STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING _____ B. WING _____	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACKENSACK MERIDIAN HEALTH PROSPECT HEIGHTS CARE C	336 PROSPECT AVE HACKENSACK, NJ 07601

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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 Standard Survey: 10/3/22 Census: 55 Sample Size: 17 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 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, and record review it was determined that the facility failed to a.) hold a medication used to treat [redacted] in accordance with the physician's order (PO), b.) accurately document in the administration record and c.) verify a PO for treatment administration in accordance with professional standards of nursing practice. The deficient practice was identified for 2 of 20 residents reviewed, Resident #407, #507.	F 658	1. LPN assigned to resident #507 was re-educated by the Assistant Director of Nursing on September 28, 2022 regarding administering medications within the parameters indicated. The Assistant Director of Nursing re-educated the nurses identified on September 21, 2022 (7-3 shift) and September 23, 2022 (3-11 shift) regarding signing for medications administered. The Assistant Director of	11/1/22

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

Electronically Signed | 10/24/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by 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 states: "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." The deficient practice was evidenced by the following: 1. On 9/28/22 at 11:50 AM the surveyor reviewed the hybrid medical records of Resident #507 which revealed the following: The resident's Admission Record showed a diagnoses which included but not limited to EX. Order 26.(4) B1	F 658	Nursing re-educated RN identified providing wound care to resident #407 regarding reviewing physician orders for treatment prior to performing EX. Order 26.(4) care and signing for treatment rendered upon completion of the procedure. The above re-educations were completed on September 28, 2022. The nurses identified expressed understanding of the re-education provided. 2. The facility recognizes that current residents have the potential to be effected by the concerns identified. 3. The facility converted to a new electronic medical records system with implementation of electronic medication and treatment administration on September 19, 2022. This new system has been configured to generate alerts for unsigned medications/treatments and warnings for medications attempted to be administered outside of ordered parameters. Nurses will have education completed by the Assistant Director of Nursing regarding these alerts and warnings along with education regarding review of treatment orders prior to providing EX. Order 26.(4) care and signing for treatments at the completion of the procedure. This re-education will be completed by November 1. 2022. 4. The Assistant Director of Nursing will review the electronic medical record clinical dashboard daily for the next twelve weeks to verify medications are not being administered outside of ordered parameters and that medications/treatments are signed for/administered. Unit Managers will	

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F 658	Continued From page 2 The Admission Minimum Data Set (MDS), an assessment tool used to facilitate management of care, dated [redacted], indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a [redacted] which indicated that the resident was [redacted]. A review of the Order Summary Report and the electronic Medication Administration Record (eMAR) indicated that Resident #507 had a PO dated [redacted] for the following: a) [redacted] Tablet [redacted] mg Give 1 tablet by mouth three times a day every Mon, Wed, Fri, Sun for [redacted] Hold for [redacted] greater than [redacted] b) [redacted] Tablet [redacted] mg Give 1 tablet by mouth three times a day every Tue, Thu, Sat for [redacted] Hold for [redacted] greater than [redacted]. A review of the [redacted] eMAR for Resident #507 revealed that the PO for [redacted] [redacted] mg tablet was administered when the medication should have been held for a [redacted] that was greater than 1 [redacted] according to the PO. On 9/28/22 at 11:59 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #507, who stated that there was a PO to hold the medication if the [redacted] is greater than [redacted] The LPN further reviewed the [redacted] eMAR for the resident in the presence of the surveyor who confirmed her initials for the 5 doses in which the [redacted] medication should have been held according to the current PO. The	F 658	perform one wound care observation weekly for the next twelve weeks to verify that treatment orders are reviewed prior to [redacted] care being performed and that [redacted] care is documented post completion of the care being rendered. Areas of concern will be addressed. Results of these observations will be reviewed at the Quality Assurance Performance Improvement meeting for the next three months will follow up as needed.	

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LPN stated that the documented blood pressure [EX. Order] in the eMAR were taken earlier at the beginning of her 7-3 shift. The LPN further stated that she checked the resident's [EX. Order 2] before administering the [EX. Order 26.(4) B1] medication but did not document the [EX. Order 26.(4) B1].

On 9/28/22 at 12:07 PM, the surveyor interviewed the LPN/Unit Manager (LPN/UM) who stated that it was expected for the nurses to follow the physician orders and hold a medication when indicated.

On 9/28/22 at 12:43 PM, the surveyor informed the Director of Nursing (DON) regarding the above concerns. The DON acknowledged that the medication had a PO for parameters that should have been followed by the nurse.

