Disease. A review of the MDS dated [DATE], Resident #2 cognition was impaired and required extensive assistance with ADLs. A review of Resident #2's CP, initiated on 05/25/2023 indicated Resident #2 has hypertension. Interventions included but were not limited to give anti-hypertensive medications as ordered. Resident #2's CP further indicated the following: Resident #2 has Diabetes Mellitus. Interventions included but were not limited to give Diabetes medication as ordered by doctor; Resident #2 has chronic pain related to knee pain, chronic conditions, and limited mobility. Interventions included but were not limited to administer analgesia [pain medication] as per orders. A review of Resident #2's OSR on 3/21/24 revealed an order for the following: On 8/17/21, Acetaminophen tab 500 mg, give 1 tablet orally three times a day related to Pain in Knee. On 2/10/23, Amlodipine 10 mg tab, give 1 tablet orally in the morning for hypertension. On 2/19/23, Clonidine tab 0.1 mg, give 1 tablet orally two times a day related to hypertension. On 2/7/23, Lisinopril tab 200 mg, give 1 tablet orally in the morning related to hypertension. On 2/17/23, metformin tab 500 mg, give 1 tablet orally one time a day for diabetes. A review of Resident #2's MAR for 3/2024 confirmed the abovementioned medications were scheduled and to be administered as follows: Acetaminophen tab 500 mg at 9:00 a.m., 1:00 p.m., and 5:00 p.m. Amlodipine 10 mg tab at 9:00 a.m. Clonidine tab 0.1 mg at 9:00 a.m. and 5:00 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lisinopril tab 20 mg at 9:00 a.m. Metformin tab 500 mg at 9:00 a.m. A review of Resident #2's MAAR indicated that the abovementioned medications were not administered according to the scheduled time. The medications were administered as follows: Acetaminophen 500 mg tab was scheduled to be administered at 9:00 a.m.,1:00 p.m., and 5:00 p.m., however, on the following days medication was given late. 3/4/24 was administered at 6:08 p.m. 3/5/34 was administered at 6:50 p.m. 3/6/24 was administered at 10:54 a.m. 3/8/24 was administered at 2:14 p.m. 3/10/24 was administered at 11:24 a.m. and at 6:09 p.m. 3/11/24 was administered at 7:33 p.m. 3/12/24 was administered at 7:21 p.m. 3/13/24 was administered at 11:16 a.m. 3/16/24 was administered at 2:03 p.m. 3/18/24 was administered at 3:04 p.m. and at 6:27 p.m. 3/19/24 was administered at 10:05 a.m. and at 6:04 p.m. 3/20/24 was administered at 6:28 p.m. 3/21/24 was administered at 11:01 a.m. Amlodipine 10 mg tab was scheduled to be administered at 9:00 a.m., however, on the following days the morning medication was given late. 3/6/24 was administered at 10:54 a.m. 3/10/24 was administered at 11:24 a.m. 3/13/24 was administered at 11:16 a.m. 3/19/24 was administered at 10:05 a.m. 3/21/24 was administered at 11:01 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clonidine tab 0.1 mg was scheduled to be given at 9:00 a.m. and 5:00 p.m., however, on the following days the medication was given late. 3/5/24 was administered at 6:50 p.m. 3/6/24 was administered at 10:54 a.m. 3/10/24 was administered at 11:24 a.m. 3/11/24 was administered at 7:33 p.m. 3/12/24 was administered at 7:21 p.m. 3/13/24 was administered at 11:16 a.m. 3/18/24 was administered at 6:27 p.m. 3/20/24 was administered at 6:28 p.m. 3/21/24 was administered at 11:02 a.m. Lisinopril tab 20 mg was scheduled to be given at 9:00 a.m., however, on the following days the morning dose was given late. 3/6/24 was administered at 10:54 a.m. 3/10/24 was administered at 11:24 a.m. 3/13/24 was administered at 11:16 a.m. 3/21/24 was administered at 11:02 a.m. Metformin tab 500 mg was scheduled to be given at 9:00 a.m., however, on the following days the morning dose was given late. 3/6/24 was administered at 10:54 a.m. 3/10/24 was administered at 11:24 a.m. 3/13/24 was administered at 11:16 a.m. 3/21/24 was administered at 11:02 a.m. A review of Resident #2's PN from 3/1/24 to 3/21/24, there was no indication in the PN that the