STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315195	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT BERKELEY HEIGHTS	35 COTTAGE STREET BERKELEY HEIGHTS, NJ 07922

(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
F 000	INITIAL COMMENTS STANDARD SURVEY: 09/23/2020 CENSUS: 67 SAMPLE SIZE: 22 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F 578		10/16/20

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

Electronically Signed | 10/12/2020

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F 578	Continued From page 1 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to inform and offer a resident's guardian, the opportunity to formulate an Advance Directive. This deficient practice was identified for Resident #37, 1 of 6 residents reviewed for Advance Directives and was evidenced by the following: Review of the Admission Record revealed Resident #37 was admitted to the facility on [redacted] with diagnoses that included, but were not limited to: [redacted] Review of the County Surrogate's Court record, dated [redacted], revealed Resident #37's family member was deemed his/her [redacted]. The document further revealed, "In conclusion, taking the time to consider, and even execute, basic advance directive can be a valuable tool for you,	F 578	F578 Compliance Due Date: 10/16/2020 Corrective Action: Resident #37 medical record was reviewed for the deficient practice. The guardian was notified and offered information regarding Advance Directives. A review of all residents, regardless of intellect and/or guardianship status, by Social Services, will be done to ensure an Advance Directive has been offered to the resident or the resident's representative. Any findings found lacking in the audit will result in contacting the resident or the resident's representative and information regarding Advance Directives will be provided. If the resident can comprehend the Advance Directive information, it will be provided to them. Identification of at risk residents: All residents admitted to the facility are	

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F 578	Continued From page 2 your family, friends, and trusted confidantes as they try to honor your wishes and make decisions on your behalf when you are unable to do so." Review of Resident #37's Order Summary Report, Care Plan, Medication Administration Record, and Treatment Administration Record did not reveal the guardian formulated an Advance Directive. During an interview with the surveyor on 09/17/2020 at 1:57 PM, the Director of Nursing (DON) stated there was no Advance Directives that the facility was aware of for Resident #37. The DON acknowledged someone should have addressed the Advance Directive at some point, since the resident was admitted in [redacted] During an interview with the surveyor on 09/18/2020 at 11:04 AM, the DON stated that the previous Social Worker (SW) documented about addressing the Advance Directive with Resident #37's [redacted] and that the [redacted] wanted to execute an Advance Directive. The DON stated she had called the [redacted] who informed the DON that he was under the impression the POLST (Physician's Order for Life Sustaining Treatment) was the same as the Advance Directives. The DON acknowledged that the Advance Directive and the POLST were not the same. The DON stated Resident #37 had been in the hospital and was readmitted to the facility on [redacted] but there was no record of an Advance Directive being addressed at that time either. During a telephone interview with the surveyor on 09/18/2020 at 11:20 AM, Resident #37's guardian stated he/she would have liked to have an Advance Directive and was under the	F 578	potentially at risk for the deficient practice. This will be identified by reviewing the resident's medical record. Systemic Changes: The Social Service Director was in-serviced by the Administrator on the facility's policy and procedure on Advance Directives. Upon admission to the facility, Social Services will discuss and provide written information to formulate an advance directive if they choose to do so. Information about whether or not the resident has executed an advance directive shall be displayed in the medical record. Social Services will provide a plan of care for each resident that will be consistent with his or her documented treatment preference and/or advance directive. Quality Assurance: The Director of Social Services will provide a copy of the audit conducted of Advance Directives of 10 residents monthly, with both acceptance and declinations, to the Administrator and DON. Any issues will be addressed immediately. Results will be reported to Administrator as well as to the QA/QAPI Committee quarterly for 6 months or until compliance is met.	

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impression the POLST was the same thing. The guardian stated someone may have mentioned Advance Directives but he/she did not receive additional information about them. The [redacted] stated he/she was interested in an Advance Directive for Resident #37.

During an interview with the surveyor on 09/18/2020 at 12:04 PM, the SW stated she was not the SW when Resident #37 was admitted or readmitted to the facility. The SW stated she spoke to the [redacted] and educated him/her on Advance Directives. The SW stated the guardian informed her he/she was never provided with papers explaining Advance Directives. The SW further stated the guardian was interested and was going to begin the process. The SW stated she was unable to provide documentation that the [redacted] had been provided the Advance Directive information or any follow up conversation.

