STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 CENSUS: 91 SAMPLE SIZE: 19+1 for additional observation of catheter use = 20	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to follow a care plan intervention to install automatic locks on a wheelchair to reduce risk of falling. This deficient practice was observed for 1 of 3 residents, Resident #5, who were reviewed for falls. On 3/20/17 during the initial tour of the facility, the Unit Manager (UM) told the surveyor that Resident #5 had depression, anxiety, and chronic back pain. On 3/22/17 at 8:30 a.m. the surveyor reviewed the medical record for Resident #5 which revealed that the resident was admitted on 6/25/16 with diagnoses that included low back	F 282	Plan of Correction for 483.21(b)(3)(I) Services by Qualified Persons/ Per Care Plan ID Prefix Tag F282 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice? 1. Resident #5 care plan was reviewed and the appropriate intervention for an Anti-Roll back device for her wheelchair is still deemed appropriate. This was installed on the day it was noted to be missing (3/23/2017).	4/30/17

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

Electronically Signed | 04/07/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 282	Continued From page 1 pain. The surveyor reviewed the Quarterly Minimum Data Set (QMDS), an assessment tool, dated 1/2/17 which revealed that the Interdisciplinary Team (IDT) assessed the resident had functional limitations in range of motion on both sides of the upper extremities and required extensive assistance of one person for transfers. The surveyor reviewed the Progress Notes and a Fall Investigation report and noted that the Registered Nurse (RN) documented a note dated 1/172017 at 3:50 p.m. indicating that Resident #5 had a fall out of the wheelchair and sustained an abrasion to the right cheek. The surveyor reviewed the care plan and noted that on 1/18/17 the IDT documented an intervention to install an "Autolock" on the resident's wheelchair to assist in preventing falls. On 3/22/17 at 9:45 a.m. and on 3/23/17 at 10:20 a.m. the surveyor observed Resident #5 seated in the wheelchair. No autolock device was observed on the wheelchair. On 3/23/17 at 10:50 a.m. the surveyor and the UM observed Resident #5's wheelchair. The UM stated that the resident did not have auto locks on the wheelchair. The UM was unable to explain why the auto locks were installed. NJAC 8:39-27.1(a)	F 282	II. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1. All residents were assessed and identified for the need of an Anti-Roll Back device to ensure that it is on and to immediately notify nursing if it is not installed. III. What measures will be put into place or what systematic changes will be made to ensure deficient practices will not continue? 1. In-Services were given to the Inter-Disciplinary Team regarding the importance of resident appropriate intervention of anti-roll back devices to prevent the wheelchair from rolling backwards when the resident tries to stand up, resulting in a fall. IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1. The Unit Managers and Unit Nurses will do daily checks on those residents whose wheelchairs have the anti-roll back devices to ensure they are on the wheelchairs and that they are properly functioning. There will be a recorded daily log and it will be submitted to the Director of Nursing. 2. The Director of Nursing/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 282	Continued From page 2	F 282	will notify the Maintenance Department for any new resident assessed, who may need an Anti-Roll Back device, or that may need adjustment or repair.	
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to incorporate and maintain clinically nutritional interventions to continue to address gradual weight loss. This deficient practice was identified for 1 of 2 residents, Resident #10, reviewed for weight loss and was evidenced by the following: On 3/20/17 during the initial tour of the facility, the Licensed Practical Nurse (LPN) stated Resident #10 was alert and oriented to self with periods of	F 325	Plan of Correction for 483.25(g)(1)(3) Maintain Nutrition Status Unless Unavoidable ID Prefix Tag F325 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice? 1. Resident #10's weight will be	4/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 325	Continued From page 3 confusion. The surveyor reviewed the medical record on 3/23/17 at 1:05 p.m. The resident was admitted to the facility on 9/21/06 with a diagnoses that included Dementia with Behavioral Disturbances, History of