STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315120		03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HILLS SUBACUTE CARE CENTER	415 SOUTHERN BLVD CHATHAM, NJ 07928

(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	F 000		
	Survey Date: 3/24/22 Census: 94 Sample: 21 + 3 = 24 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 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 facility documentation review, it was determined that the facility failed to document a. ordered behavioral monitoring and b. ordered [redacted] on 2 of 20 residents whose care was reviewed for its accordance with professional standards of practice. The deficiency is evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through	F 658	Based on observation, interview, and facility documentation review, it was determined that the facility failed to document a. ordered behavioral monitoring and b. ordered [redacted] on 2 of 20 residents whose care was reviewed for its accordance with professional standards of practice. Resident #69 behavior Monitoring TAR was reviewed, and the resident behavioral documentation started immediately. LPN # 1 was educated on documentation on behavior monitoring for side effects and effectiveness for all residents receiving [redacted] medication	5/4/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/06/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing a 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 3/14/22 at 10:30 AM, the surveyor observed and interviewed Resident #69 who was in bed in their room. A review of the electronic medical record revealed the following: The Admission Record indicated that Resident #69 had medical diagnoses that included but were not limited to [redacted]. The Order Summary Report indicated that Resident #69 had Physician Orders (PO) to give [redacted] mg once a day active as of [redacted] and a PO to give [redacted] mg 2 capsules once a day active as of [redacted] Both medications were indicated for [redacted]. The Depression care plan initiated on [redacted] had interventions including to monitor and	F 658	Resident #97 [redacted] was assessed for [redacted] and documentation started immediately LPN #2 was educated on accurate documentation for all residents with [redacted] and orders for [redacted] obtainment All residents have the potential to be affected. An audit of all residents receiving [redacted] medications was conducted to ensure that behavior monitoring for side effects and effectiveness was completed. No further issues identified An Audit of all residents with [redacted] was completed to ensure that [redacted] was documented as ordered. No further issues identified. Policies titled "Behavioral Assessment, Intervention, and Monitoring and [redacted] Measuring, and Recording" was reviewed by DON. Licensed Nursing Staff were educated on above policies. DNS/Designee will educate all licensed nursing staff regarding documentation on behavior monitoring for side effects and effectiveness for all residents receiving [redacted] medication	

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F 658	Continued From page 2 document the side effects and effectiveness of Resident #69's medication. A review of the Behaviors Treatment Administration Record (TAR) for [redacted] and [redacted] indicated that nursing staff should document daily and every shift for Resident #69, the number of times that [redacted] behavior occurred during each shift, should document whether the [redacted] behavior improved, worsened, or stayed the same, and should document interventions implemented to address the [redacted] behavior. A further review of the [redacted] Behaviors TAR revealed that nursing staff failed to document any behavioral monitoring on the 7 AM-3 PM shift on 2/6, 2/10, 2/13, 2/19, 2/23, and from 2/26-2/28, on the 3 PM-11 PM shift from 2/2-2/3, from 2/5-2/8, on 2/12, on 2/15, on 2/23, and from 2/27-2/28, and on 11 PM- 7AM shift from 2/1-2/6, from 2/8-2/12, from 2/14-2/17, on 2/19, from 2/21-2/22, and from 2/24-2/27. A further review of the [redacted] Behaviors TAR revealed that nursing staff failed to document on the 7 AM-3 PM shift from 3/3-3/5, and from 3/12-3/13, on the 3 PM-11 PM shift from 3/1-3/3, from 3/5-3/7, and from 3/10-3/14, and on the 11 PM-7 AM shift from 3/1- 3/2, on 3/5, and from 3/10- 3/11. On 3/16/22 at 10:28 AM, the surveyor interviewed Licensed Practical Nurse #1(LPN#1) regarding Resident #69's Behaviors TAR. LPN #1 stated that she documents Resident #69's behaviors every shift that she works. The LPN could not speak to why there were blanks on the Behaviors	F 658	DNS/Designee will educate all licensed nursing staff regarding accurate documentation for all residents with [redacted] and orders for [redacted] obtainment as well as CNAs for reporting the [redacted] when they empty [redacted] Facility will implement daily wrap up meeting (meeting at the end of the day) with Director of Nursing/Designee to run EMAR and ETAR report for any missing documentation and Nurse Managers/Designee will be responsible to oversee nursing documentation The Director of Nursing Services (DNS)/Designee, will audit randomly 10 residents receiving [redacted] medication weekly x 4 then monthly x 3 to ensure proper documentation on behavior monitoring for side effects and effectiveness is completed The Director of Nursing Services (DNS)/Designee will audit the EMR regarding all residents with [redacted] to ensure that [redacted] was documented as ordered the audit will be completed weekly for 4 weeks, then monthly x3 months. The Director of Nursing /Designee will report the results of the audits at the quarterly QA meeting for review and feedback. Responsible Party: DON	

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F 658	Continued From page 3 TAR and stated that she would have to investigate herself. On 3/21/22 at 12:25 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that she frequently worked as the Unit Manager. The surveyor showed the ADON the [redacted] Behaviors TAR. The ADON stated that she would not expect to see behavior monitoring documented in the way that it was and that she would expect to see it documented daily and on every shift. A review of the facility policy, "Behavioral Assessment, Intervention, and Monitoring" published 2/22/21 indicated Monitoring: 1. If the resident is being treated for altered behavior or mood, the interdisciplinary team will seek and document any improvements or worsening in the individual's behavior, mood, and function. 2. On 3/14/22 at 10:52 AM, the surveyor observed Resident #97 in bed in their room with a [redacted] that was draining [redacted] A review of the electronic medical record revealed the following: The Admission Record indicated that Resident #97 was admitted to the facility with diagnoses that included but were not limited to [redacted] and [redacted]. The Order Summary Report indicated that Resident #97 had a PO to empty the [redacted] and record [redacted] every shift active as of [redacted]	F 658		

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F 658	Continued From page 4 A review of the [redacted] TAR revealed that the urine output was not recorded on 7 AM-3 PM shift on 2/23, 2/25 and 2/26, on 3 PM-11 PM shift on 2/23, and 2/27-2/28, and on 11 PM- 7 AM shift on 2/23 and 2/26. A review of the [redacted] TAR revealed that the urine output was not recorded on 7 AM- 3 PM shift on 3/3, 3/9, 3/13-3/14, and 3/19, on 3 PM- 11 PM shift on 3/7, and 3/13, and on 11 PM- 7 AM shift from 3/2-3/3, from 3/7-3/9, 3/13, and 3/15. On 3/22/22 at 9:52 AM, the surveyor interviewed LPN #2 regarding the process by which Resident #97's [redacted] were recorded. LPN #2 stated that the certified nursing assistants (CNAs) sometimes empty the [redacted] but that they should tell the nurse the amount and the nurse records the amount in the TAR. LPN #2 stated that [redacted] should be recorded every shift every day. On 3/23/22 at 10:18 AM, the surveyor interviewed the CNA. The CNA stated that it was a CNA's responsibility to empty the [redacted] every shift and to tell the amount of [redacted] to the nurse. On 3/24/22 at 10:35 AM, the surveyor interviewed the ADON who stated that she frequently works as the Unit Manager. The ADON stated that she would expect to see [redacted] documented daily and every shift for Resident # 97. On 3/23/22 at 1:25 PM, the surveyor presented her concerns to the Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA), and Regional LNHA.	F 658		