During an interview with the surveyor on 09/22/2020 at 9:37 AM, the Licensed Practical Nurse Unit Manager (LPN/UM) stated that an Advance Directive addressed living wills and power of attorney, where as, a POLST addressed a code status for emergency treatment. The LPN/UM stated that the SW would be responsible for obtaining the Advance Directive and that if a resident had an Advance Directive, it would be kept in the physical medical chart. The LPN/UM stated that Advance Directive was part of the Interdisciplinary Team Care Plans (ITCP) with the Minimum Data Set (MDS) coordinator. The LPN/UM reviewed the [redacted] and [redacted] ITCP summaries, located in the physical medical chart, and noted the there was conflicting

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information regarding the Advance Directive. The [redacted] summary indicated there was an Advance Directive, while the [redacted] and [redacted] summaries indicated there was not an Advance Directive. The LPN/UM acknowledged she had signed all three forms.

During an interview with the surveyor on 09/22/2020 at 9:51 AM, the MDS coordinator Registered Nurse (MDS/RN) stated that she would usually check "no" under Advance Directive unless she saw the Advance Directive in the physical medical chart. The MDS/RN stated she would be the one to verify the information on the form and could not speak to why the ITCP, dated [redacted] was checked "yes" for Advance Directive. The MDS/RN acknowledged she had signed all three forms.

Review of the "Social Service Admission/Readmission Note," dated [redacted], revealed, "resident's [family member] states that [he/she] does not have an advanced directive however would like one. Resident's [family member] is appointed POA [Power of Attorney]."

Review of the facility "Advance Directives" policy, dated 10/2019, revealed that upon admission, the resident (or if resident was incapacitated and unable), the legal representative, would be provided with written information to formulate an advance directive if they choose to do so. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The plan of care for each resident will be consistent with his or her documented treatment preference and/or

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F 578	Continued From page 5 advance directive. NJAC 8:39-4.1(a)(31)(iii)(33)(b), 9.6(d)(e)(f)	F 578		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 ensure a.) a comprehensive care plan was developed for a resident who experienced pain and b.) implement non-pharmacological interventions for a resident who did not like taking [redacted] medication. This deficient practice was identified for Resident #23, 1 of 1 resident reviewed for [redacted] and was evidenced by the following: On 09/16/2020 at 10:30 AM, during the initial tour, the surveyor observed Resident #23 lying in bed, eyes closed. The resident was gripping the call bell in his/her left hand. The surveyor observed that the resident's [redacted] On 09/17/2020 at 10:17 AM, the surveyor interviewed Resident #23 while the resident was lying supine in bed. The resident stated, [redacted] medicine.	F 697	F697 Compliance Due Date: 10/16/2020 Corrective Action: Resident #23 medical record was reviewed for the deficient practice. A pain care plan has been initiated including non-pharmacological interventions. All residents requiring pain management medical records were reviewed by the Director of Nursing (DON) to ensure a comprehensive care plan addressing pain. This includes non-pharmacological interventions and documentation in the medical record. Any findings of the result will be corrected at the time of discovery. Nursing staff will be in-serviced by the Assistant Director Of Nursing(ADON) or designee, when an order is obtained for [redacted] management. A care plan must be initiated to include non-pharmacological interventions. Identification of at risk residents: All residents are potentially at risk for the	10/16/20