Psychosis and an old Cerebral Vascular Accident. On 3/23/17 at 1:05 p.m. the surveyor reviewed the resident's Electronic Medical Record (EMR) for the Annual Minimum Data Sets (MDS), assessment tools dated 8/22/15, 8/20/16 and the Quarterly MDS dated 2/15/17. The Interdisciplinary team (IDT) assessed the resident as totally dependent on one staff member for eating. The surveyor reviewed the resident's weights from the EMR and noted that the resident had a significant weight loss of 10% between July 6, 2016 when she weighed 136 pounds and August 1, 2016 when she weighed 126 pounds. The facility weighed the resident weekly during the month of August 2016. The resident's weight remained stable between 124 and 128 with a weight of 124.8 on August 30, 2016. The resident weighed 125.6 in December 2016 and on 3/7/17 the resident weighed 122 pounds. On 3/23/17 the surveyor interviewed the Registered Dietician (RD). The RD stated all the interventions recommended for Resident #10 included: On 8/12/16 the resident's Medical Doctor (MD) and family were notified of the resident's weight loss. The RD recommended weekly weights for 4 weeks, a 3 day calorie count and a bowl of super	F 325	monitored continuously. Weekly weight checks have been started on 3/24/2017, x 4 weeks. The RD and Nursing will discuss the outcome and proper interventions will be initiated. II. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken? 1. All residents have the potential to be affected by the same deficient practice. 2. Monthly weights will continue to be done and every resident with a 5lbs or more weight loss each month will be addressed by the Inter Disciplinary Team accordingly. III. What measures will be put into place or what systemic changes will be made to ensure deficient practice will not continue? 1. Any one resident identified with a 5 lbs. or more weight loss each month will be assessed accordingly during the interdisciplinary team meetings. All recommendations and or interventions will be undertaken. The attending MD and the family will be notified of such by the RD and unit manager either by phone or personally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 325	Continued From page 4 cereal at breakfast which provided 511 calories per 8 ounce (oz) serving and 11 grams (gr) of protein. On 8/18/16 the results of the 3 day calorie count was completed and indicated the resident calorie and protein intake met 76% of the resident's calories and would not sustain the resident's nutritional status to prevent additional weight loss. The RD recommended continued serving of the super cereal at breakfast and to start a milkshake twice a day (BID) with lunch and dinner to provide an additional 173 calories and 7 gr of protein per serving to prevent additional weight loss. On 9/6/2016 the resident continued with gradual weight loss. The RD suggested to discontinue the milkshake supplement BID and start a 4 oz MedPlus supplement BID to provide 10 gr protein and 200 calories per 4 oz portion and meet the resident's needs to prevent additional weight loss. On 11/03/16 the resident was 123.8 pounds. In order to prevent additional weight loss and encourage weight gain, the RD recommended to increase the 4 oz MedPlus supplement to 4 times per day to provide a total of 800 calories and 40 gr of protein per day. The surveyor reviewed the resident's Medication Administration Records (MARs) and the Physician's Order Sheets (POS) from August 2016 through March of 2017 and noted that the RD's recommendations from 11/10/16 were never acknowledged or started. A review of the resident's care plan dated 8/9/16 and revised on 3/16/17 included all the RD's previously recommended interventions.	F 325	when both are in the facility. IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1. RD will review monthly weights and or weekly weights with the Unit Managers and discuss interventions and it will be reported to the QA committee quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 325	Continued From page 5 A review of the resident's POSs from 1/1/17 through 3/24/17 indicated when the facility changed EMR systems at the end of 12/2016 the RD's recommendations were not forwarded onto the new POS or MAR. On 3/24/17 at 10:40 a.m. the surveyor interviewed the RD about the nutritional recommendation system. The RD stated that the facility used 2 ways to communicate recommendations. The first was a verbal request and/or it was written through the EMR program. No written forms were used for communication. A note is directed to the desired discipline via the EMR. Once the recommendation is implemented the RD or other discipline would receive an acknowledgement via EMR. On 3/24/17 at 1:00 p.m. the RD provided a printout of the nutritional recommendations for Resident #10. All intervention recommendations were acknowledged by the nursing department as being implemented but were not documented on the resident's POS nor were they documented on the MAR. Resident #10 did not receive the supplements to encourage weight gain as recommended.	F 325		