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F 658	Continued From page 5 On 3/24/22 at 9:30 AM, the surveyor interviewed the DON. The DON stated that there were inconsistencies in CNAs reporting the urine outputs to the nurses. A review of the facility policy, [redacted], and [redacted]" indicated that under the "Documentation" heading, the following information should be recorded in the resident's medical record: "1. The date and time the resident's [redacted] was measured and recorded. The amount (in milliliters) of [redacted]	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 properly secure an [redacted] and failed to ensure that [redacted] was delivered at a rate consistent with the physician orders for 2 of 3 residents reviewed for [redacted] care, Resident #35 and Resident #97. The deficiency is evidenced by the following:	F 695	Based on observation, interview, and record review it was determined that the facility failed to properly secure an [redacted] and failed to ensure that [redacted] was delivered at a rate consistent with the physician orders for 2 of 3 residents reviewed for [redacted] care, Resident #35 and Resident #97 Resident #35 [redacted] was	5/4/22

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F 695	Continued From page 6 1. On 3/14/22 at 10:07 AM, the surveyor observed Resident #35 seated in a chair in their room with a walker in front of them. The surveyor observed an [redacted] (an [redacted] storage vessel) propped sideways inside the open seat of the walker which had a basket inside. The [redacted] was not securely fastened to a caddy or holder. The surveyor interviewed Resident #35 who stated that this is how they, "always" store their [redacted] because this is the way that it works best for them to walk with the [redacted]. On 3/14/22 at 10:09 AM, the surveyor observed the Director of Rehabilitation (DOR) enter Resident #35's room and take the [redacted] out of the seat of the walker and place the [redacted] into a caddy. The DOR affixed the caddy with the [redacted] inside to the frame of the [redacted] On 3/14/22 at 10:10 AM, the surveyor interviewed the DOR who stated that [redacted] should be stored securely and upright in a caddy. The DOR could not explain why the [redacted] was observed leaning sideways and was not securely fastened in a caddy. On 3/16/22 at 1:36 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) about the observation of the [redacted] inside Resident #35's walker. The CNA stated that this storage was, "unacceptable" and that the [redacted] should always be securely fastened in a caddy or holder. On 3/16/22 at 1:48 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 about the observation of the [redacted] inside Resident #35's walker. LPN#1 stated that the	F 695	secured immediately and [redacted] was assessed. Resident #97 MD was notified and [redacted] PO was changed to 10LPM. LPN #2 was educated to ensure in resident [redacted] to be reported to MD and obtained PO according and to be documented. All residents have the potential to be affected. An audit of all [redacted] on residents with a Physician order for [redacted] therapy to ensure all are secured and for proper storage. No further issues identified An Audit of all residents with a physician order for [redacted] therapy to ensure that the [redacted] provided matches the physicians□ orders. No further issues identified A review of the facility policy titled [redacted] Administration was completed by Director of Nursing and no changes were required. Licensed Nursing Staff will be educated on above policy DNS/Designee will educate all licensed nursing staff regarding following the physicians order for [redacted] therapy to ensure [redacted] therapy administered according to physician orders In addition, Nursing staff will be educated regarding [redacted] tanks storage and security.	

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F 695	Continued From page 7 [redacted] should not be stored in the walker and stated that it should be securely fastened in a holder. A review of Resident #35's electronic medical record (EMR) revealed the following: The Admission Record indicated that Resident #35 had medical diagnoses that included but were not limited to [redacted] The quarterly Minimum Data Set, an assessment tool used to facilitate the management of care dated [redacted] indicated that Resident #35 was assessed as having a Brief Interview for Mental Status score of [redacted] reflecting that the resident was [redacted]. The Order Summary Report indicated that Resident #35 had an [redacted] Physician Order (PO) for [redacted] at a [redacted] On 3/17/22 at 1:05 PM, the surveyor presented her concern to the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA), who had no other information to present. 2. On 3/14/22 at 10:50 AM, the surveyor observed Resident #97 in bed with 10 LPM of [redacted] applied to the resident's [redacted] (an [redacted] an [redacted]. On 3/15/22 at 10:21 AM, the surveyor asked LPN#2 to accompany her into Resident #97's room. The surveyor asked how many [redacted] of	F 695	Unit Managers/Designees will oversee [redacted] administration according to physician orders and security of [redacted] during daily rounds The Director of Nursing Services (DNS)/Designee will audit the [redacted] storage of all residents receiving [redacted] therapy to ensure appropriate storage. The audit will be completed weekly for 4 weeks, and then monthly X 3. The Director of Nursing Services (DNS)/Designee will audit all [redacted] concentrators and [redacted] to ensure that the setting matches physician orders. The audit will be completed weekly for 4 weeks, and then monthly X# 3 The Director of Nursing/Designee will report the results of the audits at the quarterly QA meeting for review and feedback. Responsible Party: Director of Nursing	

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F 695	Continued From page 8 [redacted] Resident #97 was receiving. LPN #2 stated that the resident was receiving [redacted]. On 3/15/22 at 10:25 AM, surveyor along with LPN#2 reviewed the PO for Resident #97. The most recent PO, dated [redacted] indicated that Resident #97 was to receive 8 [redacted]. LPN#2 explained to the surveyor that Resident #97 was previously receiving [redacted] but that the doctor changed the order to [redacted] LPN #2 stated that the resident was desaturating (the percentage of [redacted] than it should be) two days ago on night shift and that the nurse put the resident back on [redacted] of [redacted]. Review of he Admission Record indicated medical diagnoses that included but were not limited to [redacted] status. Review of the [redacted] care plan dated [redacted] indicated that staff should provide treatments per physician order. Review of a Nursing Progress Note dated [redacted], indicated that Resident #97 was experiencing [redacted] and that their [redacted] (a normal level of [redacted] is usually [redacted]) on [redacted] of [redacted]. The Nursing Progress Note also indicated that the [redacted] was increased back to [redacted] and the physician was made aware. Review of the Order Summary Report failed to reveal that an order was obtained to change the resident's [redacted] from [redacted] to [redacted] On 3/23/22 at 10:37 AM, the surveyor interviewed	F 695		

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F 695	Continued From page 9 the Assistant Director of Nursing (ADON) who stated that she frequently acted as the Unit Manager. The ADON stated that a resident's order for [redacted] and the amount of [redacted] that the resident is receiving should always be consistent and should, "match". On 3/23/22 at 1:25 PM, the surveyor presented her concern to the LNHA, DON, and Regional LNHA. A review of the facility policy, [redacted] Administration" indicated under the "Preparation" heading that staff should: "1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for [redacted] administration" and indicated under the "Steps in Procedure" heading that staff should "12. Check the [redacted], etc., to be sure that they are in good working order and are securely fastened." NJAC 8:39-27.1(a)	F 695		
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,	F 755		5/4/22

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F 755	Continued From page 10 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 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 accurately document required information on the shift to shift narcotic accountability log and the Consultant Pharmacist failed to inform the facility of this discrepancy for 1 of 2 units inspected. This deficient practice was evidenced by the following: On 3/14/22 at 11:30 AM, the surveyor in the presence of the Licensed Practical Nurse #1 (LPN #1) assigned to the [redacted] medication cart. reviewed the "Shift to Shift Narcotic Accountability Log" for [redacted] 2022 and [redacted] 2022 on the [redacted] Unit. Review of the [redacted] Unit "Shift to Shift	F 755	Based on observation, interview and record review, it was determined that the facility failed to accurately document required information on the shift to shift narcotic accountability log and the Consultant Pharmacist failed to inform the facility of this discrepancy for 1 of 2 units inspected [redacted] Unit and [redacted] Unit Narcotics were counted immediately and there were no discrepancies. Licensed Nursing Staff in [redacted] Unit and [redacted] Unit were reeducated regarding "Shift to Shift Narcotic Accountability Log" to ensure incoming and outgoing nurses count	

