STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061303	A. BUILDING: _____ B. WING _____	05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR CARE AND REHABILITATION CENTER	3325 HIGHWAY 35 HAZLET, NJ 07730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S2110	8:39-31.1(a) Mandatory Physical Environment (a) No construction, renovation or addition shall be undertaken without first obtaining approval from the Department, Long-Term Care Licensing and Certification Program and/or the Department of Community Affairs, Health Care Plan Review Unit This REQUIREMENT is not met as evidenced by: Based on observation and interview and renovation of facility documents, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to obtain approvals from the	S2110	S2110 1) Survey team notified us that such capital improvements need prior notification and approvals to the DCA. We submitted for approvals on 7/22/2021.	7/22/21

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

Electronically Signed | 06/03/21

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S2110	Continued From page 1 Department of Health, Certificate of Need and Licensing Program (CN&L), or the Department of Community Affairs (DCA) prior to conducting renovations and re-occupying the areas. This deficient practice was evidenced by the following: During a tour of the facility on 05/12/21, beginning at 10:10 AM, the surveyor observed that The entire wing from resident room [redacted] including the Nurses station and day room had been renovated since the previous survey. The resident rooms had new lighting fixtures installed, new ceiling wallboard, new wall finish, flooring and new doors. Resident bathrooms had new wallboard installed, flooring, lighting fixtures, plumbing fixtures (toilet and sink). The corridor was renovated with new flooring, wallboard, lighting fixtures and nurses station. The resident dayroom was also renovated with new wallboard, flooring, lighting fixtures and flooring. In an interview during a tour of the facility on 05/12/21 at 11:30 AM, the Director of Maintenance and Regional Plant Operations Director stated and confirmed that the wing was renovated, but had no information on CN&L or DCA approvals for the renovations In an interview with the Administrator, Maintenance Director and Regional Plant Operations Director at 01:30 PM, they all stated that there was a problem with the drain pipes in the wing. The surveyor asked if the Health Department was notified of the situation through a reportable, but no information was obtained by the end of the day.	S2110	2) All other current Capital improvements have the proper notifications and approvals from the DCA. 3) Maintenance director or Corporate Maintenance director will review all other Capital improvements to ensure proper notifications and approvals form the DCA. 4) MD will report at the quarterly any upcoming or ongoing Capital improvements and ensure that they all have or will have proper notifications and approvals from the DCA	

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S2110	Continued From page 2 There was no documented evidence provided from the facility that CN&L or DCA were notified to obtain approvals for the renovation project.	S2110		

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F 000	INITIAL COMMENTS Standard Survey: 5/21/21 Census: 132 Sample size: 26 (Plus 3 closed records) A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of clinical practice by a.) not following manufacturing specifications for the administration of a delayed released medication and b.) not clarifying a physician's order for 2 of 27 residents (Resident #22 and Resident #90) reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and	F 658	I. Immediate Corrective Action. a) Resident #22: This resident able to take the [redacted] capsule as whole in applesauce. Alert placed in resident□s chart patient health information section. b) Resident #90: Transcription (error) corrected and pharmacy sent the appropriate [redacted] mg for this patient. [redacted] mg tablets, removed from cart and returned to the pharmacy. II. Identification of others a) All residents with orders for crushed meds, were audited to ensure that all meds on patient profile are crushable or appropriately tagged as DO NOT CRUSH. No negative findings. b) All current residents with orders for Abilify were reviewed, to ensure	7/16/21

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F 658	Continued From page 1 treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 5/17/21 at 9:20 AM, during the medication observation pass, the surveyor observed a Licensed Practical Nurse (LPN#1) preparing to administer medications for Resident #22. The surveyor observed LPN #1 opened a capsule of [redacted] mg [redacted] Capsule and pour the contents into apple sauce. The LPN #1 was then observed mixing the contents of [redacted] in apple sauce and then administering the medication to Resident #22. On 5/17/21 at 10:30 AM, the surveyor reviewed the Admission Record for Resident #22 which indicated that the resident was admitted to the facility on [redacted] with diagnoses which included, but not limited to [redacted]	F 658	medication orders were transcribed correctly and administered appropriately as per orders. No negative findings identified. III Systemic changes a) The policy for medication orders were reviewed and found in compliance. b) The policy for crushing medications were reviewed and found to be in compliance. The In-service Coordinator will provide in-service to all licensed nurses on: 1) The proper administration of delayed-release medication/no crushing 2) The proper method of reviewing physician orders for medication accuracy with special attention to route of administration/crushability and proper dosage. c) The process for nurse review of all physician□s orders to ensure accuracy and prevent medication errors. c) The pharmacy consultant will review physicians□ orders in the monthly Drug regimen review and notify nurse immediately if any route or dosage discrepancies are found. The pharmacy consultant will record findings and action taken and forward to DON. d) The DON or designee will ensure corrections are made in accordance with the recommendations. e) The Pharmacy Consultant provided listing of non-crushable medications utilized in the facility to provide guidance to licensed nurses. IV Quality Assurance " The DON/designee will create a competency tool to determine nurses competencies in medication	

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F 658	Continued From page 2 Review of the [redacted] Physician's Orders revealed an order for [redacted] mg capsule, delayed release dated [redacted] with a direction of 1 Capsule by mouth once daily at 9:00 AM for [redacted]. A review of Manufacturer's Specifications revealed that [redacted] mg [redacted] capsule must be administered whole. [redacted] should not be crush or opened. On 5/17/21 at 11:00 AM, the surveyor interviewed LPN #1 who stated that he was unaware that [redacted] couldn't be opened and mixed in apple sauce. After reviewing the manufacturing specifications with the surveyor, LPN #1 stated that he should have not opened the [redacted] capsule. On 5/17/21 at 1:00 PM, the surveyor met the Regional Nurse and the Director of Nursing (DON), and there was no additional information provided by the facility. 2. On 5/10/21 at 12:52 PM, the surveyor observed Resident #90 who was dressed and groomed and self-ambulating on the nursing unit. On 5/18/21 at 12:10 PM, the surveyor reviewed the Admission Record for Resident #90 which indicated that the resident was admitted to the facility on [redacted] with diagnoses which included, but not limited to [redacted]. A review of the Progress Note (PN) dated [redacted] revealed that Resident #90 had a Gradual Dose	F 658	administration as related to crushed medications and will conduct the competencies for 5 nurses monthly x 3 months. competencies will be repeated annually for all nurses. DON/designee will report to the Quarterly QAPI committee.	

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F 658	Continued From page 3	F 658		

Reduction (GDR) for Abilify. The PN indicated that the [redacted] was decreased from [redacted] mg to [redacted] mg.

A review of the [redacted] Physician's Orders revealed an order dated [redacted] for [redacted] mg to give 1 tablet ([redacted] mg) by mouth at bedtime ½ tablet ([redacted] mg) for [redacted] disorder.

A review of the [redacted] Electronic Medication Administration Record (eMAR) revealed an order dated [redacted] for [redacted] mg give 1 tablet [redacted] mg) by mouth once daily at bedtime 1/2 ([redacted] mg) for [redacted]. Further review of the [redacted] eMAR indicated that the [redacted] was plotted to be administered at 9 PM from [redacted] through [redacted]

On 5/18/21 at 12:30 PM, the surveyor in the presence of a Licensed Practical Nurse (LPN#1) inspected the [redacted] medication cart. The surveyor observed a bingo card (medication delivery system) dated [redacted] for [redacted] mg tablets that contained whole tablets. The LPN #1 was unable to find a bingo card that contained [redacted] mg tablets.

Further review of the [redacted] bingo card's cautionary auxiliary label indicated this tablet must be swallowed whole. Do not chew or crush. Furthermore, [redacted] tablet cannot be scored (broke in half).

At that same time, the surveyor interviewed LPN #1 who stated there were no bingo cards for [redacted] mg [redacted] inside the active inventory medication cart. The LPN #1 stated that the directions for [redacted] in the Physician Orders and the eMAR were confusing and should have been clarified with the physician.