F 371 SS=F	NJAC 8:39 27.1 (a) 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		4/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 6 (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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of documentation provided by the facility it was determined that the facility failed to: a.) maintain proper kitchen sanitation practices, b.) ensure proper hand hygiene and c.) maintain equipment services to prevent the development of food borne illness. This deficient practice was evidenced by the following: On 3/20/17 at 7:15 a.m. during the initial tour of the kitchen, in the presence of the Cook, the surveyor observed the following: 1. Seven covered coffee pots upright on a shelf in the entrance foyer to the kitchen filled with a 1/2 inch of standing water. When the surveyor removed a pot from the shelf, the water on the	F 371	1. Plan of Correction for 483.60(I)-(3) Food Procure, Store/Prepare/Serve - Sanitary ID Prefix Tag 371 I. What corrective Action(s) will be accomplished for those residents affected by the deficient practice? 1. All dietary staff have been re-educated on the proper procedure to wash and dry covered coffee pots. Washed and sanitized coffee pots will be air-dried upside down on a clean dish rack. Visual aids were posted on the wall where they dry as well as by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 7 top and inside the pot splashed out. A dietary aide (DA) interviewed at the time, stated the pots were cleaned. 2. The blade of the table mounted manual can opener was soiled with food debris and metal chards. 3. The wall-mounted paper towel dispenser above the hand wash sink was empty and had a note taped to it that read; "please refill, thank you." No hand washing was observed from the time the surveyor entered the kitchen at 7:15 a.m. through 8:00 a.m. when the surveyor exited the kitchen. When the dish washer/DA was interviewed he stated that it was the porter's responsibility to refill the dispenser or anyone that know's how to do it. He also stated he did not know how long it had been empty. Review of the porters daily routine/job responsibilities from 11:00 a.m. to 7:30 p.m. stated check paper towel and soap dispensers and replenish when necessary. 4. A [DA] with long braided hair, wore a netted hair restraint that failed to keep her hair covered and braids continually fell out from under the restraint. 5. The same DA as above, was observed as she removed heated metal pellets with gloved hands from the lowerator, placed a plate on each pellet and portioned out ready-to-serve breakfast French toast and scramble eggs. The DA continued to plate breakfast items and used a nail from her gloved hand to scrape off dried/caked	F 371	sink to ensure the proper way of washing and drying coffee pots. II. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken? 1. All Residents have the potential to be affected. 2. To prevent breeding grounds of bacteria, cleaned and sanitized coffee carafes and pitchers are immediately placed upside down on a clean dish rack to air dry before being stored. III. What measures will be put in place or what systemic changes will be made to ensure the deficient practice will not continue? 1. Food Service Supervisor/ Designee will monitor daily that washed coffee pots are properly drying upside down during rounds. IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1. Food Service Supervisor/Designee will review the weekly cleaning inspection checklist with the dietary staff and report to the administrator monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 8 on food debris that was stuck on the metal pellets. The DA continued to plate breakfast items and failed to change gloves or wash her hands. The DA did so after surveyor inquiry. 6. On 3/20/17 and 3/21/17 the surveyor observed lunch meal service in the day rooms for 2 of 3 nursing units (Agripina and Banita). The staff removed meal trays from open food carts and placed the trays on the table in front of each resident. Plates were uncovered and the soiled lids were placed up-side-down in front of each resident. Discarded food wrappers, disposable lids and containers and soiled napkins were placed inside each lid and were left on the tables. 