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F 755	Continued From page 11 Narcotic Accountability Log" dated [redacted], presented many missing signatures by nursing staff that were outgoing (ending their shift) and incoming (starting their shift). There were 12 missing signatures of nursing staff outgoing and 13 incoming missing signatures for [redacted] on the [redacted] Unit. Review of the [redacted] Unit "Shift to Shift Narcotic Accountability Log" dated [redacted] presented many missing signatures by nursing staff that were outgoing (ending their shift) and incoming (starting their shift). There were 13 missing signatures of nursing staff outgoing and 12 incoming missing signatures for [redacted] on the [redacted] Unit. Review of the [redacted] Unit "Shift to Shift Narcotic Accountability Log" dated [redacted], presented many missing Start # and End # Packages for Narcotics stored in the narcotic lock box of the [redacted] Unit medication cart. There were 20 missing #s of Start # Packages and 28 missing End # Packages of Narcotics for the month of [redacted]. Review of the [redacted] Unit "Shift to Shift Narcotic Accountability Log" dated [redacted], presented many missing Start # and End # Packages for Narcotics stored in the narcotic lock box of the [redacted] Unit medication cart. There were 15 missing #s of Start # Packages and 17 missing End # Packages of Narcotics for the month of [redacted] On 3/14/22 at 11:40 AM, the surveyor along with LPN #1 performed a physical count of narcotics that were stored in the [redacted] Unit medication cart and there were no discrepancies noted.	F 755	narcotic and sign the narcotic accountability log together upon the count. Pharmacy Consultant was notified immediately of the findings and requested the unit expectations An audit of the shift-to-shift accountability log was completed to ensure and showed no further issues. The facility nursing policy and procedure titled Controlled Substances was reviewed by DON no revisions were necessary Licensed Nursing staff were educated on above Policy. DNS/Designee will educate all licensed nursing staff regarding accurate documentation on shift-to-shift narcotic accountability log. Facility new Pharmacy consultant will be responsible for to assess for discrepancies related to accurate narcotic documentation per the facilities policy, Pharmacy consultant will review Narcotic documentation weekly and report findings to the facility for Director of Nursing to Review weekly. Unit Managers/Nursing Supervisors /Designees will oversee shift to shift Narcotic Accountability Log" documentation on a daily basis per each shift to ensure any Narcotic discrepancy will be identified immediately and to be	

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F 755	Continued From page 12 On 3/14/22 at 11:45 AM, the surveyor in the presence of the Licensed Practical Nurse #2 (LPN #2) assigned to the [redacted] Unit medication cart reviewed the "Shift to Shift Narcotic Accountability Log" for [redacted] and [redacted] on the [redacted] Unit. Review of the [redacted] Unit "Shift to Shift Narcotic Accountability Log" dated [redacted], presented many missing signatures by nursing staff that were outgoing and incoming. There were 9 missing signatures of nursing staff outgoing and 4 incoming missing signatures for [redacted] on the [redacted] Unit. Review of the [redacted] Unit "Shift to Shift Narcotic Accountability Log" dated [redacted], presented many missing signatures by nursing staff that were outgoing and incoming. There were 6 missing signatures of nursing staff outgoing and 5 incoming missing signatures for [redacted] on the [redacted] Unit. Review of the [redacted] Unit "Shift to Shift Narcotic Accountability Log" dated [redacted], presented many missing Start # and End # Packages for Narcotics stored in the narcotic lock box of the [redacted] Unit medication cart. There were 10 missing #s of Start # Packages and 19 missing End # Packages of Narcotics for the month of [redacted]. Review of the [redacted] Unit "Shift to Shift Narcotic Accountability Log" dated March 2022, presented many missing Start # and End # Packages for Narcotics stored in the narcotic lock box of the [redacted] Unit medication cart. There were 5 missing #s of Start # Packages and 12	F 755	addressed and investigated accordingly The Director of Nursing Services (DNS)/Designee will audit the documentation on shift to shift narcotic accountability log to ensure accuracy and daily documentation. The audit will be completed weekly for 4 weeks, and then monthly x 3 The DNS /Designee will report the results of the audits at the quarterly QA meeting for review and feedback Responsible Party: DON	

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F 755	Continued From page 13 missing End # Packages of Narcotics for the month of [redacted]. On 3/14/22 at 11:55 AM, the surveyor along with LPN #2 performed a physical count of narcotics that were stored in the [redacted] Unit medication cart and there were no discrepancies noted. 03/17/22 at 1:07 PM, the surveyor met with the Administrator and Director of Nursing (DON) to discuss the discrepancy issues. The DON explained that she was not aware of the missing nursing signatures or the package numbers missing on the "Shift to Shift Narcotic Accountability Log." The DON informed the surveyor that she was not informed of this issue by the Consultant Pharmacist in [redacted], when they performed the unit inspections for the building. On 3/21/22, the surveyor reviewed the Policy and Procedure for Controlled Substances which revealed under, "8. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift." In addition under, "12. At the End of Each Shift: a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. c. The Director of Nursing Services investigates all discrepancies in controlled medication reconciliation to determine the cause and identify any responsible parties, reports the findings to the Administrator. 14. Policies and procedures for monitoring controlled medications to prevent loss, diversion or accidental exposure are periodically reviewed and updated by the Director of Nursing Services and the Consultant	F 755		

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F 755	Continued From page 14 Pharmacist." On 3/22/22 12:03 PM, the surveyor interviewed the Assistant Director of Operations PharmD Pharmacist (ADOO PharmD) via a phone call, who stated that the facility is transitioning to a new Consultant Pharmacist (CRPh). She informed the surveyor that the, previous CRPh was at the facility for 8 months. The ADOO PharmD explained that the CRPh should be reviewing narcotic inventory, which includes Sign In/Out Narcotic sheets. The ADOO PharmD added that the CRPh should be assessing for discrepancies and identifying issues to the facility. On 3/22/22 at 2:28 PM, the surveyor received a return phone call from the ADOO PharmD, who informed the surveyor that the CRPh should have highlighted the narcotic documentation discrepancies and alerted the DON during the February 14, 2022 visit to the facility. On 3/23/22, the surveyor reviewed the February 14, 2022 Unit Inspection Report completed by the facility Consultant Pharmacist (CRPh). Review of the Inspection Report under the section marked "Controlled Drugs," there is an entry stating "Change of shift signature log is complete" and the documentation made by the CRPh is "YES." On 3/24/22 at 10:24 AM, the surveyor reviewed the CRPh "Agreement" entered with the facility on March, 2015. Documented within the agreement was, "2. Duties of Consultant: a. The Consultant shall be responsible for consultation on all aspects of the provision of pharmacy services in the Facility. More specifically, Consultant shall provide the following services: ii. Establishing a system of records of receipt and disposition of all	F 755		

