STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	C 06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(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 date 06/02/21 Census: 102 Sample Size: 21 + 12 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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide appropraite hygiene and fingernail care for resident's dependent on staff for activities of daily living. This deficient practice was identified for 2 of 21 residents, (Resident #11 & #31) reviewed for care. This deficient practice was evidenced by the following: 1. Resident #11 was admitted to the facility in [redacted] with diagnoses which included [redacted] The current Quarterly Minimum Data Set (MDS -	F 677	F677 1. A root cause analysis was conducted to identify the underlying cause of the deficient practice. The team identified lack of supervision from mid-level managers that resulted in the deficient practice. Resident #11 immediately had [redacted] fingernails cleaned and trimmed, [redacted] hands washed, and skin check of [redacted] conducted by the Unit Manager. Resident #31 immediately had [redacted] fingernails cleaned and trimmed, [redacted] hands washed, and skin check of [redacted] conducted by the Nursing Supervisor. All nurses and nursing aides were re-educated on ADL care and the process for reporting patient needs to the primary nurse. All nurses were re-educated on	6/30/21

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

Electronically Signed | 08/10/2021

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F 677	Continued From page 1 an assessment tool) with an assessment Reference date (ARD) of [redacted] coded Resident #11 of being [redacted] for [redacted]. On the [redacted] of the MDS which referred to Activity of Daily Living, Resident #11 coded 4 and 2 which indicated total dependence of staff for all activities of daily living. The [redacted] which referred to Functional limitation in Range of Motion Resident #11 coded 2 and 2 which indicated [redacted] on both [redacted] and [redacted]. A review of Resident #11's care plan dated [redacted] revealed a care plan for activities of daily living (ADL). The goal set by the facility for Resident #11 was for his/her ADL will be meet satisfactorily as evidenced by being kept clean, dry, and odor free daily. The approaches were to: a) Provide education and management training of Resident #11 current condition and needs to the direct care giver, and b) provide Resident #11 with total care for his/her ADLs. On 05/24/2021 at 10:06 AM, the surveyor observed Resident #11 in bed, his/her [redacted] were flexed to the [redacted] and both [redacted] were [redacted] On 05/25/2021 at 11:30 AM, the surveyor observed Resident #11 in bed, the Certified Nursing Assistant (CNA) was at the bedside providing care. An interview on 05/26/2021 at 11:21 AM, with the CNA who cared for Resident #11 revealed Resident #11 was totally dependent on staff for all activities of daily living. According to the CNA, Resident #11 was [redacted] his/her [redacted] The CNA stated that Resident #11 could	F 677	checking hands and palms during bi-weekly resident skin assessments. 2. All facility residents who are dependent for ADL care are at risk for not receiving adequate hand hygiene and nail care. All current resident hands were evaluated by the nursing supervisor and appropriate hand hygiene and nail care were provided as needed on 5/29/21 and 5/30/21. On 5/31/21, all facility residents were re-evaluated by the Director of Nursing to ensure that adequate nail care was performed. All resident hands were noted to be clean and fingernails were noted to be clean and short. 3. The current ADL policy will be modified to address resident nail care. The CNA assignment sheet will be updated to include nail care by 6/18/21. A new process was developed for resident nail care. Nursing staff will be educated on their roles in resident nail care. CNAs are responsible for cleaning and inspecting resident nails during care. Nails that require trimming will be reported to the nurse. The nurse can delegate trimming of nails to the CNA unless the resident is diabetic or receiving an anticoagulant or heavily contracted. All nursing staff will be educated on the updated policy and assignment sheets . Nurses will be re-educated to include evaluation of hands and palms on routine bi-weekly skin assessments. 4. The Unit Managers, or designees, will utilize an audit tool to examine the hands	

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F 677	Continued From page 2 not do anything for himself/herself. On 05/26/21 at 11:25 AM, the surveyor observed Resident #11 in bed, The CNA was in the room. The surveyor asked the CNA if she could observe Resident #11's [redacted]. When the CNA opened Resident #11's [redacted], the [redacted] were observed to be long and a black like substance was observed underneath the [redacted], no open areas were observed on the resident's hands. Upon further inquiry regarding nail care, the CNA stated that a man was responsible to provide nail care. On 05/26/2021 at 11:30 AM, an interview with the Unit Manager Nurse (UMN) revealed that the CNA was referring to the [redacted]. The surveyor escorted the UMN to the room where we both observed the [redacted] underneath the fingernails nails and the elongated fingernails. On 05/26/21 at 11:35 AM, a second interview with UMN revealed that the nurses were responsible to trim the resident's nails. The UMN further stated that the CNAs were to communicate if a resident's nails needed to be trimmed/cleaned. The UMN indicated that she was not informed that Resident #11's nails needed to be trimmed and cleaned. The UMN told the surveyor that she would trim and clean Resident #11's nails. On 05/26/21 at 12:46 PM, the Director of Nursing (DON) was made aware of the above issue. The DON told the survey team that the CNAs were responsible to provide nails care to the residents and not the nurses. The facility was asked to provide the policy for	F 677	of 10 dependent residents weekly x 1 month and then monthly x 6 months. The audit will monitor: cleanliness of fingernails, length of fingernails, cleanliness of hands, skin integrity of palms and identification of any contractures. Any residents that do not meet the standards for clean hands, clean and short nails, risk to skin integrity or risk to ROM will be immediately referred to the primary nurse for appropriate care and to the Director of Nursing or designee. Results of all audits will be submitted to the Director of Nursing for review. The Administrator will present the results quarterly to the Quality Assurance Performance Improvement committee x 3 quarters Preparation and/or execution of this Plan of Correction does not constitute admission/agreement of the provider of the truth of the facts alleged or conclusions set forth in any statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal or State Law.	

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hygienic care which would include nail care, none was provided.

On 05/28/21 at 10:06 AM, the surveyor interviewed the UMN regarding the CNA's assignment sheet. UMN stated that in the morning the assignment was made according to the census and that a verbal report was given in the morning to the direct care staff. The nurses would follow up to ensure that the assignment was carried out. The UMN provided the assignment sheet, nail care was not noted on the assignment sheet The UMN stated that all shifts should be responsible for nail care not only the 7:00 AM to 3:00 PM shift.

An observation on 05/28/2021 at 10:00 AM of Resident #11's hands revealed Resident #11's fingernails had been trimmed and cleaned. Also, Resident #11 was provided with a [redacted] to prevent the nails from injuring his/her skin.

2. Review of the Face Sheet revealed that Resident #31 had been originally admitted in [redacted] Resident #31 was noted to have cumulative diagnoses that included but were not limited to [redacted] and [redacted].

Review of the Quarterly MDS, dated [redacted], revealed that Resident #31 was unable to be assessed for a Brief Interview for Mental Status (BIMS), was [redacted] to make decisions regarding tasks of daily life, and functional status was total dependence for personal hygiene. The Quarterly MDS further revealed that the resident

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was [redacted], sometimes made themselves understood and sometimes was able to understand others.

Review of the on-going Care Plan revealed Resident #31 was totally dependent with assistance/supervision for all functional mobility and ADLs with approaches that included but were not limited to provide total care of ADLs, and was at [redacted] for conditions that included but were not [redacted], [redacted], and a history of [redacted] with approaches that included but were not limited to providing [redacted] care and performing weekly [redacted] assessments.

Review of Resident #31's Admission Order Set dated [redacted], revealed an order for skin assessment every shift on [redacted] and [redacted] Resident #31's Treatment Administration Record (TAR) for [redacted] through [redacted], revealed a skin assessment was completed on [redacted] on the 7 AM to 3 PM shift and the 11 PM to 7 AM shift with no concerns noted.

On 05/24/21 at 09:59 AM, the surveyor observed Resident #31 lying in bed, both [redacted] were [redacted] in at the [redacted] The surveyor observed there were [redacted], or [redacted] in either [redacted] or applied to either [redacted] The surveyor observed on both [redacted], the [redacted] were long and in contact with the resident's skin by the [redacted] area.

On 05/25/21 at 09:50 AM, the surveyor observed Resident #31 lying in bed, both [redacted] were bent in at the [redacted] curled in. The resident had a [redacted] under the [redacted]. The surveyor observed there were no [redacted],

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or [redacted] in either hand or applied to either [redacted]. The surveyor observed on both [redacted], the [redacted] were long and were in contact with the resident's skin by the [redacted] area.