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F 658	Continued From page 4 On 5/19/21 at 2:00 PM, the surveyor met with the Administrator, the Regional Nurse and DON and discussed the above observations and concerns. There was no additional information provided by the facility. A review of the facility's policy for Transcribing Orders in Sigma dated October 2020 indicated "Two nurses will review each order to assure accuracy and appropriateness of the orders" and "the nurse will click Authorization, read back the order to the Medical Doctor or Nurse Practitioner, click read back and complete."	F 658		
F 695 SS=D	NJAC: 8-39-27.1 (a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain the necessary respiratory care and services for a resident who was receiving [redacted] care and [redacted] treatment according to standards of practice. This deficient practice was identified for 1 of 1 resident (Resident # 278) reviewed for [redacted] care. This deficient practice was evidenced by the	F 695	I. Immediate Corrective Action a) Resident #278: The [redacted] machine was removed from the floor, [redacted] were discarded, machine sanitized and placed on resident□s night stand. New [redacted]g was attached, [redacted] dated and placed in plastic to be stored until next use. b) Hand Hygiene Competency was conducted with RN#1 and demonstrated	7/16/21

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F 695	Continued From page 5 following: According to the U.S. CDC guidelines Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated February 23, 2021, included, "Hand Hygiene: HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly; routine cleaning and disinfection procedures (e.g. using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed." According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. Immediately after glove removal." It further specified the procedure for hand hygiene which included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your	F 695	Competency in hand hygiene. II. Identification of others a) Rounds were completed for all residents with [redacted] treatments, to ensure that placement of [redacted] machines, were in accordance with infection control guidelines including placement on bed side stand, [redacted] dated and covered with plastic bag when not in use. All resident□s equipment for [redacted] was found to be in compliance. b) Nurses on the units with patients with [redacted] were observed for proper hand hygiene and proper cleaning of work space prior to performing [redacted] care. All noted in compliance. III. Systemic Changes a) The policy and procedure for [redacted] care was reviewed and revised to include preparation of work space and hand hygiene. b) Nursing staff will be re-educated on Infection Control procedures with focus on proper storage of [redacted] machines and [redacted] c) Nursing staff will be reeducated on proper hand hygiene before and after performing [redacted] care. IV. Quality Assurance; a) The DON/ADON/ in-service coordinator/designee will Audit 3 patients on [redacted] treatments for the proper storage of [redacted] machine, [redacted] and use of plastic bag to maintain cleanliness of [redacted]. This will be done weekly x 4, then monthly x 3, then quarterly x 2. b) The DON/ADON/ in-service coordinator/designee will conduct audits	

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F 695	Continued From page 6 hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds." On 5/11/21 at 10:02 AM, the surveyor observed Resident # 278 seated in a wheelchair in his/her room. The [redacted] machine was on the floor, the [redacted] was on top of the resident's bed, not stored in a plastic bag. The resident's [redacted], allowing the resident to speak. The resident stated that they used [redacted] as needed (PRN) and on a routine [redacted] treatment. The resident further stated that it was the nurse's responsibility to administer [redacted] and the [redacted] treatment. The resident indicated that the [redacted] care and changes were being done once a day by a nurse. On that same date and time, the surveyor observed the Certified Nursing Aide (CNA) who was also in the resident's room picked up the [redacted] and hung it on the hook attached to the wall just below the light. The [redacted] was not stored in a plastic bag and was not dated. The CNA stated, "I just finished am care of the resident," and left the resident's room. On 5/12/21 at 9:28 AM, the surveyor observed the resident seated on the bed with the [redacted]. The [redacted] was hung onto the hook on the wall not stored in a plastic bag and was not dated. The [redacted] machine was on the floor near the head part of the bed. The resident stated it was the nurse who administers [redacted] treatments and hung the [redacted] the wall. The resident further stated, "I don't know," if nurses store the [redacted] in a plastic bag when not in use. The resident also stated that he/she forgot who the	F 695	on Hand Hygiene on 5 nurses weekly x 4 weeks, monthly x 2 months. c) The DON/ADON/ in-service coordinator/designee will conduct audits for nurses on units with [redacted] weekly x4 then monthly x 3 then quarterly x 2. d) A competency has been developed for understanding the appropriate opportunities for hand hygiene when performing [redacted] care. In the absence of patients with [redacted]s. 4 nurses will complete this competency questionnaire to areas identified below per week x 4 then monthly x 3 then quarterly x 2. ¿ Proper disinfection of surfaces before and after [redacted] care. ¿ Handwashing before, during and after as appropriate. ¿ All results will be brought to the QAPI committee quarterly. e) The DON/Inservice Coordinator/ Designee will report to the QAPI committee quarterly	

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F 695	Continued From page 7 nurse was who administered [redacted] treatment "this morning." On 5/12/21 at 9:34 AM, the Licensed Practical Nurse #1 (LPN #1) informed the surveyor that she was the nurse of the resident. LPN #1 stated that Resident # 278 was [redacted], on a [redacted] treatment, and PRN [redacted]. She further stated that the [redacted] should be inside a plastic bag and dated when not in use for infection control purposes. LPN #1 indicated that it was the 11-7 shift nurse's responsibility to change [redacted] every 24 hours, and sign the electronic Treatment Administration Record (eTAR) for accountability. On that same date and time, the surveyor and LPN #1 entered the resident's room and observed the [redacted] hung on the wall, not inside a plastic bag, and was not dated. Also, the [redacted] machine was on the floor. After exiting the resident's room, LPN #1 stated "I don't know why the [redacted] was not inside a plastic bag and undated." She further stated that the [redacted] machine should not have been on the floor. She indicated that she did not administer [redacted] treatment to the resident "this morning," and that it was the 11-7 nurse, but she forgot the nurses name. On 5/12/21 at 9:39 AM, the CNA informed the surveyor that Resident # 278 was [redacted]. The CNA stated that it was the nurse's responsibility to administer [redacted] treatments and takes care of the [redacted]. The CNA further stated, "Yesterday was the first time I hung the [redacted] on the wall. I don't normally do that." She further stated, "I know it should be inside a plastic bag, but I couldn't find a plastic bag at that time."	F 695		

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F 695	Continued From page 8 On 5/12/21 at 9:55 AM, the Registered Nurse/Charge Nurse (RN/CN) informed the surveyor that she was aware of the above concerns and stated, "it should have been inside a plastic bag," when not in use and [redacted] machine should not be on the floor. The RN/CN further stated that the 11-7 nurse was LPN #2. She indicated that the accountability for changing the [redacted] and dating was in the eTAR and signed by the nurses. On 5/12/21 at 1:31 PM, the surveyors met with the Licensed Nursing Administrator (LNHA), Director of Nursing (DON), Regional Registered Nurse#1 (RRN#1) and discussed the above observations and concerns. A review of the resident's Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included [redacted] A review of the [redacted] Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate care management, revealed a Brief Interview for Mental Status (BIMS) score was [redacted] which indicated that the resident's cognition was [redacted]. The CMDS noted that the resident was on [redacted] care and [redacted] therapy. A review of the [redacted] Physician's Orders revealed an original order date of [redacted] for [redacted] care every shift. There was an order dated	F 695		

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[redacted] for changing the [redacted] once a week every [redacted]

Further review of the [redacted] Physician's Orders showed that the order for [redacted] change was ordered after the surveyor's inquiry.

On 5/17/21 at 9:45 AM, the surveyor in the presence of the survey team conducted a telephone interview with LPN #2 who confirmed that she was the 11-7 nurse on [redacted]. LPN #2 stated that the order for Resident # 278's [redacted] treatment was 3 times a day at 9:00 AM, 1:00 PM, 5:00 PM, and "not on my shift that was why I was not paying attention that the [redacted] was hung on the hook and was not inside a plastic bag." LPN #2 further stated that it was the 11-7 shift nurse's responsibility to change the [redacted] every [redacted], put a date on the plastic bag for infection control purposes. She indicated that it was the facility's policy to make sure the [redacted] was inside a plastic bag when not in use, date the bag, and keep the machine off the floor.