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F 755	Continued From page 15 controlled drugs in sufficient detail so as to allow an accurate reconciliation, and determine, through sampling, that drug records are in order and an accountability of all controlled drugs is maintained and periodically reconciled. On 3/25/22 at 12:00 PM, the surveyor exited with the facility. No further information was provided by the DON after the discrepancy was identified to the facility.	F 755		
F 804 SS=D	NJAC 8:39-29.3(a)(1) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that the safe and appetizing temperatures of food and drink were appropriately served to facility residents. This deficient practice was identified during the lunch time meal service on 3/17/22 on 2 of 2 nursing units tested for food temperatures ([redacted] and [redacted] units), and was evidenced by the following: On 3/16/22 at 11:29 AM, two surveyors conducted a group meeting with six residents	F 804	Based on observation, interview, and record review the facility failed to ensure that the safe and appetizing temperatures of food and drink were appropriately served to facility residents. This deficient practice was identified during the lunch time meal service on 3/17/22 on 2 of 2 nursing units tested for food temperatures [redacted] and [redacted] units) Styrofoam plates and trays were immediately replaced with regular dishes	5/4/22

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F 804	Continued From page 16 who were part of the facility's resident council. All six residents indicated that their breakfast and lunch meals are frequently late and the food is cold. The residents informed the surveyors that sometimes they do not get breakfast until 9 AM and lunch until 1 PM. On 3/17/22 at 9:35 AM, the surveyor calibrated the thermometer in accordance with manufacturer instructions in the presence of two other surveyors. On 3/17/22 at 11:55 AM, in the presence of the Food Service Director (FSD), the first set of insulated food trucks arrived in the dayroom area on the [redacted] unit. The surveyor identified and labeled a tray in the presence of the FSD that would be used for testing food temperatures. The surveyor did not open the lid to see the contents of the resident's meal and the tray was placed back into the insulated food truck to keep warm. The last tray was removed and served at 12:03 PM. The Surveyor observed that all lunch meals were served in Styrofoam containers with plastic disposable utensils. Tray Delivery Schedule for the South wing previously provided by the facility Administrator indicated that the first truck for lunch should arrive at 11:30 AM daily. The surveyor reviewed the meal ticket which indicated what was being served to the resident. The ticket indicated that the tray would consist of 4 oz of ground consistency Corned Beef, ½ cup of ground consistency Braised Cabbage, 4 oz Mashed Potatoes, 6 fl oz Chicken Noodle Soup, 4 fl oz of Whole milk, 4 fl oz Apple Juice, 8 fl oz	F 804	to ensure Food temperatures are stored accordingly and to ensure the safe and appetizing temperatures of food and drink were appropriately served to facility residents. Food Temperature were observed for next meals and all were within normal range All residents can be affected by the same practices identified. Test Tray Temperature Observations were conducted for each unit to ensure safe and appetizing temperatures. No further issues identified. Policy titled Food Temperature Policy was reviewed by DON and FSD. Dietary Staff were educated on above Policy. The Food Service Director (FSD)/Designee will educate all dietary staff regarding safe and appetizing food and beverage temperatures at point of service. The Administrator will educate the FSD and all dietary staff on ensuring that disposable dishware is only to be used in emergent situations and must be communicated to the Administrator to ensure a rapid resolution to return to regular service wares as timely as possible. The FSD/Registered Dietitian	

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F 804	Continued From page 17 Coffee, 4 oz Sherbet and 4 oz Super Pudding On 3/17/22 at 12:04 PM, in the presence of the FSD, the surveyor recorded the temperatures from the food tray that was previously saved. The 4 oz of ground consistency Corned Beef temperature was recorded at 122 degrees Fahrenheit (F). The ½ cup of ground consistency Braised Cabbage was recorded at 137 degrees F. The 4 oz Mashed Potatoes temperature was recorded at 117.8 degrees F. The 6 fl oz Chicken Noodle Soup temperature was recorded at 121 degrees F. The 4 fl oz of Whole milk temperature was recorded at 62.1 degrees F. The 4 oz Sherbet temperature was recorded at 21.1 degrees F, and found with melted liquid at the bottom. The 4 fl oz Apple Juice temperature was recorded at 62.7 degrees F. The 8 fl oz Coffee temperature was recorded at 144.5 degrees F. The 4 oz Supper pudding temperature was recorded at 65.5 degrees F. On 3/17/22 at 12:29 PM, in the presence of the FSD, the second set of insulated food trucks arrived in the dayroom area on the [redacted] unit. The surveyor identified and labeled a tray in the presence of the FSD that would be used for testing food temperatures. The surveyor did not open the lid to see the contents of the resident's meal and the tray was placed back into the insulated food truck to keep warm. The last tray was removed and served at 12:32 PM. Again, the surveyor observed all meals were served in Styrofoam containers with plastic disposable utensils. Tray Delivery Schedule for the [redacted] wing previously provided by the facility Administrator indicated that the first truck for	F 804	(RD)/Designee will conduct Test Tray Temperature Observations weekly to ensure that meal temperatures (of both Hot foods and cold foods) are served at the appropriate serving temperatures at the point of service per the facility□s policy. These Test Tray Temperature observations will continue weekly until no further areas of discrepancy are identified and then continue monthly to ensure the maintenance of appropriate temperatures for all food items served. The FSD/RD/Designee will audit conduct Test Tray Temperature Observations weekly for a minimum of 4 weeks then monthly x 3. The results of the audit will be presented to the QA committee quarterly and as needed by the FSD/RD. Responsible Party: RD	

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F 804	Continued From page 18 lunch should arrive at 12:00 PM daily. The surveyor reviewed the meal ticket which indicated the meal that was served to the resident. The ticket indicated the tray would consist of 4 oz of Regular consistency Corned Beef, ½ cup of regular consistency Braised Cabbage, 4 oz Boiled Potatoes, 4 fl oz of Fat-Free milk, 4 fl oz Cranberry Juice, 8 fl oz Hot water, 4 oz Super Pudding On 3/17/22 at 12:33 PM, in the presence of the FSD, the surveyor recorded the temperatures from the food tray saved. The 4 oz of Regular consistency Corned Beef temperature was recorded at 111.4 degrees F. The ½ cup of Regular consistency Braised Cabbage was recorded at 128.1 degrees F. The 4 oz Boiled Potatoes temperature was recorded at 126.3 degrees F. The 4 fl oz of Fat-Free milk temperature was recorded at 67.1 degrees F. The 4 fl oz Cranberry Juice temperature was recorded at 68.3 degrees F. The 8 fl oz Hot water temperature was recorded at 132.4 degrees F. The 4 oz Supper pudding temperature was recorded at 72.7 degrees F. On 3/17/22 at 12:45 PM, the surveyor conducted an interview with the FSD regarding the lunch meal food temperatures. The Surveyor asked, if the recorded temperatures taken at lunch were in safe and appropriate ranges. The FSD explained, "No, unfortunately the majority of items were out of safe temperature ranges." The surveyor asked if prior to serving, are food temperatures recorded and why do you think the food temperatures are out of range? The FSD explained, "Food temperatures are taken prior to	F 804		

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F 804	Continued From page 19 serving and they are always in the appropriate ranges. I think the Styrofoam is not holding the temperature." The surveyor asked if Styrofoam was currently needed or should regular dishes and utensils be used? The FSD stated, "We had been using Styrofoam due to Covid." The FSD informed the surveyor that at this time there was no reason for the continued use of Styrofoam and plastic utensils. On 3/22/22 at 1:03 PM, the Administrator provided a copy of the facility's Food Temperature Policy, which was updated on 6/23/21, and documented: 1. All hot foods items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees of higher. a. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees F or higher. b. Hot food items may not fall below 135 degrees F of higher after cooking, unless it is an item which is to be rapidly cooled to below 41 degrees F and reheated to at least 165 degrees F (for a minimum of 15 seconds) prior to serving. Caution should be taken to avoid serving food and liquids at temperatures that are too hot to avoid the risk of burns. 2. All cold foods must be stored and served at 41 degrees or below. On 3/17/22 at 2:00 PM, the surveyor informed the Director of Nursing and Administrator of the food	F 804		