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F 697	Continued From page 6 On 09/18/2020 at 8:16 AM, the surveyor interviewed Resident #23 while the resident was lying supine in bed. The resident stated, [redacted] The surveyor reviewed Resident #23's medical record: The Admission record indicated the resident was admitted to the facility with diagnoses that included: [redacted]. The admission Minimum Data Set (MDS), a tool used to facilitate the management of care, dated [redacted], revealed the resident had a Brief Interview of Mental Status score of [redacted], which indicated the resident was [redacted] impaired. The MDS also included, under [redacted] Management, that the resident [redacted] experienced [redacted], received scheduled, PRN (as needed) or [redacted] medication during the last 5 days and that the resident did not receive non-medication interventions for pain. Review of the Order Summary Report (OSR), dated [redacted], revealed the following physician orders (PO): [redacted] for [redacted] every 6 hours as needed for [redacted] for [redacted] MG, give 1 capsule by mouth at bedtime for [redacted] for [redacted] MG (milligrams), give [redacted] tablet by mouth one time a day for [redacted] give [redacted] tablets to = [redacted]; for [redacted] MG	F 697	deficient practice. This can be identified by reviewing the physician□s orders and medication administration record. Systemic Changes: The facility policy and procedure on [redacted] management has been reviewed and no changes are warranted at this time. All nursing will be in-serviced by the DON/ADON on the facility□s policy on [redacted] management, initiating care plans that include non-pharmacological interventions, and documenting in the resident□s medical record. Quality Assurance: The Unit Manager will review all new admissions□ charts daily to ensure a care plan is initiated to address [redacted] management, and to include non-pharmacological interventions based on the resident□s assessment. The Unit Manager/Director Of Nursing or designee will do weekly audits coinciding with the care plan calendar, to monitor [redacted] management care plans to include non-pharmacological interventions. Any issues will be corrected immediately. Findings will be reported to the Administrator as well as the QA/QAPI, quarterly for six months or until compliance is met.	

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(, give 2 tablet by mouth two times a day for

Review of an admission Evaluation, dated , revealed the resident had which increased with movement and was relieved by repositioning and medication. The likely cause of the was a and that the resident had a medication regimen that included and . The current non-pharmacological interventions section indicated the resident received PT/OT (physical therapy and occupation therapy). The area for were left blank. The Plan of Care area indicated there was satisfactory management and to continue with the current plan of care.

Review of Resident #23's care plan revealed there was no care plan for . A care plan with a focus related to the initiated on , with a goal for the resident to remain free of infection and show signs of healing did not include interventions for management. A care plan with a focus of and the resident's non-compliance with repositioning was initiated on with a goal of healing the , included an intervention to treat as per orders prior to treatment/turning etc. to ensure the resident's comfort.

Review of an physician consultation, dated , revealed a recommendation to for patients

Review of the MD/APRN/PA/NP General Notes

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documented in the Progress Notes (PN) revealed the following:

The PN, dated [redacted] at 21:57 (9:57 PM), included that the resident was hospitalized from [redacted] after a [redacted] and underwent a [redacted] ." On [redacted], the resident stated his/her [redacted] ." On 07/20/2020, "Pt [patient] reported [his/her] [redacted] Does not want to take [redacted] as it affected [his/her] mental clarity."

The PN, dated [redacted] at 15:00 (3:00 PM), indicated, [redacted] .' The patient reports [he/she] is afraid to take more [redacted] " The treatment plan revealed [redacted] medications will be adjusted as necessary.

On 09/18/2020 at 10:21 AM, the surveyor interviewed a physician who cared for Resident #23 regarding the resident's [redacted] management. She stated that the resident complained of [redacted] when the resident was moved. The surveyor inquired as to the recommendation received from the [redacted] physician for a [redacted] management consultation. She stated a [redacted] management consultation was not ordered because we asked [redacted] how [redacted] was and the [redacted] made the resident comfortable.

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F 697	Continued From page 9 On 09/18/2020 at 10:49 AM, the surveyor interviewed the Unit Manager (UM) who reviewed the resident's care plan and confirmed the resident did not have a care plan for [redacted]. The UM stated the resident was transferred from the [redacted] and that should have been care planned for [redacted] since the beginning. On 09/22/2020 at 9:27 AM, the surveyor interviewed Resident #23 who was lying supine in bed. The resident stated his/her [redacted], but they [redacted] very much, especially during the night and if he/she asked for [redacted] it was provided. The resident further stated the [redacted] did not keep him/her awake. On 09/22/2020 at 12:07 PM, the surveyor interviewed the UM regarding non-pharmacological interventions that were available and could be considered for residents who are [redacted]. She stated examples could be re-positioning the resident, distracting the resident and offering the resident a snack. She stated if Resident #23 had those types of interventions they would be documented in the resident's care plan. The UM located a recently initiated care plan, dated [redacted], with a "Focus" that the resident is receiving [redacted] medication due to [redacted] and [redacted]. The "Interventions" included to administer medications as ordered and did not include non-pharmacological interventions. On 09/23/2020 at 8:23 AM, the surveyor interviewed the Certified Nurse Aide (CNA #1) who stated she had not taken care of the resident in a few weeks and there were no complaints of [redacted] at present. She stated she used to take care of the resident when the resident was admitted	F 697		