On 9/29/22 at 10:34 AM, the surveyor reviewed the facility's policy titled, "Medication and Treatment Record Administration", with a review date of 10/2021. Under Procedure, "5.) The individual administering the medication is responsible for knowledge of specific medication: Action; Indication; Side effects; Special precautions; Contraindications; Usual dose; Route of Administration". The policy did not further address administering medications with parameters.

2.) A review of the [EX. Order 26.(4) B1] eMAR for Resident #507 revealed that on [EX. Order 26.(4) B], the 7-3 nurse did not document in the eMAR to indicate that the PO for [EX. Order 26.(4) B1] mg at 1PM was administered. Further review showed that on [EX. Order 26.(4)], the 3-11 shift nurse did not document in

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the eMAR to indicate that the medications were administered.

On 9/28/22 at 12:43 PM, the surveyor informed the DON regarding the missing signatures.There was no additional information provided.

On 9/29/22 at 10:34 AM, the surveyor reviewed the facility policy titled, "Medication and Treatment Record Administration", with a reviewed date of 10/2021. Under Procedure number 6 (q), it read, "Document medication administration by charting it in residents clinical record, to include: medication name; medication dose; medication route; medication site, as appropriate; medication administration date and time; Your full name; Your professional designation".

2. The Admission Record reflected that Resident #407 had diagnoses which included but not limited to, EX. Order 26.(4) B1

A review of the form titled, "Nursing Admission Skin Integrity/Diagram" dated EX. Order 26.(4) indicated that Resident #407 had two areas with stage EX. Order 26.(4) B1 (EX. Order 26.(4) B1 on their EX. O. Order 26.(4). Further review revealed that the resident had a EX. Order 26.(4) B1

The Admission MDS, dated EX. Order 26.(4) reflected a BIMS score of EX. Order 26.(4) B1 which indicated that Resident #407's cognition was EX. Order 26.(4 The MDS also indicated that Resident #407 had EX. O areas

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of EX. Order 26.(4) B1 and an additional EX. Order 26.(4) B1 The MDS also indicated that Resident #407 receives "EX. Order 26.(4) B1 and the "application of ointments/ medications to places other than the EX. Orde"

A review of the current PO and the electronic Treatment Administration Record (eTAR) showed that Resident #407 had a PO for:

a.) "EX. Order 26.(4) B1 Apply to EX. Order 26.(4) B1 topically every day shift for EX. Order 26.(4) Care until EX. Order 26.(4) B1 6:59" Cleanse EX. Order 26.(4) B1 EX. OrdeEX. O with EX. Order 26.(4) B1, pat dry apply EX. Order 26.(4) B1 gel and cover with CDD daily X 14 days then reassess" dated EX. Order 26.(4).

b.) EX. Order 26.(4) B1 Paste EX. Order 26.(4) B1 EX. Order 26.(4) B1 Apply to EX. Order 26.(4) B1 topically every shift for EX. Order 26.(4) Care Cleanse EX. Order 26.(4) B1 k with EX. Orde, pat dry, apply EX. Order 2 Cream and Leave Open to Air (LOTA) every shift and as needed (PRN)" dated EX. Order 26.(4) B

c.) EX. Order 26.(4) B1 Paste EX. Order 26.(4) B1 Apply to EX. Order 26.(4) B1 topically every shift for EX. Order 26.(4) Care Cleanse EX. Order 26.(4) B1 with EX. Or, pat dry, apply EX. Order 2 Cream and LOTA every shift and PRN" dated EX. Order 26.(4) B1

On 9/28/22 at 11:44 AM, two surveyors observed EX. Order 26.(4) B1 care and EX. Order 26.(4) B1 treatment administration for Resident #407 performed by the Registered Nurse (RN). Prior to beginning the EX. Order 26.(treatment, the RN removed the items from the resident's overbed table, cleaned the overbed table, and started to prepare the equipments needed from the treatment cart. The RN did not review the PO prior to performing

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the [EX. Order 26-0] treatment.

On 9/28/22 at 12:30 PM, after the RN rendered the wound treatments, she did not document in the eTAR to reflect that the treatment was rendered. The surveyor questioned if the RN needed to do anything else. The RN responded, "no, that's it."

On 9/28/22 at 12:45 PM, two surveyors interviewed the RN who acknowledged that she was supposed to review the PO as documented on the eTAR before she started the treatment. The RN further stated that she documents in the eTAR after performing any treatment but she has the entire duration of her shift to document it because the ordered treatment were only once per shift.

On 9/29/22 at 11:00 AM, two surveyors interviewed the Registered Nurse/ Unit Manager (RN/UM) regarding the above concern. The RN/UM acknowledged that the RN should have reviewed the PO before she began the treatment and further stated that, "after the treatment it really should be signed", referring to the eTAR.

