STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315126	A. BUILDING _____ B. WING _____	01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	1045 E CHESTNUT AVE VINELAND, NJ 08360

(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 Survey: CENSUS: 128 SAMPLE: 30 + 2 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.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 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 maintain the nurse call light within in reach of a resident. This deficient practice was identified for [redacted] of [redacted] sampled resident's, (Resident [redacted] and was evidenced by the following: During the initial tour on 12/10/2021 at 11:28 AM, the surveyor observed Resident [redacted]'s call light was wedged between the mattress and bedframe of the bed. The call light was observed to hang down towards the floor and was not accessible to the resident in this position. The call light was observed to be on the right side of the bed.	F 558	F558 Reasonable Accommodations, Needs/Preferences. a) Upon notification that the call bell was not accessible it was immediately placed within reach for the resident. b) All other residents call bell placement was checked immediately. No other call bells were out of reach for resident and placed properly. c) Measures put in place to be sure this does not happen again: • New clips for call bells will be replaced to assure call bells are attached to the resident and within reach.	2/1/22

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

Electronically Signed | 01/14/2022

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F 558	Continued From page 1 According to the Admission Record Resident [redacted] had the following diagnoses: [redacted]. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed Resident [redacted] had a Brief Interview for Mental Status score of [redacted], which indicates [redacted]. Section [redacted] of the MDS revealed Resident [redacted] had no [redacted] and [redacted]. A review of Resident [redacted]'s care plan, last revised on [redacted] revealed that Resident [redacted] was at risk for [redacted], [redacted], and [redacted] mobility. Care planned interventions included: "Reinforce the need to call/ring for assistance." On 12/13/2021 at 12:45 PM, the surveyor observed Resident [redacted] lying in bed after the lunch meal. Resident [redacted]'s call light was observed to be hanging above the floor and wedged between the bed frame/side rail and mattress on the right side of the bed, as previously seen on the initial tour on 12/10/2021. The surveyor asked Resident [redacted] if he/she could activate their call light. The resident stated, "I'll have to get one of the staff to get it for me the next time they come in." Resident [redacted] attempted to lift his/her [redacted] by using their [redacted] to the assist the [redacted]. Resident [redacted] was unable to access the call light with either [redacted] on this attempt. On 12/16/21 at 9:56 AM, Resident [redacted] was	F 558	• The nurse educator did an immediate in-service and education on placement of call bell within reach for residents. This education will be ongoing. d) The following corrective actions will be monitored to ensure efficient practice will not be repeated: All call bells will be audited by the unit manager and or supervisor for proper placement weekly X 4, monthly X 3 quarterly and ongoing as needed. All findings will be reported to the QAPI committee on a monthly basis. Completion date: 2/1/2022	

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F 558	Continued From page 2	F 558		

observed lying on the bed and watching television. The call light was observed to be wedged between the mattress and the right-side rail and suspended downward towards the floor. The surveyor asked Resident [redacted] if he/she was able to access the call light. Resident [redacted] attempted to lift his/her [redacted] by using their [redacted] to the assist the [redacted]. Resident [redacted] was unable to access the call light with either [redacted] on this attempt and stated to the surveyor, "I can't get it."

On 12/21/21 at 8:50 AM, Resident [redacted] was observed to be lying in bed watching television. Resident [redacted]s call light was observed on the right side of the bed to be wedged between the mattress and bed frame/right siderail and hanging downward towards the floor. The surveyor asked Resident #[redacted] if they could turn on their call light. Resident [redacted] was unable to turn on their call light due to inability to reach it. Resident [redacted] stated, "I can't. I can't reach it." The surveyor questioned Resident [redacted] how they notify the nurse or staff when they need help, Resident [redacted] shrugged their shoulders and stated, "I yell."

During an interview with the surveyor on 12/21/21 at 9:04 AM, the Certified Nursing Assistant (CNA #3) who was responsible for Resident [redacted]'s care that shift stated, "The call light should be on his/her strong side. We should make the call light accessible so that if he/she needs help he/she can use his/her left hand to put the call light on."

During an interview with the surveyor on 12/21/21 at 1:09 PM, the facility Administrator was asked what the expectation would be for resident call light accessibility. The Administrator responded, "The expectation would be that the call bell is

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F 558	Continued From page 3 accessible to all residents, of course." The surveyor reviewed the facility provide policy with SUBJECT: Call Bell Response, with revised date of 5/2017. The policy did not address the placement and accessibility of resident call lights. N.J.A.C. 8:39-31.8 (c)(9)	F 558		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 582		2/1/22

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F 582	Continued From page 4 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to issue the required beneficiary notices for 2 of 3 residents reviewed for Beneficiary Protection Notification (Resident [redacted] and Resident # [redacted]. This deficient practice was evidenced by the following: On 12/20/21 at 1:06 PM, the surveyor reviewed the SNF Beneficiary Protection Notification Review (SNFBPNR) completed by the facility for Resident [redacted]. The SNFBPNR indicated that Resident [redacted] last covered Medicare day was 6/29/21 and Resident [redacted] remained in the	F 582	F582 Medicare/Medicaid/coverage/liability notice. a) Our immediate corrective action was to review of our policy on coverage liability and notification by the administrator and a new process was implemented with the correct department. b) An audit was conducted by the social service department and no other residents were affected. c) Measures implemented to ensure this does not recur:	