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F 804	Continued From page 20 temperature concerns. No further information was provided.	F 804		
F 812 SS=D	NJAC 8:39-17.4(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: F812 - Food Safety Requirements Based on observation, interview, and record review the facility failed to maintain proper kitchen sanitation practices. This deficient practice was identified by the following: On 3/14/22 at 10:50 AM, this surveyor conducted the kitchen inspection. Surveyor observed the following: 1. Two dietary aides without hairnets while on	F 812	Based on observation, interview, and record review the facility failed to maintain proper kitchen sanitation practices DA #1 & DA #2 were educated immediately to maintain regarding proper kitchen sanitation practices. and hairnet were applied DA #2 was reeducated about	5/4/22

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F 812	Continued From page 21 the tray line. Surveyor interviewed both dietary aides (DA#1 and DA#2). Surveyor asked DA#1 while in the kitchen what should be worn? DA#1 stated, "While serving the tray line we wear disposable gloves and hairnets." DA#1 realized she was not wearing her hairnet and went to put one on. Surveyor interviewed DA#2. DA#2 put on a hairnet while DA#1 was being interviewed but had hair sticking out the front. Surveyor asked why she did not have her hairnet on prior. DA#2 stated, "Well, I had my sweatshirt hood on." Surveyor stated, but your hair was sticking out in front, is the considering safe for handling? DA#2 stated, "No, my hair should be tied back." 2. While in the presence of the Regional Dietary Manager (RDM), the surveyor observed DA#2 perform handwashing. Surveyor observed DA#2 scrubbed her hands with soap for five seconds which was timed with the surveyors watch, also DA#2 used the same papers towels to dry her hands to turn off the sink. Surveyor interviewed DA#2 and asked, how long do you think you scrubbed your hands? DA#2 stated, "Eight seconds, I think." Surveyor asked, how long should you scrub your hands for? DA#2 stated, "Ten seconds." Surveyor asked, have you been in-serviced on hand washing, how long does the handwashing handouts say to scrub your hands and why did you use the same paper towels to dry your hands and turn off the faucet? DA#2 stated, "Yes, I've had hand washing in-services. I think the hand washing handouts say 10 seconds of scrubbing." DA#2 could not explain why she used the same paper towels to dry hands and turn off faucet. 3. The RDM asked their Chef to perform hand hygiene. Surveyor observed the chef first apply soap to both hands, scrub for 20 seconds, then turn water on, rinse hands, dry hands with paper	F 812	Handwashing and a handwashing competency was performed to ensure DA #2 demonstrated the handwashing competency Facility was educated about Handwashing and a handwashing competency was performed to ensure Chef demonstrated the handwashing competency All residents have the potential to be affected by the practices identified. An audit was conducted including observations of the kitchen staff wearing hairnets and washing hands □ no further issues identified. All dietary staff were audited for handwashing and a handwashing competency was performed for all dietary staff to ensure they all demonstrated the handwashing competency according to Infection control guidelines Policy titled Handwashing & Hand Hygiene was reviewed by Director of Nursing. All dietary staff were educated on above policy. Infection Control nurse will review all dietary staff on hand washing competency. FSD will educated all dietary staff on hairnet donning compliance.	

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F 812	Continued From page 22 towels, then turn off paper faucet with clean paper towels. Surveyor asked the Chef, per the hand washing handouts above the sink, should her hands be wet before apply soap? The chef stated, "Yes, my hands should be wet prior to applying soap." The Chef was unable to explain why she did not wet hands prior to applying soap. On 3/14/22 at 11:50 AM, surveyor interviewed the RDM. The surveyor asked has the staff been in-serviced on hand washing and wearing hairnets? And when was that in-service conducted. The RDM stated, "I'm not sure when the last in-service was conducted, but I will re-in-service everyone today. When the Food Service Director (FSD) is in tomorrow, I will be able to give you the date of the last in-service. I am surprised their handwashing was not perfect." On 3/15/22 at 1:24 PM, the Administrator provided the surveyor with a copy of the facility's policy on Handwashing and hand Hygiene dated 8/2014. The Handwashing and Hand Hygiene policy states under Policy Interpretation and Implementation 2. All personnel shall follow the handwashing /hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Washing Hands procedure 1. Wet hands first with water, then apply an amount of product recommended by the manufacturer to hands. 2. Rubs hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use towel to turn off the faucet. 5. Avoid using hot water, because repeated exposure to hot water may increase the risk of	F 812	The FSD/Designee will monitor all dietary staff Infection Control practices on a daily basis including handwashing and hairnet utilization The FSD/Designee will audit hand washing procedures on all dietary staff daily for two weeks, then weekly for four weeks, then monthly X 3 The FSD/Designee will audit hairnet compliance on dietary staff working each day for 2 weeks, then weekly for 4 weeks, and then monthly until 100% compliance is achieved. The FSD/Designee will report the results of the audits at the quarterly QA meeting for review and feedback. Responsible Party: RD	

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F 812	Continued From page 23 dermatitis. On 3/21/22 at 1:56 PM, the Administrator provided the surveyor with a copy of the facility's policy on Employee Sanitary Practices, updated 7/22/2021. The Employee Sanitary Practices policy states I. General Statement of Policy: All food handlers must wear effective hair restraints that cover all exposed body hair. Examples include hair nets and beard guards. They must be designed and worn effectively to keep hair from contacting and contaminating exposed food, clean equipment, utensils, unwrapped single service items and single use articles. II. Procedure, All employees shall: A. Wear hair restrains such as, hairnets, hair covering nets, beard restraints and clothing that covers body hair. B. Always cover all hair with hair restraints. C. Never leave bangs or other part of hair hanging outside of hair restraints. D. Always cover all facial hair with beard net. E. Wear clothing that covers all body hair. NJAC 8:39-17.2(g)	F 812		
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	F 880		6/3/22

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F 880	Continued From page 24 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the 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	F 880		

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F 880	Continued From page 25 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. ensure the infection control practices for residents on transmission-based precautions were implemented in accordance with accepted national standards, and b. perform hand hygiene while caring for facility residents and c. disinfect equipment prior to and after use, d.) follow appropriate infection control procedure during [redacted] treatment. These deficient practices were observed on 11 of 20 residents reviewed for infection control practices, Resident #252, #253, #19, #97, #11, #6, #69, #35, #57, #35, #100. The deficiency is evidenced by the following: 1. On 3/14/21 at 11:04 AM, during the initial tour, the surveyor observed the Certified Nursing Assistant (CNA) #1 wearing a disposable gown, gloves and N-95 mask, enter Resident #252's room. The surveyor observed a sign posted on	F 880	Based on observation, interview and record review, it was determined that the facility failed to: a. ensure the infection control practices for residents on transmission-based precautions were implemented in accordance with accepted national standards, and b. perform hand hygiene while caring for facility residents and c. disinfect equipment prior to and after use, d.) follow appropriate infection control procedure during [redacted] treatment. These deficient practices were observed on 11 of 20 residents reviewed for infection control practices, Resident #252, #253, #19, #97, #11, #6, #69, #35, #57, #35, #100. CNA #1 was educated to wash hands prior leaving a resident on Transmission based Precautions	