On 05/26/21 at 08:44 AM, the surveyor observed Resident #31 lying in bed, both [redacted] were bent in at the [redacted] curled in. The surveyor observed Resident #31's [redacted] were long and were in contact with the resident's skin by the [redacted] area.

On 05/26/21 at 09:15 AM, the Registered Nurse (RN) stated Resident #31 was able to move and open his/her [redacted] and would do this by following simple commands. In the presence of the surveyor, the RN requested Resident #31 to open their [redacted], but the resident did not answer or acknowledge the surveyor or RN. The RN opened Resident #31's [redacted] in the presence of the surveyor. Both the RN and surveyor observed a red, indentation by the end of the [redacted] and top of the [redacted] where the nail met the skin but no open area. The surveyor and RN also observed a tan color crusted substance between the [redacted] and [redacted].

The surveyor and RN observed Resident #31's left hand, the resident was unable to straighten or open his/her [redacted]. The RN opened the [redacted] and the surveyor and RN observed a red indentation on the skin at the top of the [redacted] where the [redacted] met the skin but no open area. The RN stated Resident #31's [redacted] needed to be cut and cleaned and both [redacted] needed to be cleaned. The RN stated the resident's nails were too long and need to be cut by the CNA.

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On 05/26/21 at 09:42 AM, the RN Unit Manager on the [redacted] unit, stated resident skin checks were done twice a week and that Resident #31 had a skin check completed on [redacted]. The RN Unit Manager stated the nurses would be responsible to cut the resident nails but that she and the other RN have not had time to do anyone's nail care.

On 05/26/21 at 11:07 AM, the DON stated no skin assessment sheet would be completed unless there was a [redacted]. The DON stated the CNAs were overseen by the nurses and were responsible for [redacted] care which would be assessed during morning and evening daily care. The DON stated there would not be any documentation that nail care was done. The DON stated the CNA should have noticed the [redacted] and it was important to keep the [redacted] cut to prevent skin damage and for cleanliness and dignity.

On 05/26/21 at 12:24 PM, the CNA stated that resident care consisted of things like washing the skin and applying moisturizer, making sure the hands were clean, and checking the skin. The CNA stated the nurses would do nail care and that she was not allowed to cut nails. The CNA stated she had seen Resident #31's long nails today [redacted] and made the RN aware verbally.

On 05/26/21 at 12:48 PM, the DON stated the facility did not have any policy or procedure on nail care or ADL care.
Review of the Nursing Progress Notes dated [redacted] revealed the following:

11 PM to 7 AM shift, revealed Resident #31 was

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F 677	Continued From page 7 oriented to person only and that the skin was intact, warm, and dry. An entry timed 10 AM, that a skin assessment on the resident's hands was done and the fingernails were trimmed and cleaned. An untimed entry that recapped the assessment by the RN with the surveyor present, included the RN seeing a small red line but no skin break and that the RN would have the resident's nails clipped. The facility provided the CNA Orientation Critical Elements which included but were not limited to Patient care - ADL's Grooming - hair, nails, foot care, shaving.	F 677		
F 684 SS=D	NJAC 8:39-27.1(a), 27.2(g) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to send a [redacted] specimen to the laboratory for analysis within an	F 684	F684 1.A root cause analysis was conducted to identify the underlying cause of the deficient practice. The team identified a lack of communication in the unit,resulting	6/18/21

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F 684	Continued From page 8 appropriate time frame which led to a delay in treatment for a resident. This deficient practice was identified for one of 21 residents reviewed, (Resident #88) for quality of care and was evidenced by the following: On 05/24/21 at 11:10 AM, the surveyor observed Resident #88 lying in bed. The resident was calm and pleasant. The surveyor observed that the resident had a [redacted] bag in a [redacted] bag attached to the bed frame, hanging below the level of the resident's [redacted]. The [redacted] was observed to be clear and empty [redacted]. The surveyor asked the resident how long he/she had resided at the facility and the resident stated, "thirty minutes." On 05/25/21 at 12:30 PM, the surveyor observed the resident in his/her room seated in a wheelchair. The surveyor observed that the resident's [redacted] bag was stored in a [redacted] bag, below the level of the resident's [redacted], and attached to the seat of the resident's wheelchair. The surveyor observed [redacted] in the [redacted]. The surveyor reviewed the medical record for Resident #88. Review of the resident's admission Minimum Data Set, MDS (an assessment tool used to facilitate the management of care) dated [redacted] reflected that the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] out of [redacted] which indicated the resident had [redacted] and was confused. [redacted] and [redacted] of the resident's MDS reflected that the resident had a [redacted] to [redacted] his/her [redacted].	F 684	in the deficient practice. An investigation was initiated immediately upon identification of the missing [redacted] and [redacted] report for resident #88. The physician was made aware and a new [redacted] specimen was collected. An incident report was completed. Patient #88 was assessed for any signs and symptoms of [redacted]. [redacted] therapy was initiated to treat the [redacted]. 2.All residents with laboratory orders have potential to be affected by the deficient practice. All orders for resident lab work were written in the appropriate unit□s 24-hour report to make all nurses aware of subsequent shifts of any pending lab order results. All nurses were re-educated on the procedure to document pending lab orders in the 24-hour report. 3.A Lab Tracking Tool has been developed and attached to the 24 hour report to assist the Unit Managers and nurses in following up on any pending lab results. The lab staff was made aware to notify the facility if any specimens were not collected. All nurses will be educated on the tracking tool and the new process . All lab orders will be discussed at the morning clinical huddle meeting. 4.The Unit Manager or designee will audit 5 lab orders weekly x 1 month and then monthly x 6 months. The results will be reported to the Director of Nursing and will be presented by the Administrator quarterly at the Quality Assurance	

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F 684	Continued From page 9 [redacted] Active Diagnoses of the resident's admission MDS reflected that the resident had a [redacted]). On 05/26/2021 at 9:36 AM, the surveyor reviewed the resident's [redacted] hand-written Physician Order Sheet (POS) which revealed a physician's order dated [redacted] for a [redacted] Review of the resident's [redacted] dated [redacted] reflected that the resident's [redacted] was [redacted], a trace amount of [redacted] was present in the [redacted] and the [redacted] that indicate infection) in the residents urine were high. The resident's medical record did not reflect that the [redacted] for the [redacted] (a test that specifically indicates what type and amount of [redacted] in the [redacted] is present and offers appropriate [redacted] treatment options) was present in the medical record. On 05/26/21 at 9:44 AM, the surveyor interviewed the Change Nurse (CN) who stated that the lab did not run the [redacted] report for the resident until yesterday [redacted]). The CN stated that she was unaware of why there was a delay in the [redacted] specimen report and was looking into it. The CN stated that a [redacted] and [redacted] for a [redacted] would usually take 72 hours to be completed by the lab. The CN further stated that the staff should have followed up with the resident's [redacted] results and notified the physician of the delayed pending results. On 05/26/21 at 12:19 PM, the surveyor interviewed the Registered Nurse/Unit Manager who stated that the [redacted] specimen for the [redacted]	F 684	Performance Improvement Committee meeting x 3 quarters. Preparation and/or execution of this Plan of Correction does not constitute admission/agreement of the provider of the truth of the facts alleged or conclusions set forth in any statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal or State Law.	

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was not collected by the laboratory because the nurse did not make the laboratory aware that the urine specimen was in the refrigerator. The RN/UM further stated that due to the [redacted] not being collected in an appropriate time frame, the resident's [redacted] was delayed, and the resident did not receive treatment right away for a [redacted].

On 05/26/2021 at 1:46 PM, the surveyor reviewed the laboratory [redacted] dated [redacted] which revealed that the resident was positive for a [redacted] and had greater that [redacted] of [redacted] in his/her [redacted]

On 05/26/21 at 1:56 PM, the surveyor conducted a follow up interview with the RN/UM who stated that she had received a laboratory report that the resident was [redacted], the resident's physician was notified, and the resident was started on [redacted] therapy related to the resident's history of [redacted]. The RN/UM further stated that the [redacted] for the [redacted] was still pending, but the Dr. started the resident on [redacted] treated related to a history [redacted]. The surveyor inquired if the resident was currently symptomatic of a [redacted] and the RN/UM stated that the resident's physician was very involved in care and ordered labs on the resident because the resident was presenting with a decreased appetite. The RN/UM stated that she didn't know what happened and why the lab was not done and would investigate the reason why the lab was missed.