On 5/17/21 at 10:32 AM, the surveyors observed the RN/CN performed [redacted] care of Resident #278. The RN/CN disinfected the table before [redacted] care, removed used gloves, and performed handwashing for 14 seconds. The RN/CN after cleaning the [redacted] removed used gloves and performed handwashing for 13 seconds. The RN/CN did not disinfect the table after use and left the resident's room.

After exiting the resident's room, the RN/CN informed the surveyors that handwashing should be done for at least 20 seconds according to facility policy and protocol. The RN/CN stated that she was educated and had competency with

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regards to handwashing by the Infection Preventionist Nurse (IPN). She further stated that she should have disinfected the table after use. The RN/CN had no response when the surveyor informed her of the above observations with handwashing.

Furthermore, the RN/CN informed the surveyors that there should have been an order and accountability for checking and changing [redacted], and [redacted] should be changed every [redacted] according to the facility policy and protocol. The RN/CN stated that the order should be reflected in the eTAR and signed by the nurses. The surveyor asked the RN/CN in the presence of RRN #2 to show the order for [redacted] care and change in the electronic medical record. The RN/CN stated there was no order for [redacted] care and changes and there should be one.

On 5/17/21 at 12:46 PM, the surveyors met with the Director of Nursing (DON), RRN#1 and 2, and discussed the above observations and concerns. RRN#1 informed the surveyors that LPN #1 was disciplined because of the above concerns. RRN #1 stated that as a standard of practice, a [redacted] must be placed in a "ziplock" if not in use, and the [redacted] machine should not be on the floor.

On 5/19/21 at 12:48 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), RRN#1, and Regional LNHA. RRN #1 informed the surveyors that "handwashing starts when you wet your hands and not when you scrub your hands." RRN#1 stated that "that's why LPN #1 felt that she counted 20 seconds" when she washed her hands during the [redacted] care."

On 5/20/21 at 9:30 AM, the IPN informed the

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surveyors that staff should perform handwashing with soap and water and lather for 20 seconds. The IPN stated that "20 seconds starts when you vigorously scrub your hands with soap and water," and not when you start to open the faucet and wet your hands according to CDC guidelines. The IPN further stated that the RN/CN should have disinfected the table after use.

On that same date and time, the IPN stated that it was facility policy to change the [redacted] every 72 hours, and should have been kept in a plastic bag when not in use and dated. She further stated that the [redacted] machine should be off the floor.

A review of the facility [redacted] Care Policy and Procedure that was provided by the DON with a reviewed date of June 2020 included "#6. Ensured that [redacted] are for single resident used and are cleaned and stored as per facility policy. #7. At all times, the nurse will ensure that [redacted] does not touch the floor. #9. [redacted] should change weekly on the 11-7 shift. #10. If at any time, the nurse sees the [redacted] resting and/or touching the floor, [redacted] will be discarded and replaced with new [redacted]."

A review of the facility Cleaning/Disinfecting Policy and Procedure that was provided by the DON with a reviewed date of March 2021 included "It is the policy of this facility to clean and disinfect PPE, Resident-Care Equipment, Resident Areas and Laundry, including reusable items and durable medical equipment to current CDC, DOH, and OSHA recommendations for disinfection."

A review of the facility Hand Hygiene Competence Assessment form that was provided

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F 695	Continued From page 12 by the DON with a copyright 2013-2014 included "Demonstrates Hand Hygiene Technique: Using Antimicrobial Soap and Water. 1. Turns on the faucet and wets the hands with warm water. 2. Applies the amount of soap necessary to cover all surfaces. 3. Vigorously rubs the hands together for a minimum of 20 seconds covering all surfaces of the hands and fingers. 4. Rinses the hands with water to remove residual soap. 5. Pats the hands dry with a disposable, single-use paper drying material. 6. Turns off the faucet using a technique that does not recontaminate the hands. 7. Discards the disposable paper drying material without re-wiping the hands." On 5/21/21 at 10:47 AM, the surveyors met with the LNHA, DON, Regional LNHA, RRN#1 and 2. There was no additional information provided by the facility. NJAC 8:39-11.2 (b); 27.1(a)	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		7/16/21

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F 756	Continued From page 13 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to a.) ensure that the Consultant Pharmacist (CP) reported irregularities of a drug regimen to the facility, and b.) act upon the CP report of irregularities found while reviewing the monthly drug regimen. This deficient practice was identified for 2 of 26 residents, #31 and #119 reviewed. This deficient practice was evidenced by the following: 1. On 5/11/21 at 10:11 AM, the surveyor observed Resident #31 lying in bed awake and confused. The surveyor observed a [redacted] at bedside which was turned off and there was no [redacted] hanging.	F 756	DRUG REGIMEN REVIEW REPORT IRREGULAR, ACT ON I. Immediate Corrective Action: a) Resident #31: All orders reviewed and changed to the proper route of administration [redacted] and [redacted] b) Resident # 31 was assessed by the RN and demonstrated no adverse effects from the deficient practice. c) Resident #119: Reviewed resident□s physician□s orders and found that all recommendations from consultant pharmacist are currently implemented as suggested.	

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F 756	Continued From page 14 The surveyor reviewed the medical record for Resident #31. A review of the Resident Face Sheet (admission information), reflected the resident was admitted on [redacted] with diagnoses which included [redacted]. A review of the residents Physician's Orders for [redacted] in the Electronic Medical Record (EMR) reflected the following: Diet: [redacted]) with an original order date of [redacted]. [redacted] mg (milligram) tablet give 2 tablets [redacted] mg) by oral route every six hours as needed for [redacted] with an original order date of [redacted]. [redacted] mg[redacted] mL (milliliter) [redacted] suspension, give [redacted] mL by [redacted] route once daily as needed, followed by a full glass (8 oz) of liquid with an original order date of [redacted]. [redacted] mg tablet give 1 tablet ([redacted] mg) by [redacted] route 3 times per day every day at 1PM, 5PM and 9AM with an original order date of [redacted]. A review of the [redacted] through [redacted] Electronic Medication Administration Record (EMAR) reflected the above corresponding physicians' orders. Further review of the EMAR indicated that the [redacted] had not been administered and the [redacted] was administered on [redacted], and [redacted].	F 756	II. Identifying others affected DON and ADON reviewed all admissions/readmissions in the last 30 days for drug regimen review performed on admission to determine if all discrepancies were addressed appropriately. All recommendations were addressed with physician or Nurse practitioner and EMR updated accordingly. III. Systemic Changes a) The In-service Coordinator will conduct mandatory In-service to all licensed nurses on the following standards: " Proper transcription of medication routes of administration orders. " Proper Reconciliation of Physician Orders to ensure appropriate route of medication administration. b) Nurse will review Pharmacy consultant recommendations with MD/Nurse practitioner and make changes as accepted and document rejection of recommendations and associated rationale. c) The facility changed the Consultant Pharmacist that comes into the facility and in the process of exploring a new Pharmacy Consult Vendor. IV. Quality Assurance a. DON/ADON or designee will review 25 % per month of new	

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F 756	Continued From page 15 The [redacted] was administered three times per day at 1PM, 5PM and 9AM from 3/11/21 through 5/19/21 at 9AM. A review of the [redacted] through [redacted] Certified Consultant Pharmacist (CP) Monthly Progress Notes reflected the following: [redacted] Meds reviewed, see comment. [redacted] Meds reviewed, see comment. Meds reviewed, no irreg. Meds reviewed, no irreg. Meds reviewed, no irreg. A review of the [redacted] Monthly Consultant Pharmacy Report (MCPR) reflected the CP recommended to add "check placement q shift" to the EMAR for an order of [redacted] Patch. On the [redacted] MCPR the CP made another recommendation for the [redacted] Patch. There was no documented evidence that the CP recommended to change an [redacted] route of medication administration to via [redacted] for a resident who had a physician's order for [redacted]. On 5/19/21 at 9:50 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) in the presence of another surveyor. The LPN reviewed the EMAR and acknowledged that the [redacted] she administered at 9 AM was written as an oral route for administration and should have been written via [redacted] because the resident was [redacted]. She further stated that she crushed the medication and administered it to the resident via the [redacted]. The LPN then stated that she should have called the doctor to get the order clarified. On 05/19/21 at 9:56 AM, the surveyor interviewed the resident's Registered Nurse/Charge Nurse (RN/CN) in the presence of another surveyor.	F 756	admission/readmission Drug regimen review to ensure all recommendations have been addressed appropriately as per policy. This will be performed monthly x 3 months. b. All necessary corrections will be completed immediately. c. The DON/ADON/Designee will report all audits to the QAPI committee quarterly	

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The RN/CN stated that she did not notice the resident had orders for medications to be administered via an [redacted] route. She stated that the physician as well as the CP reviewed the medications monthly and could not speak to why the mistake was not discovered earlier. The RN/CN acknowledged that the resident was [redacted] and the physician orders should have been written to be administered via [redacted]

On 5/20/21 at 10:35 AM, the surveyor conducted a phone interview with the CP in the presence of the survey team. She stated that she reviewed her notes for her review of the resident's medications on [redacted] which indicated that all the medications were being administered via [redacted]. She stated that when "no irreg" was indicated in her progress notes that meant she found no issues during her review. She acknowledged that a resident whose diet was [redacted] should not have medications administered via an [redacted] route. The CP further stated, "I made a mistake."

