STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING _____ B. WING _____	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey: CENSUS: 143 SAMPLE: 36 + 1 closed record A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		8/26/22

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

Electronically Signed | 08/18/2022

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 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that the facility failed to ensure residents were assisted to eat their meals once delivered in a timely manner and ensure that the residents' dining experience was provided in a manner to promote the dignity and respect of the residents, who were not served their meal at the same time while seated at the same table, for 5 of 32 residents reviewed for dining, Resident # 108, #22, #582, #107, and #1. This deficient practice was evidenced by the following: On 7/13/22 at 8:55 AM, upon entering the room for Resident #108, he/she was observed lying in	F 550	Element #1 CNA□s that were involved with the cited deficient practice was counselled and re-educated to ensure that residents who requires meal assistance will be assisted to eat meals once delivered in a timely manner and to ensure that residents dining experience will be provided in a manner that promotes dignity and respect. This was completed on 7/15/22 Resident # 108, # 107, # 1, and # 22□ trays were re-organized and moved to the second truck to ensure that staff will be available to provide feeding assistance and residents who requires feeding	

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F 550	Continued From page 2 bed, head of bed elevated 30 degrees. A meal tray with breakfast was observed on top of bedside table untouched. Certified Nursing Assistant #2 came into the room and said I need to get the bed fixed before I can feed him/her. She then left the room and went across the hall. On 7/13/22 at 8:56 AM, CNA #2 reentered the room and upon interview with CNA #2, who is the assigned CNA today, said breakfast comes between 8:00 am -8:30 am. On 07/13/22 at 9:01 AM, after adjusting Resident #108 in bed and elevated the head of bed to approximately 90 degrees, CNA #2 took the bowls of eggs and pureed toast to get reheated from tray and left the room. At 9:05 AM, CNA #2 returned to the room with heated eggs and toast and began to feed the resident. A review of the Meal Truck Delivery Schedule indicated that the 1st meal truck for breakfast was delivered at 8:15 am and the 2nd meal truck was delivered at 8:30 am. A further review of the Meal Truck Delivery Schedule revealed the 1st truck lunch was scheduled to be delivered at 12:15 pm and the 2nd meal truck at 11:30 pm [12:30pm]. 07/13/22 11:40 AM, lunch meal observation on [redacted] revealed the following; The three (3) tables in the common area can accommodate 4 residents. At 12:12 PM the 1st meal truck arrived on the unit and staff signed indicating the arrival for kitchen staff. Nursing staff began passing the trays. At 12:20 PM, the 2nd meal truck arrived on unit while staff were still passing trays from the 1st	F 550	assistance are seated on same table. This was completed on 7/21/22 Element # 2. Residents who require feeding assistance have the potential to be affected by the cited deficient practice Element #3 a) CNAs and nurses were re-in-serviced regarding facility□s Meal Service Policy and Procedures to ensure that residents who requires feeding assistance will be assisted to eat meals once delivered in a timely manner and to ensure that residents dining experience will be provided in a manner that promotes dignity and respect. This in-service will be given annually, during orientation for newly hired CNA□s, license nurses, and when deemed necessary. b) Meal trucks delivery were re-arranged in accordance with residents who requires feeding assistance and the dining room/day room seating arrangement to ensure that residents who eat in same table are served and assisted at the same time. " First truck delivery -independent residents and set-up assistance residents. " Second truck delivery- residents that require meal assistance from the staff. c) The Unit nurse manager and or designee will update the Seating table arrangements for any changes and a copy will be provided to the FSD. d) Seating table arrangement will be posted inside the pantry door for nursing staff reference and will be updated for any	

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 550	Continued From page 3 truck. Nursing Staff were observed to stop passing tray and would start to assist resident with meals while lunch meal trays remained on the truck. At 12:27 PM, staff brought the tray for Residents #22 to the table then took the resident back to his/her room and then took tray the room to assist the resident to eat. At 12:28 PM, Resident #582 who was independent in feeding themselves, received his/her lunch tray. Seated at the same table was Resident # 107, who was identified as being dependent with eating, was seated without their tray or staff to assist them. As Resident # 582 began to eat his/her lunch, Resident # 107 remain at the table without his/her tray and staff assistance. At the next table, Resident # 22, who was identified as being dependent with eating, was being fed by staff. At 12:29 PM, Resident #107 received his/her tray and staff assisted the resident to eat On 7/15/22 at 12:18 PM, the 1st meal truck arrived to the unit. All staff was observed to be assisting to pass trays and set up residents. A table with 2 residents who were identified as being dependent for eating, Resident #22, and Resident #1, are seated at the table with Resident #72 who is independent in eating. Resident #72 has his/her tray and is feeding him/her self while the 2 dependent Residents have no food/tray. Resident #22 tray was placed in front of him/her at the table and left by staff while they continued to pass other trays. On 7/15/22 at 12:22 PM, the 2nd meal truck	F 550	changes by the unit nurse manager and or designee. Element #4 a. Unit Manager and or designee will perform twice weekly audits covering all meals x 4 weeks and then bi-weekly x 3 months to ensure that residents who requires feeding assistance are assisted in a timely manner and residents who are seated on same table are served and assisted at the same time. Any negative results will be corrected through re-education and or disciplinary actions as appropriate by the unit manager and or the Director Nursing. b. The Food Service Director will perform weekly audits x 4 weeks and then monthly x 3 months to ensure that meal trays are organized in accordance with the seating arrangements and residents who requires feeding assistance trays are placed in the second truck. Any negative results will be corrected through re-education and or disciplinary action as appropriate by the Food Service Director and or the nurse unit manager. c. Results of the audits will be submitted to the QAA committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken	

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F 550	Continued From page 4	F 550		

arrived on unit. 4 of the 7 staff were continuing to pass trays.

On 7/15/22 12:24 PM RN/UM #1 began to feed Resident #1. Another staff member took Resident #22 to his/her room.

On 7/15/22 at 12:52 PM, CNA #5 went into Resident #22's room to assist with lunch. RN #1 said CNA #5 had other assignments and he was just getting to him/her now

During an interview with the surveyor on 7/20/22 at 1:13 PM, the Regional Food Service Director (RFSD) who said what trays go on what cart is done through our cart sort computer system and is communicated through nursing. He said once we are notified if a resident eats in their in room or dining room the computer sorts the tray tickets for the carts. It does not take into account if resident is independent or needs assistance. Nursing should be communicating with Food Service Director so we can serve a full table at a time. The RFSD said he has only been here 6 weeks and is working towards this and I don't know how they are doing this now. I don't have the information regarding who needs assist.

On 7/20/22 at 1:57 PM, the RFSD brought in sorted diet tickets for [redacted] meal truck 1 and meal truck 2 and has all resident who require feed assist on 2nd cart. The surveyor asked if this had been separated like this before and he responded, "Not to my knowledge have we separated by resident who require feed assist before now on the cart."