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F 582	Continued From page 5 building. The SNFBPNR further revealed that a "Notice of Medicare Non-Coverage-Form CMS 10123 (NOMNC)" was not provided to Resident [redacted]. The section of the SNFBPNR #2 indicated the NOMNC was not given as Resident [redacted] still had Medicare A time available. On 12/20/21 at 1:06 PM, the surveyor reviewed the SNFBPNR completed by the facility for Resident [redacted] The SNFBPNR indicated that Resident #[redacted]s last covered Medicare day was 7/13/21 and Resident [redacted] remained in the building. The SNFBPNR further revealed that a "Notice of Medicare Non-Coverage-Form CMS 10123 (NOMNC)" was not provided to Resident [redacted]. The section of the SNFBPNR #2 indicated the NOMNC was not given as Resident [redacted] still had Medicare A time available. During an interview with the surveyor on 12/22/21 at 9:28 AM the Administrator said they did not give NOMNC to Resident [redacted] and Resident [redacted] as they still had Medicare A time available. NJAC 8:39-4.1(a)(8)	F 582	• The social service department will now review all NOMNCS and discuss with families and residents in the proper timeframe. • All potential discharge dates and cut dates will be discussed weekly in utilization review. d) All NOMNC dates will be presented by the therapy department, managed care coordinator and or business office coordinator and discussed in utilization review on a weekly basis. All cut letters will be delivered to the appropriate resident and family member by social services or designee. All findings will be reported. It will be reported to the QAPI committee on a monthly basis to ensure compliance. Completion date: 2/1/2022	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		2/1/22

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F 609	Continued From page 6 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to report an elopement to the New Jersey Department of Health (NJDOH) in accordance state requirements for [redacted] resident reviewed for [redacted], (Resident [redacted]. This deficient practice was evidence by the following: According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included but not limited to, [redacted]. A review of the most recent Minimum Data Set (MDS), an assessment tool used to manage care dated [redacted] revealed that Resident [redacted] had [redacted] and had a [redacted]	F 609	F609 Reporting of alleged violations a) Once we were informed that this was a reportable event, it was reported immediately by the administrator and Director of Nursing to the New Jersey Department of Health and Senior Services and the ombudsman office. b) No residents were harmed as a result of this practice. c) Measures put into place to ensure this does not recur: • Nursing management and administration reviewed and updated the elopement policy for the facility. • All residents who exit the building without supervision will be reported to the NJDOH and the ombudsman‘s office immediately.	

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F 609	Continued From page 7 [redacted] in place. An [redacted] Risk conducted and initiated on [redacted] indicating that the resident was at risk for [redacted] and a history of [redacted] The Physician Order Summary dated [redacted], included an order for a [redacted] with orders to check every shift for placement [redacted]) every night shift for [redacted]. A review of the Treatment Administration Record (TAR) for [redacted] and [redacted] indicated that the physician order was consistently documented as having been done. A review of an Interdisciplinary Note (IN) dated [redacted], indicated that at approximately 12:30 PM, the facility Administrator was notified by the charge nurse that she was unable to locate a resident. The IN further revealed that a Code gray was called; (a message announced over the facility's public address system, indicating the need for an emergency response to a security emergency). The IN reflected that the resident was located outside of building, unharmed or injured, alert and verbally responsive, ambulating. A full body assessment was unremarkable, no distress or complaints of pain. A review of Resident [redacted] care plan with an initiated date of [redacted], identified the [redacted] risk and included checking the placement and function of the [redacted] and redirecting to an appropriate area with supervision when exhibiting [redacted] behaviors.	F 609	d) An audit of any future [redacted] will be conducted by nursing administration/administrator or designee, to ensure our policy was followed regarding proper notifications and reporting. All findings will be reported to the QAPI committee monthly. Completion date: 2/1/2022	

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F 609	Continued From page 8 The facility provided an untitled form that was referred to as an "incident report", dated [redacted] and timed at 12:30 pm, that described that Resident [redacted] wandered off the unit and was located outside of the facility. There were no injuries reported, no witnesses found. The form indicated that the Physician and family member were notified on [redacted] at 1:00 PM. During an interview with the surveyor on 12/20/21 at 11:32 AM, the Administrator stated that she did not feel the [redacted] warranted notifying the NJ Department of Health (NJDOH). The Administrator stated, I take full responsibility for not reporting the [redacted] to the NJDOH as required by state and federal regulations. A review of a facility policy titled [redacted] and [redacted] Resident dated [redacted], included under the steps to follow; The person in command will notify the proper authorities. This is to include but not limited to the local police department, the Department of Health and Senior Services and the resident's family members.	F 609		
F 610 SS=D	NJAC 8:39 -5.1 (a) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		2/1/22

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F 610	Continued From page 9 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that the facility failed to complete a thorough investigation of an elopement for [redacted] resident reviewed for elopement (Resident [redacted]. The deficient practice was evidenced by the following: According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included but not limited to, [redacted]. A review of the most recent Minimum Data Set (MDS), an assessment tool used to manage care, dated [redacted] revealed that Resident [redacted] had [redacted] and had a [redacted]) in place. An [redacted] Risk dated [redacted], indicated that the resident was at risk [redacted] related to [redacted] and a history [redacted]. A Physician Order Summary for the period of [redacted], included a physician order for a [redacted] with orders to check every shift for placement ([redacted]) every night shift for	F 610	F610 Investigate, prevent, correct alleged violation a) Our immediate action was to perform a further investigation. At the time of the incident we received statements from staff members. They concluded that the Resident was found on facility grounds. The further investigation yielded a more detailed explanation of how long the Resident was missing and where the Resident was found. We were unable to conclude what exit point the Resident used. b) No other residents were affected by this deficient practice. c) Measures taken to ensure this does not recur: • Upon notification of incidents that need to be reported, a more detailed investigation will be conducted immediately by the manager on duty or the administrator or designee. Statements will be obtained by the supervisors as the incident occurs and reviewed by administration. Our investigation policy will be implemented and followed.	