On 9/29/22 at 12:35 PM, the surveyors expressed their concerns to the Licensed Nursing Home Administrator and the DON. The DON stated that the RN should have reviewed the PO before beginning the treatment.

The facility policy, "Medication and Treatment Record Administration Policy" revised 10/2021 indicated under the "Procedure" section "6. Medications are administered as follows: a. Verify physicians order for medication administration".

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F 658	Continued From page 7 The policy also revealed "q. Document medication administration by charting it in residents clinical record". NJAC 8:39-11.2 (b); 29.2(d)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. 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 the [EX. C. Order 26] therapy was administered to a resident in accordance with the current physician's orders (PO). This deficient practice was observed with 2 of 3 residents (Resident #24 and #4) reviewed for respiratory care. The deficient practice was evidenced by the following: 1. On 9/19/22 at 11:12 AM, the surveyor observed Resident #24 sitting in a wheelchair at the bedside, [EX. Order 26.(4) B1]. The resident was observed receiving an [EX. Order 26.(4) B1] inserted into the [EX. Order 26.(4) B1] through) that was attached to an [EX. Order 26.(4)] wall mounted	F 695	1. LPN#1 was re-educated by the Assistant Director of Nursing on September 22, 2022 regarding verifying [EX. Order 26.(4)] orders and maintaining ordered [EX. Order 26.(4) B1] [EX. Order 26.(4)] order containing liter flow was clarified for resident #24 on September 22, 2022. LPN#2 was re-educated by the Assistant Director of Nursing on September 22, 2022 regarding checking physician orders for residents to verify care and treatment needs prior to rendering care. LPN#1 AND LPN#2 verbalized understanding of the re-education provided. Physician provided order clarification to discontinue [EX. Order 26.(4)] for resident #4 on [EX. Order 26.(4) B1] [EX. Order 26.] 2. The facility recognizes that residents	11/1/22

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F 695	Continued From page 8 EX. Order 26.(4) B1). The EX. Order 26.(4) B1 was set at EX. Order 26.(4) B1 On 9/21/22 at 9:44 AM, the surveyor observed Resident #24 sitting in a wheelchair at the bedside, wearing a EX. Order 26.(4) connected to an EX. Order 26.(4) wall mounted EX. Order 26.(4) B1 The EX. Order 26.(4) B1 was set at EX. Order 26.(4) Resident #24 stated to the surveyor that they needed to use EX. Order 26.(4) at all times. The surveyor reviewed the hybrid medical records of Resident #24 which revealed the following: The resident's Admission Record revealed that Resident #24 was admitted with diagnoses that included but not limited to EX. Order 26.(4) B1 [redacted] EX. Order 26.(4) B1). The Admission Minimum Data Set (MDS) assessment, an assessment tool used to facilitate management of care, dated EX. Order 26.(4) , indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a EX. Order 26.(4) B1 which indicated that the resident's cognition was EX. Order 26.(4) B1 . A review of the EX. Order 26.(4) B1 Order Summary Report revealed that there was no PO to administer EX. Order 26.(4) therapy. The Treatment Administration Record (TAR) for EX. Order 26.(4) B1 revealed that there was no active PO to administer oxygen therapy.	F 695	ordered to receive EX. Order 26.(4) have the potential to be effected. 3. Whole house audit of residents receiving EXEX. Order 26. was completed on October 4, 2022 to verify there were physician orders in place for EXEX. Order 26.(and that EX. Order 26.(4) B being administered corresponds with physician orders. Areas of concern were addressed. Nurses re-education is being conducted by the Assistant Director of Nursing regarding reviewing physician orders for EX. Order 26.(4) and maintaining ordered EX. Order 26.(4) B1 . Nurse re-education is being conducted by the Assistant Director of Nursing regarding verifying treatment orders prior to rendering care and documentation regarding treatment rendered is completed as required. Re-education will be completed by November 1, 2022. 4. Unit Managers will audit physician orders and complete direct observations for 5 random residents receiving EX. Order 26.(4) B weekly for the next twelve weeks to verify EX. Order 26.(4) B orders are in place, ordered EX. Orde is maintained and documentation is complete/correct. Unit Managers will query 3 random nurses weekly for the next twelve weeks to verify review of physician orders prior to rendering care/treatment. Areas of concern will be addressed. Results of these audits, observations and inquiries will be reviewed at the Quality Assurance Performance Improvement meeting for the next three months with follow up provided as needed.	

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A review of the resident's care plan (CP) titled, EX. Order 26.(4) B1 .... Intervention for the care plan indicated under "4) Administer medications, EX. Order 26.(4) B1 treatments and EX. Order 26.(4) as ordered." The CP was initiated on EX. Order 26.(with a last reviewed date on EX. Order 26.(4) B

On 9/22/22 at 12:40 PM, the surveyor interviewed the Certified Nursing Assistant #1(CNA #1) who was assigned to Resident #24 regarding the resident's EX. Order 26.(4) B use. CNA #1 stated that the resident needed the EXEX. Order 26 and had to use it at all times.