During an interview with the surveyor on 7/22/2022 at 11:37 AM, the Licensed Nursing

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F 550	Continued From page 5 Home Administrator said we have assigned the independent residents to the unit dining room and those resident who require assistance will be in the common areas. NJAC 8:39-17.4(c)	F 550		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to 1) ensure that a resident who had a [redacted] was assessed consistently by the Dietician and 2) failed to obtain a physician order for dietary supplements. This deficient practice was identified for 2 of 2 residents reviewed for Nutrition (Resident # 113 and Resident #108), and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "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 wellbeing, and executing medical regimens as prescribed by	F 658	Element # 1 The involved Registered Dietician was immediately re- in-serviced of the need for proper documentation and consistent assessments for residents with [redacted] and need to obtain physician order for nutritional supplements. The Registered Dietician immediately reassessed residents # 113 & 108, and corrections were made to the resident□s diet. Element # 2 " Residents who have unintended weight loss and who receives Nutritional supplements have the potential to be affected by the cited deficient practices. " A nutritional supplement audit was completed on 7/15 by the R.D. to ensure that supplements order is consistent with the dietary system and meal tray tickets	8/26/22

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F 658	Continued From page 6 a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; 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." 1. During a lunch meal observation on 07/18/2022 at 12:27 PM, staff provided Resident #113 with his/her lunch meal. The surveyor reviewed Resident #113's meal ticket which included the diet order of double portions, [redacted] liquids [redacted]) and under supplement Health Shake. Staff assisted the Resident who consumed 100% of his/her food. According to the facility Admission Record Resident #113 was admitted to facility with diagnoses including but not limited to; [redacted]. A review of the most recent Minimum Data Set (MDS) an assessment tool dated [redacted] revealed Resident # 113 had [redacted] and required extensive assistance of 1 staff to eat. A review of Resident #133's lunch meal ticket for	F 658	Element # 3 " Registered Dietician was in-serviced on documentation/follow-up regarding [redacted]/discontinuation and ordering of nutritional supplements. This was completed on 7/22/22 " Re-Inservice was initiated with License nurses and the Dietitian on 7/22/22 regarding the facility□s policy and procedures using the Dietary Requirement Form for every resident with an order for nutritional supplements and or discontinuation. A copy of the completed form will be provided to the dietary department to update the Dietary system/meal tray tickets. " This in-service will be given annually and during orientation for a newly hired nurses and Dietitian and when deemed necessary Element # 4 " The corporate Dietitian will audit monthly x 3 months and quarterly for 3 quarters to ensure compliance with documentation on resident with unintended [redacted] and the need to for re-assessment, and compliance with ordering and discontinuing nutritional supplements. Any negative results will be corrected through re-education and or disciplinary actions as appropriate by the Director of Nursing and or the administrator " The Food Service Director will audit the Dietary system/meal tray tickets against physician□s order weekly x 4 weeks and the monthly x 3 months. Any negative results will be corrected through	

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F 658	Continued From page 7 7/18/22 revealed the following: [redacted] liquids [redacted] portions, super mash. The Supplements section of the ticket indicated Health Shake. A review of the Order Summary Report (OSR) with Active Orders as of [redacted] included the following diet order: [redacted] texture, [redacted] consistency, super (fortified to provide extra calories and protein) cereal breakfast, super potatoes L/D (lunch/dinner) assist with meals and encourage intake, double portions. The OSR also revealed an order to "offer snacks three times a day offer sandwiches for his/her snack three times per day." A further review of the OSR did not include physician orders for Magic cup or Health Shakes. A review of the July Medication Administration Record/Treatment Administration Record (MAR/TAR) did not include a physician order for the magic cup or Health Shakes. A review of Resident #113's weights in past 6 months revealed on 1/7/2022 at 11:21 AM [redacted] Lbs. 2/4/2022 at 1:46 PM [redacted] Lbs., on 3/9/2022 at 9:55[redacted] Lbs., on 4/6/2022 at 11:46 [redacted] Lbs., on 5/2/2022 at 1:19 PM [redacted] Lbs., on 6/2/2022 at 12:03 PM [redacted] Lbs. A review of the Care Plan revealed a Focus area that Resident #113 is at risk for alterations in nutritional status related to Therapeutic diet, [redacted] ... and [redacted] with an initiated date of [redacted] Under the Goal section, with a revision date of [redacted], will not experience a significant change in weight through next review. Under the intervention section includes [redacted] portions and super foods offered	F 658	re- education and or disciplinary actions as appropriate by the FSD and or the DON a. Results of the audits will be submitted to the QAA committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken	

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F 658	Continued From page 8	F 658		

at meals with initiated date of [redacted], provide diet/supplements per orders with initiated date of 6/18/2019, staff will provide assisted feeding for meals, snacks, fluids, and supplements with a revision date of 9/19/2021, weights as ordered with initiated date of 6/18/19.

A review of the most recent Nutrition Note dated [redacted] timed at 12:32 PM, indicated Diet: Regular, [redacted] texture, [redacted] liquids
Allergies: NKFA
Supplements:
- Magic cup QD (290kcal, 9g pro)
- Mighty shakes with meals TID (6600kcal, 18g pro)
- snack offered TID of sandwich
- super cereal at breakfast & super mash at lunch/dinner.

The note went on to reveal Resident #113 has good acceptance of super foods and supplements provided. [redacted] is significant and undesirable. [redacted] could likely be r/t [redacted] with overall [redacted]) and function; resident's intakes have remained adequate, 75-100%. Resident has good acceptance of super foods and supplements provided. Further [redacted] may be unavoidable d/t overall decline in [redacted] progression. Will rec (recommend) increasing magic cup (ice cream for people who require thickened liquids) to BID (two times per day) for added nutrition support and will continue to provide super foods/mighty shakes TID (three times per day). Will continue to monitor weights and PO (oral) intakes closely at this time. The note further revealed Goal: Avoid undesirable significant [redacted] changes, maintain skin integrity, maintain good PO intake >75% of meals, Continue supplemental acceptance.

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F 658	Continued From page 9	F 658		

A further review of the progress notes from [redacted] through [redacted], and the assessment tab dated from [redacted] to [redacted] which was the last date an assessment was entered, did not include any further Nutrition notesor assessments.

On 7/19/2022 at 10:01 AM, the surveyor observed the 10 AM snacks arrive on the unit. There were 6 [brand name] shakes, 5 vanilla and 1 chocolate were on the tray. None of the shakes were labeled for Resident # 113.

During an interview with the surveyor on 07/19/2022 at 10:12 AM, Licensed Practical Nurse (LPN #3) who was assigned to Resident #113, was asked if this resident was on a Health Shake. She looked in the electronic medical record (EMR) and said "I don't see he/she is ordered any health shakes. She also said sometimes they come on the tray but if ordered at 10 AM or 2 PM snack they send it separately.

A review of the May OSR on [redacted] at 11:10 AM, revealed that the magic cup and mighty shakes were discontinued on [redacted]. A review of the hard chart showed there were no verbal orders to discontinue either one of these. There were no progress notes to indicate these were discontinued or why discontinued.