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F 610	Continued From page 10 [redacted] A review of the Treatment Administration Record (TAR) for [redacted] and [redacted] indicated that the physician order to check every shift for placement ([redacted]) every night shift for [redacted] was consistently documented as having been done. A review of an Interdisciplinary Note (IN) dated [redacted] and timed at 12:30 PM, revealed the facility Administrator was notified by the charge nurse that she was unable to locate a resident. The IN further revealed that a Code gray was called; (a message announced over the facility's public address system, indicating the need for an emergency response to a security emergency). The IN reflected that the resident was located outside of building, unharmed or injured, alert and verbally responsive, ambulating. A full body assessment was unremarkable, no distress or complaints of pain. A review of Resident [redacted]'s care plan with an initiated date of [redacted] identified the elopement risk and included checking the placement and function of the [redacted] and redirecting to an appropriate area with supervision when [redacted] behaviors. The facility provided an untitled form that was referred to as an "incident report", dated [redacted] and timed at 12:30 pm, that described that Resident [redacted] off the unit and was located outside of the facility. There were no injuries reported, no witnesses found. The form indicated that the Physician and family member were notified on [redacted] at 1:00 PM.	F 610	d) Once the investigation is complete, it will be reviewed by nursing management and administration for thoroughness and reported to all appropriate agencies and personnel. All findings will be reported to the QAPI committee monthly. Completion date: 2/1/2022	

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F 610	Continued From page 11 During an interview with the surveyor on 12/20/21 at 11:32 AM, the Administrator stated that it was undetermined as to which door the resident eloped from and that the resident was found within 15 minutes, outside the building near the front door [redacted]. The administrator added that she did not follow the facility policy to conduct a thorough investigation including any corrective actions taken or follow-up information. A review of a facility undated policy titled, Accidents and Incident-Investigating and Reporting revealed that the following data, as applicable, shall be included on the Report of Incident/Accident form that includes, corrective action taken, follow-up information, other pertinent data as necessary or required .... NJAC 8:39-5.1(a)	F 610		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		2/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315126	A. BUILDING _____ B. WING _____	01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	1045 E CHESTNUT AVE VINELAND, NJ 08360

(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 623	Continued From page 12 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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F 623	Continued From page 13 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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F 623	Continued From page 14 Based on interview and record review, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman for [redacted] residents reviewed for hospitalization, Resident # [redacted], Resident # [redacted] and Resident [redacted]. This deficient practice was evidenced by the following: On 12/10/21 at 11:27 AM, the surveyor performed a record review of Resident [redacted]. A review of the progress note dated [redacted], indicated that Resident [redacted] was transferred to the hospital for [redacted]. There was no documented evidence that the Ombudsman was notified of the resident's transfer to the hospital. On 12/21/2021 at 9:25 AM, the surveyor performed a closed record review of Resident [redacted] A review of the Progress Notes dated [redacted], indicated that Resident [redacted] was transferred to the hospital for a change in mental status. There was no documented evidence that the Ombudsman was notified of the resident's transfer to the hospital. On 12/21/21 at 9:30 AM, the surveyor performed a record review of Resident [redacted] A review of the Progress Note dated [redacted], indicated Resident [redacted] was transferred to the hospital for [redacted]. There was no documented evidence that the Ombudsman was notified of the resident's transfer to the hospital. On 12/21/2021, the facility was unable to provide any documentation to show that the Ombudsman had been notified of Resident [redacted] Resident [redacted], and Resident [redacted] s transfer to the hospital.	F 623	F623 Notice Requirements before Transfer/Discharge a) We immediately reviewed our policy on Hospital unplanned transfers and re-implemented this policy. b) No residents were harmed by this deficient practice. c) The measures that were put into effect to prevent this from recurring are: • All unit managers and supervisors were inserviced on the policy. They will put a copy of the transfer form in a binder and give the original copy to the administrator. • The binder will be maintained on the proper floor of the residents room. The administrator will mail the transfer forms to the ombudsman weekly. d) Nursing management will review and audit all unplanned transfers and be sure there was a form attached to each one proper reporting to the ombudsman takes place. All findings were reported to the QAPI committee on a monthly basis. Completion date: 2/1/2022	

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F 623	Continued From page 15 During an interview with the surveyor on 12/21/2021 at 10:00 AM, the facility Administrator stated that she is the person responsible for notifying the Office of the State Long Term Care Ombudsman of a resident's transfer to the hospital. She acknowledged that she did not send the notification to the Office of the State Long-Term Care Ombudsman as required for Resident [redacted] During an interview with the surveyor on 12/21/21 at 10:25 AM, the Administrator stated she was aware the facility was supposed to notify the Ombudsman's office when a resident is sent to the hospital. She then acknowledged they did not notify the Ombudsman when Resident [redacted] was transferred to the hospital on [redacted]. When asked why the facility failed to notify the Ombudsman's office she stated "with [redacted], notifications have dropped off for the past two years." During an interview with the surveyor on 12/21/21 at 11:45 AM, the Director of Nursing confirmed the Ombudsman was not contacted regarding Resident [redacted] s transfer to the hospital because of the pandemic. "It sorta dropped off" On 12/21/2021 at 10:43 AM, the Administrator stated that there is no facility policy for notifying the Ombudsman. N.J.A.C. 8:39-4.1(a) 31	F 623		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		2/1/22

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F 690	Continued From page 16 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to place a resident's [redacted] bag inside of a [redacted]	F 690	F690 Bowel/Bladder/Incontinence, Catheter, UTI a) Once nursing staff was alerted to the	