On 09/22/22 at 12:53 PM, the surveyor interviewed the Licensed Practical Nurse #1(LPN) assigned to the resident who stated that the resident has been receiving EX. Order 26.(4 at EX. Order 26.(continuously. LPN #1 further stated that there were times when the resident would experience EX. Order 26.(4) B1 in which the EX. Order 26.(4 would be increased to EX. Order 26.(4) B1. The surveyor questioned LPN #1 on how the nurses would know what is the rate of the EX. Order 26.(4 therapy that needed to be administered to the resident. The LPN stated that the PO would indicate the EX. Order 26.(4) B1. The LPN #1 further stated that the nurses document in the eTAR for EX. Order 26.(4 therapy orders. The LPN reviewed the current PO for Resident #24 in the presence of the surveyor which revelead that there was no PO for EX. Order 26.(4 therapy to be administered to Resident #24 in the hybrid medical records. LPN #1 acknowledged that there should have been a PO for any resident receiving EX. Order 26.(4 therapy.

On 9/22/22 at 1:01 PM, the surveyor interviewed the Unit Manager/LPN (UM/LPN) and discussed

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the above concern. The UM/LPN acknowledged that there was no PO for EX. Order 26.(4) therapy to be administered and that the nurses must check for an EX. Order 26.(4) order.

On 9/22/22 at 1:07 PM, the surveyor informed the Administrator and the Director of Nursing (DON), about the above concern regarding the resident using EX. Order 26.(4) without a physician's order. The DON acknowledged there should have been an order for EX. Order 26.(4) to be administered for Resident #24.

2. On 9/19/22 at 11:02 AM the surveyor observed Resident # 4 in bed awake. The resident was sitting up, asking to get out of bed. The resident was not receiving EX. Order 26.(4) B1

On 9/21/22 at 9:54 AM the surveyor observed the resident sitting in a wheelchair by the nurses station. There was a Certified Nursing Assistant (CNA #2) sitting next to the resident and talking to the resident. The resident was not receiving EX. Order 26.(4).

On 9/21/22 at 12:12 PM the surveyor observed the resident in bed. The resident was awake and alert. The resident was not receiving EX. Order 26.(4).

On 9/22/22 at 10:46 AM the resident was in the hallway by the nurses station in a wheelchair. There was a table in front the resident with a cup of coffee and crackers. The resident was not receiving EX. Order 26.(4).

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On 9/22/22 at 10:50 AM the surveyor reviewed the resident's electronic and paper record which revealed the following:

An Admission Record with the following diagnoses; EX. Order 26.(4) B1 [redacted].

A current Physician's Order Sheet that included an order that was dated [redacted] and read "[redacted] via EX. Order 26.(4) B1 continuous-Keep [redacted] EX. Order 26.(4) B1

A Significant Change in Status Minimum Data Set Assessment (MDS) dated [redacted]. The Brief Interview for Mental Status score was [redacted], which showed that the resident had EX. Order 26.(4) B1 [redacted].

An Electronic Treatment Administration Record (ETAR) that included an order that read "[redacted] EX. Order 26.(4) B1 at [redacted] pm continuously-Keep [redacted] EX. Order 26.(4) B1 every shift." The start date on the ETAR was [redacted]. (The facility recently began using a new electronic medical record system). Except for the night shift on [redacted] the ETAR was initialed every shift on EX. Order 26.(4) B1, and [redacted] to indicate the resident was receiving EX. Order 26.(4) B1 as ordered by the physician.

On 9/22/22 at 11:00 AM the surveyor checked the resident's room for [redacted] supplies. The resident had not been observed receiving [redacted] and there was no [redacted] apparatus in the resident's room.

On 9/22/22 at 11:11 AM the surveyor spoke with CNA #3, the CNA assigned to the resident. CNA

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#3 stated that she was full time and she was assigned to the resident daily. The surveyor asked CNA #3 about the resident's EX. Order 26.(4) use. CNA #3 said the resident hadn't used EX. Order 26.(4) for a couple of weeks because the resident had progressed and the resident's EX. Order 26.(4) level had been good.