Review of the [redacted] POS reflected a physician's order dated [redacted] for the [redacted] medication, [redacted] milligrams (mg) [redacted]

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F 684	Continued From page 11 [redacted] in the resident's [redacted], [redacted], and medications) every six hours for seven days. [redacted]. Review of the resident's [redacted] dated [redacted] reflected that the [redacted] treatment the physician prescribed for the resident was effective at treating the resident's [redacted] Review of the resident's Care Plan dated [redacted] reflected a focus area for [redacted] Use. The Care Plan reflected that the resident was at risk for having [redacted] due to having a [redacted] that is inserted into the [redacted]). The goal of the resident's Care Plan was that the resident would not develop [redacted] and my current [redacted] would be properly managed and treated. The approaches in the resident's Care Plan included to monitor labs and report any abnormal findings to my primary care physician. On 06/02/21 at 9:28 AM, The surveyor interviewed the Director of Nursing who stated that the [redacted] was something that fell through the cracks. Review of the facility's, "Significant Change in Condition or status Policy and Procedure" revised 05/2020 indicated That the responsible RN would notify the resident's attending physician of the resident's condition if it was necessary and appropriate and in the best interest of the resident. The, "Significant Change in Condition or Status Policy and Procedure" further indicated that the nurse would document in the resident's medical record at least daily until there was a condition, resolution, or improvement.	F 684		

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HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

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F 684	Continued From page 12 NJAC 8:39-27.1(a)	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to: a.) assess a resident with [redacted] (a [redacted]) for the use of [redacted] (a [redacted] , b.) apply [redacted] as ordered by a physician, and c.) develop a comprehensive care plan for use of the [redacted]. This deficient practice was identified for two out of five residents reviewed, (Resident #21 and Resident #50) for position and mobility related to limited range of motion and was evidenced by the following.	F 688	F688 1. A root cause analysis was conducted to identify the underlying cause of the deficiency. The team determined that there was a lack of communication that resulted in the deficient practice. Resident #21 and Resident #50 were assessed and Physician orders were received for Occupational Therapy (OT) to evaluate and treat their [redacted]. Care plans for Resident #21 and Resident #50 were updated to reflect the use of [redacted] Nurses for Residents #21 and #50 were educated on the plan of care.	6/30/21

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F 688	Continued From page 13 1. According to the Cumulative Diagnoses Record, Resident #21 had the diagnoses that included but not limited to; [redacted]. The Admission Minimum Data Set (MDS) and assessment tool dated [redacted], indicated that Resident # 21 had [redacted] and required complete care with all aspects of activities of daily living (ADL's). The MDS reflected that the resident did not utilize [redacted] on any aspect of the body. The MDS also indicated that the resident had functional limitations in range of motion on both sides of body in the [redacted] to include the [redacted], and [redacted] On 05/24/21 at 10:40 AM, the surveyor observed Resident #21 during tour lying in bed with both hands exposed and laying on top of the blanket. The resident was not able to be interviewed due to [redacted] and was non-verbal. Both [redacted] were observed to be visibly deformed with [redacted] (a condition of [redacted] and [redacted], or other [redacted] often leading [redacted]). The surveyor did not observe the resident wearing any positioning devises on his/her [redacted] The [redacted] Treatment Administration Record (TAR) reflected a physician's order dated [redacted], that Resident # 21 was to wear [redacted] at all times and were to be removed for skin checks every shift. There was a nurse's signature on the TAR on [redacted] on the 7AM-3PM shift that indicated that the [redacted]	F 688	All nursing staff were immediately re-educated on the procedure to follow up regarding application of [redacted] and [redacted] in accordance with physician orders and how to document when a splint has not been applied and how to correct the issue. 2. All residents with [redacted] have the potential to be affected by this deficient practice. All current residents with [redacted] have been assessed by nursing staff and referred to OT for possible splint order. 3. All nursing staff and rehab staff will be educated on the policy and procedure for [redacted] application and [redacted] A new process was developed for evaluation of contractures and application of [redacted]: Nursing will obtain an order for OT Screen/Evaluation and send a referral to Rehab. OT will be responsible for the application and monitoring of any [redacted] for residents that are being trialed with new [redacted] After the trial period is completed, OT will educate the primary nurses and nursing assistants on the use and care of the [redacted] The resident□s primary nurse, or designee, will obtain a physician's orders for the use of the [redacted] including to check skin integrity every shift. After the physician orders are received, the nurse is responsible for the application and care of the [redacted] in accordance with the physician order. All nursing staff and rehab staff will be	

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F 688	Continued From page 14 [redacted] were intact and on the resident. The surveyor did not observe [redacted] on the resident or in the resident's room on [redacted] On 05/25/21 at 07:40 AM, the surveyor had a second observation of Resident # 21 lying in bed with both [redacted] laying on top of the blanket. There were no [redacted] observed on the resident at this time. A review of the [redacted] TAR reflected a nurse signed on [redacted] on the 11:00 PM-7:00 AM shift indicating that the [redacted] were in place. On 05/25/21 at 10:14 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who was caring for Resident # 21, who stated that the resident required complete care with all aspects of ADLs. She also stated that the resident had [redacted] and was not able to communicate needs or wants and was not able to move independently. The CNA added that the staff had to reposition the residents every two hours. The CNA further stated that the resident did not wear any special devices or [redacted] on his/her [redacted] or wrists. The CNA opened up the residents [redacted] to show the surveyor that the residents nails were trimmed and that there were no skin impairments on the inside of the resident's [redacted]. The CNA added that the only opening on the resident's skin was at the [redacted] area. The surveyor did note that there was a dressing on the [redacted] and that both [redacted] were offloaded with a [redacted] On 05/25/21 at 10:17 AM, the surveyor interviewed the Restorative CNA who stated that she performed [redacted]) on residents and the resident had decreased	F 688	educated on the procedures for the use and care of [redacted] All nursing staff were re-educated on the correct procedure for documenting when a splint is not applied. Any missing [redacted] will be on a 24 hour report for the unit manager to follow up. The Director of Rehab, or designee, will report all [redacted] orders, including new splint trials, completed [redacted] and their outcomes, and discontinued [redacted] at the morning clinical meeting as they occur. The Director of Rehab will keep an updated list of current [redacted] orders and provide a copy to the Director of Nursing at least weekly and when there are changes to the list. 4. The Director of Rehab, or designee, will audit 5 splint orders weekly x 1 month and then monthly x 6 months. The audit will include a visual observation that each resident is wearing the [redacted] as ordered. The results of this audit will be reported to the Director of Nursing and presented by the Administrator quarterly to the Quality Assurance Performance Improvement committee x 3 quarters. The unit manager or designee will audit 5 splint orders weekly for one month then monthly for 6 months to ensure that the splint orders are appropriate and signed properly on the treatment record. The results of this audit will be reported to the Director of Nursing and presented by the Administrator quarterly to the Quality Assurance Performance Improvement committee x 3 quarters. The Unit manager or designee will audit 5	

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F 688	Continued From page 15 mobility. She stated that she did not perform ROM on Resident # 21 and that the resident was not on her caseload. She added that she did not apply [redacted] to Resident #21's [redacted] On 05/25/21 at 10:37 AM, the surveyor interviewed the Occupational Therapist (OT) who stated that all resident on the [redacted]t unit were screened quarterly for changes in functional status and any [redacted] or positioning issues. She stated that [redacted] is a [redacted] protector for a resident with [redacted] to prevent [redacted] from digging into the skin, prevent skin breakdown, and to also aid in prevention of further [redacted]. The OT further stated that it would be important to apply these [redacted] as ordered by the physician to prevent breakdown and further [redacted] in residents with existing [redacted] On 05/25/21 at 11:05 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) for the [redacted] Unit who stated that Resident # 21 did not wear any [redacted] or [redacted] on the [redacted]. The RN/UM admitted that it was her signature on the [redacted] TAR dated [redacted] on the 7:00 AM - 7:00 PM shift that [redacted] were in place on the resident's [redacted]. She then stated that the resident has not had these [redacted] available for some time. The RN/UM stated, "I have to be honest; I don't remember the last time the resident had these [redacted]. These residents change rooms so much and are in and out of the hospital so much I'm not sure where the [redacted] are." The RN/UM stated that she should have notified the therapy department that the [redacted] were missing and that she should have circled her signature on the [redacted] TAR and wrote on	F 688	Plans of Care of residents with [redacted] orders to assure the care plans are updated weekly x 1 month and then monthly x 6 months. The results of this audit will be reported to the Director of Nursing and presented by the Administrator quarterly to the Quality Assurance Performance Improvement committee x 3 quarters. Preparation and/or execution of this Plan of Correction does not constitute admission/agreement of the provider of the truth of the facts alleged or conclusions set forth in any statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal or State Law.	