During an interview with the surveyor on 07/19/2022 at 11:23 AM, Registered Nurse/Unit Manager (RN/UM #1) said she does not know why the Magic Cup and mighty shakes were discontinued in May. She said it would be in the progress notes and the surveyor responded there is no note to indicate when or why they were

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F 658	Continued From page 10	F 658		

discontinued. She then said it could be a dietary note and the surveyor responded there were no dietary notes referencing the discontinuation of the Magic Cup and Mighty Shake. RN/UM #1 stated she would have to do some research and get back to the surveyor. The surveyor questioned RN/UM #1 that if [redacted] Health Shake was discontinued on [redacted], why did Resident #113 have it at his/her place setting today? RN/UM #1 said maybe dietary didn't get a slip. The surveyor made RN/UM #1 aware the resident had not received a Health Shake yesterday at lunch.

On 07/19/2022 at 1:20 PM, RN/UM #1 provided (2) separate order summary papers signed by the dietician dated [redacted] that the Magic Cup and Mighty Shake were discontinued due to adequate po intake.

During an interview with the surveyor on 07/20/2022 at 11:30 AM, the Dietician said we review residents quarterly for any long-term residents and usually a dietician is in the building 3 days per week, on Monday, Wednesday, and Friday. We are contracted staff. The Dietician said I keep a log to track when the residents are due to be seen. I also periodically check the MDS in the EMR. The Surveyor requested the Dietician to view Resident #113's EMR, specifically the progress notes, on his computer. The Dietician confirmed, "Yes the [redacted] note indicates a significant [redacted]". When questioned how often a resident with significant [redacted] should be seen, the Dietician replied," The follow up should be monthly and if on weekly weights would follow up sooner." The surveyor asked the Dietician when the next nutrition note was completed and the Dietician replied, "The next

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 658	Continued From page 11	F 658		

time was [redacted]." I was not here yesterday and don't know if anyone else was here. The surveyor asked the dietician if Resident #113 should have been assessed prior to [redacted], [redacted]. The dietician responded, "Yes, Resident #113 should have been seen before yesterday." When asked by the surveyor why the Magic Cup and health shake were discontinued, the dietician said, "I determined at the time based on the eating percentage oral intake and inquired with nursing staff the resident did not require it. I did not put a note in the chart and did not realize that I needed a note to discontinue a supplement."

During an interview with the Director of Nursing (DON) on 07/20/2022 at 12:44 PM the surveyor asked what the expectation is for the dietician to assess residents. The DON said the Dietician sees them, residents quarterly for their assessments. The DON said they see residents quarterly and if there are no concerns, they wouldn't have to see them.
The surveyor asked if the dietician should have seen Resident #113 and the DON confirmed someone should have followed up on Resident #113.

During a follow-up interview with the surveyor on 7/22/2022 at 11:37 AM, the DON said if the dietary workers read the ticket (meal) and it says health shakes it should be put on the tray.

2. According to the facility Admission Record, Resident # 108 was admitted to the facility with diagnosis including but not limited to: [redacted].

A review of the most recent MDS dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING _____ B. WING _____	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

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F 658	Continued From page 12 [redacted], revealed Resident #108 had severely impaired cognition and required extensive assistance of 1 to eat. A review of the diet ticket for the lunch meal on 7/15/2022, revealed Resident #108 was on [redacted]-Regular [redacted] liquids [redacted] portions, "[redacted]", Fortified Mash. Under the Supplement heading was Health Shake Diet. A review of the current OSR revealed a physician order for HOUSE diet[redacted] texture, Nectar consistency triple protein; dairy free fortified food w/ all meals. The order did not include double portions or an order for Health Shakes. A review of the current MAR/TAR did not include an order for the Health Shake. A review of Resident 108's care plan on 7/13/2022, revealed a focus area with initiated date of [redacted], of nutritional risk due to dementia, need for assistance with meals, use of a mechanically altered diet at risk for malnutrition, h/o (history of) weight loss. Under the goal section with initiated date of [redacted] and last revised on [redacted] reflects Resident #108 nutritional needs will be met by tolerating diet as ordered. Under the interventions section include but not limited to; Provide diet, liquids and supplements as ordered House; [redacted] texture, thin liquid [redacted] protein/ diary free) Mighty Shake TID Fortified cereal @ breakfast % fortified mash @ lunch/ dinner. A revised intervention dated 7/15/2022 revealed Provide diet, liquids, and supplements as ordered House; [redacted] texture, thin liquid [redacted] protein/dairy free). During an interview with the surveyor on	F 658		

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 658	Continued From page 13 07/15/2022 at 10:15 AM, RN #1 said she was not sure if they need a physician order for supplement, Health Shake, super cereal, super mashed or super pudding. They are recommendations from the dietician, and we get a verbal order from the physician. She went on to say some orders have to document the percentage of supplement consumed but not all orders. The surveyor then asked what is the process for monitoring if consumed? RN #1 replied, "We just put yes or no." I think most of my patients have percentage consumed. During an interview with the surveyor on 07/15/2022 at 10:23 AM, RN/UM #1 said "Yes, we need a physician order for supplements and yes, we need a physician order for mighty shakes or health shakes. Yes, we do use fortified foods and yes, we need a physician order for the fortified foods such as super mashed and super cereal." She went on to say the Certified Nursing Assistants have to record the amount of meal eaten on each shift and fluid taken as well. The nurses document it (supplement) on the MAR and put in the percentage consumed. During a follow up interview with RN #1 she revealed, "We do need a physician order for supplements" [redacted], health shakes). On 7/19/2022 at 10:01 AM, the surveyor observed the 10 AM snacks arrive on the unit. 6 Health shakes, 5 vanilla and 1 chocolate were on the tray. There were no Health Shakes for Resident #108 however, there was a 4-ounce cup of applesauce with his/her name on the tray. During an interview with the surveyor on 7/19/2022 at 10:07 AM, assigned LPN #2 said she picks up the AM Health Shake for Resident	F 658		

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 14	F 658		

#108 on her way in to give after his/her morning meds. He/she drinks it all.

During an interview with the Surveyor on 7/20/2022 at 11:30 AM, the dietician was asked what the process is to obtain supplements or other nutritional interventions. The Dietician responded, "The Health Shakes are supposed to come with meals from my understanding. A label is to be placed on the supplement from the kitchen and placed on the meal tray." The Kitchen is also to send sandwich snacks to unit for the residents. The dietician was asked if supplements require a physicians' order. The dietician replied, "No, I don't think I need an order for supplements, but I will check with the corporate Dietician." The dietician was questioned as to how you know if a resident is drinking the supplements. He said if a resident is on a supplement there is a report, we can run in the EMR. He also said that on the MAR the nursing staff is to record the percentage of supplement intake. Any supplement ordered for a resident is to be indicated on the MAR with the percentage of intake.

On 07/20/2022 at 12:44 PM, the dietician came back to the surveyor and said, "We do need a physician order for supplements (Health Shakes).

