STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55A009	A. BUILDING: _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTISON CROSSING AT MANALAPAN AVE	93 MANALAPAN AVENUE FREEHOLD, NJ 07728

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint survey COMPLAINT #: NJ00127168, NJ00127265 CENSUS: 156 SAMPLE SIZE: 8 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 925	8:36-11.2 Pharmaceutical Services The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00127265	A 925		

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A 925	Continued From page 1 Based on observation, interview and record review it was determined that the facility failed to ensure that a resident was provided the dose of medication prescribed by the Physician for 1 of 8 residents reviewed, Resident #3. This deficient practice was evidenced by the following: On 8/28/19 at 11:00 a.m., the surveyor reviewed the medical record of Resident #3, who moved into the facility in [redacted] with diagnoses which included [redacted] The surveyor reviewed the facility reportable event which documented that Resident #3 was given [redacted] as ordered by the prescriber. The facility took a photograph of the remaining [redacted]. The surveyor reviewed the photograph and observed that the date on the package documented was 7/24/19 as the date the pharmacy dispensed [redacted]. The surveyor also observed that there were 13 doses that remained in the photograph. According to the Progress Note dated 8/15/19 and timed at 11:51 a.m., a late entry for the 8/14/19 at 3:30 p.m., a Licensed Practical Nurse became aware of the discrepancy in the dose of [redacted] on hand and notified the Director of Nursing (DON). On 8/29/19 at 10:30 a.m., during surveyor interview the Director of Nursing (DON) stated that the pharmacy labeled the box [redacted] and inside the box were [redacted] tablets instead. The surveyor pointed to the photograph of the [redacted] and on the back of each pill was labeled [redacted]. The DON stated that the staff should have checked the label on the back	A 925		

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A 925	Continued From page 2 of the the medication and added that the medication was in unit dose. The DON stated that they checked every resident on [redacted], once the error was found, and there were no other discrepancies. The DON further stated that once the discrepancy was found, the Physician was notified and laboratory work was ordered and completed. The Physician was notified of the results and instructed the facility to send the resident to the hospital for an evaluation. The DON further stated that the resident was given [redacted] and returned to the facility.	A 925		
A 935	8:36-11.4(b) Pharmaceutical Services (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00127265 Based on interview and record review it was determined that the facility failed to ensure that a resident was administered medication in accordance with the Physician's order for 1 of 8 residents reviewed for medication administration,	A 935		

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A 935	Continued From page 3 Resident #3. This deficient practice was evidenced by the following: On 8/28/19 the surveyor reviewed the Medical Record (MR) of Resident #3, who moved into the facility in [redacted] with diagnoses which included [redacted] The surveyor observed the Medication Administration Record (MAR) documented administer [redacted], one tablet, by mouth, daily at 5:00 p.m. The surveyor reviewed the Progress Notes (PNs) and observed a note dated 8/15/19 and timed at 11:51 a.m., late entry for 8/14/19 at 3:30 p.m., which documented that Resident #3 was prescribed [redacted] once daily at 5:00 p.m. since admission to the assisted living on 5/22/19. Further, the PN documented that the pharmacy delivered a box of [redacted], which was labeled on the outside of the box, [redacted], however, inside the box were [redacted]. The surveyor interviewed the Director of Nursing (DON), who stated that once the discrepancy was found, the facility checked all the boxes of Warfarin in the facility and no other discrepancy were found. The DON further stated that the staff should have looked at the back of the label to ensure that the unit dose was accurate. The DON stated that the Physician was notified and ordered lab work. The laboratory work was performed the next day and the Physician was called with the results. The Physician ordered that Resident #3 go the the hospital for evaluation. The DON further stated that the resident was given [redacted] and returned to the facility.	A 935		

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A 935	Continued From page 4 The surveyor was unable to interview Resident #3 as he/she was not in the facility during the time of this survey. The facility failed to ensure that Resident #3 received medications in accordance with the prescriber orders.	A 935		

MATTISON CROSSING
AT MANALAPAN AVENUE
Honor. Tradition. Quality.

Mattison Crossing at Manalapan Avenue

9/20/19

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

Tag A925 8:36-11.2 Pharmaceutical Services

A. With respect to the specific resident cited:

The community's Provider Pharmacy was notified of the error and will communicate and submitted a corrective action response. Completed on 9/6/19.

A Medication order to cart audit was completed to reconcile compliance with healthcare provider orders for Resident #3. Completed on 8/30/19.

Documented counseling was completed for the employee responsible for reconciling the order with the label and delivered medication on 8/30/19.

B. With Respect to How the Community will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:

The Director of Health and Wellness completed an audit to reconcile Warfarin orders with medication on the medication carts and the pharmacy label. Completed 8/15/19.

The Director of Health and Wellness will report pharmacy and medication follow-up needs during stand-up meetings

The Director of Health and Wellness will review pharmacy and community medication errors and follow-up during weekly Executive Director 1:1 meeting.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

The Director of Health and Wellness conducted in-service training for LPNs and CMAs to review the Six Rights of Medication Administration, Medication Order Process, Use of the three-way stamp, verification of orders, receiving pharmacy delivery, sign and date requirements on pharmacy manifests, management of pharmacy delivery manifests reconciling the pharmacy label with the medication delivered and the order, communication of discrepancies to the pharmacy, Director of Health and Wellness, medication error reporting twenty-four-hour report communication and communication of corrective action when pharmacy dispensing errors occur. Completed 8/30/19.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

The Director of Health and Wellness will review pharmacy and community medication errors and follow-up during weekly Executive Director 1:1 meeting.

The Director of Health and Wellness will report Medication Order Process compliance, medication errors and follow-up during the community Quality Assurance meetings for three months. Will continue to review this process quarterly.

Tag A935 8:36-11.4 (b) Pharmaceutical Services

A. With respect to the specific resident cited:
The community's Provider Pharmacy was notified of the error and will communicate and submit a corrective action response. Completed 9/6/19.
A Medication order to cart audit was completed to reconcile compliance with healthcare provider orders for Resident #3 on 8/30/19.
Documented counseling was completed for the employee responsible for reconciling the order with the label and delivered medication on 8/30/19.

B. With Respect to How the Community will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:
The Director of Health and Wellness completed an audit to reconcile Warfarin orders with medication on the medication carts and the pharmacy label on 8/15/19.
The Director of Health and Wellness will report pharmacy and medication follow-up needs during stand-up meetings
The Director of Health and Wellness will review pharmacy and community medication errors and follow-up during weekly Executive Director 1:1 meeting.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

The Director of Health and Wellness conducted in-service training for LPNs and CMAs to review the Six Rights of Medication Administration, Medication Order Process, Use of the three-way stamp, verification of orders, receiving pharmacy delivery, sign and date requirements on pharmacy manifests, management of pharmacy delivery manifests reconciling the pharmacy label with the medication delivered and the order, communication of discrepancies to the pharmacy, Director of Health and Wellness, medication error reporting twenty-four-hour report

communication and communication of corrective action when pharmacy dispensing errors occur. Completed 8/30/19.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

The Director of Health and Wellness will review pharmacy and community medication errors and follow-up during weekly Executive Director 1:1 meeting.

The Director of Health and Wellness will report Medication Order Process compliance, medication errors and follow-up during the community Quality Assurance meetings for three months. Will continue to review this process quarterly.