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F 880	Continued From page 26 Resident #252's door indicating that Resident #252 was on [redacted] and [redacted] precautions. An additional sign posted on the resident's door indicated that the proper Personal Protective Equipment (PPE) that staff must wear prior to entering the resident's room included, gown, N-95 mask, goggles or face shield and gloves. On 3/14/21 at 11:19 AM, the surveyor observed CNA #1 exit the resident's room, remove her gown and gloves outside of the room and did not perform handwashing or sanitize her hands using an alcohol-based hand rub (ABHR) gel. On 3/14/21 at 11:20 AM, the surveyor was interviewing CNA #1 when the facility's fire alarm sounded. CNA #1 proceeded to respond to the alarm. The surveyor observed CNA #1 handling the doorknobs of 5 resident's rooms, while closing them. On 3/14/22 at 11:22 AM, CNA #1 was informed that the fire alarm was a drill. The surveyor resumed the interview with CNA #1. CNA #1 acknowledged that she did not wash her hands or sanitize using ABHR gel after exiting Resident #252's room. CNA #1 informed the surveyor that Resident #252 was placed on [redacted] and [redacted] isolation because the resident was a new admission to the facility. The surveyor questioned CNA #1 as to why she was not wearing any goggles or faceshield prior to entering the resident's room as there was a sign posted on Resident #252's door. CNA #1 stated that she did not wear any goggles or face shield since she has her personal prescription eyeglasses. A review of Resident #252's Admission Record (AR) revealed that the resident was admitted to	F 880	LPN #1 was educated about [redacted] care and handwashing during [redacted] treatment. A [redacted] care competency was performed for LPN #1 CNA #1 was educated regarding [redacted] Precaution including wearing proper eye protection instead of personal eye glasses. LPN #3 was educated on required PPE application for residents on Transmission based Precautions CNA #2 was educated on required PPE application for residents on Transmission based Precautions and Isolations Housekeeping staff was educated on required PPE application while cleaning Resident # 11 room and cleaning order and procedures for residents on Transmission based Precautions. The Associate Fire Alarm Technician was educated on required PPE application for residents on Transmission based Precautions Resident #69 Physician Order for TBP was discontinued LPN #3 and CNA #3 were educated on required PPE application for residents on Transmission based Precautions Medical Director was educated on required PPE application for residents on	

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F 880	Continued From page 27 the facility with diagnoses that included [redacted] A review of the [redacted] Physician Order Summary revealed an order dated [redacted] to "Maintain droplet precaution". Further review of the medical record indicated that the resident was not COVID vaccinated due to refusal. On 3/17/21 at 1:05 PM, the surveyor informed the facility's Administrator, Director of Nursing (DON) and the Regional Administrator regarding the above concern. The surveyor reviewed a facility's form titled, "Action Plan Updated Zones" that was provided by the Administrator which revealed, "New Admission Zone - Contact and [redacted] Precautions Patient Status: 10-day quarantine for unvaccinated. PPE for Staff: N-95 mask, eye protection/face shield, gown, and gloves." On 3/23/22 at 11:45 AM, the surveyor interviewed the Director of Nursing who stated that personal prescription eye glasses were not acceptable to be used for protection when entering a residents room who was newly or re-admitted to the facility. There was no other information provided. 2. On 3/17/22 at 10:47 AM, the surveyor observed Resident #253 in bed, alert and awake. The surveyor observed Licensed Practical Nursing (LPN) #1 assisted by CNA #1 in the room preparing for Resident #253's [redacted] care. The surveyor observed LPN #1 place the [redacted] treatment equipment and supplies on the resident's daily used overbed table without	F 880	Transmission based Precautions LPN # 2 was educated on Sanitizing [redacted] and [redacted] before and after usage LPN #2 was reeducated about Handwashing and a handwashing competency was performed to ensure LPN #2 demonstrated the handwashing competency LPN #1 was reeducated about Handwashing and a handwashing competency was performed to ensure LPN #1 demonstrated the handwashing competency All residents have the potential to be affected by the same practice. An audit has been completed to review all physician orders related to TBPs to ensure that they meet the State and Federal regulations. An audit of physician orders for transmission based precautions (TBP) was completed to ensure that the resident required(s) the TBPs ordered - no other findings identified. An audit of the facility signage corresponding to Physician orders was completed, no other findings identified. Policies titled [redacted] Care, Handwashing, Outbreak Communicable disease, Transmission Based Precautions, PPE,	

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F 880	Continued From page 28 disinfecting or placing any barrier under the equipment. The surveyor observed LPN #1 put on gloves without performing handwashing. After putting on gloves, LPN #1 was observed touching surfaces in the room, the wheelchair, doorknob and the resident's overbed table. The surveyor observed CNA #1 perform handwashing and was scrubbing both her hands with soap under the running water. After cleansing the [redacted], LPN #1 removed her soiled gloves, put on a clean glove to her right hand only without performing handwashing or sanitizing with ABHR gel. The surveyor observed LPN #1, using her gloved right hand, remove all the dirty equipment on the resident's overbed table and discarded them in the garbage bin. LPN #1 proceeded to remove the glove from her right hand then touched the resident to help CNA #1 reposition Resident #253 without performing handwashing or sanitizing using ABHR gel. The surveyor observed LPN #1 perform handwashing for 10 seconds while scrubbing both hands with soap under the running water. LPN #1 did not sanitize the resident's overbed table after rendering the [redacted] treatment. The surveyor discussed the above concern with LPN #1, who acknowledged that she did not perform handwashing and did not sanitize the resident's overbed table before and after the [redacted] treatment administration.	F 880	Cleaning and Disinfection of Resident-Care items and equipment were reviewed by DON. Facility Staff were educated on all above policies The IP will educate all staff on hand washing. The IP will educate all staff (including the facility RN Educator) on required PPE for residents on TBP and based on Action Plan and the appropriate Don/Doff techniques PPE. The Facility RN Educator/designee will ensure that all outside vendors are educated to comply with PPE standards and the appropriate Don/Doff techniques of PPE. The IP/Educator will educate all licensed nursing staff on IC practices as they relate to wound care and the facility wound care policies and procedures The IP will educate all staff (including Physician□s and Physician Extenders) about complying with Zone signage throughout the facility at all times. The Director of Nursing will educate the facility Infection Preventionist regarding current requirements related to TPB regulations and implementation. The IP reviewed the facility policy related	

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F 880	Continued From page 29 The surveyor reviewed the facility's policy and procedure titled, [redacted] Care" under procedure, "#1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. #5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. #19 Use clean field saturated with alcohol to wipe overbed table." On 3/17/22 at 1:05 PM, the surveyor informed the facility's Administrator and DON regarding the above concern. The facility did not provide any further information. 3. On 3/14/21 at 11:35 AM, during the initial tour, the surveyor observed a yellow STOP sign posted in Resident #19's door prior to entering. Further observation revealed that the resident's door had another sign posted indicating that Resident #19 was on [redacted]. There was also a sign indicating the proper PPE that staff must wear prior to entering the resident's door which included, gown, N-95 mask, goggles or face shield and gloves. The surveyor interviewed CNA #1 who stated that when she enters the resident's room, she does not have to wear any PPE except for the N-95 mask. CNA #1 further stated that she does not follow what was posted on the resident's door. The surveyor interviewed LPN #2 who stated that he does not wear any other PPE except for an N-95 mask when entering Resident #19's room. LPN #2 also stated that he does not follow the signage posted on Resident #19's door.	F 880	to infection control and zoning and no revisions were necessary. The IP will educate the Director of Environmental Services (EVS) regarding cleaning of all facility areas utilizing Infection Control Standards to clean from the least restrictive to most restrictive zones The Director of Environmental Services (EVS) will educate all housekeeping staff regarding cleaning of all facility areas utilizing Infection Control Standards to clean from the least restrictive to most restrictive zones. Facility Long Term care self assessment was completed A QA committee was convened by outside consultant to identify root cause of identified deficiencies and formulate a plan of correction Assessment of Causative factors: -lack of staff knowledge in hand hygiene, disinfect equipment prior to and after, use appropriate infection control procedure during [redacted] rounds -Lack of Staff Competency -Lack of Concentration and anxiety factor -Lack of systematic and organizational monitoring on infection Control practices -Lack of administrative supervision in staff adherence to IC practices by department heads, unit managers, unit Managers and all leaders	

