STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315143	A. BUILDING _____ B. WING _____	02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	84 COLD HILL ROAD MENDHAM, NJ 07945

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey 2/5/21 Census: 73 Sample Size: 21 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		3/1/21

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

Electronically Signed | 02/22/2021

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F 755	Continued From page 1 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain controlled substances in a manner that would decrease the possibility of loss or diversion. This was found with the delivery process of controlled substances for the automated medication dispensing machine with 1 of 2 Drug Enforcement Administration (DEA) 222 forms reviewed. The deficient practice was evidenced by the following: On 2/4/21 at 2:03 PM, the surveyor reviewed two sets of DEA-222 forms for completeness and accuracy. The most recent shipment of controlled substances dated 1/25/21 did not have a signature of receipt. The form of receipt listed the following controlled substances delivered: [redacted] Executive Order 26, 4.b. [redacted] here were two forms that listed the controlled medication which were dated 1/25/21, each required a signature of receipt. The signature line on each form was blank. The Director of Nursing (DON) identified the Assistant Director of Nursing (ADON) as the person responsible for stocking the automated	F 755	F755 SS=D HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE No residents were affected by this practice HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents had the potential to be affected by this practice WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR	

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F 755	Continued From page 2 medication dispensing machine. On 2/4/21 at 2:10 PM, the surveyor asked the ADON why there were no signatures to confirm receipt of the controlled substances delivered on 1/25/21. The ADON said it was the first time she filled out the DEA-222 form and she was unsure of the process. The ADON said she did not know who received those controlled substances when they were delivered on 1/25/21. She said the controlled substances and the forms were in her locked office on her desk when she arrived to work the morning of 1/26/21. She said she did not know who left the controlled substances there and she never did an investigation. On 2/4/21 at 2:15 PM, the surveyor asked the DON about the delivery of controlled substances on 1/25/21 and there being no signature for the person who received the 1/25/21 shipment. She said she was unaware of the incident. She agreed that there should have been a signature for the nurse who received the controlled substances. On 2/5/21 at 9:30 AM, the surveyor reviewed the inventory of controlled substances in the automated medication dispensing machine with the ADON. There were no discrepancies. The surveyor asked for a printed discrepancy report for the month of January 2021. On 2/5/21 at 1:04 PM, the surveyor received the discrepancy report. There were no discrepancies that were outstanding. There was one discrepancy for a controlled substance on the report. It listed as an error. The surveyor reviewed the facility's policy and	F 755	Education was provided to licensed staff on the management of controlled substances, and specifically on the receipt and disposition of controlled substances. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE the DON or designee will conduct weekly audits for 2 months of controlled drugs that have been delivered to ensure they have been signed off on appropriately. They will then conduct monthly audits for 2 months, and conduct audits every other month for the next 4 months to ensure compliance. The DON or designee will report the results of these audits to the QAPI Committee on a monthly basis. The Administrator will take corrective action as needed to ensure compliance.	

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F 755	Continued From page 3 procedure for the Management of Controlled Drugs. Under the heading, "Policy" it read "The management of controlled drugs-including the ordering, receipt, storage, administration, ongoing inventory, and destruction-is conducted under the direction and ultimate responsibility of the Center Executive Director and Center Nurse Executive and follows safe practice and federal/state regulations." Under the heading "Receipt" it read "Controlled drugs are received in separate containers with separate invoices. Licensed nursing staff must accept delivery and take responsibility for receipt of controlled drugs." NJAC 8:29-29.7 (c)	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		3/17/21

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F 880	Continued From page 4 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 5 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 demonstrate appropriate infection control practices when administering medication to a resident. This deficient practice as identified with [redacted] residents observed during medication pass, Resident [redacted] and was evidenced by the following: On 2/3/21 at 9:20 AM, the surveyor observed a Licensed Practical Nurse (LPN) administer medications to Resident [redacted]. After preparing the medications the resident was to receive the LPN used alcohol-based hand rub. The nurse picked up multiple items to carry into the resident's room, such as, a small plastic medication cup full of [redacted] The LPN went in the room, placed those items on the table, touched the door and the privacy curtain to adjust it with no gloves on. The LPN then went back to the medication cart to retrieve a medication cup that contained a protein supplement, brought it into the room and placed it on the table. The LPN returned and proceeded to administer the following: [redacted] the LPN [redacted] with no gloves on. [redacted], [redacted]	F 880	F880 SS=D HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE Resident [redacted] was assessed by Nursing post treatment and no adverse outcome was noted. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents had the potential to be affected by this practice WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR	

