STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315522	A. BUILDING _____ B. WING _____	10/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION PISCATAWAY	10 STERLING DRIVE PISCATAWAY, NJ 08854

(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: 10/14/2020 CENSUS: 80 SAMPLE: 19+3 closed records 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. A COVID-19 Focused Infection Control Survey was conducted in conjunction with the recertification survey. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	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, record review, and review of other facility documentation, it was determined that the facility failed to a.) label [redacted] and b.) label and store [redacted] in accordance with the facility policy for 1 of 1 residents (Resident #52) reviewed for [redacted] This deficient practice was evidenced by the following:	F 658	F658 Services Provided Meet Professional Standards This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet	11/2/20

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

Electronically Signed | 11/02/2020

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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 or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes 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 case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. According to the Admission Record, Resident #52 was admitted to the facility in [redacted] with diagnoses that included, but were not limited to: [redacted] Review of Resident #52's Admission Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that the resident's cognition was [redacted] impaired.	F 658	requirements established by state and federal law. It is the policy of the facility that any services provided or arranged by the facility, as outlined by the comprehensive care plan meet professional standards of care. " The [redacted] for Resident # 52 was discarded and replaced with a [redacted] The [redacted] was properly dated and labeled as per the facility policy. The open [redacted] was discarded and replaced with the [redacted] box for one-time use. " All nurses were immediately educated on the facility policy and procedure for Labeling of [redacted]. All nurses were immediately educated on the facility policy and procedure for [redacted] " Nurse Educator conducted a full house audit of all patients on [redacted] to ensure the same practice was not occurring with no further findings noted. " Director of Nursing/Designee will conduct audits of 2 patients on [redacted] to ensure the facility policy and procedure for labeling is followed. This will be done weekly for two weeks, then every other week for two months. The results will be addressed and brought to the monthly Quality Assurance meeting for review times three months. " Director of Nursing/Designee will conduct audits on all patients receiving	

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F 658	Continued From page 2 Review of Resident #52's Care Plan (CP), dated [redacted], revealed the resident was at risk for [redacted] and included an intervention to administer [redacted] as ordered dated [redacted] Review of Resident #52's Order Summary Report (OSR) included a physician's order for [redacted] every shift for [redacted] dated [redacted] to [redacted]. On 10/07/2020 at 11:20 AM, the surveyor observed that Resident #52 was receiving [redacted]). The [redacted] had a label that was torn off the [redacted] and did not indicate the resident's name, date, or time the [redacted] were hung. The [redacted] was also missing a label with the date and time it was used. When interviewed at that time, the Registered Nurse (RN) taking care of the resident stated the [redacted] should be labeled with the resident's name, date, and time. During an interview on 10/13/2020 at 11:15 AM, the Licensed Practical Nurse (LPN) stated the [redacted] should be labeled with the date and time it was hung so that the oncoming nurse knows when to discard the supplies. During an interview with the surveyor on 10/13/2020 at 11:45 AM, the Unit Manager (UM) stated the [redacted] should have been labeled with the resident's name, [redacted] of the [redacted], and the nurse's initials when the [redacted] was hung. The [redacted] should also be labeled with the date and time it was	F 658	[redacted] to ensure the facility policy and procedure for administration of [redacted] is followed. This will be done weekly for two weeks, then every other week for two months. The results will be addressed and brought to the monthly Quality Assurance meeting for review times three months. Completion Date: 11/2/20	

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F 658	Continued From page 3 used. The UM further stated that labeling the [redacted] supplies was important because the nurse must verify the resident was receiving the correct [redacted] and to know when to change the [redacted] per protocol. During an interview with the surveyor on 10/13/2020 at 11:55 AM, the Director of Nursing (DON) stated that [redacted] should be labeled with the resident's name, [redacted], and the [redacted] should be labeled with the date the [redacted] was used. The DON further stated it was important to label the [redacted] supplies so that the nurse on duty can verify the resident was receiving the correct [redacted] Review of the facility's "Labeling [redacted]" policy, revised 05/01/2016, included "All infusions must be appropriately labeled," and "the licensed nurse administering non-admixed [redacted] from a sealed manufacturer's package will label the bag with: patient's name, route and rate, ancillary precautions, date and time the solution was hung, nurse's initials." 2. Review of Resident #52's Admission MDS, dated [redacted], included the resident received a [redacted] Review of Resident #52's CP, dated [redacted] revealed the resident had an [redacted] to meet nutritional needs. Further review of the OSR included a physician's order for [redacted] administer [redacted] five times per day dated [redacted].	F 658		

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F 658	Continued From page 4	F 658		

On 10/07/2020 at 12:00 PM, the surveyor observed [redacted] on Resident #52's dresser that were approximately half empty. One bottle was labeled with the date "[redacted]" and the other bottle was not labeled. Review of the bottle's printed instructions included to hang the bottle for no longer than [redacted] and to protect contents from light. The bottle also included a label indicating the [redacted]

When interviewed at that time, the RN taking care of the resident stated the bottles were already in the room at the start of her shift, but she did not use them since she did not know how long the bottles were sitting out at room temperature. The RN further stated she would throw away the two bottles since they are no longer usable.