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F 690	Continued From page 17 bag, according to facility policy, to maintain resident dignity. This deficient practice was identified for [redacted] residents (Resident #[redacted]) reviewed for [redacted] and was evidenced by the following: During the initial on 12/10/2021 at 11:17 AM, the surveyor observed Room [redacted] with the door closed and a sign posted on the outside of the doorway indicating Resident [redacted] was on [redacted] precautions. On interview the Unit Manager stated, "He/she had a [redacted] placed recently." According to the Admission Record Resident [redacted] had the following diagnoses: [redacted]. A review of the most recent Minimum Data Set (MDS), an assessment tool dated [redacted] revealed Resident #[redacted] had a Brief Interview for Mental Status score of [redacted], indicating [redacted]. The MDS further revealed Resident [redacted] had an [redacted]. During an interview with the surveyor on 12/13/21 at 8:47 AM, with the Licensed Practical Nurse (LPN #4) regarding resident [redacted], LPN #4 responded, "He/ she is no longer on [redacted] precautions. They are finished the [redacted] The surveyor entered the room and observed Resident [redacted] lying in bed and was [redacted] to the surveyor's voice. The [redacted] bag was observed to be attached to the bedframe. The [redacted] bag was not in a [redacted] bag and was visible from the	F 690	missing [redacted] bag, our immediate corrective action was to place the [redacted] [redacted] bag inside of the [redacted] bag. b) There were no other residents affected by this deficient practice. c) Corrective measures involved: • Unit manager and supervisors will perform daily audits to ensure all [redacted] bags are covered with a [redacted] bag. All bags not covered will be covered immediately by the Unit Manager or designee. • All CNAs involved with this deficient practice were educated by the unit manager. Continued education regarding the proper use of [redacted] bags was provided to all nursing staff and will be conducted by the staff education nurse. d) Corrective actions will be monitored by the unit manager and supervisors. All findings will be presented to the QAPI committee monthly. Additionally, all new hires will also be educated on this practice of [redacted] bags by the nurse educator during orientation. Completion date: 2/1/2022	

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F 690	Continued From page 18 hallway. On 12/16/2021 at 10:06 AM, Resident [redacted] was observed lying in bed. The surveyor observed Resident [redacted] bag was attached to the bedframe. The [redacted] bag was not in a [redacted] bag and was visible from the hallway. During an interview with the surveyor on 12/16/21 at 10:19 AM, LPN #4 stated, "I see that the [redacted] bag is out of the [redacted] bag and it should be in the [redacted] bag. The CNA's (certified nursing assistants) are responsible for placing the [redacted] bag back in the [redacted] bag after they empty the bag." The surveyor then questioned LPN #4 if any other staff besides a CNA could be responsible for placing a [redacted] bag in the [redacted] bag. LPN #4 responded, "No, anybody could do it." During an interview with the surveyor on 12/16/2021 at 2:05 PM, the Director of Nursing (DON) asked if [redacted] bags were to be kept in [redacted] bags. The DON stated, "All catheter bags are required to be in [redacted] bags." During a follow-up interview with the surveyor on 12/21/2021 at 1:11 PM, the DON, in the presence of the facility Administrator and survey team, again asked whether resident catheter bags are required to be contained in a [redacted] bag. The DON replied, "All [redacted] are to be in a [redacted] bag." A review of a facility policy with SUBJECT: Emptying [redacted] Bag, EFFECTIVE DATE: 2/2016, the following was revealed under the heading General Guidelines:	F 690		

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F 690	Continued From page 19 10. "Replace [redacted] bag after emptying." N.J.A.C. 8:39-27.1(a)	F 690		
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, record review and review of other facility documentation, it was determined that the facility failed to implement infection control measures for the handling and storage of [redacted] equipment by leaving a [redacted] exposed to the environment and having a [redacted] on the floor that was connected a resident for [redacted] residents reviewed for [redacted] care, (Resident [redacted] & Resident #[redacted]. Resident [redacted] and Resident #[redacted] both have [redacted]). The deficient practice was evidenced by the following: During the initial tour on 12/10/21 at 10:16 AM, the surveyor observed on Resident [redacted], a [redacted], [redacted] connected to a [redacted] that allows for the [redacted]	F 695	F695 Respiratory/Tracheostomy care and suctioning a) Upon notification of the [redacted] having a portion on the floor they were immediately replaced with clean [redacted] and repositioned to be off the floor by the infection control practitioner. The [redacted] was immediately replaced and covered with a plastic bag and dated. b) No residents were affected by this deficient practice. c) Measures we will put into place to ensure this does not recur: • Infection control nurse educated all nursing staff on proper placement of [redacted]s, proper storage and handling all [redacted] equipment. d) Infection control nurse, unit Managers	2/1/22

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F 695	Continued From page 20 [redacted] to patients who have had a [redacted] covering his/her [redacted]. The [redacted] was connected to a [redacted] [redacted] is a machine used for administering [redacted]) that was in operation. A portion of the [redacted] was on the floor. On 12/13/21 at 9:50 AM, in Resident [redacted]s room, the surveyor observed the [redacted] [redacted] connected to the [redacted] covering his/her [redacted]. The [redacted] was connected to the [redacted] that was in operation. A portion of the [redacted] was observed to be on the floor on top of a linen towel that was also on the floor. On 12/14/21 at 10:35 AM in Resident [redacted] room, the surveyor observed the [redacted] [redacted] connected to the [redacted] covering his/her [redacted]. The [redacted] was connected to the [redacted] that was in operation. A portion of the [redacted] was on the floor on top of a linen towel. On 12/20/21 at 10:35 AM, in Resident [redacted] room, the surveyor observed a [redacted] ([redacted] placed in Resident #[redacted]. The other end of the [redacted] was attached to a running [redacted] (medical device that gives [redacted] to a person). A portion of the [redacted] was on the floor. A review of Resident [redacted]'s electronic medical record revealed under the medical diagnosis section, a diagnoses including but not limited to; History of [redacted]	F 695	and supervisors will perform audits weekly X 4, monthly X 3, and ongoing. All findings will be reported to the QAPI committee monthly. completion date: 2/1/2022	

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F 695	Continued From page 21 [redacted] and [redacted].	F 695		

A review the most recent Minimum Data Set, an assessment tool dated [redacted], revealed Resident [redacted] received [redacted] and had a [redacted]

A review of the physician's orders revealed Resident [redacted] was to receive [redacted] the [redacted] every shift.