During an interview with the surveyor on 7/21/2022 at 01:20 PM, the DON said supplements are separate and distributed separate from the tray. The surveyor asked the DON if a physician's order is necessary for supplements. The DON agreed, "Correct we need a physician's order for supplements."

During a follow-up interview with the surveyor on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING _____ B. WING _____	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

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F 658	Continued From page 15 7/22/2022 at 11:37 AM, the DON said if the dietary workers read the ticket (meal) and it says health shakes it should be put on the tray. A review of a facility policy titled Facility On Nutrition Program with last revised date of 6/1/2019 revealed under policy section The facility will have an organized nutrition-related program. Under the Procedure section A facility Dietician will help assess the nutritional needs and risks of all residents and patients in the facility, and help the facility assure that it provides appropriate meals and other nutritional interventions. The policy does not indicate how often the residents are assessed. A review of a facility policy titled Physician Services with a revised date of 6/1/2019 revealed under Procedure section 5. A physician's order is needed for diets, therapies, wound treatments, and others. A review of a facility policy titled Nutritional Services with last revised date of 6/1/2019, revealed under the Procedure section 5. The use of nutritional supplements will be recommended by the Registered Dietician. Supplements will be individually labeled with resident name and delivered to nursing for administration. Intake of supplements will be recorded on the medication administration record (MAR). NJAC 8:39-27.1(a)	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		8/26/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 689	Continued From page 16 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident was not in possession of [redacted] supplies for 1 of 1 resident (Resident #88) reviewed for [redacted] This deficient practice was evidenced by the following: During the tour of 1st Floor unit on 07/12/22 at 10:41 AM, the surveyor observed Resident #88 lying in bed watching television. The surveyor also observed an open pack of [redacted] and a [redacted] on the overbed table next to the resident's bed. When interviewed, Resident #88 was unable to provide information about the open pack of [redacted]. The surveyor did not observe any residents walking about the unit. According to the Admission Record, Resident #88 was admitted with medical diagnoses that included: [redacted] Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected	F 689	Element #1 Staff immediately removed s[redacted] from the resident # 88. Resident and the resident sister were re-educated by Social Worker on the [redacted] policy and possession of materials. The resident sister verbalized understanding that [redacted] s will be given to the nurse. This was completed on 7/14/22 Element # 2 2. All residents who were identified as a [redacted] have the potential to be affected by the cited deficient practice. Element # 3 Staff members were in-serviced on smoking policy and [redacted] materials storage. Residents who were identified as a [redacted] and their family members were educated on the [redacted] policy. Unit Managers and or designees will continue evaluating and identifying [redacted] residents. Staff in-service will be given annually, during orientation for a newly hired employee and when deemed necessary. Resident who were identified as a [redacted] and their responsible party	

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

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PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

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F 689	Continued From page 17 that staff assessed the resident was [redacted] and required limited assist of one staff for activities of daily living. The MDS further indicated the resident was a smoker. Review of the Smoking Assessment, dated [redacted] indicated that Resident #88 exhibited signs of [redacted], was currently a [redacted] and had no history of [redacted] related incidents. The assessment did not address the level of supervision required or if the resident was allowed to hold his/her personal [redacted] supplies. Review of Resident #88's Care Plan (CP), initiated on [redacted], revealed a "Focus" area that indicted the resident was a [redacted]. The CP included an intervention, revised on [redacted], that Resident #88's [redacted] supplies were stored in the medication cart. On 07/15/22 at 10:04 AM, the surveyor observed Resident #88 resting in bed watching television. The surveyor observed a [redacted] on the overbed table next to the resident's bed. The surveyor did not observe any residents walking about the unit. During an interview with the surveyor on 07/15/22 at 10:23 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 stated that none of the residents on the unit were allowed to keep their own [redacted] supplies. LPN/UM #1 further stated that nursing kept all [redacted] supplies locked in the medication cart. LPN/UM #1 added that residents' families know that they're supposed to bring any [redacted] supplies to the nurse. When interviewed about Resident #88, LPN/UM #1 stated the resident was a [redacted]	F 689	will be educated on the facility□s [redacted] policy during admission and when deemed necessary. Element # 4 Unit Managers and or designee will complete weekly environmental/room audits x 4 weeks and then monthly x 3 months to ensure resident and resident responsible party are in compliance with the [redacted] policy and procedures. Any negative outcome of the audit will be corrected immediately by re-educating resident, staff and or the resident responsible party and removing the [redacted]. Results of the audits will be submitted to the QAA committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken	

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 689	Continued From page 18 [redacted] resident and was able to complete most tasks with supervision. LPN/UM #1 further stated that residents who [redacted] did not have to sign a [redacted] agreement and that a verbal understanding of the policy was enough. On 07/15/22 at 10:33 AM, the surveyor, accompanied by LPN/UM #1, entered Resident #88's room. At that time, LPN/UM #1 confirmed the surveyor's findings and noted the [redacted] positioned on the overbed table next to Resident #88's bed. LPN/UM #1 removed the [redacted] stated she would label it with the resident's name and lock it in the medication cart. LPN/UM #1 further stated the resident should not have had the [redacted] in his/her possession. During an interview with the surveyor on 07/21/22 at 1:46 PM, the Director of Nursing (DON) stated that staff were aware that Resident #88 should not have any [redacted] supplies in his/her possession. The DON further stated that she expected staff to remove any [redacted] supplies from the resident's possession. The DON added that the resident's [redacted] brought in the [redacted] and that she had to be reeducated on the [redacted] policy. A review of the facility's [redacted] Policy-Resident," revised July 2017, indicated that "Residents without independent smoking privileges may not have any [redacted] articles, including [redacted], etc., except when they are under direct supervision." NJAC 8:39-27.1(a)	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		8/26/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING _____ B. WING _____	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 19 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was	F 690	Element #1 1. Resident #100 s [redacted]	