On 5/20/21 at 1:29 PM, in the presence of the survey and administrative team, the Regional RN stated that "anyone who opened that chart should have picked up on it." The administrative team acknowledged that the CP should have picked up the error as well.

A review of the facility's policy "Physician Medication Orders", with a review date of January 2021 indicated that drug and biological orders recorded in the residents' EMR were reviewed by the Pharmacist on a monthly basis.

A review of the facility's policy "Remote Access Medication Regimen Review," with a review date of March 2021 indicated that the CP conducts a

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thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated medication. The process included review of the medical record in order to prevent, identify, report and resolve medication-related problems, medication errors, or other irregularities.

2. On 5/11/21 at 10:27 AM, the surveyor toured [redacted] with the Registered Nurse/Charge Nurse (RN/CN), and both observed Resident #119 seated in a wheelchair watching television in his/her room. The resident stated that he/she was "ok."

On that same date and time, upon exiting the resident's room, the RN/CN informed the surveyor that the resident was [redacted] and independent with most activities of daily living (ADLs).

On 5/18/21 at 11:56 AM, the surveyor interviewed the resident who stated, [redacted] The resident further stated that he/she was happy with the care at the facility. The surveyor observed the resident was able to self-propel the wheelchair and there was no concern.

A review of the resident's Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included [redacted]

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[redacted]

On 5/19/21 at 12:34 PM, the Director of Nursing (DON) provided a binder of Medication Regimen Review (MRR) for new admission and re-admission which included a copy of the Pharmacy Consulting Services Nursing Recommendations dated [redacted] of Resident #119. The [redacted] MRR Action and Signature were blank and did not indicate that the recommendations were acted upon by nursing. The following were the nursing recommendations:

1.Clarify [redacted] (a medication used for [redacted] management) coding, should be every 72 hours (hrs), update please. Document [redacted] removal time.
Action:_____
Signature:____

2.Clarify need for [redacted] (used to treat certain [redacted] BID (twice a day) dosing and duration of therapy at this high dose.
Action:_____
Signature:____

3.Monitor for [redacted] while on [redacted]), rotate sites.
Action:_____
Signature:____

4.Document Nicotine patch removal time.
Action:_____
Signature:____

5.Monitor for dizziness, drowsiness, muscle

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F 756	Continued From page 19 weakness, confusion, falls, etc. with [redacted] (used short-term to treat [redacted] and [redacted]) use. Action:_____ Signature:____ 6.Monitor for sedation, dizziness, confusion, falls with higher-dose [redacted] Action:_____ Signature:____ 7.Monitor for [redacted] side effects/adverse reactions, sedation, confusions, falls, etch with [redacted] used to treat allergies, also used as a sedative to treat [redacted]) use, evaluate continuous dosing need, clarify duration of therapy. Action:_____ Signature:____ On 5/19/21 at 12:48 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), DON, Regional Registered Nurse#1 (RRN#1) and discussed the above concerns. On that same date and time, the DON informed the surveyors that she receives the MRR report from the CP, makes a copy, and sends it to the nurses to respond to the recommendations. The DON stated that the nurse have to call the doctor if necessary, write the responses to the recommendations in the Action, and then the nurse will sign which means the recommendations were addressed and acted upon. She further stated that the nurse would document in the progress notes if the doctor declined the recommendations. The DON stated that she will get back to the surveyor to provide a copy of the completed [redacted] MRR of Resident #119 with action-filled out and signature of the	F 756		

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F 756	Continued From page 20 nurse. On 5/20/21 at 11:31 AM, the DON provided another copy of Resident #119's [redacted] MRR with the following information that the recommendations were acted upon with a signature of the RN/CN: 1. Clarify [redacted] patch coding, should be every 72 hours, update please. Document [redacted] removal time. Action: done. Signature: RN/CN 2. Clarify need for [redacted] BID dosing and duration of therapy at this high dose. Action: decreased to [redacted] once a day (OD) [redacted] Signature: RN/CN 3. Monitor for [redacted] while on [redacted], rotate sites. Action: [redacted] Signature: RN/CN 4. Document [redacted] patch removal time. Action: discontinued (d'cd) [redacted] Signature: RN/CN 5. Monitor for dizziness, drowsiness, muscle weakness, confusion, falls, etc. with [redacted] use. Action: [redacted] Signature: RN/CN 6. Monitor for sedation, dizziness, confusion, falls with higher-dose [redacted] Action: [redacted] Signature: RN/CN 7. Monitor for [redacted] side effects/adverse	F 756		

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ANCHOR CARE AND REHABILITATION CENTER	3325 HIGHWAY 35 HAZLET, NJ 07730

(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 756	Continued From page 21 reactions, sedation, confusions, falls, etch with [redacted] use, evaluate continuous dosing need, clarify duration of therapy. Action: [redacted] Signature: RN/CN A review of the [redacted] and [redacted] electronic Medication Administration Record (eMAR) revealed that the above [redacted] MRR was not acted upon not until [redacted] after the surveyor's inquiry. The [redacted] eMAR reflected that the above changes were documented on [redacted] eMAR on [redacted] and not on [redacted]. A review of the medical record revealed that there was no documentation supporting why the CP's MRR was not acted upon by the facility, not until the surveyor's inquiry. On 5/20/21 at 11:38 AM, the surveyor informed the DON of the above concerns. The DON informed the surveyors that it was the RN/CN who documented and signed that the [redacted] MRR was acted upon on [redacted]. The DON stated "I don't know" when inquired by the surveyor why the Action part of the [redacted] MRR was documented as done on [redacted] when it reflected in the May 2021 eMAR that the above recommendations were carried out on [redacted] On 5/20/21 at 11:59 AM, the RN/CN informed the surveyors that "it was my fault that I put the [redacted] date in the CP's MRR." The RN/CN stated that when she received the [redacted] MRR on [redacted] "honestly, I was interrupted and I was busy, and I forgot to go back to respond to the recommendations." She further stated that the intention was to act upon the recommendations on [redacted] as soon as she received the CP's [redacted] MRR according to the facility protocol.	F 756		

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F 756	Continued From page 22 On that same date and time, the RN/CN stated "I called the doctor yesterday for the orders" regarding the [redacted] MMR recommendations that was why it was reflected in the [redacted] eMAR effective [redacted]. Furthermore, the RN/CN informed the surveyors that there was no negative effect on the resident. On 5/21/21 at 10:47 AM, the surveyors met with the LNHA, DON, RRN#1 and 2, Regional LNHA, and discussed the above concerns. A review of the facility's Remote Access Medication Regimen Review that was provided by the DON with a reviewed date of [redacted] included "The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist reviews the resident's medication therapy and communicates their findings to the nursing staff/physician to implement the recommendations, and respond in an appropriate and timely fashion." On 5/21/21 at 11:35 AM, the surveyors met with the LNHA, RRN#1 and 2, DON, Regional LNHA, Concierge staff, and there was no additional information provided by the facility. NJAC 8:39-29.3 (a) (1)	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		7/16/21