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and the resident had complaints [redacted]

On 09/23/2020 at 9:12 AM, the surveyor interviewed Resident #23, who was sitting upright in bed, in the resident's room. The resident stated he/she did not like taking [redacted] medication because he/she did not like the way it made him/her feel. The resident was interviewed about other options that he/she thought would help [redacted] The resident stated the first time that the facility discussed [redacted] medication options to help him/her alleviate [redacted] was yesterday.

On 09/23/2020 at 9:42 AM, the surveyor interviewed the Rehabilitation Director who stated the resident was not presently on the caseload. The Rehabilitation Director provided the surveyor with the resident's initial Occupational Therapy Assessment, dated [redacted] which revealed the resident had [redacted] at a level of [redacted] at that time. She stated to the surveyor that [redacted] was a [redacted] and that [redacted] was in the middle. She stated the resident was not currently receiving therapy. The Rehabilitation Director stated she was part of the interdisciplinary team and that the rehabilitation department was available to be consulted for [redacted] management. She stated rehabilitation could be consulted by the physician or nursing and that depending on the appropriateness, there were other options that rehabilitation could offer for [redacted] management. Options could include [redacted] She stated that on [redacted], a therapy screen was received for Resident #23. The screening was specific to [redacted] with standing and walking. She stated

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the [redacted] would help to relieve pressure and maybe help with pain when the resident was standing or walking and could make the resident more comfortable.

Further review of the Occupational Therapy Evaluation, dated [redacted], revealed a verbal pain assessment was completed by the occupational therapist and the resident verbalized intermittent throbbing and [redacted] in the [redacted] at a [redacted] of [redacted] at rest. [redacted] upon movement increased to a [redacted] level of [redacted] and was constant. The [redacted] limited bed mobility, transfers and self-care tasks. The [redacted] management was over-the-counter remedies and sitting, standing, and prolonged activity exacerbated [redacted]

On 09/23/2020 at 9:50 AM, the survey team conducted a telephone interview with Resident #23's attending physician. The attending physician stated that "initially we thought the resident had [redacted], and then the resident developed [redacted] and then [redacted] is definitely contributing to the resident's [redacted] She further stated that the non-pharmacological interventions for [redacted] were that the staff went in and spoke with the resident. She stated non-pharmacological interventions for [redacted] were always important and should always be taken into consideration.

Review of the [redacted] Clinical Protocol Policy, reviewed and updated 11/2019, revealed under Treatment/Management, "With input from the resident to the extent possible, the physician and staff will establish goals of [redacted] treatment; for example, freedom from [redacted] with minimal

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(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
F 697	Continued From page 12 medication side effects, less frequent headaches, or improved functioning, mood, and sleep. The physician will order appropriate non-pharmacologic and medication intervention to address the individual's [redacted] Staff will provide the elements of a comforting environment and appropriate physical and complimentary interventions; for example, [redacted]	F 697		
F 812 SS=E	NJAC 8:39-27.1(a) 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. §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 document review, it was determined that the facility failed	F 812	F812 date: 10/16/2020 Completion	10/16/20