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F 880	Continued From page 30 LPN #2 informed the surveyor that Resident #19 goes to [redacted] outside of the facility. A review of Resident #19's AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted]. A review of the March 2022 Physician Order Sheet revealed an order dated "[redacted]s every [redacted], [redacted] pick up at 5 AM." Further review of the medical record indicated that Resident #19 was fully [redacted] from [redacted] On 3/17/22 at 1:05 PM, the surveyor discussed the above concerns with the facility's Administrator and DON. A review of the facility's policy titled, "Outbreak Communicable Diseases" documented, "#12. (a) Ordering Isolation precautions, as needed or as per state regulations;" A review of the CDC guidelines updated 2/2/22 stated that "In most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) and do not have close contact with someone with SARS-CoV-2 infection. Quarantining residents who regularly leave the facility for medical appointments (e.g., dialysis, chemotherapy) would result in indefinite isolation of the resident that likely outweighs any potential benefits of quarantine."	F 880	-Lack of concentrated emphasize on infection control practices during orientation and onboarding due to pandemic and staffing challenges Education provided to all members of the QA committee and IDT members regarding QA process Staff will be educated on following courses: Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/10813SO/ Provide the training to: Topline staff and infection preventionist CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw Provide the training to: Frontline staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Sparkling Surfaces https://youtu.be/t7OH8ORr5Ig Provide the training to: Frontline staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Clean Hands https://youtu.be/xmYMUly7qiE Provide the training to: Frontline staff	

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F 880	Continued From page 31 On 3/23/22 at 11:45 AM, the surveyor interviewed the DON who stated that the Infection Preventionist (IP) was responsible to make rounds and ensure which resident must be placed on Transmission Based Precautions (TBP) and which resident does not require any TBP. On 3/23/22 at 12:27 PM, the surveyor interviewed the Infection Preventionist (IP) who stated that she started the role of being an IP beginning [redacted]. The IP could not explain why Resident #19 was placed on [redacted]. There was no further information provided. 4. On 3/14/22 at 10:17 AM, the surveyor observed a yellow STOP sign, a sign indicating contact precautions, and instructions on how to put on and take off PPE, posted on Resident #97's door. The surveyor interviewed LPN #3 regarding what sort of PPE needs to be worn in Resident #97's room. LPN #3 stated that the only PPE that she wears is an N-95 mask. On 3/16/2021 at 1:28 PM, two surveyors observed CNA #2 in Resident #97's room wearing a N-95 mask and no other PPE. The surveyor interviewed CNA #2 regarding her use of PPE. CNA #2 stated that while in Resident # 97's room a gown, goggles, and gloves should be worn. The surveyors observed that the two straps of CNA #2's N-95 mask were both around her neck. The surveyor asked CNA #2 how her N-95 mask should be worn. CNA #2 stated that the top strap of her N-95 mask should be worn higher on her head.	F 880	CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Closely Monitor Residents https://youtu.be/1ZbT1Njv6xA Provide the training to: Frontline staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 https://youtu.be/YYTATw9yav4 Provide the training to: Frontline staff Nursing Home Infection Preventionist Training Course Module 5 - Outbreaks https://www.train.org/cdctrain/course/l08l803/ Provide the training to: Topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module lIB - Environmental Cleaning and Disinfection https://www.train.org/main/course/l08l8l5/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 4 - Infection Surveillance https://www.train.org/cdctrain/course/108l802/ Provide the training to: Topline staff and infection preventionist only Nursing Home Infection Preventionist Training Course Module 7 - Hand Hygiene https://www.train.org/main/course/l08l806/ Provide the training to: All staff including	

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F 880	Continued From page 32 A review of the electronic medical record (EMR) for Resident #97 revealed the following: The Order Summary Report indicated that Resident #97 had a Physician Order (PO) for "Maintain Contact Precautions every shift for [redacted]" (extended [redacted]) and a history of [redacted] 5. On 3/14/22 at 10:18 AM, the surveyor observed a yellow STOP sign, a sign indicating droplet precautions, and instructions about how to put on and remove PPE on the outside of Resident #11's door. The surveyor observed the Housekeeper cleaning inside of Resident #11's room wearing a N-95 respirator mask, a hairnet, and gloves. On 3/14/22 at 10:20 AM, the surveyor interviewed the Housekeeper regarding the type of PPE that she was observed wearing in the room. The Housekeeper stated that the room is, [redacted] (known COVID-19 negative) and that the PPE that she was wearing was appropriate for the room. The surveyor asked about the order in which the Housekeeper cleaned the resident rooms on the unit. The Housekeeper stated that the entire unit is, [redacted]" and that she goes from room to room and does not have to clean particular rooms first or last. A review of the EMR for Resident #11 revealed the following:	F 880	topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/1081804/ 'Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module IIA - Reprocessing Reusable Resident Care Equipment https://www.train.org/main/course/1081814/ Provide the training to: Topline staff and infection preventionist only Training for videos was completed by staff on 5/3 Unit Mangers/Supervisors will Monitor Staff compliance and Adherence to infection control practices on a daily basis The Director of Nursing Services (DNS)/Designee, will implement) an audit to monitor staff/vendor compliance with Infection Control Practices related to TPBs □ the audit will be completed	

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F 880	Continued From page 33 The Admission Record indicated that Resident #11 was admitted to the facility with medical diagnoses that included but were not limited to [redacted]. The [redacted] Physician Orders indicated that Resident #11 had a PO for transmission based/ [redacted] active as of [redacted] 6. On 3/14/22 at 11:02 AM, the surveyor observed a yellow STOP sign, a sign indicating droplet precautions, and instructions about how to put on and remove PPE on the outside of Resident #6's door. The surveyor observed the Associate Fire Alarm Technician enter Resident #6's room wearing a surgical mask and no other PPE. The surveyor interviewed the Associate Fire Alarm Technician about the signs on Resident #6's door. The Associate Fire Alarm Technician stated that the signs meant that nurses needed to wear a "gown and gloves and stuff" while in the resident's room. The Associate Fire Alarm Technician indicated that the signs did not apply to him as he was just in the room briefly. The surveyor asked if he was ever educated about wearing PPE in certain rooms while at the facility. The Associate Fire Alarm Technician stated that he was not. A review of the EMR for Resident #6 revealed the following: The Admission Record indicated that Resident #6 was admitted to the facility with medical	F 880	weekly for 4 weeks, then monthly x3 The Director of Nursing Services (DNS)/Designee, will implement) an audit to observe 10% of all staff for hand washing compliance weekly for 4 weeks, then monthly x3. The Director of Nursing Services (DNS)/Designee, will implement) an audit to observe 10% of licensed staff compliance with equipment disinfection weekly for 4 weeks, then monthly x3 The Director of Nursing Services (DNS)/Designee will implement) an audit to observe 10% of licensed staff compliance with infection control practices during wound care treatments weekly for 4 weeks, then monthly x3 The EVS Director/designee will implement) and audit to observe 10% of all housekeeping staff to ensure that they are cleaning utilizing Infection Control Standards to clean the least restrictive to most restrictive zones, weekly for 4 weeks, then monthly x3 The Results of the audits will be presented by the DNS at the quarterly QA meeting for review and feedback. Responsible; DON DPOC	