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F 761	Continued From page 23 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in 4 of 7 medication carts inspected. This deficient practice was evidenced by the following: On 5/20/21 at 11:00 AM, the surveyor inspected [redacted] medication cart in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed an opened bottle of [redacted] Drops with an opened date of 4/03/21. An opened bottle of [redacted] drops have a 42-day expiration date. The surveyor interviewed LPN#1 who stated that the opened bottle of [redacted] drops was expired and should have been removed from the active inventory medication cart. On 5/20/21 at 11:10 AM, the surveyor inspected	F 761	I. Immediate action All outdated medications identified in medication carts were promptly discarded and replaced. Discharged residents medication [redacted] was removed and discarded. II. Identification of Others ¿ All medication carts were re-checked for expired medications and no additional expired medications found. III. Systemic Changes a) Pharmacy provided a list of medications with shortened expiration dates to use as reference. b) This list was posted in all med rooms and will be attached to med cart medication accountability binder. c) The inservice coordinator will conduct	

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F 761	Continued From page 24 the [redacted] medication cart in the presence of LPN #2. The surveyor observed an opened [redacted] Pen with an opened date of 4/20/21. An opened [redacted] pen has a 28-day expiration date. The surveyor interviewed LPN #2 who stated that the opened [redacted] pen was expired and should have been removed from the active inventory medication cart. On 5/20/21 at 11:17 AM, the surveyor inspected the [redacted] side medication cart in the presence of LPN #3. The surveyor observed an opened [redacted] pen with an opened date of 4/17/21, an opened [redacted] with an opened date of 4/4/21 and an opened bottle of [redacted] drops with an opened date of 4/12/21. An opened [redacted] pen has a 10-day expiration date, an opened [redacted] has a 30-day expiration date and an opened bottle of [redacted] drops have a 28-day expiration date. The surveyor interviewed LPN #3 who stated that [redacted] insulin pen, an opened [redacted] and an opened bottle of [redacted] drops were expired and should have been removed from the active inventory medication cart. On 5/20/21 at 11:20 AM, the surveyor inspected the [redacted] PUI medication cart in the presence of LPN #4. The surveyor observed an opened [redacted] that was not dated. The surveyor interviewed LPN #4 who stated that the resident was discharged from the facility and that an opened [redacted] should have been dated and that all medication belonging to a discharged resident should have been removed from the medication cart. A review of the Manufacturer's Specifications for the above medications indicated the following:	F 761	a mandatory inservice on storage of medications and biologicals to include 1) Shortened expiration dates 2) Labeling of injectable (vials and pens), [redacted] drops and [redacted] IV. Quality Assurance a) All nurses will be required to complete a post-test (competency) for medication and biological storage. b) Audits will be conducted by DON/designee on all med carts weekly x 4 then monthly x 3 then quarterly x 2. c) Any findings will be addressed immediately. d) The DON/designee will report outcome of audits quarterly at the QAPI meeting quarterly.	

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F 761	Continued From page 25 1. [redacted] drops once opened had an expiration date of 42-days. 2. [redacted] pen once opened had an expiration date of 28-days. 3. [redacted] insulin pen once opened had an expiration date of 10-days. 4. [redacted] once opened had an expiration date of 30-days. 5. [redacted] drops once opened had an expiration date of 28-days. A review of the facility's policy for Medication Storage, Labeling and Expiration dated 12/20 indicated to record date opened as required on the medications package/labeled container received from the pharmacy and Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with the facility policy.	F 761		
F 808 SS=E	NJAC: 8:39-29.4 (a) (h) (d) Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 808	I. Immediate Action: Resident #92:	6/18/21

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F 808	Continued From page 26 and review of pertinent facility documents, it was determined that the facility staff failed to ensure a resident received and consumed liquids in the appropriate amount according to physician orders for 1 of 1 resident (Resident #92) who was on a [redacted] restricted diet. This deficient practice was evidenced by the following: On 5/11/21 at 1:34 PM, two surveyors observed Resident # 92 lying upright in bed with an overbed table positioned over his/her lap. The resident was alert, oriented and interviewable. The surveyors observed an opened 12-ounce can of diet gingerale on the overbed table. On 5/13/21 at 8:51 AM, two surveyors observed the resident in bed with eyes closed. The surveyors observed a 12-ounce can of diet gingerale and a water pitcher on the resident's overbed table and a 16-ounce bottle of diet gingerale on the resident's dresser. The resident had not eaten breakfast yet. The surveyors reviewed the residents breakfast tray and meal ticket. The meal ticket indicated that the resident was on a [redacted] Controlled - Regular diet. A note on the bottom of the meal ticket indicated "NO EXTRA FLUIDS ON TRAY." There was no notation of a fluid restriction nor a specific volume allotted for the breakfast meal. There was a four-ounce cup of skim milk, a four-ounce cup of apple juice and a six-ounce mug of coffee on the tray; all of which were indicated on the meal ticket. A review of the Resident Face Sheet (admission information) reflected that Resident # 92 was admitted to the facility on [redacted] and had diagnoses which included but were not limited to;	F 808	a) [redacted] restriction orders changed to Dietary to ensure that dietary is made aware of the [redacted] restrictions and will prepare meals accordingly. b) Resident was seen by DON and Dietician to discuss resident□s compliance with [redacted] restriction. The resident expressed desire to increase the fluid intake. c) The resident□s primary care physician was notified of the residents□ request and ordered a [redacted] restriction increase from [redacted] ml/day to [redacted] ml/day. d) The facility dietician and the [redacted] center were informed of the change and in agreement. e) Resident□s water pitcher and cans of ginger ale were removed from resident□s room. Resident□s requests for ginger ale or free water can be exchanged for provided fluids within resident□s [redacted] restriction. f) [redacted] Restriction care plan updated to reflect all changes. II. Identification of Others: a) All residents on [redacted] restrictions were reviewed to ensure that proper order designation (Dietary order type) was indicated and all orders for [redacted] restrictions were accurate and complete. All orders were appropriately designated as Dietary orders, accurate and complete. III. Systemic Changes a) Policy and Procedure for [redacted] Restrictions were reviewed and revised to include proper designation in the EMR physician□s orders under Dietary order type.	

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F 808	Continued From page 27 [redacted] A review of the Annual Minimum Data Set (MDS), dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which reflected that the resident had an [redacted]. It also reflected the active diagnoses of [redacted] and dependence on [redacted]. It further reflected that the resident was on a therapeutic diet and the Care Area Assessment (this process is the link between the MDS data collection and the individualized resident care plan) indicated that staff discussed risk verse benefits with the resident regarding snacking and weight gain. There was no indication that the resident was non-compliant with a [redacted] restricted diet. A review of the Physician Order's dated [redacted], reflected that the resident had an order for [redacted] Restrictions [redacted] ml (milliliters) with [redacted] ml allotted to dietary and 120 ml per each nursing shift 7-3, 3-11, 11-7. The resident also had a diet order for [redacted] Controlled Regular consistency dated of [redacted] A review of the Electronic Medication Administration Record (eMAR) for [redacted] through [redacted] revealed the above corresponding physician's order. A review of the resident's Care Plan Activity Report (CPAR) reflected a "Nutrition" focus dated [redacted] with a goal to adhere to the diet prescribed. Interventions included "We will monitor and encourage fluid-water intake within [redacted] restricted" and "We will provide nutritional education as needed."	F 808	b) In-service Coordinator will conduct an in-service to licensed nurses and dietician on: " [redacted] Restriction orders to ensure correct breakdown of fluids for every meal in accordance with the physician□s order. " [redacted] Restriction order transcribed under dietary order type. " Identifying, reporting and documenting resident□s non-adherence with fluid restriction. IV. Quality Assurance ¿ Dietician will conduct a monthly audit x 3 months to ensure with [redacted] restriction orders are transcribed correctly and ensure compliance with breakdown of fluids in accordance with the physician□s order. ¿ The Dietician/designee will report to the QAPI committee quarterly.	