During an interview with the surveyor on 10/08/2020 at 11:55 AM, the Dietician stated an open [redacted] may be stored in the refrigerator for [redacted].

During an interview with the surveyor on 10/13/2020 at 11:15 AM, the LPN stated an open [redacted] may be stored in the refrigerator for up to [redacted]. The LPN further stated the [redacted] must be refrigerated between use because it contained [redacted] and could go bad.

During an interview with the surveyor on 10/13/2020 at 11:45 AM, the UM stated an open [redacted] can be stored in the refrigerator for up to [redacted]. The UM further stated that the [redacted] should be

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F 658	Continued From page 5 labeled so that the oncoming nurse knew if the [redacted] was still good. If the bottle was not labeled or was past the [redacted], it should be thrown out to prevent illness. During an interview with the surveyor on 10/13/2020 at 11:55 AM, the DON stated an open [redacted] can be stored in the refrigerator for up to [redacted] The DON further stated that if the bottle was not refrigerated, it should be thrown away because it could be spoiled. Review of the facility's [redacted] " policy, revised 11/01/19, included "Label (with patient's name and date) and cover any unused [redacted]. Place in refrigerator. Discard unused, covered [redacted] NJAC 8:39-27.1(a)	F 658		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary	F 756		11/6/20

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F 756	Continued From page 6 drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to address recommendations made by the Consultant Pharmacist in a timely manner for 1 of 16 residents (Resident #6) reviewed for drug regimen. This deficient practice was evidenced by the following: On 10/07/2020 at 11:44 AM, the surveyor observed Resident #6 in bed eating breakfast. The resident stated when he/she received	F 756	F756 Drug Regimen Review, Report Irregular, Act On This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the policy of the facility to ensure a	

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F 756	Continued From page 7 [redacted] it was effective for [redacted] management. According to the Admission Record, Resident #6 was admitted to the facility on [redacted] diagnoses that included, but were not limited to: [redacted]. Review of Resident #6's Order Summary Report (OSR) reflected an active order dated [redacted] mg (milligram) every eight hours for [redacted] Further review revealed an active order dated [redacted] for [redacted] mg two tablets every six hours as needed [redacted]. Review of Resident #6's Medication Administration Record (MAR) for August and September 2020 included the aforementioned orders. Review of the Consultant Pharmacist Progress Notes, dated [redacted], revealed the Consultant Pharmacist (CP) recommended to discontinue the as needed [redacted] order. Review of additional Consultant Pharmacist Progress Notes, dated [redacted], revealed the same CP recommendation to discontinue the as needed [redacted] order. Review of the August Monthly Consultant Pharmacist Report, dated [redacted], revealed a recommendation to discontinue the as needed [redacted] order. Included in the recommendations, were areas indicating the "response date" and a	F 756	drug regimen review of each resident is reviewed at least monthly by a licensed pharmacist. This review must include a review of the resident□s medical chart. The facility must act on any irregularities noted by the pharmacist during the monthly drug regimen review. " The Medical Director was made aware of Resident # 6 PRN [redacted] for [redacted] and the order was discontinued immediately. A full review of the August and September Pharmacy Consultant Report was completed to ensure all other pharmacy recommendations were addressed accurately. " The Facility ran a full audit on all patients with standard [redacted] orders to ensure a similar practice was not occurring with no further findings noted. " A new process was implemented to ensure timely and accurate compliance of the monthly pharmacy reports are being met. Effective immediately monthly pharmacy reports will be sent to not only the Director of Nursing (DON) but will also include the Medical Director, Administrator and Clinical Director. The Medical Director will act on any immediate irregularities at that time. The DON will distribute the monthly pharmacy report to her designee with a target date of return back to the DON. The DON will then provide this completed pharmacy report with a target date of return to the night shift Clinical Director to perform an audit of orders for transcription accurateness.	