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F 812	Continued From page 13 to a.) label and date potentially hazardous food to ensure they are not used beyond their use by date, b.) maintain the ice machine in a manner to prevent microbial growth and cross contamination, and c.) store resident food items in a unit refrigerator in a manner to ensure they are not used beyond their date of expiration. This deficient practice was evidenced by the following: On 09/16/2020 at 8:54 AM, the surveyor began touring the kitchen with a Cook (Cook #1) and observed the following: Inside the walk-in refrigerator on a wheeled cart was the following: A cardboard box, labeled "keep frozen," contained a bag of defrosted diced chicken which was dated 8/18, use by 11/18. Cook #1 stated she could not locate a date the chicken was defrosted or a use by date. Three bags containing raw chicken breasts. One bag was opened and re-sealed. There was no use by date on any of the bags. Cook #1 confirmed the chicken was not dated. On 09/16/2020 at 9:24 AM, two managers (M#1 and M#2) from the food service management company joined the tour. On 09/16/2020 at 9:26 AM, the surveyor interviewed a Cook (Cook #2) who stated that when you take something out of the freezer, you date it as soon as you pull it out. He then showed the surveyor a pull sheet and stated the chicken items were not listed.	F 812	Corrective Action: Raw chicken and diced chicken inside walk-in refrigerator on a wheeled cart with no use by date discarded immediately. Metal pan containing defrosted chicken thigh with no use by date discarded immediately. All small yogurts with expired manufacture dates discarded immediately. Dietary and nursing staff educated by Director of Dietary Services and Director of Nursing on policy and procedures for labeling and dating all food brought in by families and stored on nursing units. Nursing staff will monitor all refrigerated food brought in from families and check refrigeration on units daily for expiration dates. Dietary staff educated by Food Service Director on facility food storage and labeling and dating policy. The large ice machine containing a pink substance emptied and put out of service immediately. Dietary staff sanitized ice machine inside and outside and maintenance cleaned all filters before ice machine put back in service. Daily, weekly and monthly cleaning schedules/logs revised. All kitchen equipment including ice machine scheduled for routine cleaning. Identification of At Risk Residents: All residents have the potential to be affected by not Storing, preparing, distributing and serving food in accordance with professional standards for food service safety.	

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F 812	Continued From page 14 A metal pan containing defrosted chicken thighs did not contain a use by date. M#1 confirmed she could not locate a date. The surveyor observed a pink substance on the corner of the baffle located inside of the large ice machine. The pink substance was able to be removed with a paper towel. M #1, M #2 and Cook #1 were present and stated the ice machine was not clean. On 09/16/2020 at 12:23 PM, two surveyors toured the [redacted] pantry with the Unit Manager (UM) and observed the following manufacturer expiration dates on small yogurt containers: 1-07/13/2020; 1-01/19/2020; 2-01/28/2020; 2-08/14/2020; and 1-09/12/2020. The yogurts were stored inside a plastic bag with Resident #23's name on them. The freezer contained a pint of ice cream that was un-labeled and un-dated. The container was filled with ice build-up on top of the ice cream. The UM stated the kitchen was responsible for monitoring the refrigerator and she would discard all of the items. On 09/16/2020 at 2:00 PM, the district manager for the food service management company provided the surveyor with the following policies: Labeling and Dating Inservice, undated, which revealed that all foods should be dated upon receipt. Before being stored, food labels must include the food item name, the date of preparation/receipt of removal from freezer. Items that are removed from a labeled case in the freezer and placed in the refrigerator for thawing should be labeled with the date of	F 812	Systemic Change: All dietary staff in serviced by Director of Food Service on daily, weekly and monthly cleaning schedules/logs including the ice machine. All dietary staff and nursing staff education on labeling and dating policies by Food Service Director and Director of Nursing on policy and procedure conducted upon hire, monthly, annually and as needed. Dietary education on cleaning schedules/logs conducted upon hire, monthly, annually and as needed by Food Service Director. Quality Assurance: Weekly audit conducted by the Food Service Director/Cook/Designee regarding maintaining ice machine cleanliness. If ice machine identified as dirty or scheduled cleaning not completed, ice machine will be put out of service until cleaned. Weekly audit conducted by the food Service director Cook/Designee regarding labeling and dating policies. Any issue identified during audit will be corrected immediately and further action determined. All issues found with cleanliness and labeling and dating will be brought to Administrator/Designee attention immediately as well as the Quality Assurance Committee/QAPI Quarterly for 6 months or until compliance is met	