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F 688	Continued From page 16 the back of the [redacted] TAR detailing that the [redacted] were missing. On 05/25/21 at 11:42 AM, the DON stated that the nurse should have signed the TAR and circled her signature that the [redacted] were not available and then signed the back of the TAR on the rational as to why the [redacted] were not applied. The DON further stated that if the nurse knew that the [redacted] were missing, then she should have contacted the therapy department to get new [redacted] or assured that the resident was reevaluated. On 05/26/21 at 08:30 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who worked on the [redacted] unit and took care of Resident # 21 on the 11:00 PM - 7:00 AM shift. The LPN stated that Resident # 21 was unresponsive and required complete care with all aspects of ADLs. The LPN admitted that she signed the [redacted] TAR on [redacted] on the 11:00 PM - 7:00 AM shift that the splints were on Resident #21's [redacted] but did not apply them and could not locate then in the resident's room. She stated that she could not recall the last time she saw the [redacted] on the resident. "I should have checked that the [redacted] were in place before I signed the TAR and I take full responsibility." When the surveyor asked the LPN what she should have done when she could not find the [redacted], she did not have a response. The surveyor reviewed Resident #21's medical record which revealed the following information: The Vent Admission Order Set dated [redacted] reflected physician orders for the resident to wear [redacted] at all times and	F 688		

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remove during care and skin checks every shift.

The Physician's Order Sheet (POS) dated [redacted] indicated that a on [redacted] there was a physician's order for Resident #21 to wear [redacted] at all times and to be removed during care and skin checks every shift.

The Interdisciplinary Plan of Care (IPOC) with a readmission date of [redacted], indicated that the resident may have [redacted] related to [redacted] and to have the resident evaluated and treated by rehab (Physical therapy, Occupational Therapy and Speech Therapy). There was no mention of [redacted] written on the IPOC.

On 05/26/21 at 10:59 AM, the surveyor interviewed the Director of Nursing (DON) who stated that Resident #21 was readmitted to the facility with [redacted] orders. She added that when a resident was admitted with [redacted] or any adaptive equipment then the admitting nurses should have notified therapy department and then a therapy screen or evaluation would have been performed by the therapy team. The DON further stated that she does not know why this process was not implemented or why the resident was not screened by therapy for these [redacted] after admission to the facility on [redacted].

On 05/26/21 at 11:30 AM, the surveyor interviewed the acting Director of Rehabilitation (DOR) who was also a physical therapist who stated that the therapy department evaluated Resident #21 on [redacted] and provided the evaluation to the surveyor.

The Occupational Therapy Plan of care

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F 688	Continued From page 18 (evaluation only) dated [redacted], indicated that the resident was [redacted] with [redacted] and had [redacted] on all [redacted]. The [redacted] was donned (applied) and recommended to be worn and to take off during care and skin checks each change of shift to prevent further [redacted] and to prevent skin breakdown. The DOR also provided a manufacturers description and use of a '[redacted] from [redacted] for [redacted] management, which indicated that the [redacted] supports and positions weakened [redacted]. Reduces [redacted] by immobilizing hand and prevents and treats the development of [redacted], [redacted] and [redacted] and [redacted] and [redacted]. 2. According to the Resident #50's [redacted] POS, the residednt had diagnoses which included but were not limited to [redacted], and [redacted]. The most recent Significant Change MDS dated [redacted], indicated that Resident #50 had Brief Interview of Mental Status (BIMS) score of [redacted] which indicated the resident was [redacted]. The MDS further indicated that the resident had functional limitations in range of motion on one side of his/her [redacted] to include the [redacted], and [redacted] On 05/24/21 at 12:10 PM, the surveyor observed Resident #50's in his/her room. The surveyor further observed that the resident's [redacted] was [redacted], and the resident was not wearing a [redacted]. The surveyor attempted to interview the resident and the resident stated,	F 688		

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F 688	Continued From page 19 "No, no, no," or "Yes, yes, yes." While giving the [redacted] when stating, no and the [redacted] when stating, yes. On 05/25/21 at 9:57 AM, the surveyor observed the resident seated in his/her wheelchair in front of the nurse's station manually touching a computer tablet with his/her [redacted]. The surveyor observed that the resident's [redacted] was [redacted], and the resident was not wearing a [redacted]. The surveyor further observed that the resident's [redacted] on his/her [redacted] were trim and clean. On 05/25/21 at 12:32 PM, the surveyor observed the resident seated in front of the nurse's station in his/her wheelchair. The resident's [redacted] was positioned in front of him/her and resting on the right cushioned side bar of the wheelchair. The surveyor did not observe a [redacted] device to Resident #50's [redacted]. On 05/28/21 at 10:07 AM, the surveyor observed the resident seated in front of the nurse's station in his/her wheelchair. The surveyor observed a hand [redacted] attached to the resident's [redacted] On 05/28/21 at 11:09 AM, the surveyor interviewed the resident's CNA who stated that the resident was somewhat [redacted] and able to express himself/herself by pointing to things. The CNA stated that she took care of the resident regularly and stated that the resident was on [redacted] services and would sometimes refuse to eat. The CNA stated that one of the resident's [redacted] was [redacted], but she forgot which side. The CNA further stated that for the longest time she had not seen the resident wear a [redacted] device to his/her [redacted].	F 688		

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F 688	Continued From page 20 On 05/28/21 at 11:22 AM, the surveyor interviewed the resident's LPN who stated that the resident was alert and oriented, had [redacted], although comprehension remains [redacted], and she took care of the resident frequently. The LPN told the surveyor that the resident went on [redacted] services because he/she was refusing medications. The LPN further stated that the resident's [redacted] was [redacted] and the resident wore a [redacted] device to his/her [redacted] during the day and that usually someone working in the therapy department would apply it to the resident's [redacted]. The LPN stated that the nurses were responsible for signing the treatment book as accountability that the resident was wearing the [redacted]. The LPN further stated that the resident never refused to wear the [redacted]. On 05/28/21 at 11:32 AM, the surveyor interviewed the Charge Nurse (CN) who stated that she was familiar with the resident and that sometimes the resident would refuse morning care depending on his/her [redacted]. The CN stated that she thought the resident's [redacted] was weak and she could not recall if the resident wore a [redacted]. The CN stated that if the resident refused a treatment, the nurses would circle that the resident refused and write an explanation on the back of the TAR. The CN stated that the purpose for wearing a [redacted] device was to prevent further [redacted] and wounds from developing. The CN further stated that if the resident refused to wear the [redacted] device, that would be documented in the resident's Care Plan.	F 688		

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F 688	Continued From page 21	F 688		

On 05/28/21 at 11:37 AM, the surveyor observed the resident's [redacted] in the presence of the CN. The surveyor observed that the resident's [redacted] were trimmed short, clean, and that there were no marks or indentations on the resident's [redacted]

On 05/28/21 at 11:51 AM, the surveyor interviewed the resident's OT who stated that she was familiar with the resident and the resident had [redacted] ([redacted]) on the [redacted] and his/her [redacted] was [redacted] The OT further stated that the resident did wear a [redacted] and the nurses or CNA's were the staff members responsible for the application of the [redacted] and would sign daily in the TAR when it was applied. The OT stated that therapy was involved in the screening and assessment process for the use of the [redacted] related to [redacted] and the therapy department would provide the nurses with education on the application of the [redacted] device. The OT further stated that the [redacted] purpose was to prevent [redacted] from worsening.

On 06/02/21 at 9:20 AM, the surveyor interviewed the DON who stated that the resident had a long history of refusing care and medications. The DON further stated that she interviewed the residents regular LPN who stated that she would be documenting all the time because the resident refused his/her [redacted] all the time so that was the reason why she didn't document in the resident's medical record that the resident refused to wear his/her [redacted].