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F 756	Continued From page 8 nurse's signature. These areas were blank. Review of the September Monthly Consultant Report, dated [redacted] revealed the same recommendation to discontinue the as needed [redacted]. Further review of the report revealed the recommendation was addressed on [redacted] During an interview with the surveyor on 10/13/2020 at 9:45 AM, the Registered Nurse Clinical Director (RN/CD) stated each shift was responsible to review the monthly pharmacy recommendations. The surveyor and the RN/CD reviewed Resident #6's Electronic Physician Orders. The review revealed the resident could receive a total of [redacted] in a 24-hour period. The RN/CD stated the maximum amount of [redacted] in a 24-hour period would be [redacted] mg and the resident could receive more than the manufacturer's recommended amount of [redacted] During an interview with the surveyor on 10/13/2020 at 10:47 AM, the DON stated the September Consultant Pharmacist Report recommended to discontinue the as needed [redacted] orders since the resident was receiving [redacted] mg) daily. The DON stated the recommendation were not followed at the time of the review. During an interview with the surveyor on 10/13/2020 at 11:11 AM, the CP stated he recommended to discontinue the as needed [redacted] order for Resident #6 in August and September. The CP stated the resident had a routine [redacted] order for [redacted] mg to be given every 8 hours and if the resident also received [redacted] mg every 6 hours when needed, the	F 756	" The facility DON will conduct a monthly audit on 5 random areas of the pharmacy monthly report. This information will be reviewed with the Quality Assurance team at the monthly QAPI meeting for the next 6 months. Any findings or need to change the POC will be discussed collectively at this point. Completion Date: 11/6/2020	

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F 756	Continued From page 9	F 756		

amount could exceed the recommended daily dose of [redacted] mg which could cause [redacted] toxicity. The CP stated that he would expect after writing the monthly recommendations, that the nursing staff would have addressed the recommendations. He stated if the second recommendations were not being addressed, he would speak to the DON.

During a follow up interview on 10/14/2020 at 9:22 AM, the DON stated the Consultant Pharmacist Reports were given to the supervisors to follow up with the recommendations or given directly to the nurse practitioner to be addressed. The DON stated she would receive the report back when they were finished. The DON confirmed that the CP recommendations for Resident #6 were overlooked for August and September and were not addressed until [redacted]

Review of the facility's Medication Regimen Review Policy, with an effective date of 12/01/2007 and 11/28/2016, indicated the attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visits to the facility to assess the resident. The facility should encourage physician/prescriber or other responsible parties receiving the Medication Regimen Review (MRR) and the Director of Nursing (DON) to act upon the recommendations contained in the MRR. The facility should encourage the physician/prescriber to either accept or reject all or some of the recommendations contained in the MRR with an explanation as to why the recommendations were rejected.

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F 756	Continued From page 10 NJAC 8:39-29.3	F 756		
F 812 SS=F	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 review of facility documentation provided, it was determined that the facility failed to maintain proper kitchen sanitation practices, store dry foods in a safe and sanitary environment to prevent the development of food borne illness, and maintain 2 of 3 ice machines used for residents in a sanitary manner. The deficient practice was observed and was evidenced by the following: On 10/06/2020 at 9:25 AM, during the initial tour	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	10/30/20

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F 812	Continued From page 11 of the kitchen in the presence of the Food Service Director (FSD), the surveyor observed the following: 1. On the drying rack, there were 20 multiple sized serving trays/pans nestled on top of each other. The surveyor asked the FSD to separate the trays/pans and observed moisture between them. The FSD stated the pans should be separated to allow for proper drying to prevent bacteria growth. 2. On the drying rack, there were multiple different colored cutting boards drying. The surveyor asked the FSD to pull out the cutting boards. There were three white cutting boards that had multiple gouges and contained a black substance. The FSD stated that they should not be used because they could contain bacteria and get someone sick. The FSD threw the three white cutting boards in the trash. 3. In the dry storage room, there were paper coffee filters on the top shelf of a storage rack, open to air. The FSD stated that they should not be open to air because dust could contaminate them. 4. In the dry storage room, there was an opened container of pink peppercorns with a handwritten date of 04/18/2019 and an opened container of coriander with a handwritten date of 10/12/2018. The FSD stated that the facilities "use by" policy was that the spices were good for 6 months after the date they were opened. 5. In the dry storage room, there was a Styrofoam cup inside the sugar storage bin which directly touched the sugar. The FSD stated that it	F 812	It is the policy of the facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety. I. 1. Ceiling Vents Dirty 2. Coffee Filter Bag Open to Air 3. Cutting Boards w/ Deep Grooves Containing Residue 4. Dry Spices Out of Date 5. Cup in Bulk Sugar Bin 6. Metal Food Pans Stacked Holding Water (Wet-Nesting) II. 1. Ceiling Vents were immediately cleaned as per policy. Weekly Sanitation Audits being completed by the District Manager and reported to the Administrator. Corrective action for items not in compliance. 2. Coffee Filter bags were immediately discarded with proper covers placed on the coffee filter bins. Monthly Sanitation Audits being completed by the Regional Director and reported to the District Manager & Administrator. Corrective action for items not in compliance. 3. Cutting boards cited were discarded and replaced with new cutting boards. 4. Dry spices cited were immediately discarded. All spices were checked for proper dating with no further findings. Dry storage area inspected for proper/secure storage of all food and non-food products. Daily Label & Dating Audits being completed by the Regional Director and reported to District Manager &	