During the initial tour on 12/10/21 at 10:37 AM, the surveyor observed a [redacted] (a [redacted] that [redacted]) connected to a [redacted] set on top of a bed side table in Resident [redacted]'s room. The [redacted] was not covered and was exposed.

On 12/13/21 at 9:55 AM, the surveyor observed the [redacted] connected to a [redacted] set on top of a bed side table in Resident [redacted] room. The [redacted] was not covered and was exposed.

A review of Resident [redacted]s electronic medical record revealed under the medical diagnosis section, diagnoses including but not limited to; [redacted]

A review of the most recent Minimum Data Set. an assessment tool dated [redacted], revealed that Resident #[redacted] was receiving [redacted] care while a resident in the facility.

A review of the physician's orders revealed Resident [redacted] had an order for [redacted] ([redacted] used to treat [redacted] and

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F 695	Continued From page 22 [redacted]) via the [redacted] once daily for [redacted]. During an interview with the surveyor on 12/21/21 at 9:07 AM, the Infection Prevention Nurse (IPN) said [redacted], including [redacted] should be stored in a plastic bag. The IPN further stated [redacted] should never be on the floor. A review of a facility policy titled, [redacted] Equipment Care dated 12/2019, revealed, [redacted] equipment to be dated when provided to pt (patient) and kept at bedside in bag. The policy also revealed, Unit to be kept in plastic bag at bedside for individual pt. and Date and placed in bag for patient use.	F 695		
F 804 SS=E	N.J.A.C. 8:39-19.4(k) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to consistently serve foods at a safe and appetizing temperature. This deficient practice was evidenced by the following:	F 804	F804 Nutritive Value/Appear, Palatable/Prefer Temp a) Food temperatures were lower than the recommended serving temperature. We	2/1/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 23 On 12/14/2021 at 10:30 AM, the surveyor conducted the Resident Council Meeting with seven alert and oriented residents. 7 of 7 residents in attendance stated the food was often not served hot enough for their preference. The residents stated that less than warm meals occurred at all mealtimes. On 12/16/2021 at 11:15 AM, the surveyors entered the kitchen to monitor food temperatures for the lunch meal. At 11:30 AM, an interview was conducted with the Cook who confirmed that food temperatures are not obtained prior to food being placed into the steam table or prior to plating. However, the cook confirmed that food temperatures are taken upon completion of the cooking process. At 12:06 PM, at the request of the surveyors, a test tray was plated from the lunch tray line. At 12:07 PM, the test tray was placed on the meal cart and exited the kitchen. This was the last meal cart that was to be delivered to residents on the third floor. At 12:10 PM, the food cart arrived on the third floor and staff immediately began to distribute resident meals. The last resident meal tray was delivered at 12:16 PM. At 12:19 PM the cook, in the presence of the surveyors, tested the food temperatures on the test tray using the same digital thermometer the cook used to take temperatures in the kitchen prior to the lunch meal service. The following temperatures were obtained: Barbeque Chicken- 125.2 degrees Mashed potatoes- 121.9 degrees Carrots- 119 degrees	F 804	immediately changed our current practice to keep plates in the oven to help keep food hot when plated and served. This was changed in our policy temporarily. B) All residents have the potential to be affected. No residents were affected by this deficient practice. c) The following corrective measures were put in place to be sure this does not recur: • It was determined that the pellet warmer was not in working order due to a faulty on and off switch. • The on/off switch on the pallet warmer was purchased and will be replaced by the Maintenance Director to keep the pellets warm and the plates warm for the food to maintain proper temperatures. • All food will be placed on plates warmed by the pallet warmer once repaired and covered with the top dome. d) A weekly audit will be conducted by the food service Director or designee, to ensure the pellet warmer is in working condition. Any equipment not found in working order will be repaired immediately. Weekly test tray temperatures will be taken at the floor level by the Food Service Director or designee once all trays are delivered. Audits will be conducted by food service personnel weekly X 4, monthly X 3, and ongoing as needed. All findings will be reported to the QAPI committee monthly. Completion date: 2/1/2022	

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F 804	Continued From page 24 Chilled peaches- 55 degrees Coffee- 160 degrees Cranberry juice- 45 degrees At 12:20 PM, the surveyor observed the test tray after the cook had completed the food temperatures. The surveyor observed that the entree was plated and covered with a plastic pellet lid (a system used in food service to keep hot foods at safe temperatures), and the plate sat on the tray. There was no bottom pellet to enclose the meal plate. On interview the cook stated, "We only have lids, we never had bottoms (pellets). The food service director wondered why we didn't have bottoms, either. We never had them in the 3 years I have been here." During an interview at 12:26 PM, with the Food Service Director, who confirmed that the appropriate food temperature should be "a minimum now of 135 degrees." A review of a facility policy titled Food Temperatures, effective 11/30/2017, revealed under the heading Process: 4. During transportation of food from the kitchen to the dining rooms, patient/resident rooms, or other dining locations, care is taken to keep hot food hot and cold food cold and protected from contamination.	F 804		
F 812 SS=F	NJAC 8:39-17.4(a)2,(e) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		2/1/22

