STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	C 03/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WANAQUE CENTER FOR NURSING & REHABILITATION, THE	**1433 RINGWOOD AVE HASKELL, NJ 07420**

(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: 3/29/16 CENSUS: 218 SAMPLE: 30 NJ00082993; NJ00084225; NJ00084888; NJ00085748	F 000		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to follow care plan interventions to prevent falls and/or accidents and injury for Resident #2, who was 1 of 3 residents reviewed for falls. The resident sustained a fracture to the left femur that caused pain and required surgical intervention. This deficient practice was evidenced by the following: On 3/16/16 at 12:30 p.m. during the initial tour of the facility, the Unit Manager informed the surveyor that Resident #2 was a high fall risk and had sustained a fall with a hip fracture. Resident #2 used a wheel chair for mobility, was unable to self-propel, was able to verbalize needs and was alert and oriented to person, place and time.	F 282	1. Resident #2 was transferred to the hospital, had surgery for open reduction internal fixation of the left distal femoral shaft. She returned to the facility on 1/10/16 and underwent physical and occupational therapy and is currently back to her previous physical functional ability prior to the fall. 2.Plan of care for all residents identified as at risk for falls will be reviewed to ensure that the transfer assistance needed during shower is appropriate and it specifies the need for shower bed or shower chair. These will be noted on both the IDCP Care Plan and CNA Care guide for each resident.	4/6/16

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

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F 282	Continued From page 1 On 3/17/16 at 12:55 p.m. the surveyor reviewed the medical record for Resident #2. The resident was admitted on 2/23/13 with diagnoses that included Anoxic Brain Syndrome, Myoclonus (involuntary spastic movements of the muscle), Cerebral Vascular Accident (CVA), and Seizure Disorder. The nurse documented in the written Fall Risk Assessment dated 7/27/15 that the resident was at high risk for falls due to functional limitations with range of motion to bilateral upper and lower extremities and was unable to stand independently. A second Fall Risk Assessment dated 9/17/15 noted that the resident's risk for falls was due to the following factors: the resident received anti-seizure medication, had a history of falls; was incontinent of bowel and bladder, had a neurologic disorder, and musculoskeletal problems. The Interdisciplinary (IDC) team assessed the resident utilizing Quarterly Minimum Data Set (MDS), an assessment tool, dated 7/2/15, 9/24/15, 3/3/16 and the Annual MDS dated 12/17/15. The IDC team assessed that the resident was alert and oriented to person, place and time; was dependent for transfer and required the help of two people; needed extensive assistance of one person for dressing, toilet use and personal hygiene; and was totally dependent on one person for assistance with bathing. On 3/18/16 at 10:10 a.m. the surveyor reviewed the plan of care developed by the IDC team to	F 282	3.All CNAs will be in-serviced on following resident's care plan and care guide as recommended by the IDCP team. All CNAs will be in-serviced on the Fall Prevention Policy and Reporting of Fall Incidents. 4. DON/designee will perform a random observation monthly of CNAs while providing shower to residents to ensure that plan of care is being followed as recommended by the IDCP team. Outcome of the monthly audits will be reported quarterly to the QA Committee.	

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F 282	Continued From page 2	F 282		

prevent the resident from falling as well as the facility's investigations of the falls sustained by the resident. The care plan was initiated 2/25/13 and identified that the resident's risk for falls and/or injury related to impaired balance, involuntary movements, a diagnoses of CVA, anoxic encephalopathy, seizures and obesity. The care plan intervention to prevent falls dated 5/11/15, indicated that a mechanical lift to transfer the resident with the assistance of two staff members was to be utilized.

On 3/18/16 the surveyor reviewed the following fall investigations:

Resident #2 sustained a fall on 9/17/15 at 6:33 p.m. The nurse documented the resident slipped off the shower chair when two Certified Nurses Assistants (CNAs) were giving the resident a shower.
On 9/17/15 the IDC team discontinued use of the shower chair and initiated the use of a shower bed for safety. This intervention was also added to the resident's care plan.