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F 812	Continued From page 15 removal from the freezer and an appropriate "use by" date. The Food Storage: Cold Foods Policy, dated 5/2014, revealed all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. The Ice Policy, dated 05/2014, revealed ice will be prepared and distributed in a safe and sanitary manner. Ice bins will be cleaned monthly and as needed. The Food Brought by Family/Visitors Policy, undated, revealed the food service staff was responsible for discarding perishable foods on or before the "discard" date. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, date received, and the "discard' date. NJAC 8:39-17.2(g)	F 812		
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	F 880		10/16/20

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F 880	Continued From page 16	F 880		

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 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

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F 880	Continued From page 17 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. 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 pertinent facility documentation, it was identified that the facility failed to ensure staff appropriately donned and doffed Personal Protective Equipment for a resident on droplet Transmission-Based Precautions. This deficient practice was identified for Resident #168, 1 of 2 residents reviewed for infection control practices for new and re-admissions to the facility and was evidenced by the following: On 09/16/2020 at 9:14 AM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) regarding the facilities infection control practices for new and re-admissions into the facility. The ADON/IP stated that all new and re-admissions that entered the facility were monitored for 14 days for signs and symptoms of COVID-19. The ADON/IP stated that the facility only admitted residents from the hospital that had tested negative for COVID-19. The ADON/IP further	F 880	F880 Completion date: 10/16/2020 Corrective Action: Resident # 168 medical record was reviewed. All resident on transmission based precautions medical records reviewed no issues found. The NP and Housekeeper were in Serviced on Transmission based precautions, donning and doffing of PPE and Hand hygiene. Facility-wide in-service included attending physicians and APNs was done by the Infection Control Preventionist on the facility Infection Control policy and procedure and CDC guidelines regarding transmission based precautions. Staff in-service on the different categories of Transmission Based Precautions, that i.e., CONTACT PRECAUTION, Droplet precaution and Air Borne precaution with the appropriate PPE (gowns, gloves surgical mask, N-95 OR k-95 mask,	

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F 880	Continued From page 18 stated that the Personal Protective Equipment (PPE) the staff were required to wear when caring for the new and re-admission residents included a gown, N95 or KN95 mask, gloves, goggles, and a face shield. On 09/16/2020 at 10:44 AM, the surveyor observed signage posted outside of Resident #168's door that indicated the resident was on transmission-based-precautions and specific PPE needed to be applied prior to entering the resident's room. The sign indicated to stop before entering the room because the resident was on droplet precautions and in addition to standard precautions everyone must clean hands when entering and leaving the room, wear a mask, wear eye protection, wear a gown, and wear gloves. Pictures of hands utilizing ABHR, a person wearing a mask, goggles, a gown, and gloves were also displayed on the signage. Outside of the resident's room the surveyor observed a plastic bin stocked with PPE which included disposable gowns, washable gowns, K95 masks, face shields, and gloves. During that time, the surveyor observed Resident #168 lying in bed. A facility staff member was observed standing next to the resident's bed wearing a gown, gloves, and a surgical mask. The surveyor did not observe the staff member wearing a face shield, goggles, a KN95 or N95 mask. At 10:45 AM, the surveyor interviewed the staff member after she exited the room. The NP identified herself as the resident's Nurse Practitioner (NP). The NP stated that the resident's COVID-19 test was negative and the resident had been residing at the facility for 10	F 880	Specialized Respiratory mask goggles/face shields). Staff were educated on donning and doffing PPE as well as Hand hygiene with return demonstration. Identification of at risk residents: All residents are potentially at risk for this deficient practice. This can be identified by reviewing the physician order, Electronic treatment record Electronic medication records and signage posted on the entrance of resident' room Systemic Changes: All staff will be re-in-serviced by the Infection Control Preventionsst or designee on hand washing, donning and doffing PPE, Appropriate PPE for the different categories of isolation and evaluated through a competency and demonstration. UPON Hire to the facility, Staff will receive in-serviced and competency on hand washing, Donning/doffing PPE and appropriate PPE per facility policy and CDC guidelines by the Infection Control Preventionist The IP will perform a daily documented Infection Control rounds the ensure staff are compliance with transmission Based Precaution as per facility infection control policy and procedure and CDC guidelines. Any issues observed during rounds will be addressed immediately. Quality Assurance: A weekly Random audit of 5 staff members including Physicians and APN/NP, will be conducted by the Infection Preventionist	