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F 812	Continued From page 25 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 other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent foodborne illness. This deficient practice was evidenced by the following: On 12/10/2021 at 9:53 AM, the surveyors, accompanied by the Head Cook (HC) observed the following in the kitchen: 1. In the Dry Storage area on a lower shelf, (1) open bag of shell pasta and (2) open bags of rotini pasta did not have an open or use by dates. On the shelf above, (1) open bag of spaghetti wrapped in plastic wrap had no open or use by date. When interviewed the HC stated, "We usually have an open and use by date on	F 812	F812 Food procurement, store/prepare/serve- sanitary a) All improperly stored food items that were outdated, undated, improperly stored or not labeled, were immediately discarded by the food service director and unit managers. • All areas in the kitchen, walk-in refrigerator, single door reach in refrigerator, double door reach in, and dry storage room were immediately cleaned of all debris and discarded. • The box of plastic wrap was discarded by Dietary personnel, The Stand up Mixer backsplash and the slicer were immediately recleaned and sanitized by dietary personnel once they were alerted to it being unclean. Both items	

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F 812	Continued From page 26 anything that is opened and not completely used". 2. In the Walk-In Refrigerator on a rear shelf, one half onion was observed in a plastic container. The container had no dates. On the same shelf, a turkey sandwich in a plastic disposable container had no dates. Both items were removed and thrown away by the HC in the presence of the surveyors. 3. In the Double Door Reach-In Refrigerator on the top shelf, (2) packages of opened sliced cheese wrapped in plastic wrap had no dates. On the middle shelf, an opened (5) pound bag of low moisture shredded mozzarella cheese had no dates. On a bottom shelf, a half sheet pan contained (9) turkey sandwiches in individual plastic containers. The containers had no dates. On the same shelf, a block of unidentified cheese wrapped in plastic wrap had no dates. 4. A review of the Double Door Reach-In Refrigerator Temperature Log revealed that internal temperatures were not recorded for 12/7/21 PM and 12/9/21 AM. When interviewed the HC stated, "Temperatures are to be recorded twice a day." 5. In the Single Door Reach-In Refrigerator, a white bucket contained hard boiled eggs. The bucket had a use by date of 12/8/2021. On interview the HC stated, "I will throw them away." 6. A box of plastic wrap on a table was observed with the top removed, the plastic wrap was exposed to contamination. A cleaned, sanitized, and bagged stand-up mixer in the prep area had unidentified food debris on the black splash.	F 812	were bagged to keep clean. • The wet nesting pans were immediately removed by the food service personnel, re-washed and sanitized and properly air dried before storing. • All Dietary aids and food service personnel were instructed by the food service director on taking temperatures in all refrigerators twice a day to ensure that they are at proper temperature. b) All food storage areas and pantries were inspected for proper storage. No residents were harmed by this deficient practice. c) All policies regarding food procurement, storage, preparation, service, sanitation, food temperatures, refrigerator temperatures have been reviewed and all staff have been inserviced on procedures and compliance of the above policies. d) Food service director and regional Director of Dietary Service will monitor daily and audit weekly all food procurement practices, cleanliness, proper storage of items needing air drying, proper cooking/serving temperatures, proper air drying and storage practices in the kitchen and on all other food service locations. • Unit manager will complete weekly audit for resident foods stored in nourishment rooms and proper storage and placement of employee foods weekly X 4, monthly X 3, and quarterly. • All auditors will report findings to the QAPI committee meetings quarterly. Completion date: 2/1/2022	

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7. (2) stacks of 1/3 pans were on a middle shelf of the drying rack across from the three-compartment sink. The (2) stacks of 1/3 pans were stacked on top of each other in a perpendicular and non-inverted position. The surveyor separated several pans of each stack and determined that the pans were wet with a water like substance on the inside and outside of the pans. The Food Service Director (FSD) stated, "They're wet. That's wet nesting. They need to be air dried prior to stacking and they should be in the inverted position. I'm going to show this to my staff and then I will conduct an in-service."

8. A cleaned, sanitized, and bagged meat slicer had unidentified yellow debris on both the front and bottom slicer guide. The FSD stated, "Yes, that is cleaned and sanitized." The surveyor then showed the FSD the meat slicer guide. The FSD stated, "Yeah, that's dirty".

9. On a mobile multi-tiered cart, a tray contained (11) chocolate puddings, 6 apple sauces and 1 vanilla pudding. All were labeled "use on or by 12/15". The FSD stated, "Yeah, they are expired." The items were removed and thrown away by the FSD in the presence of the surveyors.

On 12/21/2021 at 10:18 AM, the surveyors observed the following on second floor pantry:

1. In the refrigerator, a sandwich had its container lid open, exposing the sandwich to the air and had an expiration date of 12/21/21. On the same shelf, an additional sandwich in a plastic container had an expiration date of 12/20/21. No names were labeled on the containers.

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2. Inside a plastic bag was a plastic take-out style container of unidentified food. The container and bag had no name or dates.

3. On the same shelf an unidentified food item wrapped in aluminum foil had no name or dates.

4. A second plastic bag contained unidentified food and was labeled with a resident's name and a date of 12/16/21.

5. A plastic zip-lock bag contained unidentified food. The bag was dated 12/13/21.

6. A Ziploc type bag appeared to contain a slice of bread, an open bag of potato chips, and two oranges. The bag had no name or dates.

On 12/21/2021 at 10:32 AM, the surveyors observed the following on first floor pantry:

1. In the freezer, a frozen chocolate milkshake had no name or date.

2. In the refrigerator, a wrapper with a receipt identifying item as Classic Italian Hoagie had no name or date.

3. A plastic storage style container with a blue lid contained unidentified food. The container had no name or date.

4. A plastic take-out style container contained unidentified food and had no name or date.

5. A pizza box that appeared to have pizza inside had no name or date.

6. Two individual portion-controlled containers

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F 812	Continued From page 29	F 812		

contained what appeared to be banana and sweet peppers were in a plastic bag. Neither the bag or containers had a name or date.