7. On 3/20/17 and 3/21/17 multiple staff were observed in the day rooms feeding residents with gloved hands. 8. On 3/20/17 and 3/21/17 the surveyor observed lunch meal service in the day rooms for 2 of 3 nursing units (Agripina and Banita). Soiled meal trays were placed on open food carts with ready-to-serve resident meal trays. 9. On 3/22/17 at 12:15 p.m. the surveyor observed the side-by-side residential refrigerator/freezer in the Agripina day room. The 4 ounce (oz) portion controlled (pc) ice cream cups in the freezer were very soft and the ice cream was in various stages of defrost and the internal thermometer registered +28 degrees Fahrenheit (F). When the cup was removed from the freezer the ice cream oozed out from the top and down the sides. At 12:20 p.m., the surveyor placed a calibrated thermometer inside the unit and after 5 minutes	F 371	Reports will be presented quarterly to the QA committee. 2. Plan of Correction for 483.60(I)-(3) Food Procure, Store/Prepare/Serve - Sanitary ID Prefix Tag F371 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice? 1. A new table-mounted manual can opener has been ordered. To maintain cleanliness and to prevent rust formation, it will be wiped, sanitized, and dried thoroughly after every use. It will be cleaned after each use and the blade will be replaced as needed to prevent rust. II. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken? 1. All residents have the potential to be affected. 2. A new cleaning and maintenance schedule has been established for the manual can opener. To prevent cross-contamination and rust formation, the can opener	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 9 the thermometer register +50 degrees F. On 3/23/17 at 10:30 the surveyor repeated the above process and placed a calibrated thermometer inside the freezer. After five minutes the thermometer registered +20 degrees and the ice cream containers were soft to touch. At 11:05 a.m. the surveyor interviewed three staff members about the refrigerator/freezer temperatures; a DA, Licensed Practical Nurse (LPN) and the Food Service Supervisor (FSS). The DA stated that the unit was used to store resident snacks and the temperatures are recorded at night by the nurses. The FSS stated a DA records the temperatures when the unit is refilled in the morning. The LPN stated the temperatures were recorded by a nurse on the 11:00 p.m.-7 a.m. shift. 10. Multiple staff food items were observed in the refrigerators and microwave ovens on 3 of 3 nursing units. The items were not labeled or dated. Review of facility documentation provided, failed to identify the department or staff member responsible for the maintenance of the unit. Review of the facility's "Food Storage" Policy and Procedure (P&P) dated February 2009 stated remember to cover, label and date. Review of facility's "Sanitation Guidelines" P&P stated employees shall thoroughly wash their hands and the exposed portions of their arms with soap and warm water before starting work; during work as often as is necessary to keep	F 371	will be wiped, sanitized, and dried thoroughly after each use. The blade will be replaced as needed and quarterly if necessary to prevent rust formation. A new can opener has been purchased on April 4, 2017. III. What measures will be put into place or what systemic changes will be made to ensure deficient practice will not continue? 1. The material for the new can opener is rust resistant and the can opener will not go through the dishwashing machine after every use to prevent the blade form getting dull right away. The can opener will be cleaned, sanitized, and wiped after every use. If the blade shows sign of wear and rust, it will be replaced as needed and quarterly as necessary. Food service supervisor will monitor the can opener daily. IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1. The FSS will check the can opener daily to ensure cleanliness and record findings on the inspection checklist. Findings will be presented to the QA Committee on a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 10 them clean. Employees shall use effective hair restraints to prevent the contamination of food or food-contact surfaces. Review of facility's "Food Storage" P&P stated that all frozen products purchased be held at a temperature of 0 degrees F or at a temperature that maintains the food frozen. Refreezing or defrosted food is not recommended because of the increase in growth of food bacteria and the deterioration in food quality. There is no evidence this policy was consistenly followed during surveyor observation. NJAC 8:39 17.2 (g)	F 371	3. Plan of Correction for 483.60(I)-(3) Food Procure, Store/Prepare/Serve - Sanitary ID Prefix Tag 371 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice? 1. Implement once a week meetings with the Dietary Department to discuss, improve, and finalize daily rountine/ job responsibilities. 