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F 808	Continued From page 28 In addition, the CPAR reflected a "[redacted]" focus dated [redacted] with interventions that included "[redacted] and receive information from the [redacted] center". There was also a note dated [redacted] on the CPAR that indicated the resident was on a [redacted]) Regular diet and [redacted] restriction [redacted] ml in 24 hours. Further review of the CPAR reflected a [redacted] focus dated [redacted] with goals that included "[redacted] and "[redacted]" Interventions that were indicated were, [redacted]" There was also notes on the CPAR that reflected the resident had been compliant with the [redacted] restriction dated [redacted] and [redacted] A review of the residents [redacted] communication composition book reflected a note from the [redacted] Registered Dietitian (RD) that indicated the resident's diet should be [redacted] with [redacted] ml of fluid. A review of the RD's Progress Notes reflected the following: On 3/2/21, the RD documented he/she met with the resident and discussed the resident's diet. This included a [redacted] restriction of [redacted] ml/day which was documented to be appropriate. Dietary to provide [redacted] ml/day and nursing [redacted] ml [redacted]	F 808		

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F 808	Continued From page 29 ml/shift). On [redacted], and [redacted] the RD documented the same as above in regard to the [redacted] restriction. On 4/18/21, the RD completed a "Dietary-Readmission/Quarterly Assessment" which reflected an answer "false" to the question, "Is resident on a [redacted] restriction?" On 5/14/21, the RD documented the resident was able to verbalize likes and dislikes and that he/she updated the kitchen as appropriate to the diet order. There was no documented evidence after [redacted] (date [redacted] restriction was ordered) that the resident was not compliant with the prescribed [redacted] restriction. A review of the breakfast, lunch and dinner meal tickets dated [redacted], reflected the pattern of fluids provided equaled [redacted] ml/day which was [redacted] ml more per day than the prescribed diet of [redacted] ml from dietary. The words [redacted] restriction" was not observed on the meal tickets. During an interview with the surveyor on 5/18/21 at 10:19 AM, and in the presence of another surveyor, the Food Service Director (FSD) stated that when a new diet was prescribed or there was a diet change, nursing communicated this via a computer notification. She further stated that when there was a change a "red bubble" would appear on the screen of their food service software program "Meal Tracker" which would alert her or the supervisor to make the appropriate changes. The FSD also stated that this system had been in place for two years and	F 808		

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F 808	Continued From page 30 she thought it was "fail proof." She added that she and nursing communicate as well. During an interview with the surveyor on 5/18/21 at 11:12 AM, and in the presence of another surveyor, the Certified Nursing Assistant (CNA) stated that she would have to check the meal ticket to know the type of diet a resident was prescribed. During an interview with the surveyor on 5/18/21 at 11:28 AM, and in the presence of another surveyor, the resident stated that he/she was prescribed a [redacted] diet and had to avoid foods like potatoes and tomatoes. The resident also stated that the HDRD informed the facility that he/she should be on a [redacted] restriction. The resident further stated that he/she received excess fluids and that "I would follow the [redacted] restriction if it was given correctly." During an interview with the surveyor on 5/19/21 at 10:17 AM, and in the presence of another surveyor, four-ounces of skim milk, four-ounces of apple juice and six-ounces of coffee was observed on the breakfast tray. The surveyors also observed a gray water pitcher on the resident's overbed table approximately a quarter filled with water. The resident stated, [redacted] During an interview with the surveyor on 5/19/21 at 10:17 AM, and in the presence of another surveyor, Licensed Practical Nurse (LPN) # 1 stated that when there were diet changes they enter this into the Electronic Medical Record (EMR) but was not sure how the kitchen received that information. LPN # 1 reviewed the resident's [redacted] restriction order in the EMR and stated that	F 808		

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F 808	Continued From page 31	F 808		

she would have expected the RD to breakdown the [redacted] ml of fluid allotted to dietary for breakfast, lunch and dinner and that he/she provided that information to the kitchen.

During an interview with the surveyor on 5/19/21 at 10:41 AM, and in the presence of another surveyor, the Food Service Supervisor (FSS) and the Regional FSD (RFSD), the FSD stated that a [redacted] restriction order would be noted at the bottom of the meal ticket in the notes section. She also stated that the RD would have given them a fluid breakdown for breakfast, lunch and dinner to ensure the correct amount of fluid was provided. The food service staff reviewed the meal tickets for that day and acknowledged that they were providing 10 ounces more than the prescribed allotment of [redacted] ml that day. The food service staff reviewed three communication binders (dietary related communication sheets from the RD to the kitchen) in the presence of the surveyors which did not reveal any communication for [redacted]. The FSD then reviewed the "Meal Tracker Activity Log" in the food service software program in the presence of the surveyors and the RFSD. There was no evidence of communication for a [redacted] restriction prescription for Resident # 92 from nursing. The FSD and the RFSD acknowledged that if a resident on [redacted] received too much fluid, they could gain weight.

During a telephone interview with the surveyor on 5/20/21 at 9:20 AM, and in the presence of the entire survey team, the HDRD stated that the resident had been her patient since he/she started on [redacted] in [redacted]. She also stated that in the beginning the resident was not compliant with [redacted] restricting but has since greatly improved with education. The HDRD

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F 808	Continued From page 32 further stated the resident should be on a [redacted], [redacted] controlled, high protein diet with a [redacted] restriction of [redacted] ml/day. During an interview with the surveyor on 5/20/21 at 10:59 AM, and in the presence of another surveyor, LPN # 2 stated that the resident was on a [redacted] restriction and the water pitcher was for ice. She stated that the resident was allowed to have ice in place of water. LPN #2 reviewed the resident's orders in the EMR and acknowledged there was no physician's order to allow ice chips. During an interview with the surveyor on 5/20/21 at 11:12 AM, and in the presence of another surveyor and the RFSD, the FSD stated that a RD had not been to the kitchen to crosscheck diets and preferences in a long time and would expect the RD to have provided a breakdown of fluids for breakfast, lunch and dinner to ensure the correct amounts of fluid were served. During a telephone interview with the surveyor on 5/20/21 at 1:08 PM, and in the presence of the entire survey team, the RD stated that she visited the resident this month to update food preferences. She did not recall if the resident was on a [redacted] restricted diet. The RD further stated that when a resident was on a [redacted] restricted diet she would ensure there was a correct breakdown of fluids for breakfast, lunch and dinner in accordance with the physician's order and would cross check with the food service department to ensure the resident received the correct amount of fluid. During an interview with the surveyor on 5/20/21 at 1:31 PM, in the presence of the entire survey team, the Licensed Nursing Home Administrator (LNHA), the Regional LNHA, and the Director of	F 808		

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F 808	Continued From page 33 Nursing, the Regional Nurse stated that the [redacted] restriction order was entered into the EMR incorrectly "should have been a dietary entry not a general entry" and that it did not translate to the food service software program. He further stated,"it should have been picked up." He also stated that if the resident wanted ice, he would have discussed that with the RD to incorporate that into the fluids allotted on the [redacted] restriction. A review of the facility's policy for "Diet Order" with a review date of [redacted] indicated that a diet order should be entered into the EMR under dietary orders. A review of the facility's policy for [redacted] Restriction" with a review date of November 2020 indicated that it's the facility's policy to maintain [redacted] restrictions as per "MD/NP" order "and/or" in accordance with the recommendations from [redacted]. The dietitian or designee determine the amount of fluid that will be provided on the dietary tray and communicates this with the dietary department. The dietitian documents the [redacted] restrictions and updates care plans. A review of the facility's policy for [redacted] with a review date of March 2021 indicated to remove water pitcher from bedside and the resident should carry a notebook to and from [redacted] to foster communication between facilities. A review of an undated "Dietician Job Description" indicated that an administrative function included "review therapeutic and regular diet plans and menus to assure they comply with the physician's orders." NJAC 8:39-17.4(a)(1)	F 808		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		7/15/21