7. A white plastic bag contained a white styrofoam take out style container with unidentified food. Neither the bag or container had a name or date.

8. A pizza box appeared to contain pizza slices. The box was labeled with a resident's name and room number. The box had no date.

A review of a facility policy titled Labeling and Dating, effective 11/28/2017, revealed the following under the heading Process:

1. All food items must be labeled with either a manufacturer label or handwritten label.

2.1 Foods that are marked with the manufacturer's "use by" date, that are properly stored, can be used until that date as long as the product has not been combined with any other food or prepared in any way including portioning. Once a product has been prepared or portioning. Once a product has been prepared or portioned, a new "used by" date is established.

2.3 Once prepared or portioned (individually wrapped) food items will be dated with compliance of the 72-hour rule and labeled with a "use on or by" date.

2.5 All bulk pre-packaged prepared items, i.e., mayonnaise, salad dressing, pickles, barbeque sauce, etc. will be marked with an "opened date" and discarded per FDA regulations.

3. Any item which is found not properly dated and

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F 812	Continued From page 30	F 812		

labeled shall be discarded.

A review of a facility policy titled Use & Storage of Foods brought in by Family/Others, last updated December 25, 2016, revealed under the heading Procedure: If the prepared food is not served immediately to the resident, the food must be stored in a container, clearly labeled with the resident's name and the date the food was brought to the resident. The policy also included if the food is not eaten within the 48 hours, the refrigerated foods should be discarded. These foods may not be stored in the Dietary Department.

A review of a facility policy titled Cleaning Schedule, effective 11/30/2017. revealed under the heading Process: The Director of Dining Services establishes a Department Cleaning Schedule. The Department Cleaning Schedules includes all equipment and areas in the department, frequency of cleaning, and position assigned. It is not intended for after-use or daily cleaning. Employees clean the assigned equipment/area as scheduled following the established cleaning procedures.

A review of a facility policy titled Refrigeration/Freezer Temperatures Standards, effective 11/30/2017, revealed under the heading Process: The Director of Dining Services or designee observes and records the temperatures of refrigerator and freezers daily using the Refrigeration/Freezer Temperature Log. Temperatures are not taken during the defrost cycle.

N.J.A.C. 18:39-17.2(g)

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F 880	Continued From page 31	F 880		
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 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;	F 880		3/17/22

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F 880	Continued From page 32 (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 other facility documentation, it was determined the facility failed to a.) to ensure visitors and staff members wore the appropriate personal protective equipment (barriers, such as gowns, face shields, and gloves worn to protect the eyes, mouth, and skin from infectious disease) in a resident's room, b.) ensure appropriate hand hygiene was followed by visitors	F 880	F880 Infection Prevention and Control a) The immediate corrective action taken by the Infection Control Nurse was to raise and reposition the [redacted] bag and [redacted] so it did not rest on the floor and the [redacted] was emptied and sanitized by dietary personnel. The Infection Control nurse	

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F 880	Continued From page 33 and staff members, and c.) ensure a [redacted] bag was not in contact with the floor to prevent the possibility of disease transmission. This deficient practice was identified for [redacted] residents reviewed for the infection control task, (Resident [redacted]) and [redacted] residents reviewed for [redacted] (Resident [redacted]. The deficient practice was evidenced by the following: a.) During the initial tour on 12/10/21 at 11:38 AM, Surveyor #1 observed Licensed Practice Nurse (LPN) #1 and LPN #2 inside Resident [redacted] room. On the door of room was a sign labeled "[redacted] Precautions". The sign indicated, "Everyone Must: Clean hands with sanitizer when entering room. Wash with Soap and water upon leaving room. Gown and glove when entering the room." Both nurses were not wearing gowns while inside the room. Surveyor #1 observed a bin outside the doorway of the room containing gowns. A Review of laboratory results in Resident [redacted] medical record revealed a [redacted] result on [redacted]) through a [redacted] On 12/13/21 at 12:00 PM, Surveyor #1 observed a visitor, who later identified themselves as Resident [redacted], inside Resident [redacted] room. The visitor had no gown on. At that time, the visitor said [redacted] was never told to wear a gown when visiting. After speaking to Surveyor #1, the visitor exited the room without performing any	F 880	educated the LPN, CNA, staff, visitors, and transport company on wearing proper PPE usage and proper hand hygiene pertaining to the affected residents. b) No residents were affected by this deficient practice. c) The following measures were put into place to ensure this does not recur: " Nurse educator and infection control nurse in-serviced and completed competencies on PPE, Hand Hygiene, keeping drainage bag and tubing off the floor with all nursing staff. " Infection control nurse and social service director contacted the family member to discuss the importance of wearing proper PPE, importance of wearing PPE properly, performing hand hygiene before entering and exiting the isolation room. The family member verbalized understanding and will communicate with the entire family so this does not happen again. " An educational sheet containing information on proper handwashing techniques and proper PPE use will be distributed to all visitors and transport employees upon entry. " Directed education, in-services, and audits were conducted by the IP nurse with all staff. A root cause analysis was conducted by the ad hoc QAPI committee to determine what caused the deficiency. Data gathered indicated several staff /visitors/transport staff were not in compliance. After interviewing staff, they indicated the reason for not following proper procedures was due to nit dealing	