2. The porters are responsible in the replenishing of the paper towels in the paper towel dispenser, but the whole staff will be taught how to replenish it if the porters are unavailable. 3. The Maintenance Department will provide keys for the soap dispensers for the Dietary Department to replenish the soap dispensers. 4. The Dietary Staff were in-Serviced on how to use the service desk to request for the Maintenance Department Assistance. II. How will you identify other residents having the potential to be affected by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 11	F 371	same deficient practice and what corrective actions will be taken? 1. All Residents have the potential to be affected. 2. Weekly meetings have been established to encourage open dialogue and to make sure everyone is on the same page when it comes to responsibilities and ways to improve teamwork. The meetings are held on Thursdays. The first meeting was on March 30, 2017. The Dietary Department will be trained by the Maintenance and Housekeeping Department as how to change the soap dispensers and paper towels. Supply of paper towels and hand soap will be regularly provided for the kitchen. III. What measures will be put in place or what systematic changes will be made to ensure deficient practice will not continue? 1. Dietary Staff will be trained how to replenish the paper towel dispenser and soap dispenser. 2. Defined responsibilities will be established and each dietary aide will be evaluated on the job performance by the FSS quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 12	F 371	IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1. The FSS will monitor, observe and ensure that the dietary aides keep their work place clean and safe by checking and correcting when needed that they perform their job satisfactorily during daily rounds , weekly inspections and monthly inspections with the administrator. 4. Plan of Correction for 483.60(I)-(3) Food Procure, Store/Prepare/Serve - Sanitary ID Prefix Tag F371 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice? 1. The Dietary Staff were in-serviced on proper hair restraint. Hair should be secured at all times while working in the kitchen/ food areas. II. How will you identify other residents having potential to be affected by the same deficient practice and what	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 13	F 371	corrective action will be taken? 1. All residents have the potential to be affected. 2. To prevent foodborne illnesses, female dietary staff have been educated to keep their hair in a tight bun when on duty and all dietary staff have been instructed to wear a hairnet to keep hair in place. FSS will check on all dietary staff on a daily basis on proper hair restraint. III. What measures will be put into place or what systemic changes will be made to ensure that deficient practice will not continue? 1. In-Services, meetings, and random check-ups will be conducted by FSS to ensure that corrective measures are in order. IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1. The FSS will make sure that the proper hair restraint is worn at all times during daily rounds in the morning and evening shifts and will report results Quarterly in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 14	F 371	Continuous Quality Improvement meetings. 5. Plan of Correction for 483.60(I)-(3) Food Procure, Store/Prepare/Serve - Sanitary ID Prefix Tag 371 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice? 1. The entire Dietary Staff went through and in-service on the importance of hand washing and the proper hand washing technique. Nails must be cut short and they must wash their hands thoroughly under warm soapy water for at least 20 seconds. Dietary Staff was informed to wash hands and put on a new pair of gloves before each different task they will take up. Each staff member was watched and graded on how they washed their hands. 2. The dietary aide concerned was given a disciplinary action for proper hygiene and will go through retraining. II. How will you identify other residents having potential to be affected by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 15	F 371		