The DON provided the surveyor with a statement written by the resident's LPN which indicated, "I

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was the nurse for [resident's name redacted] on [redacted] The [redacted]e was put on those days. I basically place the brace once [gender redacted] is out of bed, but some days [gender redacted] would refuse. It all depends on [gender redacted] mood. In those particular days I would go back during the day to put it on." The LPN's statement provided to the surveyor by the DON contradicted the surveyor's interview with her conducted on [redacted] at 11:22 AM.

The surveyor reviewed the medical record for Resident #50.

The [redacted] POS reflected a physician's order dated [redacted] for [redacted] at all times. Remove for hygiene and skin check every shift.

The [redacted] TAR reflected that the 7:00 AM - 3:00 PM nurse signed on [redacted] and on [redacted] that the resident's [redacted] was always on the resident.

The resident's IPOC updated [redacted] indicated a focus area for mood and behavior that the resident refused care and medications. The IPOC further reflected that the resident had [redacted]. There was no mention in the resident's IPOC that the resident had a [redacted], refused the [redacted], or interventions to promote the resident's use of the [redacted]

The resident's Occupational Therapy Plan of Care (Evaluation Only) dated [redacted] indicated that the resident had a [redacted] and [redacted]. The reason for the referral indicated that the resident was

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F 688	Continued From page 23 referred to OT services to establish [redacted] t wearing services. There was no indication on the resident's OT evaluation that the resident's range of motion had deteriorated. The facility policy with effective date of 10/2021 and titled, "[redacted] Precautions" indicated that all request for [redacted] for physical and occupational therapy require a physician's order and therapist should evaluate the following areas before fabrication or ordering [redacted] device: gross appearance notes: redness, edema, open wounds, trophic changes, suture sites, and deformities). The policy also indicated that therapist will provide an in-service to a nursing staff, patient or family. A further review of the, "[redacted] Precautions" Policy indicated that [redacted] were fabricated for resident's that required intervention and [redacted] would be carried out in a standardized practice. NJAC 8:39-27.1(a)	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.)	F 689	F689 1.(a) A root cause analysis determined	6/30/21

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F 689	Continued From page 24 dispose of a needle with a syringe (sharps) in it's appropriate receptacle and b.) maintain a safe environment during medication administration. This deficient practice was identified for two of four resident's reviewed, (Resident #67 and Resident #75) for medication administration. The deficient practice was evidenced by the following: 1. On 05/25/2021 at 7:40 AM, the surveyor observed the Registered Nurse (RN) on the [redacted] Unit administer the medication, [redacted] medication) to Resident #67. The RN administered the medication, pulled up the top of the plastic safety syringe attached to the needle so the needle was not exposed, removed her gloves, washed her hands, exited the room with the used syringe, and discarded the used syringe in the waste receptacle bin attached to the medication cart. The surveyor observed that the receptacle bin was directly underneath the sharps container (container used to dispose of used syringes). The used syringe was visible and within reach. The RN went to the next room to check on another resident. The surveyor stayed by the medication cart and summoned another staff member who was in the hallway. The staff member identified herself as the facility's Infection Control Preventionist (IP). At 8:25 AM, immediately upon the staff member identifying herself as the IP, the surveyor inquired about the policy for sharps disposal. The IP told the surveyor that all syringes should be disposed in the sharps container. The surveyor then showed the IP the used syringe that was visible and within reach placed in the waste receptacle. The IP guarded the medication cart until the	F 689	that the deficiency was caused by human error. The RN was promptly made aware of the syringe in the trash receptacle by the Infection Preventionist. After ensuring the needle safety was in place, the RN retrieved the used syringe from the trash receptacle and placed it in the sharps disposal container attached to her medication cart, just above the trash receptacle. The RN was immediately re-educated on the procedure for proper sharps disposal. RN was able to verbalize the procedure and rationale for disposing of used sharps in a puncture -proof sharps disposal container. (b) A root cause analysis determined that the deficiency was caused by human error. Resident #75 was immediately assessed by the Nursing Supervisor. Vital signs, including pain level, were obtained, names and doses of missed medications were recorded and the primary physician was notified that the medications were not administered. Orders were obtained and carried out. The LPN was immediately instructed not to leave medication on the resident's bedside and was able to verbalize understanding of the rationale. An Incident Report was initiated. The LPN was then placed on close supervision by the Nursing Supervisor to observe all further medication administration. That same day, the LPN was then provided with the appropriate orientation of agency nurses and successfully completed the education required. The LPN was given a one to one education on accident and incident policy.	

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F 689	Continued From page 25 nurse returned to the hallway. At 8:30 AM, the IP instructed the RN to remove the used syringe from the receptacle bin. The RN discarded the used syringe in the sharps container attached to the medication cart. At 8:30 AM, the RN stated that she should have disposed of the used syringe in the sharps container and stated, "I am sorry". At 11:38 AM, the surveyor notified the Administor and Director of Nursing (DON) that the RN placed the used syringe in the waste recepticle and not the sharps container on the medication cart. The surveyor asked the facility's administration to provide the policy for sharps disposal, none was provided for review. On 06/02/21 at 9:08 AM, the DON stated the RN told her that she thought she had thrown the used syringe into the sharps container and not the waste receptacle.The DON stated that she thought the RN was a good nurse and it was done by accident. 2. Resident #75 was admitted to the facility with diagnoses which included, unspecified [redacted] The Annual Minimum Data Set (MDS - an assessment tool) dated [redacted] revealed a score of [redacted] on the Brief Interview for Mental Status (BIMS)assessment, which indicated a [redacted]. Surveyor interviews with staff reflected that	F 689	2.(a) All residents and staff in the facility have potential to be affected by improper sharps disposal. All nurses were re-educated on the correct procedure for disposing of sharps in a puncture-proof sharps disposal container. (b) All residents in the facility are at risk for accident and incident hazards. All rooms were checked to ensure that the environment is free from any accident hazards. 3.(a) On 6/10/21 appropriate sharps disposal containers were mounted in resident rooms on the unit where the deficiency occurred in order to provide easy access to a disposal canister for all staff giving injections on that unit. All nursing staff were re-educated on sharp disposal policy. The medication competency was revised to include proper disposal of sharp. (b) Education and training for new nurses and agency nurses was revised to include Accident and Incident hazards All agency nurses and new nurses will be educated on Accident and Incident policy. All agency nursing staff and new nurses will be provided with Medication pass competency . Ongoing Medication Pass competency testing for all nurses will continue. The unit managers will make rounds after med passes to ensure that there is no medication left on the resident's bedside. 4. (a) The pharmacy consultant or designee will do an audit of proper sharps disposal during medication pass 3 nurses	

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F 689	Continued From page 26 Resident #75 was able to make his/her needs known and was forgetful at times. On 06/01/21 at 9:30 AM, the surveyor observed on Resident #75's bedside table, eight tablets inside a medication cup. Resident #75 stated that the nurse left his/her medications that morning. The surveyor observed no residents in the area who were ambulatory or who had access to the medications on the bedside table. On 06/01/21 at 09:40 AM, the surveyor interviwed Resident #75's Licensed Practical Nurse (LPN) who stated that Resident #75 received the medications that morning at 8:40 AM. The LPN showed the surveyor the [redacted] Medication Administration Record (MAR) where the she had signed for the administration of the medications. The LPN further stated she observed Resident #75 swallow the medications. Again, in the presence of the Charge Nurse, the LPN confirmed that she observed Resident #75 swallow the medications that morning. On 06/01/2021 at 9:45 AM, a review of the [redacted] MAR revealed that the following medications were administered and signed for on [redacted] at 8:00 AM. [redacted] (medication to relieve [redacted]) [redacted] milligram (mg), [redacted] supplement) [redacted] mg, [redacted] (medication to [redacted] mg, [redacted] supplement) [redacted] Milliequivalents (MEQ), [redacted] (vitamin supplement) [redacted] micrograms, [redacted] (vitamin supplement) International Units (IU), [redacted] (an[redacted]) [redacted] mg, and [redacted] (medication to [redacted]) [redacted] mg.	F 689	weekly for one month then monthly for 6 month. . Audit results will be reported to the Director of Nursing and presented quarterly to the Quality Assurance Performance Improvement Committee by the Administrator x 3 quarters. (b) The Unit Manager or designee will do observation audits using an audit tool for 5 residents weekly then monthly for 6 months to ensure no medications are left at the resident bedside. Results of the audit and the medication pass competencies will be reported to the Director of Nursing and presented quarterly to the Quality Assurance Performance Improvement Committee by the Administrator x 3 quarters. Preparation and/or execution of this Plan of Correction does not constitute admission/agreement of the provider of the truth of the facts alleged or conclusions set forth in any statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal or State Law.	