On 9/22/22 at 11:22 AM the surveyor spoke with the Licensed Practical Nurse (LPN #2) who was assigned to the resident and asked her if the resident should have been receiving EX. Order 26.(4). LPN #2 said no. The surveyor asked LPN #2 if there was an order for the resident to receive EX. Order 26.(4) B1 LPN #2 said she would look at the chart. LPN #2 looked and found the paper physician's order for the EX. Order 26.(4) B1 LPN #2 then said she would look at the ETAR. LPN #2 looked at the ETAR and found the order for EX. Order 26.(4) B1. LPN #2 stated "Oh, I did not see it. They didn't tell me in report this morning and I didn't look at the ETAR yet because I started with the EMAR (Electronic Medication Administration Record)." LPN #2 said she checked the resident's EX. Order 26.(4) B1 EX. Order 26.(4) B1 and it was EX. Order that morning. She said she would call the doctor and find out if the order should be discontinued. The surveyor asked LPN #2 if she ever worked with the resident before. LPN #2 said "No I never did but to tell you the truth they did not tell me in report that the resident was getting EX. Order 26.(4) but I should have looked at the ETAR."

On 9/22/22 11:39 AM the surveyor spoke with the resident's physician and the Unit Manager/LPN # 2 (UM/LPN #2). The physician said that the resident had been stable and the resident did not need the EX. Order 26.(4). The physician and UM/LPN #2 confirmed that the order for EX. Order 26.(4) should have

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been discontinued if the resident wasn't using it. The surveyor discussed the concern with the physician and UM/LPN #2 that the resident had not been seen using EX. Order 26.(4) yet the nurses were signing for it on the ETAR. The physician and UM/LPN #2 agreed that should not have been done.

On 9/22/22 at 1:08 PM the surveyor spoke with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) about the resident not receiving EX. Order 26.(4) but having an order for EX. Order 26.(4) B1 and the nurses signing for it despite it not being used. The DON confirmed that the nurses should not have been signing for it and the order should have been discontinued.

On 9/23/22 at 11:00 AM the surveyor reviewed the facility's policy and procedure that was last reviewed and approved on 4/2022 and titled EX. Order 26.(4) B1 Administration Policy". Under "Policy" it read; "It is the policy of the organization that the EX. Order 26.(4) is treated as a prescribed therapy, which is solely administered in accordance with the physician's orders." Under "Procedure" it read:

1. Physician's order for EX. Order 26.(4) B1 is obtained and documented. Orders include: liter flow, the method of delivery and indication for use when PRN.
2. The order is transcribed to the MAR.
3. Nurse will initial the MAR each shift to indicate EX. Order 26.(4) is being administered as ordered.
4. Nursing staff is to monitor the liter flow and saturation levels as ordered by physician.
5. Any change or weaning of EX. Order 26.(4) will need to be ordered by the physician.
6. Any employee switching a resident to portable EX. Order 26.(4) must verify that both the EX. Order 26.(4) B1 and

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F 695	Continued From page 14 delivery device is as ordered by physician taking care to ensure proper setup when returning the resident to any wall based [redacted] delivery if appropriate. NJAC 8:39-27.1 (a)	F 695		
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 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	F 880		12/14/22

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F 880	Continued From page 15 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. 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	F 880	1. Certified Nurse Aide (CNA) was re-educated by the Infection Preventionist	

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F 880	Continued From page 16 was identified that the facility failed to a.) appropriately don (put on) Personal Protective Equipment (PPE) while providing care to a resident who was placed on Transmission Based Precautions (TBP); practice appropriate hand hygiene in accordance with the Centers for Disease Control and Prevention guidelines for infection control and b.) appropriately provide [redacted] treatments in accordance with infection control protocols. This deficient practice was identified for Resident #55 and Resident #407 on two out of four nursing units. The deficient practice was evidenced by the following: a.) On 9/19/22 at 10:52 AM, during the initial tour, the surveyor interviewed the RN/UM (Registered Nurse/Unit Manager) who stated that Resident #55 who resided in Room [redacted] was placed on [redacted] precaution due to diagnosis of [redacted] in [redacted], an EX. Order 26.(4) B1 from being able to [redacted]. On 9/19/22 at 11:05 AM, the surveyor observed that Room 301 had a red signage posted by the door prior to entering the room which indicated that Resident #55 was on [redacted] Precautions. The signage further indicated for staff to wear the proper PPE prior to entering the room which included, gloves and gown. There was a PPE bin located next to the resident's door. On 9/19/22 at 11:19 AM, the surveyor, after donning gown and gloves, opened the resident's	F 880	on September 19, 2022 regarding proper PPE utilization for [redacted] precautions. Infection Preventionist completed a review of handwashing/hand hygiene protocols along with a direct observation to verify competency for the CNA identified on September 19, 2022. Infection Preventionist completed a [redacted] care/treatment observation and handwashing/hand hygiene observation on September 28, 2022 to verify competency of the RN identified. 2. The facility recognizes that residents have the potential to be effected by the concerns identified. 3. The [redacted] care nurse will complete wound care/treatment observations for nurses to verify competency and adherence to protocol. The Infection Preventionist will complete education for the nursing staff related to proper PPE usage for isolation precautions and conduct handwashing/hand hygiene observations of nursing staff to verify competency. Re-education and direct observations will be completed by November 1, 2022. 4. The [redacted] care nurse will complete two wound care/treatment observations of random nurses weekly for the next twelve weeks to verify continued compliance/competence. The Infection Preventionist will complete three handwashing/hand hygiene and two observations of PPE usage compliance with random nursing staff members weekly for the next twelve weekst o verify continued adherence to infection control practices. Areas of concern will be	