same deficient practice and what corrective action will be taken?

1. All residents have the potential to be affected.

2. The FSS must be present and observe each dietary staff before, during, and after food prep/ handling on a daily basis.

III. What measures will be put into place or what systemic changes will be made to ensure deficient practice will not continue?

1. Monthly in-services on the importance of hand-washing and the proper technique of hand washing (return demonstration) will be given.

2. Dietary employees will be observed on return demonstration of proper hand washing technique by the FSS on a monthly basis.

IV. How will corrective actions be monitored to ensure the deficient practice will not recur?

1. The FSS will ensure that all necessary items needed during hand washing by the staff are available and in place such as soap in the soap dispenser

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 16	F 371	and paper towels. FSS will ensure paper and soap dispenser are functioning properly. 6. Plan of Correction for 483.60(I)-(3) Food Procure, Store/Prepare/Serve - Sanitary ID Prefix Tag 371 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice? 1. Working with the nursing department, the certified nursing assistants were given an in-service. Once they serve each resident a meal tray and remove the lid, the lid is considered dirty and it will be placed right away on the designated utility cart for dirty trays, plates and utensils. Food wrappers and soiled napkins will be thrown out right away and not left on the table. II. How will you identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken? 1. Communicating with the Director of Nursing and making sure that the nursing staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 17	F 371	understand the importance of keeping the tables clean at all times during meal service. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not continue? 1. In-services, meetings, and random check-ups will be conducted by the FSS to ensure that corrective measures are in order. IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1. In-services, meetings and random check-ups will be conducted by the FSS to ensure that corrective measures are in order. 7. Plan of Correction for 483.60(I)-(3) Food Procure, Store/Prepare/Serve - Sanitary ID Prefix Tag F371 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 18	F 371	1. Staff that were assigned to feed the residents who need assistance during meal times were given an in-service to not wear gloves during meal times to maintain the respect and dignity each resident deserves. II. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken? 1. All residents have the potential to be affected by the same deficient practice. 2. Staff will assist residents that need help eating with clean hands and no gloves. III. What measures will be put into place or what systemic changes will be made to ensure deficient practice will not continue? 1. In-service and monitoring will be conducted during meal times to ensure that gloves are not worn by the staff. IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1. Any staff noted to be wearing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 19	F 371	gloves at meal time should be reprimanded. 8.Plan of Correction for 483.60(I)-(3) Food Procure,Store/Prepare/Serve - Sanitary ID Prefix Tag 371 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice? 1. Staff that serve and retrieve meal trays were given and in-service to keep ready to serve meal trays and dirty meal trays separate to prevent cross contamination. 2. 4 Black utility carts that are clearly labeled have been purchased and will be used solely for soiled trays, plated, and utensils. The staff have been in-serviced to clear out finished plates before placing it on the black utility cart. II. How will you id3entify other residents having potential to be affected by the same deficient practice and what corrective action will be taken? 1. All residents have the potential	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 20	F 371	to be affected by the deficient practice. 2. Unit nurses will make rounds during meal times to ensure used trays, plates, utensils will be taken off of the tables and placed in the designated utility carts. III. What measures will be put into place or what systemic changes will be made to ensure deficient practice will not continue? 1. In-services, meetings, and random check-ups will be conducted by FSS to ensure that corrective measures are in order. IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1. In-services, meetings, and random check-ups will be conducted by FSS to ensure that corrective measures are in order. 9. Plan of Correction for 483.60(I)-(3) Food Procure,Store /Prepare/ Serve - Sanitary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 21	F 371	ID Prefix Tag 371 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice? 1. Dietary Staff in charge of recording the temperatures for the refrigerator/freezer units in Agripina and Benita day rooms respectively have been given an in-service in recording the correct temperatures and to contact the maintenance department and/or FSS immediately if the freezer thermometer reads above 0 degrees Farenheit and if the refrigerator thermometer reads +40 degrees. II. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken? 1.A new refrigerator/freezer unit has been purchased for the Agripina Day Room. Roles and responsibilities have been clarified among dietary and nursing departments. Temperatures are taken at night by the 11pm-7am nurse on duty and recorded on the daily log sheet found at the side of the refrigerator. III. What measures will be put into place	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 22	F 371		

or what systemic changes will be made to ensure deficient practice will not continue?

1. Temperature readings will be checked daily using a correctly calibrated thermometer and recorded in the daily log sheet. FSS will review this record weekly and address discrepancy immediately.

IV. How will corrective actions be monitored to ensure the deficient practice3 will not recur?

1. New thermometers were placed in the refrigerator/freezer unit and will be tested weekly to check for accuracy. Any discrepancies must be reported to the FSS who then would report it to the maintenance department.

10.Plan of Correction for 483.60(I)-(3) Food Procure, Store / Prepare/ Serve - Sanitary
ID Prefix Tag 371