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F 689	Continued From page 27	F 689		

On 06/01/21 at 9:46 AM, the Charge Nurse observed the medication cup with the medications and stated the process was not safe and was unacceptable. The Charge Nurse stated the LPN should not have left the medications unattended at the resident's bedside and should not have signed for the medications if they were not administered. The Charge Nurse further stated that this process violated the facility's protocol and five rights of passing medications (right resident, right dose, right time, right route, and right medication). The Charge Nurse indicated that Resident #75 was [redacted] to follow directions. Upon further inquiry, the Charge Nurse stated that Resident #75 did not have an order to self administer medications. The surveyor requested the facility's Medication Administration Policy along with the medication pass competency for the nurse.

On 06/01/21 at 9:56 AM, the surveyor conducted a second interview with the LPN who stated that the medications in the cup belonged to Resident #75. The LPN stated that Resident #75 was eating breakfast so she left the medications at the bedside at 8:40 AM. The LPN recanted her story and stated that she did not observe Resident #75 swallow the medications that morning. The LPN further stated she had expected Resident #75 to take the medications while eating breakfast. According to the LPN, the protocol was to observe residents swallow their medications and then sign the MAR that the medications were administered.

On 06/01/21 at 10:41 AM, the DON stated that her expectations would be for the nurse to have stayed in the room to ensure the resident

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swallowed their medications before signing the MAR. The DON stated the facility's process of medication administration competency was different with every nurse because medication pass orientation was based on the nurses level of experience and the severity of the facility's needs. The nurses would meet with the educator and review the orientation materials which covered medication pass. The DON further stated that the Consultant Pharmacy or the Unit Manager would be responsible to follow the nurse to ensure they were administering medications correctly and safely.

The DON further stated, if medications were not administered, the protocol would be to inform the physician and assess the patient for an adverse effect. The DON stated that on the [redacted] unit, the residents were appropriately social distanced on the unit, continuously monitored, or remained their rooms. The DON further stated that Resident #75's roommate was unable to the get out of bed on his/her own.

On 06/01/2021 at 11:06 AM, during a follow up interview with the Nurse Educator (NE), regarding the medication competency for the nurse, the Charge Nurse was present and stated, "I did not have any documentation that it (LPN's medication competency) was done." The NE stated that based on the agreement with the staffing agency, the facility would expect that the agency staff would be competent in administering medications. The NE told the surveyor that the only competencies that the LPN completed were the hand hygiene observation and Personnel Protective Equipment (PPE). There was no documentation that the LPN had completed the medication pass competency with the facility. The

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F 689	Continued From page 29	F 689		

NE indicated that he did not have an employee file for the LPN.

On 06/01/21 at 11:27 AM, the NE showed the surveyor the orientation list that needed to be completed for agency staff, but there had not been one completed for LPN. The LPN had been provided with the, "Corporate Health Nursing and Rehab Nursing Orientation for agency Nurses", but did not complete the Medication Pass Competency located in the orientation book.

A review of the facility's policy titled, "Standards of Nursing Practice: RN, LPN, CNA, APN", initiated 02/2020 last revised 07/2021 indicated the following under Medication Administration:

A) To administer medications, all nurses must pass a medication exam and Medication Pass competency observation.

B) Each facility's Pharmacy and Therapeutics Committee approves a medication reference book or database which serves as a guideline for drug dosages and precautions.

C) Provider Pharmacy procedure manuals are available at each facility as a further reference.

Another Corporate Policy titled, " Medication Administration", last revised 02/2020, indicated, "The nurse shall remain in the resident's room until the resident has taken the medications."

On 06/02/2021 at 10:15 AM, during an exit conference with the administrative staff, the DON indicated that she could not explain what had happened or why Nurse #1 had not completed the orientation required by the facility.

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F 689	Continued From page 30 NJAC: 8: 39-27.1(a)	F 689		
F 804 SS=D	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: Complaint: NJ00145612 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to: a.) serve hot and cold foods at an acceptable temperature for the residents and b.) have a facility policy and procedure for maintaining appropriate food temperatures. This deficient practice was identified on the [redacted] during a food test tray observation and by two out of seven residents during the [redacted] Resident Council Meeting Minutes. The deficient practice was evidenced by the following: On 05/28/21 at 11:30 AM, the surveyor observed the food trucks containing the resident's lunch meal leave the kitchen. At 11:31 AM, the surveyor observed the food	F 804	F804 1. An investigation of the underlying cause of the inadequate food temperatures identified a need for assistance in distribution of the meals when communal dining has been suspended. Due to quarantine, paper and plastic plates and utensils were used to be in compliance with infection control protocols. This resulted in unacceptable food temperatures. 2. All residents who receive meals are at risk of receiving meals outside of acceptable temperature ranges. Residents that day were offered a replacement meal or the option of having staff reheat their meal. Six test trays were tested between 6/10/21 and 6/15/21 for proper food temperatures as well as distribution time of trays. Food	6/30/21

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F 804	Continued From page 31 trucks arrive on the [redacted] floor to be passed out to residents who resided on the unit. The surveyor observed that the food was stored and served to the residents on a plate which was covered by a dome container. The surveyor further observed that the soup was served in plastic container with a plastic lid over it. The cold drinks were placed on top of the resident's meal tray. At 11:35 AM, the surveyor conducted an interview with the Food Service Director (FSD) who stated that the goal was for hot foods temperatures to be between 150 to 160 degrees Fahrenheit (F) and cold food temperatures should be below 41 degrees F. At 11:50 AM, the surveyor took the temperatures of the food of the last tray remaining on the food truck. The surveyor had calibrated the thermometer prior to taking the temperatures of the food on the tray. The surveyor's thermometer registered the temperature of the baked cod at 113.3 degrees F. The FSD utilized her thermometer to take the temperature of the food on the tray after the surveyor. The FSD's temperature of the baked cod was 109 degrees F. The surveyor's temperature of the potato wedges was 117.8 degrees F. The FSD temperature of the potato wedges was 100 degrees F. The surveyor's temperature of the soup was 139.1 degrees F. The FSD temperature of the soup was 140 degrees F. The surveyor's temperature of the 4 ounces (oz) of whole milk on the resident's lunch tray was 53.4 degrees F. The FSD temperature of the 4 oz of whole milk was 53 degrees F. The surveyor's temperature of the 4 oz of apple juice was 56.6 degrees F. The FSD temperature of the 4 oz of apple juice was 56	F 804	temperatures were within the proper ranges. 3. To ensure that food trays are distributed in a timely manner, and to ensure proper food temperatures, all department heads will be assigned a unit to assist during meal times. This will include, but not be limited to therapy aides, recreation staff, social work staff, and department heads. Food service Director will evaluate alternate methods of food delivery when communal dining is suspended. A policy was created and dietary staff was in-serviced on proper holding temperatures on the tray line, as well as proper point of service temperatures. Hot food items to be held in steam tables at 150 degrees (F) or above. Soup and coffee/hot water to be held at 160 degrees (F) or above. Cold food items will be chilled in the freezer for 30 minutes before meal tray line begins. 4. An ongoing Quality Assurance Performance Improvement (QAPI) will be started with the intent of ensuring food is held and served to residents at the correct food temperatures. One (1) test tray will be sampled on two shifts, 5x/week on rotating floors/units. The temperature on the test tray will be taken after last tray on the cart has been served. Temperatures and length of time to pass the trays will be logged and evaluated for further potential process changes. This will be done for a period of 6 months. The Food Service Director will provide the information to the Administrator and report to the quarterly	

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F 804	Continued From page 32 degrees F. The FSD stated that the temperature of the food was not in an acceptable range. At 11:58 AM, the FSD stated that she wasn't sure if the facility had a food temperature policy and procedure. At 12:07 PM, FSD confirmed that the facility had no specific policy for the temperature of food when it was to be served to the resident. Review of the [redacted] Resident Council Meeting minutes revealed two out of seven residents interviewed stated that the food was served cold. One resident stated, "The coffee is like water and the food is usually cold." Another resident stated, "The food is cold." Review of the Resident Council Response Form dated [redacted] indicated that the FSD followed up with the resident's concerns and told them that because the facility was using paper products during the Pandemic, it was resulting in the food not being served as hot as it used to be. The Resident Council Response Form further indicated that the residents could ask the staff for another tray or have the food heated up if it needed to be.	F 804	QAPI Committee.	
F 880 SS=D	NJAC 8:39-4.1 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	F 880		7/31/21