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F 880	Continued From page 19 days. The surveyor inquired about droplet precautions. The NP stated that she had to wear a gown, gloves, N95 mask, and a face shield when she was in the room with the resident. The NP stated she was not wearing a N95 mask or a face shield when she was in the room with the resident because she did not have them available. On 09/16/2020 at 11:28 AM, the surveyor interviewed the resident who stated that he/she had been residing at the facility for about a week and everything was good. On 09/17/2020 at 10:02 AM, the surveyor observed a housekeeping staff member (HKSM) exit Resident #168's room without removing his PPE. The HKSM was observed wearing a surgical mask, face shield, gown, and gloves. After exiting the room, the HKSM walked across the hallway to the housekeeping cart, picked up a mop and then re-entered the resident's room and began to mop the floor. After mopping the floor, the surveyor observed the HKSM exit the resident's room, without removing his PPE, walk over to the housekeeping cart across the hall, gather additional cleaning supplies and then re-enter the resident's room. The surveyor observed that the PPE bin outside of the resident's room was stocked with PPE. On 09/17/2020 at 10:42 AM, the surveyor interviewed the HKSM who stated that before exiting the resident's room he was required to remove his PPE and wash his hands. The surveyor reviewed the medical record for Resident #168.	F 880	or designee on Handwashing and donning/Doffing PPE to ensure Infection Control compliance. Any issues will be immediately addressed and results will be reported to the Administrator as well as the Quality Assurance Committee /QAPI Quarterly for 6 months or until compliance is met.	

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F 880	Continued From page 20	F 880		

A review of the resident's Admission Record indicated that the resident was recently admitted to the facility and had diagnoses which included, but were not limited to: [redacted].

A review of the resident's most recent admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] reflected that the resident had a Brief Interview of Mental Status (BIMS) score of [redacted], which indicated the resident was alert with confusion.

A review of the resident's September 2020 Treatment Administration Record (TAR) revealed a Physicians Order (PO) dated [redacted] for droplet precautions for COVID-19 prophylaxis every shift for prevention for 14 days. A further review of the September 2020 TAR reflected that the nursing staff signed that droplet precautions were maintained for the resident.

A review of the resident's laboratory results dated [redacted] indicated that COVID-19 was not detected.

A review of the resident's Care Plan (CP), dated [redacted], reflected that the resident had a focus area for isolation precautions for droplet precautions. The goal of the CP reflected that the resident was on droplet precautions to prevent the transmission of infectious agents to other residents' and the environment. The interventions for the CP included staff would adhere to hand hygiene policy, dedicate equipment to the resident, and staff to wear

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F 880	Continued From page 21	F 880		

protective gear as needed and ordered.

On 09/23/2020 at 11:57 AM, the Director of Nursing stated that the NP and housekeeping staff were in-serviced on appropriate usage of PPE and hand hygiene.

A review of the in-service education provided by the facility, dated 09/22/2020 and timed at 3:00 PM, indicated that the housekeeping staff members were educated on Infection Control Practices. The in-service indicated, "Policy and Procedure was reviewed with employees that when cleaning an isolation room staff must wear full PPE before entering in droplet precaution room; KN95's, gowns, face shield, gloves, and proper hand washing. Also proper clean and disinfect or sterilize reusable equipment before use of another resident's room. Employees must keep the housekeeping cart directly to the room that has been worked on, and PPE must be remove[d] before exit the room."

A review of an e-mail communication between the facilities Administrator and NP, dated 09/22/2020 and timed at 6:41 PM, reflected that the NP was made aware of CDC guidelines regarding the proper use of PPE and isolation precautions for resident's and self.

A review of the facility's Policy and Procedure titled, "Monitoring New and Re-Admissions for Possible COVID-19," dated 05/14/2020, indicated that new and re-admitted residents would be screened for COVID-19 and be placed in an isolation room for 14 days with Droplet isolation precautions instituted, with Full PPE when providing care. IE (mask, gown, gloves, eye shield).

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F 880	Continued From page 22 NJAC 8:39-27.1(a)	F 880		