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 690	Continued From page 20 determined that the facility failed to a.) maintain a [redacted] in a manner to promote dignity, b.) ensure the [redacted] did not come into contact with the floor, and c.) ensure the [redacted] was kept below the level of the [redacted] for 1 of 6 residents (Resident #100) reviewed for [redacted]. This deficient practice was evidenced by the following: On 07/12/22 at 10:39 AM, the surveyor observed Resident #100 lying in bed. The resident's [redacted] did not have a [redacted] cover and the [redacted] inside the bag was visible. The [redacted] was not secured to the resident's bed and was lying flat on the floor. On 07/14/22 at 11:46 AM, the surveyor observed Resident #100 sitting up in a [redacted] chair) in his/her room. The [redacted] was resting directly on the resident's [redacted] which were elevated by the [redacted] and was not secured to the resident's chair below the level of the resident's [redacted]. The [redacted] did not have a privacy cover. When asked at that time, the resident stated he/she liked having the [redacted] and requested a [redacted] cover. On 07/20/22 at 11:30 AM, the surveyor observed Resident #100's [redacted] was secured to the resident's bed rail and was not hanging below the level of the resident's [redacted]. According to the Admission Record, Resident #100 was admitted to the facility with diagnoses that included, but were not limited to, [redacted]	F 690	[redacted] was immediately changed with a [redacted]. The [redacted] was secured so that it was hanging below the resident□s [redacted] 2. CNA□s who were involved of the cited deficient practices were immediately re-educated on the importance of maintaining the [redacted] off the floor and below the resident□s [redacted] and covering the [redacted] with a [redacted] This was completed on 7/20/22 Element # 2 All residents who have [redacted] have the potential to be affected by the cited deficient practices. Element # 3 Inservice for Nurses and CNAs were initiated on 7/20/22 and ongoing on the importance of keeping [redacted] [redacted] off the floor, securing the bag below the residents□ [redacted] and maintaining resident dignity by putting [redacted] bag into the [redacted] CNAs were also in-serviced on reporting to the nurse if the [redacted] is found on the floor so it can be exchanged. Inservice will be given annually, during orientation for a newly hired nursing staff and when deemed necessary. Element # 4 Infection Preventionist or designee will conduct a weekly audit x 3 months, then monthly to ensure [redacted] are not touching the floor, kept below the level of the [redacted], and are covered with	

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F 690	Continued From page 21 [redacted] Review of Resident #100's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included the resident had a Brief Interview for Mental Status of [redacted] which indicated that the resident's cognition was [redacted] Further review of the MDS revealed the resident had an [redacted]. Review of Resident #100's [redacted] Physician Order Summary included an order to maintain the [redacted], dated [redacted]. Review of Resident #100's Care Plan (CP) included a focus that Resident #100 was "at an increased risk for [redacted] related to ... presence of [redacted]," and, "risk for reoccurrence of [redacted] related to [redacted]" Further review of the CP included a focus that Resident #100 had [redacted] in place with an intervention to "position [redacted] and [redacted] below the level of the [redacted] and away from the entrance room door and [redacted] cover," and, "secure catheter per facility protocol." Review of Resident #100's Progress Notes, dated [redacted] through [redacted], did not include any documentation of the resident manipulating his/her [redacted] and/or [redacted] cover.	F 690	[redacted] Negative results will be corrected immediately by re-education and or disciplinary actions as appropriate to assure that policy for the care of residents with [redacted] are followed. Results of the audits will be submitted to the QAA committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken	

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 22	F 690		

During an interview with the surveyor on 07/21/22 at 9:09 AM, Certified Nurse Aide (CNA) #4 stated that Resident 100's [redacted] should be hooked to the bottom of the bed and placed in a [redacted] cover for the privacy of the resident. CNA #4 further stated that the [redacted] should not be touching the floor and should be kept below the level of the [redacted] to prevent infection.

During an interview with the surveyor on 07/21/22 at 10:25 AM, Licensed Practical Nurse (LPN) #5 stated that a resident's [redacted] is kept in a [redacted] cover for the resident's dignity. LPN #5 further stated that the [redacted] should not touch the floor and be kept below the level of the [redacted] to prevent infection.

During an interview with the surveyor on 07/21/22 at 10:28 AM, Registered Nurse/Unit Manager (RN/UM) #2 stated the [redacted] should be placed in a [redacted] cover for the dignity of the resident. RN/UM #2 further stated it was important for the [redacted] to be kept below the level of the [redacted] and not touch the floor to prevent infection in the [redacted].

During an interview with surveyor on 07/21/22 at 1:15 PM, the Director of Nursing (DON) stated the [redacted] was placed in a [redacted] cover whether the resident was in bed or in a wheelchair. The DON also stated the [redacted] are to be kept off the floor and below the level of the [redacted] The DON further stated these procedures are important for infection control and dignity of the resident.

Review of the facility's [redacted]" policy, last revised 6/15/20, included under the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING _____ B. WING _____	07/26/2022

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PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

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F 690	Continued From page 23 procedure section, "do not allow the [redacted] to touch the floor," and to "keep the collection bag below the level of the [redacted]" Review of the facility's "Promoting/Maintaining Resident Dignity" policy, last revised 06/01/19, included compliance guidelines to "maintain the resident's privacy." N.J.A.C. 8:39-23.2(a)	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain a current physician order for dialysis for 1 of 1 resident (Resident #128) reviewed for [redacted] This deficient practice was evidenced by the following: During the tour of the facility on 07/12/22 at 10:59 AM, the surveyor interviewed Resident #128 who stated that he/she goes to [redacted] every week. According to the Admission Record, Resident #128 was admitted to the facility with diagnoses	F 698	Element #1 Physician order was immediately obtained for resident #128 for [redacted] Element # 2 All residents on [redacted] have the potential be affected by the cited deficient practice. Element #3 " License nurses were re- in-serviced on the facility□s policy to obtain and maintain physician order for residents on [redacted] This in-service will be given annually, during orientation of a newly hired license nurse and when deemed	8/26/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING _____ B. WING _____	07/26/2022

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PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

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F 698	Continued From page 24 that included, but were not limited to, [redacted]. Review of the Annual Minimum Data Set, an assessment tool utilized to facilitate the management of care, dated [redacted], reflected that Resident #128 was [redacted] and was receiving [redacted] Review of the Care Plan revealed a focus that Resident #128 received [redacted] weekly on [redacted], and [redacted]. Review of the Order Summary Report for Active Orders, as of [redacted], did not reflect a current order for [redacted] for Resident #128. During an interview with the surveyor on 07/15/22 at 12:44 AM, Registered Nurse/Unit Manager (RN/UM) #2 reviewed the physician orders in the electronic medical record for Resident #128 and confirmed there was no current [redacted] order in the electronic medical record. RN/UM #2 stated that the resident went out to the hospital and when the resident returned, the order was not carried over. During an interview with the surveyor on 07/15/22 at 2:05 PM, the Director of Nursing stated that Resident #128 should have had a [redacted] order. On 07/22/22 at 9:31 AM, RN/UM #2 provide a copy of the Physician's Orders which reflected an order dated [redacted] "TVO [telephone verbal order]/ [signed by] RN/UM#2, [redacted] on [redacted], [redacted]." Review of the Census for Resident #128 reflected that the resident was discharged and then	F 698	necessary. " Nursing admission checklist will be completed by the nursing supervisor/nurse unit manager for new and or re-admit residents to assure that resident who are admitted/re-admitted and are receiving [redacted] treatment have the physician order for the [redacted]. The completed checklist will be submitted to the Director of Nursing for review. Element #4 Director of Nursing and or nurse designee will complete a weekly audit x 4 weeks and monthly x 3 months to ensure that residents who receives [redacted] treatment have current physician order for [redacted]. Negative outcome will be corrected immediately through re-education and or disciplinary actions as appropriate. Results of the audits will be submitted to the QAA committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken.	