Resident #2 sustained a 2nd fall on 1/4/16 at 7:15 p.m. when one CNA showered the resident in the shower room. The investigation revealed that the resident held onto the shower rail, the resident's legs gave way and the CNA eased the resident to the floor. The CNA asked another CNA to help and they assisted the resident to a chair without reporting the fall to the nurse or supervisor. The resident was not assessed by a nurse for potential injuries prior to the transfer to the chair. The CNA also did not use the shower bed for safety during showering as indicated on

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F 282	Continued From page 3 the care plan. NJAC 8:39-27.1(a)	F 282		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 provide a safe environment for Resident #2, 1 of 3 residents reviewed for falls. The resident sustained a fracture to the left femur which caused pain and required surgical intervention. This deficient practice was evidenced by the following: On 3/16/16 at 12:30 p.m. during the initial tour of the facility, the Unit Manager informed the surveyor Resident #2 was a high fall risk and had sustained a fall with a hip fracture. Resident #2 used a wheel chair for mobility, was unable to self-propel, was able to verbalize needs, and was alert and oriented to person, place and time. On 3/17/16 at 12:40 p.m. the surveyor observed Resident #2 seated in a wheelchair at the lunch meal in the 4th floor dining room. A seat belt was	F 323	1. Resident #2 was transferred to the hospital, had surgery for open reduction internal fixation of the left distal femoral shaft. She returned to the facility on 1/10/16 and underwent physical and occupational therapy and is currently back to her previous functional ability. 2. All residents will be reviewed to identify individual need for a shower chair or a shower bed. This information will be noted on the CNA Care Guide for each resident. 3. All CNAs will be in-serviced on following the resident's plan of care for shower needs as noted on the CNA care guide. All CNAS will be in-serviced on the Fall Prevention Policy and Reporting of Fall	4/6/16

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F 323	Continued From page 4 fastened across the Resident's lap and a lift pad was under the resident. The surveyor talked with the resident about lunch and the resident was able to answer appropriately and converse with the surveyor. On 3/17/16 at 12:55 p.m. the surveyor reviewed the medical record for Resident #2. The resident was admitted on 2/23/13 with diagnoses that included Anoxic Brain Syndrome, Myoclonus (involuntary spastic movements of the muscle), Cerebral Vascular Accident (CVA), and Seizure Disorder. The nurse documented in the written Fall Risk Assessment dated 7/27/15 that the resident was at high risk for falls due to functional limitations with range of motion to bilateral upper and lower extremities. Resident #2 was unable to stand independently. A second Fall Risk Assessment dated 9/17/15 noted that the resident's risk for falls was due to the following factors: the resident received anti-seizure medication; had a history of falls; was incontinent of bowel and bladder; had a neurologic disorder, and musculoskeletal problems. A numeric fall risk range from 0-3 indicated a minimal risk for falls, a range of 4-7 indicated a moderate risk for falls and 8 or more was considered a high risk for falls. Resident #2's total score on 7/27/15 was 13 and on 9/17/15 was 15. The Interdisciplinary (IDC) team assessed the resident utilizing Quarterly Minimum Data Set (MDS), an assessment tool, dated 7/2/15, 9/24/15, 3/3/16 and the Annual MDS dated 12/17/15. The IDC team assessed that the resident was alert and oriented to person, place	F 323	Incidents. 4. DON/designee will perform a monthly random observation of CNAs providing shower to residents to ensure that appropriate transfer and equipment needs are provided as per resident's care plan. Outcome of the monthly audits will be reported quarterly to the QA Committee.	