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F 812	Continued From page 12 should not be there because the surface could be contaminated. The FSD stated that staff should get a clean scoop to get what they need out of the bin and then the scoop should be removed and washed. It should not be stored in the bin. On 10/08/2020 at 8:52 AM, during a tour of the kitchen with the FSD, the surveyor observed the following: 1. The ceiling vents over the drying rack and over the pot sink had dust build up on the vents. The FSD stated the vents should be kept clean because dust could contaminate the clean dishware on the drying rack. 2. On the drying rack, there were 3 [redacted] containers nested on top of each other. The FSD separated the containers and there was water between them. The FSD stated that water should not be there because bacteria could grow. The containers should be separated to allow proper drying. On 10/08/2020 at 10:04 AM, upon examination of the residents' ice machine, located on the [redacted] floor [redacted], the surveyor observed a white and brown substance around the dispensing portion of the ice machine, a white substance around the back portion of the machine, and a brown moist substance in the base of the machine. During an interview with the surveyor on 10/08/2020 at 10:15 AM, the maintenance employee stated that housekeeping was responsible for the daily cleaning of the ice machines, but they should notify maintenance if they cannot get the machine clean.	F 812	Administrator. 5. Entire sugar bin was emptied and cleaned with no cup or scoop left in the bin. Bulk food storage bins inspected daily by Regional Director and weekly by District Manager. 6. All metal food pans were separated and washed through the dishwasher as per policy. Pans and Utensils inspected Daily within Regional Director Audit and weekly within District Manager audit for proper storage practice. III. 1. All staff were in-serviced on the proper procedure to properly label all food items with the corrective action to take when food exceeds its□ used by date. 2. All staff were in-serviced on proper storage of non-food items in dry storage area. 3. All staff in-serviced on proper drying procedures of all food pans and utensils. IV. 1. The monitoring of all food storage locations will be completed by the FSD/designee during the opening and closing inspections. The monitoring of food storage will be completed during the weekly sanitation inspection by the FSD/District Manager. Unit inspections will be reported to the administrator and Quality Assurance team for monitoring at the bi-weekly infection control QAPI.	

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F 812	Continued From page 13 Review of the "Ice Machine Quarterly Check" log, located on the side of the ice machine, revealed documentation that the ice machine was last checked 07/01/2020. On 10/08/2020 at 10:20 AM, the surveyor and maintenance employee inspected the residents' ice machine located on the [redacted]. The surveyor observed a white, pink and brown substance around the dispensing portion of the ice machine, a white substance around the back portion of the machine, and a brown moist substance in the base of the machine. Review of the "Ice Machine Quarterly Check" log, located on the side of the ice machine, revealed the ice machine was last checked 04/05/2020. The maintenance employee stated that he changed the filters in July but did not sign the log. He stated that the ice machine should be kept clean because bacteria could grow and make the residents sick. On 10/08/2020 at 10:35 AM, during an interview with the surveyor, the [redacted] Housekeeper (HK) stated that housekeeping was supposed to wipe down the countertop, the ice maker, cabinets, and microwave in the [redacted]. The HK stated that he did not clean the [redacted] area yet today. He stated that the ice machine was not clean and did not look like it was cleaned recently. The HK stated the he would wipe down, clean, and sanitize the ice machine, but if he could not get it cleaned, he would unplug it and report it to his supervisor because people could get sick if the ice machine was dirty.	F 812	2. The monitoring of all drying rack procedures will be completed by the Food Service Director/designee during the opening and closing inspections. The monitoring of drying racks will be completed during the weekly sanitation inspection by the Food Service Director/District Manager. Unit inspections will be reported to the administrator and Quality Assurance team for monitoring at the bi-weekly infection control QAPI. 3. The monitoring of all label and dating procedures will be completed by the Food Service Director/designee during opening and closing inspections. The monitoring of label and dating will be completed during daily RD audits and weekly District Manager audits. Unit inspection results will be reported to the administrator and Quality Assurance team for monitoring at the bi-weekly infection control QAPI. 4. The monitoring of all sanitation procedures will be completed by the Food Service Director/designee during opening and closing inspections. Ceiling vents in need of cleaning will be reported to facility maintenance utilizing facility protocol to ensure the safety of Dining Staff employees who are not permitted to utilize equipment such as a ladder to access ceiling vents and tiles. Findings will be reported to the administrator and QI team for monitoring at the bi-weekly infection control QAPI.	