Resident's PCP was notified that the medications were not administered according to the scheduled time. Also, there was no documented evidence of harm to the resident from the late administration of medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. According to the AR, Resident #3 was admitted with diagnoses including but not limited to Hypertension, Encephalopathy, Anemia, Osteoarthritis, Long Term Use of Antibiotics, and Seizure Disorder. A review of the MDS, an assessment tool dated 8/9/23, indicated that Resident #3's cognition was moderately impaired and needed help from staff with ADLs. A review of Resident #3's CP, 3/30/23, indicated that Resident #3 had Seizure Disorder and at risk for constipation related to decrease mobility. The intervention which included but was not limited to give medications as ordered. A review of Resident #3's OSR on 3/21/24 revealed an order for the following: On 1/10/24, Doxycycline Hyclate Oral tablet 100 mg, give 100 mg by mouth every 12 hours for prosthetic knee infection ppx [prophylaxis]. On 1/12/24, Miralax Oral Packet 17 gm, give 17 gm by mouth one time a day for constipation mix with 4-6 ounces of juice. On 9/27/23, Phenobarbital Oral Tablet 30 mg, give 1 tablet by mouth every 12 hours for seizures. A review of Resident #3's MAR for 3/2024 confirmed the abovementioned medications were scheduled and to be administered as follows: Doxycycline Hyclate Oral Tablet 100 mg at 9:00 a.m. and 9:00 p.m. Miralax Oral Packet at 9:00 a.m. Phenobarbital Oral Tablet 30 mg at 9:00 a.m. and 9:00 p.m. A review of Resident #3's MAAR indicated that the abovementioned medications were not administered according to the scheduled time. The medications were administered as follows: Doxycycline Hyclate 100 mg was scheduled to be given at 9:00 a.m. and 9:00 p.m., however, on the following days the morning dose was given late. 3/4/24 was administered at 10:27 a.m. 3/5/24 was administered at 10:22 a.m. 3/6/24 was administered at 11:34 a.m. 3/10/24 was administered at 11:12 a.m. 3/13/24 was administered at 11:04 a.m. 3/16/24 was administered at 10:27 a.m. 3/21/24 was administered at 10:35 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Miralax 17 gm was scheduled to be given at 9:00 a.m., however, on the following days the morning dose was given late. 3/4/24 was administered at 10:27 a.m. 3/5/24 was administered at 10:22 a.m. 3/10/24 was administered at 11:12 a.m. 3/13/24 was administered at 11:04 a.m. 3/16/24 was administered at 10:27 a.m. 3/21/24 was administered at 10:58 a.m. Phenobarbital 30 mg was scheduled to be given at 9:00 a.m. and 9:00 p.m., however, on the following days the morning dose was given late. 3/4/24 was administered at 10:27 a.m. 3/5/24 was administered at 10:22 a.m. 3/10/24 was administered at 11:12 a.m. 3/13/24 was administered at 11:05 a.m. 3/16/24 was administered at 10:28 a.m. 3/21/24 was administered at 10:36 a.m. A review of Resident #3's PN from 3/1/24 to 3/21/24, there was no indication in the PN that the Resident's PCP was notified that the medications were not administered according to the scheduled time. Also, there was no documented evidence of harm to the resident from the late administration of medications. 4. According to the AR, Resident #4 was admitted with diagnoses including but not limited to Dementia, Atrial Fibrillation, Major Depressive Disorder, Metabolic Encephalopathy, and Muscle Weakness. A review of Resident #4's MDS dated [DATE], indicated that Resident #4 had a BIMS score of 03, indicating that Resident #4's cognition was impaired and required total assistance with ADLs. A review of Resident #4's CP, initiated on 8/28/23, indicated that Resident #4 has altered cardiovascular status related to atrial fibrillation. The CP included goal intervention but not limited to the importance of Resident's compliance with treatment. Furthermore, Resident #4's CP indicated Resident has impaired cognitive function or impaired thought processes related to dementia. The CP interventions