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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;
(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

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F 880	Continued From page 34 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, and review of other pertinent facility documentation, it was determined that the facility failed to: a.) ensure staff followed current standards of practice at point of care testing regarding transport and disposal of used [redacted] safely, b.) performed appropriate hand hygiene during a [redacted] treatment observation according to facility policy and the Center of Disease Control (CDC) guidelines, and c.) wore the facility required Personal Protective Equipment (PPE) on the [redacted] unit. This deficient practice was identified for one of five medication carts reviewed for infection control, one of one resident's reviewed, (Resident #1) during during a [redacted] care observation, and on one of two	F 880	F880 1.(a) The team determined through root cause analysis that human error caused this deficiency. All [redacted] and alcohol pads that were in the same container as the used [redacted] were immediately discarded. The [redacted] was immediately disinfected according to manufacturer instructions. The medication cart was also disinfected with the assistance of the Infection Preventionist. The Nurse involved was immediately re-educated on the policy and procedure for proper disposal of used [redacted]. The Nurse involved successfully completed competency testing for [redacted]	

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F 880	Continued From page 35 nursing units in the facility. The deficient practice was evidenced by the following: 1. On 05/25/2021 at 09:30 AM, the surveyor went to the [redacted] Unit to check the medication carts as part of the survey process. At 09:45 AM, the surveyor checked the medication cart on the [redacted] side with Nurse #1. Nurse #1 opened the medication cart drawer and there was a little basket that contained two used [redacted] stored with alcohol pads, seven clean, and unused [redacted] along with the facility [redacted]. The surveyor inquired about the used and unused [redacted] comingled together with the [redacted]. The nurse stated that the open [redacted] were used that morning to monitor the resident's [redacted] and could not be used again. On 05/25/2021 at 10:10 AM, the surveyor asked Nurse #1 for the protocol for the disposal of used [redacted]. The nurse told the surveyor that the protocol was to disinfect the [redacted] after each resident and to dispose of used [redacted] after use in the sharp's container. The Infection Control Preventionist (IP) was nearby and heard the conversation. The IP intervened and asked the nurse to discard all the [redacted], the alcohol pads and to disinfect the tray along with the [redacted] Nurse #1 discarded all the [redacted] in the sharp container attached to the medication cart in the presence of the surveyor. The [redacted] was removed and disinfected.	F 880	[redacted] monitoring on 5/25/21. (b) The team determined through root cause analysis that this deficiency was caused by human error. The resident receiving the [redacted] care was monitored for signs and symptoms of infection during daily [redacted] treatments and was assessed by the facility [redacted] MD the following day. Resident vital signs were taken every shift for additional monitoring of infection. The Nurse involved was re-educated on the procedure for proper hand washing and then successfully completed a hand washing competency on 6/1/21. (c) The team has determined through root cause analysis that this deficiency was caused by human error. The RN/Unit Manager immediately donned the appropriate N95 mask with a surgical mask over it and eye protection when instructed to do so. All residents on the unit were monitored every shift for signs and symptoms of COVID-19. All residents on the unit have vital signs monitored on every shift to monitor for signs and symptoms of infection, regardless of vaccination status. The RN/UM was re-educated on the Personal Protective Equipment Policy and successfully completed competency testing for donning/doffing of PPE. 2.(a) All residents receiving point-of-care [redacted] monitoring have potential to be affected by this deficient process. All facility nurses were re-educated on proper [redacted] disposal. A sharp disposal container was installed in the resident□s	

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F 880	Continued From page 36 On 05/25/21 at 10:21 AM, the IP stated Nurse #1 had been employed by the facility for many years. According to the facility's policy the nurse should have discarded the [redacted] in the sharp's container after use. The used [redacted] should never have been stored with the clean, unused [redacted] for infection control prevention. The IP indicated that she counseled the nurse, assisted the nurse to disinfect the medication cart and the [redacted]. The IP indicated that Nurse #1 always followed the facility's policy and procedure but could not explain what was going on with Nurse #1 today. On 05/25/21 at 10:31 AM, during a second interview with Nurse #1, she stated that she monitored the [redacted] at 9:00 AM for a resident and at 9:10 AM for another resident. She told the surveyor that she disinfected the [redacted] after each resident. The surveyor verified that neither resident was on Transmission Based Precautions. On 05/25/2021 at 11:15 AM, a follow up interview with Nurse #1 revealed that there were no sharp's containers in the resident rooms to dispose of the used [redacted] so she placed the used [redacted] in the tray along with the clean, unused [redacted] and the [redacted]. Nurse #1 stated that she should have disposed of the used [redacted] after use in the sharp's container attached to the medication cart. On 05/25/2021 at 11:40 AM, the survey team discussed with the Administrator and the Director of Nursing (DON) the observed practice of the used [redacted] stored in the medication cart along with clean, unused [redacted] and the clean [redacted].	F 880	nursing unit. (b) Residents who were under the care of the RN who performed hand washing incorrectly. Of these residents, 2 required wound care by the nurse. The nurse was observed by the Unit Manager, or designee, for a period of 5 shifts, beginning 6/3/21 when performing wound care on these residents to ensure proper hand hygiene. (c) Residents on the [redacted] unit, where the unit manager assigned,has potential to be affected by this deficient practice. 3.(a) All nurses were educated on the Point-of-Care testing policy and disposal of used lancets and Infection Control policy and procedure. Sharps disposal containers were placed in all rooms on the affected unit. (b) All staff were educated on the hand washing policy. The hand washing competency assessment was modified on 6/1/21 to more closely reflect the facility hand washing policy. Visual cues on proper hand washing were posted throughout the facility. (c) All staff were re-educated on the importance of PPE compliance. Any staff member who cant comply with PPE usage due to illness must notify the supervisor and not be allowed to be in the unit. Signs are placed at the facility entrance and at the elevator to inform team members of the PPE requirement. The PPE requirements are also discussed at the clinical huddle on each unit with all nursing staff at the beginning of every shift. The nursing staff are all required to	

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F 880	Continued From page 37 On 05/25/2021 at 11:43 AM, the DON stated that her expectations would be for staff to dispose of the used [redacted] in the sharp's container to prevent the spread of infection. The team requested the facility's policy for Infection Control and sharps disposal. On 05/25/2021 at 12:30 PM, the surveyor requested the Infection Control Policy from the IP. The IP stated that Nurse #1 had been working at the facility for [redacted] and she could not explain what happened. The IP told the surveyor that the nurse had been educated on Infection Control Prevention. On 05/27/21 at 1:23 PM, the DON provided a policy and procedure titled: "HMNR Medical Device Safety and Point of Care Testing" revised 01/2021 which indicated the following under Purpose: Prevention and control of transmission of Infection. Policy: Medical devices may be used for administration of medications, point of service testing and other medical uses. Procedure: Point of care testing may be accomplished through use of portable handheld instrument which may include [redacted] monitoring, [redacted], I-stat device (e.g. [redacted]) , and COVID-19 testing. 1. [redacted] specimen by [redacted] Single use auto-disabling device only may be used. These are devices that are disposable and prevent reuse through an auto-disabling feature. Must never be used for more than one resident/ patient. Dispose of used needle stick device in a sharp container. Never put devices or supplies in pocket.	F 880	sign that they have attended the huddle. Any team member who is not in compliance with the PPE requirement will have an education note put in their employee file. More than one education note on this topic will result in an appropriate corrective disciplinary action as recommended by Human Resources. All staff were given a mandatory education on the CMS youtube video on Infection control including Clean Hands, Combat COVID-19!, Keeping COVID-19 Out!, Use PPE Correctly for COVID-19!. All CMS videos were added to the new orientation education. All staff were educated on the CMS YouTube video on Infection control,focusing on hand hygiene, Infection Prevention and Use of PPE. Topline staff and infection Preventionist completed Module 1-Infection Prevention and Control Program. 4.(a) The Facility Educator will use an audit tool to monitor 3 nurses per week x 1 then, monthly x 6 months for [redacted] Monitoring and proper [redacted] disposal. Results of the audit will be reported to the Director of Nursing and reported by the Administrator to the Quality Assurance and Performance Improvement Committee x 3 quarters. (b) The Infection Preventionist, or designee, will use an audit tool to assess the hand hygiene during the [redacted] care process of 1 nurse weekly then 2 nurses monthly x 6 months . Results of the audit will be reported to the Director of Nursing	