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F 812 SS=D	Continued From page 34 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices and properly store potentially hazardous foods in a safe and sanitary environment to prevent the development of food borne illness. This deficient practice was observed during kitchen tours and was evidenced by the following: On 5/10/21 at 9:54 AM, two surveyors toured the kitchen with the Food Service Director (FSD) and observed 35 loaves of white bread stored in a dry storage area dated "5/2" with a handwritten marker. The FSD stated that "5/2" was the date the bread was delivered. There was no expiration date on the loaves of white bread. The FSD	F 812	" All bread that was found out of date was discarded on 5/10. " All other bread found to be in compliance with the use by date " All staff were in serviced by June 3rd on proper dating of bread. Bread will be labeled with a received/pull date as well as discard date. " Bread audit to be completed by FSD or designee weekly for 2 months and thereafter monthly x 2. The Months Findings will be reported to the QA meeting. " Item with missing date was corrected immediately. " All other food items were found to be	

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F 812	Continued From page 35 informed the surveyors that if the bread was in the freezer it would last for seven days and since the 35 loaves of white bread were not in the freezer or refrigerated it should have been discarded. On 5/11/21 at 9:53 AM, two surveyors toured the kitchen with the FSD and observed the following: There was an opened five-pound tub of peanut butter with no opened date in the walk-in dairy refrigerator. There were also three closed, two-pound cartons of creamer stored horizontally in a shallow restaurant pan leaking a large amount of white fluid. There was food stored less than 18 inches from the ceiling in the dry storage area. There was ice buildup on a pipe leading to a sprinkler head in the walk-in freezer. There were six, six-inch-deep full-size metal restaurant pans that were heavily blackened stored on the meat pot rack. In the meat walk-in refrigerator there were four wire racks, each with four wire shelves with buildup that was able to be wiped off with a paper towel. There was also a dark fuzzy buildup on two fan covers and a brownish sticky buildup on 2 light covers. In addition, there was loose white wall board near the door which formed a gap. There was a hanging S hook over a meat preparation area with a blackish fuzzy buildup. There was no food being prepared there at that time. There was a stainless-steel preparation table on	F 812	with in compliance with the facilities dating policy " Staff was in serviced by June 3rd on dating all items. " FSD or designee will audit fridges on a daily basis for 2 weeks on random items to ensure items are properly dated. Weekly audits for 3 months will be performed. Findings will be reported to the QA meeting. " Items noted to be above 18 inches were moved immediately to be under the 18 mark. " All other areas were noted to be in compliance with the 18 inches " Maintenance indicated the 18" point from the ceiling with tape on 5/11, Weekly audits for the first 4 weeks will ensure items are not within 18" of ceiling. Monthly audits will be performed for 4 months to ensure proper storage. Findings will be reported to the QA meeting. " Hotel pans identified were cleaned on 5/11. " All other pans were checked to ensure cleanliness. " Audit and inventory of all hotel pans has been taken. All pans needed to be replaced, will be replaced by July 15th " FSD will monitor monthly for 6 months. Findings will be reported to the quarterly QA meeting. " Ice build up was removed. Sprinkler heads were replaced.Plastic curtains were installed to the freezer doorway to help ensure no further ice build up. Loose boards were secured.	

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F 812	Continued From page 36 the meat side of the kitchen. The bottom shelf was heavily pitted and was covered with a blackish, reddish substance. There was a buildup of dry food debris on the underside of a shelf over a six well steam table on the dairy side of the kitchen. There was no food on the steam table at that time. There was a hard-plastic beige dunnage rack under the dairy pot sink that had a blackish reddish substance on top of it. There were two deep pots, a standing mixer bowl and whisk stored on top. There was a standing mixer with a yellow flaky substance on the underside of the mixer. The mixer was not in use at that time. A review of the facility's policy "Bread Dating," dated 1/15/21 indicated that upon arrival bread is marked with the delivery date and should be used or discarded within seven days. A review of the facility's policy "Labeling, Dating, and Food Storage," dated 1/26/21 indicated that food should be stored 18 inches from the ceiling. It also indicated that opened food should be labeled and dated. A review of the facility's policy "Small Wares," dated 1/5/21 indicated that hotel pans, pots and pans will be replaced as needed. A review of the facility's policy "Kitchen Sanitation/Maintenance," dated 3/23/21 indicated that policy was to ensure that the kitchen was clean and sanitary for food service operations. NJAC 8:39-17.1(a);17.2(g)	F 812	" No other sprinkler heads had ice build up. No other loose boards were found " Maintenance director/designee will inspect monthly x3 months for any ice build up and loose boards and quarterly thereafter. " Corporate Maintenance director/designee will round to ensure that there is no ice build up on sprinkler heads or loose boards. Findings will be reported at the quarterly QA meeting " Wire racks/fan covers identified were cleaned on 5/11/21. S hook identified was removed on 5/12/21. Light covers were cleaned 5/11/21. Underside of steam table and mixer was cleaned 5/11/21. Leaking cream area was cleaned 5/11/21. Bottom shelf of the prep table on meat side of the kitchen has been covered in layers of aluminum foil on 5/11/21.New [redacted] rack will be ordered by June 7th. " All other areas were checked to ensure they are clean. " Cleaning schedule had been updated to specify all the necessary items to ensure that all items will be addressed. All Staff will be in serviced on the updated cleaning schedules. in-service was completed by June 3rd. We are working with the purchasing department to purchase a new table. (Quotes obtained for prep table, anticipated compliance 30 days) " FSD or designee will monitor for 4 weeks the cleaning assignments. This will	

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F 812	Continued From page 37	F 812	be followed by monthly audits x 6 months to ensure cleaning assignments are being done appropriately. Findings will be reported to the quarterly QA meeting.	
F 880 SS=E	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;	F 880		6/25/21

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F 880	Continued From page 38 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) perform handwashing appropriately for 4 of 10 staff and, b.) disinfect and sanitize the equipment used in the COVID-19 screening process, and table used in testing visitors for 3 of 3 staff in accordance with the Centers for Disease Control and Prevention guidelines for infection control to	F 880	Immediate Action a) The hand-held thermometer was removed from the screening area. b) An additional kiosk for screening will be ordered. c) A paper for visitor screening/documentation will be maintained by receptionist and given to	

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F 880	Continued From page 39 mitigate the spread of COVID-19. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated February 23, 2021, included, "Hand Hygiene: HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly; routine cleaning and disinfection procedures (e.g. using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed." According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. Immediately after glove removal." It further specified the procedure for hand hygiene which included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to	F 880	each visitor individually upon entry. d) Additional pens were be made available in 2 containers, one for clean pens and one for used pens. e) Disinfecting wipes were made available to all Covid-19 screening and testing areas. f) The Receptionist will be responsible for disinfecting the screening area every 2 hours or as needed, and will disinfect the testing area before and after use. Receptionist will sanitize used pens after use and place disinfected pens into the clean pens container. g) The Receptionist who is performing rapid testing on visitors will clean all touched surfaces between testing. h) A hand hygiene competency was performed on the staff involved with the deficient practice and demonstrated competency for Hand Hygiene Procedure. i) The observed PTA was reeducated immediately on the proper method of donning, and doffing gloves, washing hands before and after donning and doffing gloves. a. The PTA will carry an adequate amount of cloth gloves without holes in a plastic bag to complete patient load. b. She must remove all gloves between patients, wash hands with hypoallergenic soap and don a new pair of cloth gloves for each patient and cover with clean exam gloves. c. Soiled cloth gloves will be stored away in a plastic bag d. The PTA must abide by all infection control principles for donning and doffing gloves between patients and when visibly soiled as per facility policy and CDC	