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F 880	Continued From page 17 room door and observed a Certified Nurses Assistant (CNA) not wearing gown and gloves, holding plastic bags with used linens and night gown inside. The surveyor interviewed the CNA who stated that Resident #55 had no infection in the [redacted]. The CNA further stated that she was in the room to change the resident's [redacted] and the bed linens. The surveyor showed the red signage posted by the door to the CNA who stated that she was aware of the required PPE to be worn. On 9/19/22 at 11:22 AM, after the CNA discarded the bags which contained the soiled bed linens and used [redacted] in the soiled utility room, the CNA proceeded to the nourishment room to wash her hands, the surveyor observed the CNA performed handwashing for a total of 10 seconds and used the same paper towel to dry her hands and shut the faucet. The surveyor interviewed the CNA who stated that she was supposed to wash her hands for 25 seconds. According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, updated 5/17/2020 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom." It further specified the procedure for hand hygiene which included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a clean towel to turn off the	F 880	addressed. Results of these observations will be reviewed at the Quality Assurance Performance Improvement meeting for the next three months with follow uo as needed.	

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faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times."

A review of Resident #55's hybrid medical records showed that the resident was admitted to the facility on [redacted] and readmitted on [redacted] with diagnosis that included EX. Order 26.(4) B1 [redacted].
A review of the EX. Order 26.(4) B1 Physician Order (PO) form revealed an order dated [redacted] for EX. Order 26.(4) B1 [redacted]".

A review of Resident #55's most recent Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected that Resident #55 had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating [redacted].

A review of the laboratory report dated [redacted] with results of EX. Order 26.(4) B1 [redacted] revealed that Resident #55 was [redacted] for [redacted] precautions was indicated."

A review of the facility's policy titled, [redacted] Precautions Policy" with a review date of 10/2021 indicated under Policy: "...., the organization will use Contact Precautions to reduce the risk of transmission of epidemiology important microorganisms by direct or indirect contact." Under Procedure: "#1. Gowns and gloves must be worn by all personnel upon entering the room. This is a proactive measure, as unexpected resident EX. Order 26.(4) B1 with environmental surfaces or items in the resident's room cannot

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always be anticipated." "#4. Hand hygiene must be performed after removal of gown and gloves either before or upon exiting the room."

On 9/22/22 at 1:10 PM, the above concerns were discussed to the facility's Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The DON acknowledged that the CNA did not follow the EX. Order 26.(4) precaution policy and did not perform proper handwashing.

b.) On 9/28/22 at 11:20 AM, the surveyor reviewed the medical records for Resident #407.

The Admission Record reflected that Resident #407 had diagnoses including but not limited to an EX. Order 26.(4) B1 .

A review of the form titled, "Nursing Admission Skin Integrity/ Diagram" dated EX. Order 26.(4) B indicated that Resident #407 had two areas of EX. Order 26.(4) B1 EX. Order 26.(4) B1 on their EX. Order 26.(4) B1 and EX. Order 26.(4) B1 .

The Admission MDS, dated EX. Order 26.(4) reflected a BIMS score of EX. Order 26.(4) B1 which indicated that Resident #407's cognition EX. Order 26.(4) B1. The MDS also indicated that Resident #407 had EX. Order 26.(4) B1 EX. Order 26.(4) B1 and an additional EX. Order 2 EX. Order 26. The MDS also revealed that Resident #407 received EX. Order 26.(4) B1 and the application of ointments/ medications to places other than the EX. Order

A review of the current PO and the EX. Order 26.(4) EX. Order 26. electronic Treatment Administration Record