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F 880	Continued From page 38 2. [redacted] may be shared in the rehabilitation facility but must be disinfected after each use per manufacturer's instruction, meeting the criteria specified by the FDA. Nurse #1 although aware of the facility's policy for Infection Control did not follow the policy. 2. On 05/26/21 from 10:02 AM to 10:32 AM, the surveyor observed the Resident Nurse (RN) perform the [redacted] care treatment to Resident #1's [redacted] with assistance from the Charge Nurse (CN). At 10:02 AM, prior to performing the [redacted] care treatment, the surveyor observed the RN turn on the faucet to the sink in the resident's bathroom with her hands, apply soap without rinsing her hands under the running water and rub both her hands together under the running water for 15 seconds. The surveyor did not observe the RN rub her hands outside of the running water to produce a lather from the soap. The surveyor then observed the RN gather supplies at the treatment cart outside of the resident's room and bring them into the resident's room to perform the treatment to the resident's [redacted]. The surveyor then observed the RN clean fecal matter from the resident's [redacted] At 10:12 AM, the surveyor observed the RN perform hand hygiene again in the resident's bathroom. The surveyor observed the RN turn on the faucet to the sink in the resident's bathroom with her hands, apply soap without rinsing her hands under the running water and rub both her hands together under the running water. The surveyor further observed the RN add more soap from the soap dispenser three times. Each time the RN added soap to her hands, the surveyor observed that she never	F 880	and reported by the Administrator to the quarterly Quality Assurance and Performance Improvement Committee x 3 quarters. (c) Infection Preventionist or designee will use an audit tool to monitor 5 staff members weekly x 1 then monthly x 6 months on proper use of PPE. Results of the audit will be reported to the Director of Nursing and reported by the Administrator to the quarterly Quality Assurance and Performance Improvement Committee x 3 quarters. Preparation and/or execution of this Plan of Correction does not constitute admission/agreement of the provider of the truth of the facts alleged or conclusions set forth in any statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal or State Law.	

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produced a lather with the soap and had her hands were positioned under the running water in the sink while she rubbed them together. The RN then went over to the resident to perform the wound care treatment.

At 10:34 AM, the surveyor interviewed the RN who stated that appropriate hand hygiene required her to turn on the faucet, wet hands with water, apply soap, and run hands together for 20 seconds in the sink under the water in a downward position. The RN then stated that she would dry her hands with a paper towel, and then turn off the faucet with a new paper towel.

At 12:30 PM, the surveyor interviewed the CN who stated that the correct procedure to wash hands was to turn on the faucet, wet hands, apply soap, rub hands with friction outside running water to produce a lather for 20 seconds. Then rinse the soap from the hands under the running water. The CN further stated that hands would be dried with a clean paper towel and another paper towel would be utilized to turn off the faucet. The CN stated that the purpose of hand hygiene was to prevent the spread of germs.

On 06/01/21 at 9:50 AM, the surveyor interviewed the IP who stated that the correct hand washing procedure was the staff member should turn on the water, wet hands, get soap on hand and lather both hands together with friction outside of the running water for 20 seconds. The IP further stated the staff member would then rinse off hands under the running water, use paper towel to dry hands, and use new paper towel to turn off the faucet.

Review of the Handwashing Observation

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Checklist conducted for the RN dated 1/12/21 reflected that the RN, "1. Hands washed properly with clear running water 2. Disinfectant or soap used 3. Front and back of hands properly scrubbed 4. Hands rinsed appropriately 5. Faucet turned off with paper towel 6. Hands dried correctly 7. Towels properly discarded" and Handwashing was done in 20 seconds. The Handwashing Observation Checklist reflected that the RN appropriately washed her hands.

Review of the updated Handwashing Observation Checklist conducted for the RN dated 6/1/21 reflected that the RN, "1. Remove hand and wrist jewelry/watches and push sleeves up above the wrist prior to handwashing 2. Stand well away from the sink in order to prevent getter splashed 3. Turn on the water gently and adjust water temperature to a comfortable level 4. Wet hands and wrist thoroughly 5. Dispense the correct amount of soap 6. Scrub each hand with the other, creating as much friction as possible by interlacing the fingers and moving the hands back and forth 7. Scrub the hands for 20 seconds outside of the running water 8. Rinse the hands thoroughly under running water, keeping the hands down below the level of the elbows 9. Does not touch the surface of the sink 10. Dry the hands and wrists gently with a paper towel and discard into the wastebasket 11. Turn the faucet off with a new, dry paper towel 12. Discard the paper towel into the wastebasket"

Review of the facility's, "Handwashing and Hand Hygiene Policy and Procedure" revised 08/2020 indicated that the purpose of performing hand washing was to prevent the spread of infection. The, "Handwashing and Hand Hygiene Policy and Procedure" further indicated to perform hand

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hygiene before and after touching wounds.

Review of the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Clean Hands Count for Healthcare Providers, reviewed 1/8/2021, included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry."

3) During the survey teams' entrance on 05/24/21, the facility informed the surveyors that there were no COVID-19 positive residents in the facility but there were residents on TBP or observations as new or readmissions. The facility informed the surveyors that on the [redacted] and [redacted] floors, the staff and surveyors were required to wear an N95 mask with a surgical mask over it and eye protection. The facility had supplied a facility floor plan which indicated rooms highlighted in yellow to be TBP rooms which required PPE. The [redacted] floor had four rooms highlighted.

During a tour of the facility, the surveyor approached the elevators in the lobby and observed a sign that indicated, "NO ONE IS ALLOWED ON THE [redacted] FLOOR WITHOUT PROPER P.P.E. IE, GOGGLES OR SHIELD AND N95". The surveyor toured the [redacted] floor on 05/24/21 and observed four rooms to have STOP see nurse signs and bins with PPE

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F 880	Continued From page 42 supplies outside the room. On 05/25/21 at 12:13 PM, the surveyor observed the Registered Nurse Unit Manager (RN/UM) on the [redacted] floor wearing two surgical masks and a face shield. During an interview at that time, the RN/UM stated her allergies were bothering her, so she was not wearing the facility required N95 mask. She stated the N95 mask was for the protection of the staff and the residents on the floor. The RN/UM further stated she had an assignment and was caring for residents on the [redacted] unit, she had been fit tested for the N95 mask, and had the N95 mask available to her. On 05/25/21 at 12:25 PM, the Director of Nursing (DON) stated the purpose of staff on the [redacted] and [redacted] floors wearing full PPE was because there were quarantined residents. The DON stated the staff were to wear the N95 mask to prevent spread of infection. The DON further stated the RN/UM on the [redacted] floor, especially with an assignment that included [redacted] and TBP residents, would be required to wear the N95 mask, surgical mask over it and eye protection. Review of the facility provided assignment sheet for [redacted], revealed the RN/UM was responsible for the care of 10 residents on the [redacted] unit and three of those residents were on TBP. Review of the facility PPE Donning and Doffing Competency Tool included but was not limited to, PPE was worn to minimize exposure to hazards and prevent the spread of germs, PPE must remain in place and be worn correctly for the	F 880		

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F 880	Continued From page 43 duration of work in potentially contaminated areas, and that the appropriate PPE should be worn according to the TBP in effect. The RN/UM was noted to be competent in all the steps and signed her competency on [redacted]. Review of the Fit Test Record dated [redacted], revealed the RN/UM had been fit tested for the respirator mask. Review of the facility Universal Pandemic Precautions policy and procedure, dated 11/23/20, revealed but was not limited to, the N95 masks were recommended for use with residents who are COVID-19 suspects, Persons Under Investigation (PUI), and Quarantined; eye protection was required for residents who were PUI or on quarantine; universal eye protection must be worn when providing direct care or having close (within six feet) contact with residents and at all times on the units where suspect, PUI or quarantine residents were located. NJAC 8:39-19.4(a)(1,2); 19.4(l,n); 27.1(a)	F 880		