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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315445 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/13/2024 |
| NAME OF PROVIDER OR SUPPLIER Arbor at Laurel Circle, The | | STREET ADDRESS, CITY, STATE, ZIP CODE 100 Monroe Street Bridgewater, NJ 08807 | |

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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193</p> <p>Complaint # NJ 169997</p> <p>Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to a.) thoroughly review the hospital discharge summary (After Visit Summary) and communicate the recommendations for an anti-anxiety (AA) medication to the physician, and b.) follow a physician's order for an AA medication (Clonazepam) ordered to be administered daily at bedtime. This resulted in Resident #152 not receiving the physician ordered AA medication for 14 days (from 12/5/23 through 12/19/23) which resulted in Resident #152 experiencing a change in behaviors which included: agitation, anxiety, insomnia and wandering at night. This deficient practice was identified for 1 of 7 residents (Resident #152), reviewed for medication administration and was evidenced by the following:</p> <p>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 well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist.</p> <p>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.</p> <p>On 09/10/24 at 11:15 AM, a review of the closed medical record for Resident #152 revealed the following:</p> <p>Review of the Admission Face Sheet reflected that Resident #152 was admitted to the facility on [DATE], and discharged [DATE]. The diagnoses included, but was not limited to, history of falling, other specified anxiety disorder, chronic heart failure and muscle weakness.</p> <p>A review of the After Visit Summary (hospital discharge instructions), revealed a medication list with an order for Clonazepam 1 milligram (mg), to be administered by mouth nightly.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 315445 |
| | | If continuation sheet Page 1 of 5 |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the December 2023, Order Summary Report revealed a physician's order dated 12/06/2023, for clonazepam oral tablet 1 mg (Clonazepam) give 1 tablet by mouth at bedtime for anxiety. Further review of the medical record revealed that the order was transcribed on 12/6/2023 as a telephone order.</p> <p>A review of the December 2023 Medication Administration Record (MAR), revealed that the Clonazepam 1 mg was not administered on: 12/5/2023, 12/6./2023, 12/7/2023, 12/8/2023, 12/9/2023, 12/10/2023, 12/11/2023, 12/12/2023, 12/13/2023, 12/14/2023, 12/15/2023, 12/16/2023, 12/17/2023, and 12/18/2023 (14 days). The electronic boxes where the nurses were to sign for the administration of the Clonazepam were documented with code 05 and 09. Code 05 indicated to hold the medication and to see Nurses Notes; and Code 09 indicated that the medication is not available. Review of the Nurses Notes indicated medication not available.</p> <p>A review of the progress notes dated 12/04/23, revealed a treatment plan initiated 12/04/23, which indicated the following:</p> <p>Fall/Gait Dysfunction: PT (Physical) /OT(Occupational Therapy)</p> <p>CHF (Congestive Heart Failure: Lasix</p> <p>HTN (hypertension) Lisinopril</p> <p>Neck pain/muscle spasm: Tylenol, soft collar, Baclofen, Lidocain patch.</p> <p>Anxiety: Clonazepam.</p> <p>GERD (Gastroesophageal Reflux Disease: Carafate.</p> <p>Labs reviewed.</p> <p>PT/OT evaluation and treatment.</p> <p>Medications reviewed and reconciled.</p> <p>Transfer Records reviewed.</p> <p>Orders reviewed.</p> <p>Discussed with nursing.</p> <p>A review of the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 12/11/2023, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated that the resident's cognition was mildly impaired. The assessment further reflected the resident was dependent on staff for hygienic care, and needed assistance with meals.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>A review of an individualized care plan initiated in December 2023, included that the resident used anti-anxiety medications (Clonazepam) related to anxiety disorder. The goal specified that the resident would be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. The care plan interventions included the following:</p> <ul style="list-style-type: none"> - Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms. - Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. <p>A review of the History and Physical Assessment from the hospital record dated 12/01/23, reflected that the resident was status-post fall, had a work-up done in the emergency room and was admitted to the facility on [DATE], with a list of medications to be continued. The AA medication Clonazepam was changed to 1 mg to be administered at bedtime. The hospital discharge summary indicated that Resident #152 received Clonazepam 1 milligram (mg) on 12/03/23 at 8:24 PM.</p> <p>A review of the medication reconciliation sheet revealed that the AA medication Clonazepam was not transcribed as ordered on 12/04/23.</p> <p>A review of a Nurse's Notes dated 12/06/23 and timed 8:50 PM, reflected that Clonazepam oral tablet, 1 mg at bedtime for anxiety. Medication not available.</p> <p>A review of a Nurse's Note dated 12/06/23 and timed 8:50 PM, reflected that Clonazepam oral tablet, 1 mg at bedtime was not administered at bedtime for anxiety. Medication not available. The nurse's note dated 12/6/23, reflected that [Resident #152] was anxious, recent change in mood, agitated, wanders at night.</p> <p>A review of a Nurse's Note dated 12/07/23 and timed 12:15 PM, suggested to engage Resident #152 in activity to help with their anxiety.</p> <p>On 12/7/23 at 3:23 PM, the nurse's notes reflected that Resident #152 was agitated and threw all morning medications on the floor. The family was notified, the Nurse Practitioner was called and gave order to increase Zolofit an anti-depressant medication to 50 mg daily. There was no documented evidence that the physician or the Nurse Practitioner was made aware that Resident #152 had not been receiving the Clonazepam for their anxiety as ordered.