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(eTAR) indicated Resident #407 had PO for:

a.) EX. Order 26.(4) B1 Apply to EX. Order 26.(4) B1 topically every day shift for EX. Order 26.(4) B1 Care unti EX. Order 26.(4) B1 6:59" Cleanse EX. Order 26.(4) B1 EX. Order 26.(4) with EX. Order 26.(4) B1, pat dry apply EX. Order 26.(4) B1 gel and cover with CDD daily X 14 days then reassess" dated EX. Order 26.(4)

b.) "EX. Order 26.(4) B1 (EX. Order 26.(4) B1) Apply to EX. Order 26.(4) B1 topically every shift for EX. Order 26.(4) Care Cleanse EX. Order 26.(4) B1 with EX. Or, pat dry, apply EX. Order 2 Cream and Leave Open to Air (LOTA) every shift and as needed (PRN)" dated EX. Order 26.(4) B

c.) EX. Order 26.(4) B1) Apply to EX. Order 26.(4) B1 topically every shift for EX. Order 26.(4) Care Cleanse EX. Order 26.(4) B1 with EX. Ord pat dry, apply EX. Order 2 Cream and LOTA every shift and PRN" dated EX. Order 26.(4).

On 9/28/22 at 11:44 AM, two surveyors observed EX. Order 26.(4) B1 and EX. Order 26.(4) B1 treatments administration for Resident #407 performed by the Registered Nurse (RN).

At 11:47 AM, two surveyors observed the RN performed hand hygiene, donned (put on) clean gloves, and removed the items from the resident's overbed table. The RN doffed (removed) her gloves and immediately applied new gloves without performing hand hygiene in between. The RN proceeded to clean the overbed table using disninfectant wipes then doffed her gloves after cleaning. The surveyors observed that the RN washed her hands for 14 seconds before rinsing them under running water.

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At 11:51 AM, prior to the wound treatment, two surveyors observed that the RN donned gloves, signed and dated the [redacted] dressing and then doffed gloves. The surveyors further observed that the RN locked the treatment cart, closed the resident's door, and brought the overbed table into the resident's room before she performed hand hygiene.

At 11:55 AM, two surveyors observed that the RN donned clean gloves and cleaned Resident #407's [redacted] with gauze soaked in [redacted] (a cleansing solution). The RN applied [redacted] Paste on a tongue depressor to the resident's [redacted] using the same contaminated gloves used to clean the [redacted]. The RN doffed the gloves and immediately donned new gloves and did not perform hand hygiene in between.

At 12:02 PM, two surveyors observed the RN cleaned Resident #407's [redacted] with gauze soaked in [redacted] and dried the [redacted] with dry gauze. The RN immediately applied [redacted] (an [redacted] used to treat infections) on a tongue depressor to the resident's [redacted] and covered the [redacted] with a dry dressing using the same contaminated gloves used to clean and dry the [redacted]. The two surveyors observed that the RN doffed the gloves, donned new gloves, and did not perform hand hygiene in between.

At 12:06 PM, two surveyors observed that the RN performed hand hygiene, reopened the resident's privacy curtain, and disposed of the bag of garbage used during the treatments. The RN who did not perform hand hygiene was observed

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donning gloves, and then cleaned the overbed table using disinfectant wipes.

On 12:45 PM, two surveyors interviewed the RN regarding the concern when she performed handwashing for 14 seconds. The RN stated that she must have, "counted quickly" and acknowledged that she should have washed her hands for at least 20 seconds. The surveyor expressed concern over the several times when the RN doffed used gloves and proceeded to donn new gloves without performing hand hygiene in between. The RN acknowledged that she should have performed hand hygiene before she donned new gloves and after she doffed the used gloves. The surveyor further discussed the concern to the RN when she cleaned the resident's two different areas of [redacted] without changing her gloves in between cleaning the areas and the applications of the ointments. The RN responded to the surveyor that, that's how she performs [redacted] treatments.

On 9/29/22 at 11:00 AM, two surveyors expressed their concerns about the wound treatment to the RN/UM who stated that handwashing should be done between 20 and 30 seconds. The RN/UM further stated that the RN should have washed her hands before she donned new gloves and the expectation was to clean the [redacted] doff gloves, wash hands, and don new gloves.

On 9/29/22 at 12:35 PM, the surveyor expressed their concerns to the LNHA and the DON. The DON acknowledged that hand washing should be done for at least 20 seconds and that hand

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F 880	Continued From page 23	F 880		

hygiene should occur between when contaminated gloves are doffed and when clean gloves are donned.

The facility policy, "Hand Washing and Hand Hygiene Policy" with a revised date of 10/2021 indicated under the "Hand Washing and Hand Hygiene Indications" section that hand hygiene was indicated, "After removing gloves". The policy also revealed under the "Hand Washing Method" section to "7. Scrub the hands for at least 20 seconds".