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F 880	Continued From page 6 which the LPN administered [redacted] the resident's [redacted] [redacted]. The LPN held the [redacted] [redacted] that the LPN held in [redacted] of the [redacted]. The LPN instructed the resident to [redacted] and then [redacted] as the LPN held it in place. [redacted], that the LPN [redacted]. The LPN washed her hands for 20 seconds when she was done. On 2/03/21 at 9:47 AM, the surveyor asked the LPN if she usually wore gloves while [redacted] The LPN stated "Yes I do, I was just nervous I guess." On 2/3/21 at 10:10 AM, the surveyor reviewed the resident's record which revealed the following: According to the face sheet the resident was [redacted] The most recent Minimum Data Set Assessment, dated 11/30/20, included a [redacted] The top [redacted] which indicated the resident [redacted]	F 880	The LPN who was observed during her medication pass with resident [redacted] was given corrective action on 2/3/2021 for failing to follow policy & procedure by not wearing gloves while administering the medications to Resident [redacted] Licensed staff were re-educated on medication administration and infection control policies & procedures. Staff received the following Directed In-service Training: Module 1 - Infection Prevention & Control Program https://www.train.org/main/coure/1081350/ Provided to : Topline staff / Infection Preventionist CDC Covid19 Prevention Message for Front Line Long Term care staff: Keep Covid19 Out! https://youtu.be/7srwrF9MGdw Provided to: Front Line Staff CDC Covid19 Prevention Message for Front Line Long Term Care staff: Clean Hands https://youtu.be/xmYMUly7qiE Provided to: Front Lint staff RCA completed. Final Conclusion: The nurse had been educated and inserviced on donning and doffing gloves/ hand hygiene during medication pass, however stated that the observation of her med pass by a state surveyor made her	

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F 880	Continued From page 7 Executive Order 26, 4.b. On 2/3/21 at 1:45 PM, the surveyor discussed the concern with the Director of Nursing (DON). The DON agreed that the LPN should have worn gloves while administering those medications. On 2/5/21 at 9:00 AM, the surveyor reviewed the following facility policies and procedures: "Medication Administration: Eye (Drops and Ointments)." Under the heading "4. Administer Medication" Number 4.4 read; "Perform hand hygiene. Put on gloves." Number 4.5 read; "If eye has discharge, remove discharge by cleaning around the eye with moisten 4 X 4 gauze with warm water. With patient's eyes closed, clean from inner to outer canthus using a fresh pad for each stroke." Number 4.6 read; "If eye is crusted with secretions, moisten gauze pad with warm water. Ask the patient to close the eye and place gauze pad over it for 1 or 2 minutes. Remove the pad, then repeat with new moist gauze pad, if necessary, until the secretions are soft enough to be removed without traumatizing the mucosa." Number 4.7 read; "Remove gloves. Perform hand hygiene. Number 4.8 read; "Put on clean gloves." Number 4.9 read; "Instill drops/ointment." "Medication Administration: Nasal" Under the heading "Administer Medication" Number 3.3 read; "Perform hand hygiene." Number 3.4 read; "Put on gloves." Number 3.7 read; "To administer nasal spray." Number 4 read; "Remove and discard gloves." Number 5 read; "Perform hand hygiene." NJAC 8:39-19.4 (a)	F 880	nervous causing the breakdown. The Audit tool was initiated and will be utilized by the Infection Preventionist or designee. Staff will be held accountable to be in compliance with Infection Control Practices. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE the DON or designee will conduct weekly audits on medication pass to ensure Infection Control practice is followed appropriately x 4 weeks. Audits will then be conducted monthly for 2 months , and every other month for the next 4 months to ensure compliance with Infection control policies and procedures. The DON or designee will report the results of these audits to the QAPI committee on a monthly basis. The Administrator will take corrective action as needed to ensure compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315143		3/23/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR CENTER	84 COLD HILL ROAD MENDHAM, NJ 07945

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 03/22/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 03/23/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/5/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO