Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315468	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Parsippany	100 Mazdabrook Road Parsippany Troy Hill, NJ 07054

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. 40823 Complaint #: NJ00165681 Based on interviews and record review, as well as a review of pertinent facility documents on 4/4/24 and 4/8/24, 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 for 1 of 3 residents (Resident #1) reviewed for medication administrations. This deficient practice was evidenced by the following: 1. According to the ADMISSION RECORD (AR), Resident #2 was admitted with diagnoses including but not limited to Depression and Sepsis A review of Resident #2's care plan (CP), dated 4/27/23, indicated that Resident #2 was had Neurological deficiencies. Interventions included but not limited to administer medications per physician orders. A review of Resident #2's Order Recap Report (ORR) revealed an order for the following: On 4/26/23, Gabapentin Capsule 300 mg (milligram), give 2 capsules by mouth every 12 hours for Neuropathy. On 5/8/23, Vancomycin 125 mg, by mouth every 6 hours for Clostridium Difficile (is a bacterium that causes an infection of the colon, the longest part of the large intestine) for 10 days. A review of Resident #2's Medication Administration Report (MAR) for 05/2024 confirmed the abovementioned medications were scheduled and to be administered as follows: Gabapentin Capsule 300 mg at 9:00 a.m. and 9:00 p.m. Vancomycin 125 mg at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. A review of Resident #2'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: (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	Gabapentin Capsule 300 mg was scheduled to be administered at 9:00 a.m. and 9:00 p.m., however, on the following days the medication was given late. 5/2/23 was administered at 10:46 a.m. 5/5/23 was administered at 10:58 a.m. 5/7/23 was administered at 10:36 a.m. and at 10:40 p.m. 5/9/23 was administered at 10:38 a.m. 5/12/23 was administered at 10:25 a.m. and at 11:29 p.m. 5/13/23 was administered at 10:56 a.m. 5/16/23 was administered at 10:53 a.m. Vancomycin 125 mg at 12:00 p.m., 5/11/23 was administered at 4:14 p.m. 5/12/23 was administered at 2:26 p.m. 5/15/23 was administered at 4:58 p.m. A review of Resident #2's progress notes (PN) from 5/1/23 to 5/16/23, 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. In addition, 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 4/4/24 at 1:07 p.m., RN #1 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 Administrator and the Director of Nursing (DON) on 4/4/24 at 3:02 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's policy titled Administering Medication, dated on 5/21/19, indicated Policy Statement Medications are administered in a safe and timely manner, and as prescribed 4. Medications are administered in accordance with prescriber orders, including any required time frame .7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified .21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication .For centers utilizing electronic documentations (i.e., eMAR), utilize the appropriated documentation code . (continued on next page)

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