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F 698	Continued From page 25 readmitted to the facility two times in [redacted]. The surveyor observed that with each readmission, the facility did not provide documentation of a [redacted] order for Resident #128. Review of the facility's Physician Orders policy, last reviewed 06/01/2019, reflected that the physician shall "provide timely, accurate and complete orders." Review of the facility's [redacted] policy, created 10/20/2020, reflected "The facility shall ensure that residents who require[redacted] receive services consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences." NJAC 8:39-27.1(a)	F 698		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		8/26/22

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F 812	Continued From page 26 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner designed to prevent food borne illness. This deficient practice was evidenced by the following: On 7/12/2022 from 9:17 AM to 10:17 AM, the surveyor, accompanied by the Regional Food Service Director (RFSD), observed the following in the kitchen: 1. In the dry storage room on a lower shelf an opened bulk bag of rice had no dates and was exposed to the air. The FSD stated, "That's going in the garbage." 2. A stand up mixer was on top of a metal counter adjacent to the dietary office wall and was uncovered and exposed to dust and splash contamination. The surveyor asked the cook if he had used the mixer at any time since he had arrived to work. The cook replied, "No." The surveyor then asked the RFSD if the standup mixer was cleaned and sanitized. The RFSD then asked the cook if he had used the mixer. The cook replied, "No." The RFSD then stated, "That and the meat slicer should be covered or bagged between use." 3. On the designated pot/pan storage rack a stack of six 1/3 pans (a pan that measures	F 812	1a. The opened bulk bag of rice was disposed of. 1b. The stand up mixer was cleaned, sanitized, and covered with a plastic bag. 1c. The stack of six 1/3 pans were cleaned, sanitized, and air dried. The two half deep pans were cleaned, sanitized, and air dried. 1d. The opened bag of green beans in the walk-in freezer were disposed of. The bag of French toast slices were disposed of. 1e. The plates from the middle opening of the plate holder cart were cleaned, sanitized, and covered. 1f. The plastic container with a clear plastic lid in the resident fridge was disposed of. 1g. The black plastic take-out style container in the resident fridge was disposed of. 1h. The clear plastic portion control cups with clear plastic lids in the resident fridge containing red and white food were disposed of.	

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F 812	Continued From page 27 roughly 12 inches by 6 2/3 inches, generally used for serving side dishes on hot food bars) stored on the middle shelf of the pot/pan storage rack were in the inverted position. According to the RFSD the pans were cleaned, sanitized, and air dried. The surveyor lifted the top 3 1/3 pans and observed a watery, clear, wet substance on the outside and interior of each 1/3 pan. The RFSD stated, "I'm going to have to do an in-service on wet nesting." On the same shelf (2) half deep pans (a pan half the size of a full pan used to hold and serve resident foods) were stacked on top of each other in the inverted position. The pans were cleaned and sanitized, according to the RFSD. Upon removal of the top pan the RFSD and surveyor observed a wet, clear, watery substance on the bottom of the half pan beneath the top half pan and a clear, water like substance on the interior of the top half pan. The RFSD stated, "That's wet nesting. I'm going to in-service the staff on proper air drying." 4. In the Walk-In Freezer on an upper shelf an opened bag of green beans was removed from the original container and had no dates. The RFSD stated, "I'm going to pitch these." On a middle shelf a clear plastic bag contained frozen French toast slices and was removed from its original container. The bag had no dates. The RFSD removed to the trash. 5. A wheeled plate holder cart used to store, and heat cleaned, and sanitized plates used to serve resident meals was adjacent to the tray line and next to the food serving station. The cart had 3 separate openings to hold cleaned and sanitized plates. The middle opening contained plates that were not inverted and not covered. The plates were exposed to dust and splash contamination.	F 812	1i. The clear plastic portion control containers with clear plastic lids in the resident fridge containing yellowish food were disposed of. 1j. The clear plastic portion control container with a clear plastic lid in the resident fridge containing applesauce was disposed of. 2. The deficiencies cited under F812 are related to food storage, sanitation, and labeling. All residents have the potential to be affected by these deficient practices. 3. All dietary staff were in-serviced on proper dating and labeling. An in-service was also done with dietary staff regarding sanitary procedures for the mixer, hotel pans, and plates. 4. The food service director or designee are inspecting the kitchen and second floor pantry on a daily basis for proper labeling, sanitary procedures, and food storage. They are also ensuring that the staff is adhering to all in services. All findings will be given to the quarterly quality assurance committee.	

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 812	Continued From page 28 On 7/18/2022 from 9:02 AM to 9:20 AM the surveyor, accompanied by the Registered Nurse/Unit Manager (RN/UM #2) observed the following on the [redacted] floor resident pantry: 1. In the designated resident refrigerator on an upper shelf a plastic container with a clear plastic lid contained unidentified food. The container was labeled 7/16/22 and room [redacted] On the same shelf a black plastic take-out style container with unidentified contents was labeled 7/17/2022 and room [redacted] On a middle shelf (2) clear plastic portion control cups with clear plastic lids contained an unidentified red and white food (appeared to be [redacted] with whipped topping). The containers were dated "7/11." (3) clear plastic portion control containers with clear plastic lids contained a yellowish unidentified food (appeared to be vanilla pudding). One container was dated "7/16" and 2 containers were dated "7/15". A fourth clear plastic portion control container with a clear plastic lid contained what appeared to be applesauce. The container had no dates. On interview the RN/UM #2 stated, "The date on there is the date the food was put in the refrigerator." The surveyor explained to the RN/UM #2 that according to the facility policy all resident food placed in the fridge is to be labeled with the name, item and the "use by" date. The RN/UM #2 then stated, "Ok" and removed all the food items to the trash. The surveyor reviewed the facility policy titled Sanitizing Equipment, Last Review Date: 5/25/22. The following was revealed under the heading POLICY: "It is the policy of [facility name] to maintain clean	F 812		

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 812	Continued From page 29	F 812		

and sanitary equipment."

The policy further revealed under the heading PROCEDURE:

1) All equipment will be assembled, then cleaned. Next the equipment will be sanitized with Quat (quaternary ammonium, disinfectants used to kill bacteria, mold, and viruses) to ensure no food debris or bacteria are present.

2) Equipment will then be covered to designate that the piece of equipment is clean.

The surveyor reviewed the facility policy titled Wet Nesting, Last Review Date: 6/8/22. The following was revealed under the heading POLICY:

"It is the policy of [facility name] to maintain sanitary pots and pans for food service."

The following was revealed under the heading PROCEDURE:

Duties

5) Pots/Pans will be air dried before storing.