included but not limited to administer medications as ordered. A review of Resident #4's OSR on 3/21/24 revealed an order for the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/23, Memantine HCL Tablet 5 mg, give 1 tablet by mouth one time a day. On 12/10/23, Diltiazem HCL Oral Tablet, give 300 mg by mouth one time a day. A review of Resident #4's MAR for 3/2024, confirmed the above-mentioned medications were scheduled and administered as follows: Memantine HCL Tablet 5 mg at 9:00 a.m. Diltiazem HCL Oral Tablet 300 mg at 9:00 a.m. A review of Resident #4's MAAR indicated that the above-mentioned medications were not administered according to the scheduled time. The medications were administered as follows: Memantine 5 mg was scheduled to be administered at 9:00 a.m., however, on the following days the medication was given late. 3/1/24 was administered at10:56 a.m. 3/2/24 was administered at 11:16 a.m. 3/4/24 was administered at 10:28 a.m. 3/5/24 was administered at 10:21 a.m. 3/10 24 was administered at 11:20 a.m. 3/11/24 was administered at 10:20 a.m. 3/13/24 was administered at 11:10 a.m. 3/19/24 was administered at 1:05 p.m. 3/20/24 was administered at 10:53 a.m. 3/21/24 was administered at 10:51 a.m. Diltiazem 300 mg was scheduled to be administered at 9:00 a.m., however, on the following days the morning dose given late. 3/1/24 was administered at 10:56 a.m. 3/2/24 was administered at 11:16 a.m. 3/4/24 was administered at 10:28 a.m. 3/5/24 was administered at 10:21 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/10 24 was administered at 11:20 a.m. 3/11/24 was administered at 10:20 a.m. 3/13/24 was administered at 11:10 a.m. 3/19/24 was administered at 1:05 p.m. 3/20/24 was administered at 10:53 a.m. 3/21/24 was administered at 10:48 a.m. A review of Resident #4's PN from 3/1/24 to 3/21/24, there was no indication in the PN that the Resident's PCP was notified that the aforementioned medications were not administered according to the scheduled time. Also, there was no documented evidence of harm to the resident from the late administration of the medications. 5. According to the AR, Resident #5 was admitted with diagnoses including but not limited to Hyperglycemia, Acute Kidney Failure, Hypotension, Depressive Disorder, Heart Failure, Localized Edema, Metabolic Encephalopathy, Arthritis, and Anxiety Disorder. A review of Resident #5's MDS dated [DATE], indicated that Resident #5's cognition was moderately impaired and required assistance with ADLs. A review of Resident #5's CP, initiated on 5/4/2023, indicated that Resident #5 had altered in cardiovascular status related to Hypertension, Hypotension, and Hyperlipidemia. The CP included interventions but were not limited to administering medications as ordered. A review of Resident #5's OSR on 3/21/24 revealed an order for the following: On 10/10/21, Artificial Sol Tears, instill 1 drop in both eyes two times a day for dry eyes. On 11/24/19, Aspirin Tab 325 mg EC [enteric coated], give 1 tablet orally in the morning for prophylaxis. On 2/22/23, Bupropion HCL 100 mg Tabs, give 1 tablet orally every 12 hours for depressive disorder. On 1/24/24, Furosemide Tablet 20 mg, give 1 tablet by mouth one time a day for edema. On 2/21/23, Labetalol Tab 100 mg, give 1 tablet orally every 12 hours for HTN [hypertension]. On 4/24/20, Vitamin C Tab 500 mg, give 2 tablets orally one time a day as supplement. A review of Resident #5's MAR for 3/2024, confirmed the medications were scheduled and to be administered as follows: Artificial Sol Tears at 9:00 a.m. and 5:00 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Care at Dover	65 North Sussex Street Dover, NJ 07801

