STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315506	A. BUILDING _____ B. WING _____	09/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-WASHINGTON TOWNSHIP	**378 FRIES MILL ROAD SEWELL, NJ 08080**

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** Complaint # NJ 873 Based on observation, interview, and document review, it was determined that the facility failed to remove controlled medications from 1 of 6 active medication carts inspected. This deficient practice was evidenced by the following: 1) On [DATE] at 1:23 PM, the surveyor inspected the narcotic count and storage on Cart One, South Unit with the Registered Nurse (RN) assigned to the cart. The bottom drawer contained a lock box that contained the narcotics. The RN stated that there were 18 narcotics that were locked in this drawer. Upon review of the declining inventory sheets when compared to the bingo cards and two bottles of liquid [MEDICATION NAME] (a controlled substance used to treat pain). The RN stated that Resident #7 had been deceased for approximately one month. The RN added that the medication should be removed from the medication cart and destroyed by two licensed professionals. She added that it remains stored in the active medication cart and that she would have to reach out to the Director of Nursing (DON) to find out how to handle Resident #7's medications. On the same day at 1:45 PM, the surveyor observed a white binder that was stored at the Nurses Station on the South Unit and the cover had the label: Controlled Substance, Glucometer Check, 24 Hour Report Sheet, Reference Sheet and SBAR Sheets. This binder contained a form titled Master Narcotic Controlled Substance Count Sheet and had a handwritten label for Resident #7 dated ,[DATE] numbered with 11 for [MEDICATION NAME] was on the list. The Master Narcotic Sheet also had the date received of ,[DATE] for Resident #7 [MEDICATION NAME] ER (a narcotic used to treat pain) 30 mg (milligram) 28 tablets. The surveyor then reviewed the facility form titled, Controlled Substance Record which was the declining inventory sheets for the [MEDICATION NAME] 20 mg/ml solution was last dated [DATE]. There was a third Controlled Substances Record for Resident #7 for the medication, [MEDICATION NAME] ER 30 mg tablet that was blank. The actual bingo card in the medication cart contained 28 tablets had the word, Expired written in pen on the top right corner. At 1:50 PM, the surveyor interviewed the same RN who stated that medications were always wasted in the presence of two nurses and that either the DON or Assistant Director of Nursing (ADON) would waste the medication. The RN stated that ideally the narcotic should be wasted the following day after it had been discontinued, discharged or resident expired. She added that it was the responsibility of the DON and ADON to waste the medication. On the same day at 4:07 PM, the surveyor interviewed the DON, who stated that two nurses should complete the narcotic count together at the beginning and end of each shift. She added that the UM or me would collect the narcotics to waste them. She the added that if a resident was deceased the medication should be removed and destroyed. On [DATE] at 5:32 PM, the surveyor reviewed the facility policy titled, Medication Disposal/Destruction with a date of ,[DATE]. Under Procedure it read: 1. When appropriate, Nursing Center staff should destroy and dispose of medications in accordance with Nursing Center policy and Applicable Law when medication should not be returned to pharmacy. 2. Once an order to discontinue a medication is received, the Nursing Center staff is to remove this medication from the resident's drug supply, 3. The Nursing Center communicates the order discontinuing the medication to the pharmacy, 4. The Nursing Center will place all discontinued medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction, 5. When medications should not be returned to pharmacy, the Nursing Center destroys medications in the presence of a registered nurse and witnessed by one other licensed nurse or pharmacist, in accordance with Nursing Center policy or applicable law, and, 7. Discontinued medications or medications left in a Nursing Center after discharge will be disposed of by the Nursing Center within 30 days of the date the medication was discontinued by the prescriber, 8. Destruction of controlled medications is documented with the signatures of DON or designee and witnessing licensed nurse. On [DATE] at 11:35 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that he was not involved in the destruction of narcotics but that they should be wasted by two nurses and that they should follow the facility policy. On [DATE] at 1:16 PM, the surveyor reviewed the closed record of Resident #7 which revealed an Order Summary Report that identified the [MEDICATION NAME] 20 mg/ml Solution and the [MEDICATION NAME] Extended Release 30 mg had a start order of [DATE]. The surveyor then reviewed a Progress Note dated [DATE] at 14:18 (2:18 PM) that read: Patient expired at 2 PM. At 12:32 PM, the DON was made aware that Resident #7 passed away on [DATE] and that the [MEDICATION NAME] sulfate solution and tablets remained on the active medication cart greater than 30 days. The DON reviewed the policy and confirmed that the narcotics should have been destroyed prior to the surveyor's inspection and stated that the staff should follow the policy. N.J.A.C 8:,[DATE].1(c)

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

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.