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F 323	Continued From page 5 and time; was dependent for transfer and required the help of two people; needed extensive assistance of one person for dressing, toilet use and personal hygiene; and was totally dependent on 1 person for assistance with bathing. On 3/18/16 at 10:10 a.m. the surveyor reviewed the plan of care developed by the IDC team to prevent the resident from falling as well as the facility's investigations of the falls sustained by the resident. The care plan was initiated 2/25/13 and identified that the resident's risk for falls and/or injury was related to impaired balance, involuntary movements, a diagnoses of CVA, anoxic Encephalopathy, seizures and obesity. The care plan to prevent falls included an intervention dated 5/11/15 to use a mechanical lift to transfer the resident with the assistance of two staff members. On 3/18/16 the surveyor reviewed the following fall investigations: Resident #2 sustained a fall on 9/17/15 at 6:33 p.m. The nurse documented the resident slipped off the shower chair when two Certified Nurses Assistants (CNAs) were giving the resident a shower. The resident stated "I slid." The resident did not sustain an injury. The facility noted in the fall investigation that a wet floor and the resident's gait imbalance, weakness and incontinence as predisposing factors that could have contributed to the fall. On 3/18/16 at 12:15 p.m. the surveyor interviewed the Administrator, Director of Nurses	F 323		

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F 323	Continued From page 6	F 323		

(DON), Assistant Director of Nurses (ADON) and the Staff Development Nurse. They stated that at the time of the fall on 9/17/15 there were two CNAs in the shower room with the resident. The resident was seated in a shower chair and moved very quickly. The CNA's were unable to stabilize the resident so the resident was eased to the floor and the situation was immediately reported to the charge nurse.

On 9/17/15 the IDC team discontinued use of the shower chair and initiated the use of a shower bed for safety. This intervention was also added to the resident's care plan. The IDC team also requested a rehabilitation screen for safety awareness.

Resident #2 sustained a 2nd fall on 1/4/16 at 7:15 p.m. when one CNA showered the resident in the shower room. The investigation revealed that the resident held onto the shower rail, the resident's legs gave way and the CNA eased the resident to the floor. The CNA asked another CNA to help her and they assisted the resident to a chair without reporting the fall to the nurse or supervisor. The resident was not assessed by a nurse for potential injuries prior to the transfer to the chair. The CNA also did not use the appropriate assistive device, a shower bed, to provide a safe environment for the resident. The shower bed was initiated on 9/17/15 following a prior fall which discontinued the use of a shower chair and initiated the use of a shower bed for safety during showering.

On the 11 p.m. to 7 a.m. shift the resident told the staff that s/he had a fall during the 3 p.m.-11 p.m. shift. The nurse completed a body assessment

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F 323	Continued From page 7 and no apparent injury was noted. The physician ordered an x-ray of the right hip at 11:50 a.m. which revealed a "fracture of the distal femoral shaft with lateral displacement and anterior angulation of the distal fragment." Pain medication was ordered and the Resident was sent to the hospital on 1/5/16 at 3 p.m. for evaluation. The hospital report of the resultant surgery dated 1/7/16 noted that the resident had open reduction internal fixation of the left distal femoral shaft. On 3/21/16 at 2 p.m. the surveyor asked Resident #2 if the fall in the shower room caused the resident pain. The resident stated that s/he did not have pain right away but later in the night it was painful and the nurse gave a pill for the pain.	F 323		
F 431 SS=D	NJAC 8:39-27.1(a) 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		4/6/16

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F 431	Continued From page 8 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to discard a medication after the medication expiration date based on the manufacturer's instruction. This deficient practice was evidenced by the following: On 3/24/16 at 11:30 a.m. the surveyor checked the medication cart for expired medications. The surveyor found a bottle of Blink Gel Tears in the med cart. The LPN stated the bottle was dated when opened on 1/19/16. The manufacture's instructions were to discard the solution 45 days after opening. The medication should have been discarded on 3/5/16.	F 431	1. Blink Gel Tears was discarded. 2. All medication carts, treatments carts, emergency kits and Pyxis will be inspected to ensure that no medications are in use after the medication expiration date as per the manufacturer's instruction. 3. All licensed staff will be in-serviced to ensure that all medications are being administered within the manufacturer's instruction for use and expiration. 4. DON/designee will perform a random monthly audit of medication carts, treatment carts, emergency kits and Pyxis	

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F 431	Continued From page 9 On 3/24/16 at 1:30 p.m. the surveyor showed the LPN the bottle. The LPN confirmed that the eye drops should have been discarded on 3/5/16. 8:39-27.1(a)	F 431	to ensure that medications are discarded within the manufacturer's instruction for use and expiration. Outcome of the monthly audit will be reported quarterly to the QA Committee.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		4/6/16