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F 880	Continued From page 34 diagnoses that included but were not limited to [redacted]. The [redacted] Order Recap Report indicated a PO for transmission based/ [redacted] precautions active as of 10/10/2021. 7. On 3/16/22 at 10:21 AM, the surveyor observed a green STOP sign on the outside of Resident #69's door indicating that Resident #69 was not on transmission-based precautions (TBP). The surveyor reviewed the Order Summary Report for Resident #69 which revealed that Resident #69 had a PO for transmission based/ [redacted] precautions active as of [redacted] On 3/16/22 at 10:24 AM, the surveyor interviewed CNA #3 and asked if Resident #69 was on TBP. CNA #3 was asked if PPE needed to be worn in the resident's room. CNA #3 stated that the resident is in the [redacted] " zone and that no PPE aside from a N-95 mask needed to be worn in the resident's room. On 3/16/22 at 10:28 AM, the surveyor interviewed LPN #3 and asked if Resident #69 was on TBP. LPN #3 was asked what PPE was worn in the resident's room. LPN #3 stated that Resident #69 was not on TBP and stated that only a N-95 mask was needed to be worn in the Resident #69's room. On 3/16/22 at 10:38 AM, the surveyor interviewed the Director of Nursing (DON). The DON stated that Resident #69 was not on TBP and that the PO needed to be discontinued.	F 880		

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F 880	Continued From page 35 8. On 3/16/22 at 1:47 PM, the surveyor observed a green STOP sign on the outside of Resident #35's door which indicated that Resident #35 was not on TBP. A review of the Order Summary Report indicated that Resident #35 had a PO for transmission based/[redacted] precautions active as of [redacted] On 3/16/22 at 1:48 PM, the surveyor interviewed LPN #3 and asked if Resident #35 was on TBP. LPN #3 stated that Resident #35 was not on TBP and that no additional PPE needed to be worn in that room. On 3/17/22 at 1:05 PM, the surveyor presented these concerns to the DON and Licensed Nursing Home Administrator (LNHA). On 3/22/22 at 10:42 AM, the surveyor interviewed the LNHA regarding the TBP policies of the facility. The LNHA stated that during the COVID-19 pandemic residents who were leaving the facility for [redacted] were on TBP. This requirement has changed and residents receiving [redacted] no longer need to be on TBP. The LNHA stated that she is not exactly sure when this change took effect. The LNHA stated that the change in TBP status was not communicated to staff and was not implemented properly. 9. On 3/23/22 at 10:27 AM, the surveyor observed a blue STOP sign on a resident's room indicating that the resident was a new admission. The resident's room had a sign indicating that the resident was on [redacted] precautions, and instructions on how to put on and remove PPE.	F 880		

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F 880	Continued From page 36 On 3/23/22 at 10:28 AM, the surveyor observed the Medical Director, and a Medical Doctor enter the resident's room with the blue stop sign wearing surgical face masks and no other PPE. The surveyor observed CNA #4 inform the Medical Director and the Medical Doctor that they were in an isolation room and needed to wear PPE. The Medical Director responded to the CNA #4 explaining that he did not see the blue sign. The Medical Director indicated that he should have worn appropriate PPE, gown, gloves and a face shield. On 3/23/22 at 11:45 AM, the survey team interviewed the DON, LNHA, and Regional LNHA. The surveyor asked who was responsible for creating and carrying out the TBP policy for the facility. The DON stated that the Infection IP was responsible. The surveyor asked what the expectation was for what PPE would be worn in isolation rooms. The DON stated that she would expect to see full PPE worn in isolation rooms including gloves, gowns, goggles or face shield, and a N-95 mask. On 3/23/22 at 12:27 PM, the survey team interviewed the IP. The surveyor asked whose responsibility it was to make sure the correct residents were on isolation precautions. The IP stated that it was her responsibility and stated that her process was to review the residents on TBP daily. The surveyor asked why some residents had orders for TBP when they no longer needed to be on TBP. The IP could not give any further	F 880		

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F 880	Continued From page 37 information. The surveyor asked about the facility's policy for residents who leave the facility for [redacted]. The IP stated that the facility's policy recently changed and that residents who left the facility for [redacted] no longer had to be on TBP. The IP provide any further information to when the policy change took effect. 10. On 3/17/22 at 9:21, the surveyor observed LPN #2 monitor the blood pressure (BP) via a cuff and Oxygen level using a device, a pulse oximiter for Resident #57. The surveyor observed LPN #2 utilize the two devices and store them in a stand without sanitizing, cleaning the instruments or washing their hands. The surveyor then observed LPN #2 administer the scheduled medication to Resident #57 and wash his hands for 5 seconds under running water. Review of the Admission Record for Resident #57 documents that the resident was admitted with diagnosis that included but were not limited to [redacted]. 11. On 3/17/22 at 9:31 AM, the surveyor observed LPN #2 monitor the blood pressure (BP) via a cuff and Oxygen level using a device, a pulse oximiter for Resident #35. The surveyor observed LPN #2 utilize the two devices, sanitize the devices and store them in a stand. The surveyor observed LPN #2 wash his hands for 5 seconds under running water.	F 880		

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F 880	Continued From page 38 On 3/17/22 at 9:50 AM, the surveyor interviewed LPN #2 who stated that he should have sanitized/cleaned the reusable equipment before and after every resident use. LPN #2 did not offer any further information for handwashing. Review of the Admission Record for Resident #35 documents that the resident was admitted with diagnosis that included but were not limited to [redacted]. 12. On 3/17/22 at 9:59 AM, the surveyor observed LPN #1 administer the scheduled medication to Resident #100 and wash her hands for 5 seconds under running water. On 3/17/22 at 10:20 AM, the surveyor asked LPN #1 to wash her hands, while being observed. LPN #1 washed her hands for 10 seconds under running water. On 3/17/22 at 10:22 AM, the surveyor interviewed LPN #1, she did not offer any further information regarding handwashing. Review of the Admission Record for Resident #100 documents that the resident was admitted with diagnosis that included but were not limited to [redacted]. On 3/23/22 at 1:02 PM, the surveyor reviewed the "Cleaning and Disinfection of Resident-Care Items and Equipment" and "Handwashing / Hand Hygiene Policies. Review of the "Cleaning and Disinfection of	F 880		

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F 880	Continued From page 39 Resident-Care Items and Equipment" policy documents, "Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. 1. The following categories are used to distinguish the levels of sterilization / disinfection necessary for items used in resident care: d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). 4. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions." Review of the facility "Handwashing/Hand Hygiene" policy that documents, "This facility considers hand hygiene the primary means to prevent the spread of infections. Washing Hands 1. Wet hands first with water, then apply an amount of product recommended by the manufacturer to hands. 2. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel." On 3/17/22 at 1:07 PM, the surveyor discussed the device sanitizing/cleaning and hand washing issues with the DON and the Administrator. There was no further information that was supplied at the time. NJAC 8:39 - 19.4, 27.1 (a),	F 880		