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F 812	Continued From page 14 During an interview with the surveyor on 10/08/2020 at 10:38 AM on the [redacted], the Environmental Services Director (ESD) stated that he was the director for maintenance and housekeeping. The ESD stated that housekeeping cleans the ice machines daily and that maintenance should inspect the ice machines monthly to make sure they were clean and working properly. The ESD stated he did daily checks to make sure that the maintenance and housekeeping staff were doing what they were supposed to do. He stated that he noticed that the ice machines on the [redacted] did not look clean the day before and that he needed "CLR" to clean them, but the facility was out of it. Review of the facility's "Food and Nutrition Services Use By Dating Guidelines" policy, revised on 12/01/2015, revealed liquids/flavorings: "Use by" date six months after opening and properly closed. Review of the facility's "Food Storage: Dry Goods" policy, revised date 09/2017, revealed: Policy Statement: All dry goods will be appropriately stored in accordance with the FDA Food Code. Procedures: 5. All packaged and canned food items will be kept clean, dry and properly sealed, 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. Review of the facility's "Warewashing" policy, revised 09/2017, revealed Procedures: 1. The Dining Services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine and proper handling of sanitized dishware, 4. All dishware	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the policy of the facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety. " The center□s [redacted] floor Ice Machine□s located at the power bars were turned off and immediately serviced. Ice was provided to the units by other means while the machines were serviced that day. Proper cleaning and filter changes were conducted at this time for both floor ice machines. No patients were noted to have an untoward effect due to the deficient practice. " Immediate education on the centers policy and procedure on Category: Ice Machine was issued to the entire Housekeeping department and Maintenance Director. " Ice Machine will continue to be cleaned daily by the housekeeping department assigned to that unit. Filters and coils will be cleaned and changed quarterly and documented on the Ice	

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F 812	Continued From page 15 will be air dried and properly stored. Review of the facility's "Manual Warewashing" policy, revised 09/2017, revealed Procedures: 3. All serviceware and cookware will be air dried prior to storage. Review of the facility's undated policy for "check filters (if present), clean coils, sanitize interior, delime as necessary" included, Recurrence: Monthly, Category: Ice Machines. Sanitize Interior: 1. Sanitize interior of ice machine per manufacturer's instructions; Clean Exterior: 1. Clean and wipe down exterior. NJAC 8:39-17.1(a);17.2(g)	F 812	Machine Quarterly Check Log by the Maintenance Director. Environmental Director will conduct daily rounds and assess the machines to ensure compliance is in place. " All findings will be corrected immediately and reported at the Infection Control monthly QAPI meeting for the next 3 months. Completion Date: 10/30/2020	
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	F 880		11/5/20

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facility assessment conducted according to §483.70(e) and following accepted national standards;

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

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

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 17 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, and record review, it was determined that the facility failed to ensure that staff wear the appropriate personal protective equipment (PPE) for residents on contact plus airborne isolation, to address the risk for infection transmission, in accordance with the facility policy and acceptable standards of infection control practice. This deficient practice was identied for 3 of 3 residents (Residents #18, #22, and #27) reviewed for infection control practices and was evidenced by the following: On 10/08/2020 at 8:10 AM, as Surveyor #1 entered the facility's conference room, a notice was left from the Administrator that the facility had a positive employee who worked on the second floor, and that after consultation with the local health department, the facility was on outbreak status with full house precautions for both floors in the facility. During an interview with Surveyor #1 on 10/08/2020 at 8:30 AM, the Administrator stated that the staff were to wear N95 masks, face shields and gowns when entering resident rooms on both floors. On 10/08/2020 at 9:40 AM, on the [redacted] Surveyor #2 observed a Certified Nursing	F 880	F880 Infection Prevention and Control This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the policy of the facility to ensure that all staff wear the appropriate personal protective equipment (PPE) for patients on contact plus airborne isolation, and to address and minimize the risk for infection transmission. • Resident #18, #22, and #27 did not have untoward effect due to the deficient practice. The CNA was immediately stopped from entering any further rooms during meal pass without wearing the correct PPE and re-educated by the Supervisor at that moment. • The Nurse Practice Educator/Designee completed in-servicing for all clinical staff on the facility's Infection Control Policies and Procedures.	