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(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 - Some	Aspirin Tab 325 mg EC at 9:00 a.m. Bupropion HCL 100 mg at 9:00 a.m. and 9:00 p.m. Furosemide Tablet 20 mg at 9:00 a.m. Labetalol Tab 100 mg at 9:00 a.m. and 9:00 p.m. Vitamin C Tab 500 mg at 9:00 a.m. A review of Resident #5's MAAR indicated that the abovementioned medications were not administered according to the scheduled time. The medications were administered as follows: Artificial Sol Tears was scheduled to be administered at 9:00 a.m. and 5:00 p.m., however, on the following days, the medications were given late. 3/2/24 was administered at 10:37 a.m. 3/5/24 was administered at 6:30 p.m. 3/6/24 was administered at 10:35 a.m. 3/10/24 was administered at 11:26 a.m. 3/11/24 was administered at 6:55 p.m. 3/12/24 was administered at 7:14 p.m. 3/13/24 was administered at 11:21 a.m. 3/21/24 was administered at 10:28 a.m. Aspirin 325 mg was scheduled to be administered at 9:00 a.m., however, on the following days the morning medication was given late. 3/2/24 was administered at 10:37 a.m. 3/6/24 was administered at 10:35 a.m. 3/10/24 was administered at 11:26 a.m. 3/13/24 was administered at 11:21 a.m. 3/21/24 was administered at 10:27 a.m. Bupropion 100 mg was scheduled to be administered at 9:00 a.m. and 9:00 p.m., however, on the following days the morning dose was given late. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/2/24 was administered at 10:54 a.m. 3/6/24 was administered at 10:35 a.m. 3/10/24 was administered at 11:26 a.m. 3/13/24 was administered at 11:21 a.m. 3/21/24 was administered at 10:28 a.m. Furosemide 20 mg was scheduled to be administered at 9:00 a.m., however, on the following days the morning dose was given late. 3/2/24 was administered at 10:54 a.m. 3/6/24 was administered at 10:35 a.m. 3/10/24 was administered at 11:27 a.m. 3/13/24 was administered at 11:22 a.m. 3/21/24 was administered at 10:28 a.m. Labetalol 100 mg was scheduled to be administered at 9:00 a.m. and 9:00 p.m., however, on the following days the morning dose was given late. 3/2/24 was administered at 10:54 a.m. 3/6/24 was administered at 10:35 a.m. 3/10/24 was administered at 11:27 a.m. 3/12/24 was administered at 11:04 a.m. 3/13/24 was administered at 11:22 a.m. 3/21/24 was administered at 10:28 a.m. Vitamin C 500 mg was scheduled to be administered at 9:00 a.m., however, on the following days morning dose was given late. 3/2/24 was administered at 10:55 a.m. 3/6/24 was administered at 10:36 a.m. 3/10/24 was administered at 11:28 a.m. 3/13/24 was administered at 11:22 a.m. (continued on next page)

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(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 - Some	3/21/24 was administered at 10:28 a.m. A review of Resident #5's PN from 3/1/24 to 3/21/24, there was no indication in the PN that the Resident's PCP was notified that the medications were not administered according to the scheduled time on the aforementioned dates. Also, there was no documented evidence of harm to the resident from the late administration of medications. During an interview with Registered Nurse (RN #1) on 3/21/24 at 1:52 p.m., RN #1 stated that red bars in the EMAR means late medications not given within the hour before and after the medications' scheduled administration time. The RN also stated that if the medications were not administered according to the scheduled time or running late with medications, RN would document that the medications were given late and would call the doctor to notify that the medications were not administered according to the scheduled time. During an interview with the Director of Nursing (DON) on 3/21/24 at 4:35 p.m., the DON stated that the nurses were to administer the medications according to the schedule. DON further stated that if the medications were not administered on scheduled time, the nurse was to notify the doctor and document in the residents' PN. A review of the facility provided document titled, Color indication on EMAR: Red - Documentation overdue, administration window to document has passed . A review of the facility's policy titled Medication Administration, dated on 3/2024, under Procedure .4. Verify the Five rights and check labeling for expiration date prior to administration. e) Right