The surveyor reviewed the facility provided policy titled Label & Dating, Last Review Date: 4/18/22. The following was revealed under the heading Procedure:

Person responsible

Stock Person/All Food Service Staff

Dietary Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING _____ B. WING _____	07/26/2022

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PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

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F 812	Continued From page 30 Duties 1) All food items will be dated with the day it is received. 2) Any item removed from its original box will be dated with that date. 3) All food items prepped for service will be discarded after 72 hours. 4) All leftover foods from service will be discarded/froxen (sic) in 72 hours. The surveyor reviewed the facility provided policy titled Foods Brought by Family/Visitors, Revised October 2017. The following was revealed under the heading Policy Interpretation and Implementation: 7. Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. b. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the "use by" date. 8. The nursing staff will discard perishable foods on or before the "use by" date. 9. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). NJAC 8:39-17.2(g)	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly	F 814		8/26/22

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 814	Continued From page 31 CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris and to have a cover over the opening of 1 of 1 garbage compactors. This deficient practice was evidenced by the following: On 7/15/2022 at approximately 9:30 AM the surveyor, accompanied by the Regional Food Service Director (RFSD) observed a green trash/garbage compactor at the end of the facility loading dock. The compactor had (2) green metal doors in the open position and were secured in the open position with a bolt type latch on either side. The contents of the compactor were exposed and accessible. The contents consisted of garbage in clear plastic bags, loose surgical masks, and what appeared to be a blue mattress cover. On interview the RFSD stated, "Whoever dumps trash is responsible for closing the doors. Our staff is not trained on the compactor, so they don't go near it." 2. On the loading dock and opposite the door to the kitchen the surveyor observed (3) individual wheeled trash containers with their lids closed. On the ground in front of the trash cans the surveyor observed greater than 25 cigarette butts on the ground of the loading dock, as well as several clear plastic garbage bags and an empty 16 oz paper beverage cup.	F 814	1a. Both doors to the compactor were immediately closed. 1b. The cigarette butts from the ground of the loading dock were swept up and cleaned. The clear plastic bags and the paper cup were swept up and cleaned. 2. The deficiencies cited under F814 are related to sanitation, and proper garbage disposal. All residents have the potential to be affected by these deficient practices. 3. Housekeeping and dietary staff were in-serviced on garbage disposal and on the importance of keeping compactor doors closed and loading dock clean. 4. The Housekeeping/Food service director or designee are inspecting the loading dock area on a daily basis for proper garbage disposal and cleanliness. They are also ensuring that the staff is adhering to all in services. All findings will be given to the quarterly quality assurance committee.	

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 814	Continued From page 32 The surveyor reviewed the facility policy titled "Proper Procedure For Garbage Disposal", last review date: 4/18/2022. The following was revealed under the heading PROCEDURE: Person Responsible 1. Dietary/Housekeeping Duties 1. The dining services director coordinates with the director of housekeeping to ensure the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris. NJAC 8:39-19.3(c)	F 814		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		9/1/22

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 880	Continued From page 33	F 880		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 880	Continued From page 34 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent facility documentation, it was determined that the facility failed to ensure staff members wore the appropriate personal protective equipment (PPE; protective items or garments worn to protect the body) in a resident's room under contact precautions (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment) for 1 of 9 residents investigated under the Infection Control task. This deficient practice was evidenced by the following: On 7/13/22 at 8:58 AM, the surveyor observed two, Certified Nursing Assistants (CNA) and a housekeeping (HK) staff member in Resident #83's room. The CNAs were performing care on Resident #83 while he/she was in bed. The CNAs did not have gowns on. At that time, the surveyor observed a Contact Precaution sign. The Contact Precaution sign revealed, "Put on gown before room entry, discard gown before room exit." The surveyor also observed a bin outside of the door containing gowns. On the same date at 8:59 AM, during an interview	F 880	Element # 1 A. CNAs who were involved in the cited deficient practice were provided with one-on-one re-education by the facility's Infection Preventionist on 7/14/21 regarding the importance of following transmission-based precautions, PPE requirements, and proper donning and doffing of PPE for residents on transmission-based precautions. B. Root cause: " The CNAs who failed to properly don and doff proper PPE when entering the room of a patient on transmission-based precautions have received multiple in-services and training education for infection control practices, for proper PPE donning and doffing, and the importance of following procedure for transmission-based precautions, as well as COVID-19 prevention and control and many others but did not follow procedure while being observed due to stress and anxiety of being under observation. They felt worried about the surveyor watching them and were trying to hurry and get the task done so they could get out of the line of sight. Upon root cause analysis with CNA and other nursing staff members,	

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 880	Continued From page 35 with the surveyor, the HK staff member confirmed that the the two CNAs should be wearing gowns because they were doing care. On the same date at 9:06 AM, during an interview with the surveyor, CNA #1 stated, "It's completely my fault," when the surveyor asked why she was not wearing a gown while providing care. At that time, CNA #1 handed an [redacted] to the other CNA in the room. During an interview with the surveyor on 7/18/22 at 10:40 AM, the Infection Preventionist confirmed that staff should be wearing gowns when performing care on Resident #83. During an interview with the surveyor on 7/21/22 at 1:15 PM, the Director of Nursing stated, "Yes" in response to the surveyor asking if the the CNAs should have worn gowns while providing care to the resident. A review of Resident #83's 5-day Minimum Data Set (a clinical assessment tool) dated [redacted] and [redacted] revealed that Resident #83 was occasionally [redacted] A review of Resident #83's electronic medical record (EMR) revealed under "Orders" a physician's order to "Maintain contact isolation precautions due to [redacted] check isolation cart every shift to ensure supplies and signage are in place." A review of a facility policy titled, "Contact Precautions (In addition to Standard Precautions)" dated 6/2019 revealed under section, "5. Gown", to "Wear gown when entering	F 880	they felt the root cause was related to the anxiety and stress of being observed, as well as possible COVID PPE fatigue and the many times that CNAs are required to go through the donning and doffing procedures daily over the last two years. " The CNAs who failed to properly don and doff proper PPE when entering the room of a patient on transmission-based precautions also conveyed that they were confused about PPE requirements as there were multiple changes in PPE donning and doffing throughout the last few years which added to their confusion. " Lack of ongoing direct monitoring of CNAs from nursing top management during the provision of proper donning and doffing during transmission-based precautions to ensure consistent compliance with the infection control practices also contributes to poor sustainable compliance with the proper procedures. With the increasing guidance from the DOH, CMS during the COVID-19 pandemic, the facility is inundated with the additional tasks□ requirements. The facility has been challenged in hiring Nurse Unit manager, nursing supervisors, nurses, and CNAs because of the overabundance of nursing job availability in the area and the shortage of nursing staff across the state. Element #2 All residents who are on transmission-based precautions (TBP) have the potential to be affected by the cited deficient practice. Root Cause:	

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	315244	A. BUILDING _____ B. WING _____	07/26/2022