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F 441	Continued From page 10 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to demonstrate proper infection control techniques during medication pass by 1 of 2 nurses observed. This deficient practice was evidenced by the following: On 3/17/16 at 8:40 a.m., the surveyor observed two nurses pass medications to seven residents. Before administering eye drops to one resident the LPN lathered/scrubbed her hands for eight seconds then rinsed them under running water. After she administered the eye drops she did not scrub her hands after applying soap but instead washed her hands under running water for eight seconds. After administering nasal spray to the same resident the LPN again applied soap without scrubbing her hands but immediately placed her hands under running water for 15 seconds. On 3/21/16 at 12:00 p.m. the surveyor requested the facility's policy and procedure on hand hygiene. The administrator provided a copy to the surveyor at 12:20 p.m. which instructed to work lather over hands and wrists and scrub for at least 20 seconds, then rinse thoroughly under	F 441	1. Nurse who did not follow proper hand washing protocol during medication pass was in serviced and observed for proper hand washing techniques. 2. All licensed staff will be observed for proper hand washing techniques during medication administration. 3. All licensed staff will be in serviced on the proper hand washing techniques. 4. Infection Control Coordinator/designee will perform a random monthly observation of licensed staff during medication pass to ensure that proper hand washing techniques are being used. Outcome of the monthly audit will be reported quarterly to the QA Committee.	

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F 441	Continued From page 11 running water. The surveyor obtained a copy of the Center for Disease Control and Prevention hand hygiene guidelines which also instructed to lather hands by rubbing/scrubbing them together with soap for at least 20 seconds before rinsing under running water. 8:39-19.4(a)1	F 441		

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	061628	A. BUILDING: _____ B. WING _____	C 03/29/2016

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S1685	8:39-25.2(b)(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a) above) on the basis of: 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This REQUIREMENT is not met as evidenced by: Based on a review of the staffing schedules provided by the facility for the weeks of 3/6/16	S1685	1. Deficient staffing practice were noted and will be avoided.	4/6/16

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

Electronically Signed | 04/06/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061628	A. BUILDING: _____ B. WING _____	C 03/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WANAQUE CENTER FOR NURSING & REHABILITATIC	1433 RINGWOOD AVE HASKELL, NJ 07420

(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) COMPLETE DATE
S1685	Continued From page 1 and 3/13/16 it was determined that the facility was deficient in providing sufficient Certified Nursing Assistant (CNA) hours for the following dates: For the week of 3/6/16 to 3/12/16 on the following days: Sunday 3/6/16 - deficient for minus 26 hours for CNA hours. The CNA requirement was 434 hours but the facility provided 408 hours. Wednesday 3/9/16 - deficient for minus 42 hours. The CNA requirement was 434 hours but the facility provided 392 hours. Saturday 3/12/16 - deficient for minus 42 hours. The CNA requirement was 434 hours but the facility provided 392 hours. For the week of 3/13/16 - 3/19/16 on the following day: Sunday 3/13/16 - deficient for minus 52 hours. The CNA requirement was 436 hours but the facility provided 384 hours.	S1685	Staffing Coordinator was in serviced on the Mandatory Nurse Staffing Guidelines. 2. Staffing will be reviewed daily by the Staffing Coordinator and DON/ADON/Nursing Supervisor to ensure that staffing numbers are sufficient per mandatory nurse staffing guidelines. 3. Nursing Management and Staffing Coordinator will be inserviced on the Mandatory Nurse Staffing guidelines. 4. Staffing Coordinator/Nursing Supervisor will check staffing requirements daily to make sure that staffing are sufficient per mandatory nurse staffing guidelines. Staffing Coordinator/Nursing Supervisor will report to the DON the status of the daily staffing.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061628 Y1	A. Building B. Wing Y2	4/29/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WANAQUE CENTER FOR NURSING & REHABILITATION, THE	1433 RINGWOOD AVE HASKELL, NJ 07420

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S1685 Reg. # 8:39-25.2(b)(2) LSC	Correction Completed 04/06/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/29/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**