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F 880	Continued From page 40 your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds." According to the U.S. CDC Guidance for SARS-CoV-2 Point-of-Care and Rapid Testing, page updated on 3/12/21 included, "Disinfect surfaces within 6 feet of the specimen collection and handling area before, during, and after testing and at these times: before testing begins each day, between each specimen collection, at least hourly during testing, when visibly soiled, in the event of specimen spill or splash, at the end of every testing day." 1. On 5/10/21 at 09:10 AM, the surveyors entered the facility and were instructed by the receptionist to use the kiosk to answer screening questions for COVID-19. There was an alcohol-based hand rub (ABHR) mounted on the wall, one pen next to a binder with a paper screening COVID-19 questionnaires, and a thermometer that was placed directly on top of the table in the screening area where the kiosk was located. There were no disinfecting wipes on top of the table. On that same date and time, the Occupational Therapist (OT) and the Director of Maintenance (DM) were in the screening area. The DM and the OT both used the thermometer on top of the table and used the same pen to answer the COVID-19 screening questions on the paper without performing hand hygiene. Both the DM and OT did not disinfect the thermometer and pen after use.	F 880	guidelines. e. Failure to abide by this rule will exempt employee from working in this facility. II. Identifying others: a) All residents have the potential to be affected. b) There are no other employees identified with similar allergies or restrictions. III. Systemic Changes a) Signage will be posted to remind all staff and visitors of proper hand hygiene and pen placement post use. b) The In-service Coordinator will conduct an in-service to all staff on: " Hand Hygiene Procedure " Each staff members role in infection control during screening process. " Importance of Disinfecting/Cleaning high touch surfaces and pens in the screening and testing areas. " All staff will complete a post test on infection control at screening area. IV. Quality assurance a) The DON/designee will conduct 10 audits/week x 4 weeks then 10 audits monthly x 3 months and then quarterly x 2 at random times of the screening area to ensure compliance with Infection Control Policy. b) The PTA/ and other staff will be observed for compliance in proper method of donning, and doffing gloves, washing hands before and after donning and doffing gloves, hand hygiene competency at random times during the	

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F 880	Continued From page 41 On 5/10/21 at 9:14 AM, the Licensed Nursing Home Administrator (LNHA) informed the surveyor that there were no disinfecting wipes in the screening area because "it was the housekeeper who cleans the kiosk area every now and then." The LNHA had no answer when asked by the surveyor why the thermometer was placed directly on top of the table. At that same time, the surveyor informed the LNHA of the above concerns. On 5/17/21 at 12:46 PM, the surveyors met with the Director of Nursing (DON), Regional Registered Nurse #1 and 2 (RRN#1, and RRN#2). RRN #1 informed the surveyors that there was no need to disinfect commonly used equipment like the pen and the thermometer if the staff performed hand hygiene. On 5/18/21 at 9:12 AM, the OT informed the surveyors that he was educated on the screening process, use of the thermometer and the paper COVID-19 questionnaire when unable to use the kiosk. He stated that he was educated about disinfecting and performing hand. He further stated, "I was in a hurry on that day," which was why he was not able to perform hand hygiene in the screening area. He stated that there were no disinfecting wipes and the thermometer was placed directly on top of the table without a barrier. On 5/18/21 at 10:30 AM, the DM informed the surveyors that he was educated on the proper way of performing hand hygiene. He stated that he should have performed hand hygiene after using the pen and the thermometer. He further stated that staff utilizes the paper COVID-19	F 880	week by Rehab Director/Inservice Coordinator/designee. This will be performed weekly x 4 weeks, monthly x 3 months then quarterly x 2. Deficient practice will be corrected immediately. Findings will be reported to the Administrator and reported to the QAPI committee c) The DON/designee will report the audits to the QAPI committee quarterly. V. DPOC RCA was completed and identified the employees were impatient and did not follow the proper infection control procedures in screening area. Disinfecting wipes was displaced and employees felt nervous from testing the surveyors. Employee failed to comply with hand hygiene protocol due to fear of exasperating skin allergies. Videos viewed. -Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program Training to:Topline staff and infection preventionist -CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! Training to:Frontline staff -CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Sparkling Surfaces Training to:Frontline staff	

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F 880	Continued From page 42 questionnaire for screening if the kiosk was not available to use. He indicated that there should have been disinfecting wipes available in the screening area. On that same date and time, the DM stated, "oops, I was in a hurry," when asked by the surveyor why he did not perform hand hygiene on 5/10/21 and did not disinfect the equipment used. 2. On 5/10/21 at 9:16 AM, the receptionist informed the surveyors that she would conduct the COVID-19 BINAX testing at the back of the reception area. The receptionist did not disinfect the table used for testing after each use. There were no disinfecting wipes in the testing area. Three surveyors were tested one after the other. The receptionist did not answer when asked why she did not disinfect the table before and after each surveyor was tested for COVID-19. On that same date and time, the receptionist informed the surveyor that she was educated on the proper way of performing COVID-19 testing for visitors. On 5/11/21 at 8:43 AM, the Director of Nursing (DON) assisted the surveyor to perform a COVID-19 BINAX test at the back of the reception area. There were disinfecting wipes on a hard-plastic utility cart and a pen to fill out a testing form. The DON did not disinfect the surface area before and after she conducted the test. On 5/12/21 at 1:31 PM, the surveyors met with the LNHA, DON, RRN #1 and discussed the above concerns. On 5/17/21 at 8:50 AM, the DON informed the	F 880	-CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Clean Hands Training to:Frontline staff	

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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
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surveyors that it was the receptionist's responsibility to perform the COVID-19 test for visitors, and will call the nurse to read the results. The DON stated that the receptionist was educated on the proper procedures for COVID-19 testing and the table should have been disinfected before and after use.

3. On 5/17/21 at 10:26 AM, the surveyors observed the Physical Therapist Assistant (PTA) did not perform hand hygiene after removing vinyl gloves while inside Resident #278's room. The surveyors observed the PTA was wearing double gloves and the second pair of gloves were not removed after exiting the resident's room. Resident #278 was a non-COVID, non-PUI, and not on any transmission-based precautions.

At that same time, during the interview, the surveyors observed the PTA was wearing white cloth gloves (second pair) that had holes in it. The PTA informed the surveyors that she had an allergy to all gloves. The PTA provided the surveyor a doctor's handwritten prescription which indicated she can use the cloth gloves while at work. The PTA stated that she wears the cloth gloves "all the time," and applies vinyl gloves over the cloth gloves. The PTA showed the surveyors an extra pair of cloth gloves which she kept inside her uniform pocket. The pair of cloth gloves were not in a plastic bag.

On that same date and time, the surveyor asked the PTA if she should have washed her hands after removing the vinyl gloves. The PTA stated, "not me." The surveyor asked the PTA if she was able to perform hand hygiene after removing the vinyl gloves. The PTA stated, "yes."

Further review of the doctor's handwritten

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315314	A. BUILDING _____ B. WING _____	05/21/2021

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prescription provided by the PTA indicated "Patient will need to use cloth gloves along with the with other protective gloves while working." There was no documentation on the prescription that the PTA does not need or cannot perform hand hygiene after removing protective gloves.

On 5/17/21 at 12:46 PM, the surveyors met with the DON, RRN #1, and #2. Both RRN #1 and #2 informed the surveyors that no staff was exempt from performing hand hygiene in the facility.

On 5/19/21 at 12:48 PM, the surveyors met with the LNHA, DON, RRN #1, Regional LNHA. RRN #1 informed the surveyors that the PTA acknowledged that she did not perform hand hygiene after removing gloves when she exited a resident's room and she should have washed her hands.

On 5/20/21 at 9:30 AM, the Infection Preventionist Nurse (IPN) informed the surveyors that hand hygiene must be done when hands are visibly soiled, before and after personal protective equipment (PPE) use were some criteria when to perform hand hygiene. The IPN further stated that the PTA should have washed her hands after removing gloves.

Furthermore, the IPN stated that the facility follows the CDC guidelines with regards to COVID-19 screening and testing. The IPN further stated that the thermometer should not be on top of the table. She indicated that the receptionist should have disinfected the table before and after the COVID-19 testing of the visitors.

A review of the facility's Cleaning/Disinfecting Policy and Procedure that was provided by the DON with a reviewed date of March 2021

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F 880	Continued From page 45 included "It is the policy of this facility to clean and disinfect PPE, Resident-Care Equipment, Resident Areas and Laundry, including reusable items and durable medical equipment to current CDC, DOH, and OSHA recommendations for disinfection." A review of the facility's Infection Control Guidelines that was provided by the LNHA with a reviewed date of October 2020 indicated under "General Guidelines # 3. Employees must wash their hands for twenty seconds using soap and water under the following conditions .... d. after removing gloves. #4. In most situations, the preferred method of hand hygiene is with an ABHR ...i. after contact with objects (e.g. medical equipment) ... and j. after removing gloves." NJAC 8:39-19.4 (a) (1) (n) (2)	F 880		