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F 880	Continued From page 36 resident/patient room if you anticipate that your clothing will have direct contact with the residents/patient, environmental surfaces, or items in the resident's patient's room, or if the resident/patient is incontinent..." N.J.A.C 8:39-19.4(a)	F 880	1. Based on NJDOH guidelines, there are multiple instances where residents are identified that require different types of transmission-based precautions and will require PPE during care. This is a high volume, problem prone area as it involves multiple CNAs working in three shifts, 7 days a week, placing a higher risk for potential non-compliance with PPE donning and doffing when caring for patients that are on transmission-based precautions. Element # 3 Re-education was initiated immediately and ongoing on the following: 1. Re-Education of CNAs related to proper PPE donning and doffing 2. Re-Education Training for Nursing Management on Infection Prevention and Control Program (module 1)-Topline staff and Infection Preventionist to view 3. CDC COVID -19 Prevention Messages for Front-line, Long-Term Care staff: Keep Out COVID-All staff to view 4. CDC COVID-19 Prevention Messages for Front line staff: Sparkling Surfaces-All staff to view 5. CDC COVID-19 Prevention Messages for Front Line Staff: Closely Monitor Residents-All staff to view 6. CDC COVID-19 Prevention Message for Front line. Long Term Care Staff: Use PPE correctly for COVID-19- All staff to view 7. Nursing Home Infection Preventionist Training Course- Module 5- Outbreaks-Topline Staff and Infection Preventionist to view	

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F 880	Continued From page 37	F 880	8. Nursing Home Infection Preventionist Training Course- Module 4- Infection Surveillance- Topline Staff and Infection Preventionist to view 9. Nursing Home Infection Preventionist Training Course- Module 7- Hand Hygiene- All staff, including topline staff and Infection Preventionist to view 10. Nursing Home Infection Preventionist Training Course- Module 6A- Principles of Standard Precautions- All staff including topline staff and Infection Preventionist to view 11. Nursing Home Infection Preventionist Training Course- Module 6B- Principle of Transmission Based Precautions- All staff including topline staff and Infection Preventionist to view 12. Verbal and written competency of PPE donning and doffing- All CAN 13. Establish schedule for on- going monitoring of PPE donning and donning compliance for ALL CNA□s 14. Develop an audit/skill competency check for PPE donning and doffing 15. Posting ads for additional nursing staff 16. The facility will develop and implement an infection signs and symptoms tracking tool to monitor all residents and staff for communicable respiratory infections. All nursing leaders will be educated on how to use the tool. Completed on 8/23/2022 Element #4 The infection preventionist will do an audit of five staff requiring PPE for resident room on transmission-based precautions weekly covering all shifts for 4 weeks and	

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F 880	Continued From page 38	F 880	then monthly for 3 months. The results of the observations/audits will be submitted during the monthly QAPI meeting as well as the quarterly Quality Assurance meeting. The infection preventionist, director of nursing, and other nursing leadership will alternately conduct rounds on all shifts throughout the facility to ensure all staff is exercising appropriate use of PPE (personal protective equipment) and to ensure infection control procedures are being followed, and any one noted to be in non-compliance will be investigated and addressed immediately. Initiated on 8/24/2022 The results of all audits will be reviewed by the QAA committee who will determine the necessity and the frequency of future audits.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other pertinent facility documentation, it was	F 881	Element # 1. The Infection Preventionist was	8/26/22

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F 881	Continued From page 39 determined the facility failed to implement [redacted] use protocols to prevent the use of unnecessary [redacted] (medications used to [redacted]) by continuing a prescribed [redacted] found to be ineffective against a [redacted] for 1 of 9 residents (Resident #83) investigated under the Infection Control task. This deficient practice was evidenced by the following: On 7/13/22 at 9:06 AM, the surveyor observed Resident #83's room had a Contact Precaution (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment) sign in the doorway. At this time, during an interview with the surveyor, Certified Nursing Assistant (CNA) #1 stated that Resident #83 had a [redacted] A review of Resident #83's Electronic Medical Record (EMR) under "Prog (progress) Note" revealed a Nursing/Clinical note dated [redacted] at 7:37 AM, that revealed an order was given for a [redacted] (test used to show [redacted] A review of Resident #83's EMR under "Results" revealed the [redacted] was collected on [redacted]2 and the result was received on [redacted]. The result revealed that [redacted] was resistant to [redacted]. A review of Resident #83's EMR revealed under "Orders" that he/she had the following orders; an order for [redacted] mg	F 881	immediately re-in-serviced/educated on antibiotic stewardship/time-out to ensure that antibiotic use protocols are followed. This was completed on 7/14/22 Element # 2 All residents receiving antibiotics have the potential to be affected by the cited deficient practices. Element # 3 License nurses were re-in-serviced/educated regarding proper procedures for antibiotic stewardship/time-out policy and procedures to ensure that antibiotic use protocol is being followed and unnecessary antibiotic use is reviewed with the physician/Nurse Practitioner. This in-service will be given annually, during orientation of a newly hired license nurses and when deemed necessary. Element # 4 The Infection Preventionist will complete a daily audit for residents who have new order for antibiotic x 4 weeks and will review diagnostic/laboratory results to ensure compliance with facility□s antibiotic use protocols. And then weekly x 3 months. The results of the audit will be submitted to the Director of Nursing. Negative outcome will be corrected immediately through re-education and or disciplinary actions as appropriate by the DON Regional Infection Preventionist and or nurse designee will perform monthly audits x 6 months for residents on	

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F 881	Continued From page 40 (milligram) started on [redacted] prescribed as a [redacted] (gram) solution started on 7/12/22 prescribed to treat a [redacted] (a [redacted] and a discontinued order of [redacted] mg started on [redacted] and discontinued on [redacted] prescribed to treat a [redacted] A review of Resident #83's Medication Administration Record (MAR) revealed that [redacted] continued to be administered until [redacted] days after the [redacted] revealed [redacted] was resistant to [redacted] Further review of Resident #83's EMR revealed under "Care Plan" that Resident #83 had a [redacted] During an interview with the surveyor on 7/14/22 at 1:14 PM, the Infection Preventionist (IP) stated she thinks staff should have contacted the doctor on what to do once the [redacted] result was received. She further stated that the facility does not perform [redacted] time-outs (active assessment of an [redacted] prescription that occurs 48-72 hours after first administration). A review of Resident #83's EMR under "Prog Note" revealed a late entry Physician/Practitioner Progress Note created on [redacted] at 12:56 PM, after the surveyor interviewed the IP, that stated [redacted] to continue." A review of the facility policy titled, "[facility name] Antibiotic Stewardship Policy for Long-Term Care Facilities" with an implementation date of 1/1/18, under section "4. Antibiotic Stewardship Actions"	F 881	antibiotic use to ensure that antibiotic use protocol/ antibiotic utilization/time out is completed to prevent the use of unnecessary antibiotic use. Negative outcome will be corrected immediately through re-education and or disciplinary actions as appropriate by the Director of Nursing Results of all audits will be submitted to the QAA committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken.	

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F 881	Continued From page 41 subsection "iv. Antibiotic 'time-out'" revealed, "At 72 hours after antibiotic initiation or first dose in the facility, each resident will be reassessed for consideration of antibiotic need, duration, selection, and de-escalation potential." The policy further revealed that, "At this time, laboratory testing results, response to therapy, resident condition, and facility needs (e.g.; outbreak situation) will be considered. Completion of an antibiotic time-out must be recorded in the resident record." NJAC 8:39-19.4(a)	F 881		