The facility policy, "Skill: Clean Technique/ Treatment" dated 12/2021 indicated under Critical Elements to 16. cleanse the [EX. Order 26.1], 18. remove gloves, discard, wash hands, 19. apply new gloves, 20. apply treatment and dressing to [EX. Order 26.(4)]

NJAC 8:39-19.4 (a), (1) (2) (n),

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	056300	A. BUILDING: _____ B. WING _____	10/03/2022

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	1. Facility is at risk for this practice. 2. The Administrator and Director of Nursing reviewed recruitment procedures currently in place. Incentive bonuses are in place, agency staff is utilized as needed. We have instituted a hiring incentive for all nurses and Certified Nurse Aids. Nursing and Certified Nursing Assistant schools have been contacted for recruiting new graduates. We continue to hire temporary Certified Nursing Assistants and in obtaining certifications.	12/12/22

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

Electronically Signed | 10/24/22

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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.	S 560	Pay rates are being reviewed for increases. We are advertising on job sites. Nursing management is utilized for patient care as needed. Nursing management is on call on a rotating basis to assist with staffing issues should the need arise. All open shifts are posted weekly. 3. Director of Nursing will monitor staffing daily and will meet with staffing coordinator to review schedules. Director of Nursing or designee will be responsible to verify adequate staffing levels to ensure we are meeting requirements. Staffing is reviewed with supervisors daily. 4. The Licensed Nursing Home Administrator will monitor daily staffing to verify that state mandated staffing ratios continue to be met. Areas of concern will be addressed. Results of these monitoring activities will be reviewed at the Quality Assurance Performance Improvement meeting for the next three months with follow up as needed.	

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S 560	Continued From page 2 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 9/4/22 and ending 9/17/22 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements in CNAs to total staff on 2 of 14 evening shifts as follows: -09/14/22 had 6 CNA's to 14 total staff on the evening shift, required 7 CNA's. -09/16/22 had 6 CNA's to 15 total staff on the evening shift, required 7 CNA's. On 10/3/22 at 11:00 AM, the surveyor discussed the staffing ratio concerns with the Licensend Nursing Home Administrator and the Director of Nursing. There were no further information provided.	S 560		
S2235	8:39-31.6(c) Mandatory Physical Environment (c) Fire regulations and procedures shall be posted in each unit and/or department. A written evacuation diagram that includes evacuation	S2235		11/22/22

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S2235	Continued From page 3 procedures and locations of fire exits, alarm boxes, and fire extinguishers shall be posted conspicuously on a wall in each resident care unit and/or department throughout the facility. This REQUIREMENT is not met as evidenced by: Based on observations on 09/28/22 and 9/29/22 in the presence of the Facility Management, it was determined that the facility failed to identify fire alarm pull stations and fire extinguishers for 12 of 12 emergency evacuation diagrams posted in the facility. The evidence includes the following: During the building tour on 09/28/2022 starting at 9:57 AM and continued on 09/29/2022, in the presence of the facility's Director of Maintenance (DOM) an inspection of the 2nd., 3rd., 4th., 5th., 6th. And 7th. Floors was conducted. The surveyor observed 12 emergency evacuation diagrams posted that failed to include the locations of the fire alarm pull stations and fire extinguishers in the following locations: On 09/28/2022, 1. On the seventh floor at 10:13 AM, one emergency evacuation diagram posted next to elevators #1 and #2. 2. On the seventh floor at 10:27 AM, one emergency evacuation diagram posted next to elevator #3. 3. On the sixth floor at 10:34 AM, one emergency evacuation diagram posted next to elevators #1 and #2.	S2235	The facility is at risk for this practice. Environmental rounds were conducted and no other issues were noted. New emergency evacuation diagrams were posted to include the locations of the fire alarm pull stations and fire extinguishers. Maintenance Director or designee will visually inspect for proper diagram placement monthly. The Maintenance Director will report any findings and will be immediately addressed and reported to the QAPI committee monthly for the next three months.	

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S2235	Continued From page 4 4. On the sixth floor at 10:53 AM, one emergency evacuation diagram posted next to elevator #3. 5. On the fifth floor at 11:06 AM, one emergency evacuation diagram posted next to elevators #1 and #2. 6. On the fifth floor at 11:25 AM, one emergency evacuation diagram posted next to elevator #3. 7. On the fourth floor at 11:35 AM, one emergency evacuation diagram posted next to elevators #1 and #2. 8. On the fourth floor at 11:47 AM, one emergency evacuation diagram posted next to elevator #3. 9. On the third floor at 11:51 AM, one emergency evacuation diagram posted next to elevators #1 and #2. 10. On the third floor at 12:10 PM, one emergency evacuation diagram posted next to elevator #3. On 09/29/2022, 11. On the second floor at 10:10 AM, one emergency diagram posted next to elevators #1 and #2. 12. On the second floor at 10:23AM, one emergency evacuation diagram next to elevator #3. The facility did not identify the locations of the fire alarm pull station and fire extinguishers on the diagrams as required by regulation.	S2235		