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F 880	Continued From page 34 hand hygiene. [redacted] then, with [redacted] bare hands, accessed the water dispenser in the hallway and returned to Resident [redacted]'s room. On 12/14/21 at 9:14 AM, Surveyor #1 observed Certified Nurse Aide (CNA)#1 and CNA #2 inside Resident [redacted]'s room. The "[redacted] Precautions" sign was on the door to the room. The CNAs were not wearing gowns. At that time, during an interview with Surveyor #1, CNA #1 said they did not have any gowns when they first entered the room. The surveyor observed gowns inside the drawers of the bin outside of the room. CNA #1 said she should not have entered the room without a gown. On the same date and approximate time, after speaking with CNA #1, Surveyor #1 observed two transport employees enter Resident [redacted] room. The transport employees did not wear gowns upon entering. At this time, the surveyor spoke to the Infection Prevention nurse (IPN) who was outside of the room. The IPN said the transport employees should not be in the room without wearing gowns. On 12/14/2021 12:16 PM, Surveyor #2 observed Resident [redacted] in the room sitting in a chair next to the resident's bed with no gown or gloves on. During an interview with Surveyor #2, the daughter said [redacted] had no idea [redacted] was required to wear a gown. b.) During an interview with Surveyor #1 on 12/10/2021 at 11:40 AM, in the doorway of the room, LPN #1 confirmed Resident [redacted], who resides in the room was diagnosed with [redacted] After speaking with the surveyor, LPN #1 and LPN #2 used alcohol-based hand sanitizer	F 880	with this organism for such a long time and forgot protocol. They were used to gel-in-gel in gel-out. The visitors were interviewed and they indicated that they choose not to comply with our precautions. The emergency personnel stated they were exempt from following the precautions. All above were informed they must wear proper PPE when entering/exiting a resident□s room with precautions, and performing proper hand hygiene. Very in-depth education for all staff/visitors/transport personnel was conducted by the infection prevention nurse and supervisors and designee. The components of a directed plan of correction were necessary to educate all staff/visitors/transport staff as appropriate on wearing proper PPE in rooms with precautions, proper hand hygiene, and keeping drainage bag and tubing off the floor. The directed plan of correction specifically requires all staff to view four videos from the CDC on: Keep [redacted] out! , Clean Hands, Use PPE Correctly for [redacted] and Closely Monitor Residents. All staff signed that they viewed these videos and three modules titled: Module 7- Hand Hygiene, Module 6A- Standards of Precaution, Module 6B □ Principles of Transmission Based Precautions, Module 11B □ Environmental Cleaning and Disinfection. All topline staff and infection prevention nurse viewed three more modules in addition to those previously stated. They viewed: Module 1- Infection Prevention and Control Program, Module 4-Inspection Surveillance, Module 11A- Reprocessing Reusable Resident Care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315126	A. BUILDING _____ B. WING _____	01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 35 (ABHR) after exiting the room. At that time, LPN #1 said she did use ABHR but should have used soap and water. During an interview with Surveyor #1 on 12/14/21 at 9:45 AM, the IPN said staff are required to wash their hands with soap and water when exiting a room under [redacted] Precautions for [redacted]. The IPN added that visitors should have worn gowns in the room under [redacted] Precautions. During an interview with Surveyor #1 on 12/14/2021 1:10 PM, the IPN confirmed that Resident [redacted] has [redacted] and staff should have used soap and water when exiting room. She acknowledged that the [redacted] should wear gown and gloves when entering resident room. A review of a facility policy titled, "[redacted]" with an effective date of 6/2016, revealed under "Policy Interpretation and Implementation"; under number 10(a.), "Healthcare workers will wear gloves and gowns upon entering the room of a resident with [redacted] infection, and will remove gowns and gloves prior to exiting the room." The policy also revealed under 10(c.), "Visitors will be encouraged to wear gowns and gloves, and to perform proper hand hygiene." The policy revealed after number 11., "When caring for residents with [redacted] incontinence caused by [redacted], staff will maintain vigilant hand hygiene. Hand washing with soap and water is superior to ABHR (alcohol-based hand rub) for the mechanical removal of [redacted] from hands." c.) On 12/13/2021 at 1:35 PM, Surveyor #3 observed Resident [redacted]	F 880	Equipment. Further in services and audits were conducted by the IP nurse with all staff on the importance of wearing PPE and performing proper hand hygiene, to prevent the spread of infection as well as other infectious organisms. All staff were given a copy of the educational materials regarding proper PPE procedures and hand hygiene and sanitary handling of equipment for reference. Also audits of infection control practices throughout the building were conducted by the nurse educator, IP nurse and designee to ensure staff were in compliance with hand hygiene and wearing of PPE at proper times. Training will be conducted Quarterly by the IP nurse and/or the Nurse Educator as needed and with all new employees upon hire while in orientation. d) The IP nurse, or designee, will complete weekly infection control audits of all staff regarding proper usage of PPE and hand hygiene to ensure compliance and understanding of the education and training provided them. This will be conducted weekly X 4, monthly X 3, quarterly X 3. All findings will be reported to the QAPI committee monthly. Completion date: 3/17/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315126	A. BUILDING _____ B. WING _____	01/04/2022

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F 880	Continued From page 36 [redacted]) [redacted] bag and tubing lying floor on the door side of the bed. On 12/14/2021 at 10:07 AM, Surveyor #3 observed Resident [redacted] bag and [redacted] lying on the floor on the door side of the bed. During an interview with Surveyor #3 on 12/20/2021 at 11:37 AM, LPN #3 said it was not acceptable for the [redacted] bag to be on the floor. A review of a facility policy titled, [redacted] Care, Urinary, revealed under section Infection Control, 2(b), Be sure the [redacted] and [redacted] bag are kept off the floor. A review of a facility policy titled, Emptying [redacted] Bag, with an effective date of 2/2016, revealed under the section General Guidelines, 9. Keep the [redacted] bag and [redacted] off the floor at all times to prevent contamination and damage. N.J.A.C. 8:39-19.4(a)	F 880		