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F 880	Continued From page 18 Assistant (CNA) #1 delivering breakfast trays to the residents. CNA #1 entered Resident #18's room with a breakfast tray, wearing a N95 mask, gloves and face shield. There was a yellow sign on door. The yellow sign read "Patient-Specific Contact Plus Airborne Precautions, wear a N95/approved KN95 Respirator, Gown, Face Shield and gloves upon entering this room." CNA #1 then entered Resident #27's room with a breakfast tray, wearing a N95 mask, gloves and face shield. There was a yellow sign on the door. The yellow sign read "Patient-Specific Contact Plus Airborne Precautions, wear a N95/approved KN95 Respirator, Gown, Face Shield and gloves upon entering this room." CNA #1 then entered Resident #22's room with a breakfast tray, wearing a N95 mask, face shield, and gloves. There was a yellow sign on door. The yellow sign read "Patient-Specific Contact Plus Airborne Precautions, wear a N95/approved KN95 Respirator, Gown, Face Shield and gloves upon entering this room." On 10/08/2020 at 9:46 AM, as CNA #1 was exiting Resident # 22's room, Surveyor #2 asked CNA #1 what the yellow sign on the door meant. She stated that the yellow sign meant you must wear a gown, gloves, mask, and face shield when you are giving care. CNA #1 stated she was only passing trays and was told by her supervisor that she did not need to wear a gown while passing trays. During an interview with Surveyor #2 on 10/08/2020 at 9:47 AM, the Clinical Supervisor (CS) stated that the yellow signs meant that upon entering the room, full Personal Protective Equipment (PPE), a face shield, a N95 mask, gloves, and gown should be worn to protect	F 880	• The clinical directors/supervisors will oversee the meal process three times per week covering each meal to ensure that compliance is being met. This audit will be completed for one month and transition to three times a month times two months. Any noncompliance will be corrected immediately with findings provided to the Nurse Practice Educator/Designee. The facility will continue to conduct infection control audits on every shift by assigned designees with findings reported on our bi-weekly infection control QAPI meetings. • The Nurse Practice Educator/Designee will gather all audit data from the clinical directors/supervisors for any noncompliance noted during their audits and report findings at our bi-weekly infection Control QAPI meeting for the next 3 months. Completion date: 11/5/2020	

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yourself and the resident from spreading the infection.

On 10/08/2020 at 9:48 AM, the CS stopped CNA #1 from entering another room and told her that she needed to wear a gown upon entering the room, even if she was just passing trays.

During an interview with the surveyors on 10/13/2020 at 1:11 PM, the Infection Control Nurse (ICN) stated that all staff were aware they must follow the directions on the yellow sign. This would include donning (putting on) full PPE: a mask, a face shield, gown, and gloves, from the moment the room was entered. The ICN stated while delivering trays, full PPE must be worn to prevent the spread of an infection.

Review of the facility's "Infection Control Policies and Procedures IC405 COVD-19" policy, revised 10/01/2020, revealed that Airborne Precautions was defined as wearing an N95/approved KN95 respirator upon entry into the patient's room to prevent the development and transmission of COVID-19.

Review of the facility's "Infection Control Policies and Procedures, IC304 Infectious Disease and Transmission Based Precautions" policy, reviewed 11/15/2019, revealed that the appropriate types and duration of Transmission Based Precaution would be followed based on patient's condition, Center for Disease Control and Prevention (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in HealthCare Settings. Purpose: To prevent the spread of infection/infectious disease.

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F 880	Continued From page 20 Review of the facility's "Infection Control Policies and Procedures, IC400 Infectious Disease Management" policy, revised 11/15/2019, revealed that Emerging/Novel Organisms/Infections: Manage care according to Centers for Disease Prevention and Control (CDC) and state/local health department recommendations to prevent the transmission of infectious diseases. NJAC 8:39-19.4(a)(1-2)(c)	F 880		