</p> <p>A review of a Nurse's Notes dated 12/20/23, reflected that Resident #152 has period of anxiety and agitation, Resident is being followed by psychologist.</p> <p>A review of the Nurses Progress Notes from 12/5/23 through 12/19/23, did not address that the pharmacy was called and inquired about the Clonazepam not being available and/or notification of the physician in regards to the resident being agitated and anxious. There was no documented evidence that the family or the physician were notified.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>A review of the December 2023 Medication Administration Record (MAR) reflected the corresponding physician's order (PO) dated 12/05/23, to administer Clonazepam, give 1 mg at bedtime for anxiety. The order was plotted for the medication to be administered at 9:00 PM, but there was no evidence that the Clonazepam order was ever faxed to the pharmacy.</p> <p>On 9/10/24 at 10:30 AM, the surveyor requested all investigation reports for Resident #152.</p> <p>On 9/11/24 at 10:00 AM, the Assistant Director of Nursing (ADON) provided a Medication Error -Other dated 12/20/23 and timed 10:26 AM, that indicated the following:</p> <p>Nursing Description: Medication Clonazepam 1 mg po [orally] at hour of sleep was not administered from 12/6/23 to 12/18/23. Pharmacy was called to find out why the medication was not sent and they replied that they needed the order.</p> <p>Resident Description: Resident unable to give description.</p> <p>Immediate action taken: The order was in the chart and had a date faxed 12/18/23. Both the order and the hard copy of the order was sent to pharmacy and requested STAT [immediate] delivery. Medication arrived physician was notified and no new orders at this time. Family to be called today.</p> <p>Statements: No statements found.</p> <p>Notes: No notes found.</p> <p>Further review of the December 2023 MAR revealed a PO dated 12/05/23, to administer Clonazepam, give 1 mg at 9:00 PM for anxiety. According to the MAR, the first dose was administered on 12/19/23 at 9:00 PM and was signed as administered.</p> <p>On 09/12/24 at 9:34 AM, the surveyor interviewed the Physician in charge of Resident #152 care. The physician stated that she cannot recall that she was notified of the Clonazepam not being administered for 14 days. The Physician further stated that Resident #152 had been on the Clonazepam for a long time. When asked about her expectations, she stated, My expectation would be that the order will be carried executed, and, if the medication was not available, I would expect to be notified.</p> <p>On 9/12/23 at 10:51 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN). The surveyor asked what the reasons were why the medication was not administered, as ordered by the physician. The LPN stated that Resident #152 was admitted during the night, the orders were verified and faxed and the 7:00 AM-3:00 PM shift was to review the admission order and follow up. He worked the 11:00 PM- 7:00 AM shift and was not aware that the Clonazepam was not being administered as ordered. The surveyor then inquired regarding the 24 hours chart check scheduled on the 11:00 PM-7:00 AM shift, the nurse did not have any comment. The LPN confirmed that the resident did not receive any Clonazepam from 12/05/23 through 12/19/23. He further stated that he did not know if there was documentation in the resident's medical record as to why the Clonazepam was not given or if there was any communication with the physician or the family. The surveyor asked the LPN if he was ever asked to write a statement regarding the medication as he was the nurse who admitted the resident, he replied, No. The surveyor then asked regarding the process for new admission. The LPN stated that the nurses were responsible for documenting those issues, the nurses were to call and review all orders with the physician.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 9/12/23 at 11:35 AM, the surveyor interviewed the ADON who stated he would need to get back to the surveyor with the information.</p> <p>On 09/12/24 at 12:42 PM, the surveyor interviewed the Registered Nurse (RN) regarding the process for medication verification with the physician. The RN stated that the physician must be called, all orders must be verified with the physician, then faxed and called to the provider pharmacy. The RN stated that some medications could be obtained from the backup [electronic medication dispensing system]. If not available, the nurses must call and notify the physician that the medication was not available. The facility could also call the pharmacy and request a stat delivery and the Director of Nursing must be informed.</p> <p>On 9/12/24 at 12:50 PM, the ADON provided the hospital discharge summary with the order to administer the Clonazepam 1 mg at bedtime. When inquired regarding the rationale for not calling the pharmacy or the nurses not faxing the order, the ADON did not have any comment.</p> <p>On 09/12/24 at 1:30 PM, the surveyor interviewed the Director of Nursing in the presence of the survey team. The DON stated that she was made aware only yesterday (9/11/24). When asked regarding the investigation, she stated, there was no proper investigation.</p> <p>A review of the Manufacturer's specification indicated that Clonazepam, should not be stopped suddenly or without the direct supervision and guidance of a medical professional. Potentially fatal seizures or a coma may occur with the sudden cessation of Clonazepam.</p> <p>On 9/12/24 at 1:45 PM, the Director of Nursing provided a form titled, Employee Education Attendance Record dated 12/20/23. Topic of in-service. Adverse Consequences and medication errors which indicated that the staff were in-serviced regarding the medication. Attached to the in-service was the policy titled, Adverse Consequences and Medication Errors . the Policy Statement included that The Interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drugs reactions (ADRs) and side effects . and Medication Errors was defined as the preparation and administration of drugs or biological which is not in accordance with physician's order, manufacturer specifications, or accepted professional standards and principles of the professional (s) providing services.</p> <p>NJAC 8:39-27.1(a)</p> | | |