Time . A review of the facility's policy titled Physician Services, dated on 2/2024, under Procedure .8. All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift. NJAC 8:39-29.2 (d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40823 Complaint# NJ 00164594 Based on observations, interviews, and record review, it was determined that the facility failed to a.) ensure that expired medications were removed from the medication cart, b.) ensure that each medication cabinets and refrigerator (Unit 2B) were locked. This deficient practice was identified for 2 of 2 units and was evidenced by the following: During the medication administration observation with the surveyors on 3/21/24 at 9:46 am, the surveyor observed Registered Nurse (RN #1) went to Unit 2B nurses' station (observed there was no one at the nurse's station) to look for a medication for an unsampled resident. RN #1 was able to open the cabinets without using a key and started looking for the medication. RN #1 then closed the cabinet without locking and stated, I will go to Pyxis [the facility's back up medications storage] to get the unsampled resident's medication, the RN left the unit and the cabinets remained unlocked. The RN went to the medication room and was able to find the unsampled medication and continued to administer medication. At 10:12 a.m., RN #1 pulled a bottle of Aspirin 325 milligram (mg) from Unit 2B's medication cart, the bottle had an expiration date of 2/2024 and a written date of 3/13/24 to indicate when the bottle was opened. Then RN #1 pulled the bottle of Aspirin and went back to Unit 2B's nurse station, for the second time around, RN #1 opened the cabinets without using a key and took a bottle of Aspirin, however she did not find one. The RN then went to Unit 2A nurse station's medication cabinet, opened the unlocked cabinet without using a key. RN took a bottle of unexpired Aspirin and continued to give medication on Unit 2B. From 9:46 am to 10:42 am, Surveyor #2 did not observe any residents wandering around the unit, the surveyor observed Unit 2B medication cabinets were unattended and unlocked. The Director of Nursing (DON) was notified. The DON and the Surveyor observed current and discontinued medications were inside the cabinets. Furthermore, the DON and the Surveyor observed that the fridge at the nurse's station's padlock was unlock. The DON pointed out a signage indicated Don't leave this Fridge unlocked. According to the DON, the cabinets and the fridge must always be locked and only the nurse can open the cabinets. During the interview with the surveyor on 3/21/24 at 1:52 pm, RN #1 stated that the cabinet must be locked at all times. RN #1 further stated that the cabinets were locked in the morning, however, she was unable to explain the reason why the cabinets were unlocked during the medication administration. She stated that the cabinets had to be locked at all times because if anyone takes the medication, they can ingest it and a lot of things can happen, like nausea, vomiting, or worse. The surveyors asked the RN regarding the expired Aspirin. The RN stated that the nurses were to check and remove all expired medications in the cart. The RN stated, I guess I did not check my cart today, otherwise I would've have seen the expired medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the interview with the surveyors on 3/21/24 at 4:35 pm, in the presence of Assistant DON, Administrator, Regional Clinical Nurse, Administrator in Training, the DON stated that the nurses had to remove all expired medications from the cart and will do a med error and audit to make sure there was no expired medications in the medication carts. Review of the facility policy titled Medication Storage, dated 2/2024, reflected INTENT: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. PROCEDURE: 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .4. Compartments (Including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use . NJAC 8:39-29.4 (g)(h)