I. What corrective action(s) will be accomplished for those residents affected by the deficient practice?

1. A letter has been sent out to all respective family members/POA's of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 23	F 371	residents stating that any personal food that is brought into the facility and stored in the refrigerators must be labeled with a name and date. 2. If the refrigerated food item has not been used within 3 days of the labeled date, it will be thrown out. 3. In-service has also been provided to all nursing home staff regarding food placed in the refrigerators. II. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken? 1. All residents have the potential to be affected by the deficient practice. 2. The FSS has to check the unit refrigerators to ensure food stored are labeled with names and dated. III. What measures will be put into place or what systemic changes will be made to ensure deficient practice will not continue? 1. The FSS will check the refrigerator in all units daily.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 371	Continued From page 24	F 371	2. Monthly in-service will be done for all employees from different departments by the FSS/designee to ensure protocols are being followed. IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1.The FSS/designee will check the refrigerators and take out all items that are not labeled and check with staff before throwing items out.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		4/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 441	Continued From page 25 (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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 441	Continued From page 26 spread of infection. (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.) follow appropriate infection control practices during lunch meal and housekeeping services and b.) maintain aseptic technique and proper storage of urinary catheter drainage bags for 3 of 4 residents, Residents #3, #8, and #20, reviewed for use of indwelling catheters and was evidenced by the following: 1. On 3/21/17 at 12:35 p.m. the surveyor observed the lunch meal preparation and service in the small kitchenette and dining room for the sub-acute/Catalina unit. As a dietary aide plated the ready-to-serve hot meal entree the surveyor observed a male staff member with full head of hair, full beard and a surgical mask pulled down below his noise enter the kitchenette. The surveyor observed the male staff member sneezing, coughing, sniffling and blowing his noise as he placed a container of food in the microwave oven. This transpired while the food was being plated and served by the dietary aid. The microwave was approximately three feet from the plated food. The male staff member told the surveyor he was not aware of the need to cover his hair. At 12:40 p.m. the surveyor approached the individual above. He identified himself as the Occupational Therapy Assistant Student and stated he wanted to heat his lunch. The student	F 441	1.Plan of Correction for 483.80(a)(1)(2)(4)(e)(f) Infection Control, Prevent Spread, Linens ID Prefix Tag 441 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice? 1. The employee concerned, who entered the kitchenette without observing appropriate infection control practices was reprimanded and in-serviced regarding these practices. II. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken? 1. All residents have the potential to be affected by the same deficient practice. 2. Signs were posted in strategic areas in the kitchenette to warn non-dietary staff and/or visitors not to enter while food is being served. 3. Included in the letter to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 441	Continued From page 27 was unaware that meal service was started and only dietary staff were allowed to be in the kitchenette. The surveyor reviewed the facility's "Sanitation Guidelines for Employee Health Practices" Policy and Procedure (P&P) and the "Infection Control P&P" which instructed that employees shall use effective hair restraints to prevent contamination of food or food-contact surfaces. Hands are to be washed thoroughly with soap and warm water...after using a tissue for coughing or sneezing, after handling objects which are not clean. Compliance with the facility's P&P's was not observed by the surveyor. On 3/20/17 at 7:15 a.m. during the initial tour of the kitchen, in the presence of the Cook, the surveyor observed that the wall-mounted paper towel dispenser above the hand wash sink was empty and had a note taped to it that read; "please refill, thank you." No hand washing was observed from the time the surveyor entered the kitchen at 7:15 a.m. through 8:00 a.m. when the surveyor exited the kitchen. When the dish washer/DA was interviewed he stated that it was the porter's responsibility to refill the dispenser or anyone that know's how to do it. He also stated he did not know how long it had been empty. Review of the porters daily routine/job responsibilities from 11:00 a.m. to 7:30 p.m. stated check paper towel and soap dispensers and replenish when necessary.	F 441	families regarding labeling and dating their food items in the common refrigerators, a reminder not to enter the kitchen/kitchenette while food is being served was also added. III. What measures will be put into place or what systemic changes will be made to ensure deficient practice will not continue? 1. All employees were in-serviced on the importance of infection control and prevention of the spread of any communicable diseases from direct contact with residents or their food to prevent disease transmission. IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1. No other unauthorized person or employee will be allowed to enter any other locations where food is being prepared or ready to be served to the residents without wearing proper protective gear. 2. FSS and/or Designee will make rounds during meal service times to ensure proper	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 441	Continued From page 28 2. During the initial tour on 3/20/17 at 9:15 a.m. on the Agripina Unit, the surveyor observed a staff member wearing gloves and pushing a linen cart down the hall. The surveyor asked the staff member what her position was and her reponse was an "RHK" but was unsure of what RHK stood for. She told the surveyor that her responsibilities included making beds, filling water pitchers and delivering laundry to residents' rooms. The RHK then went into a resident's room, removed a soiled pad from the bed, went back out to the hallway, retrieved clean linen off the linen cart and went back in and made the resident's bed. She never removed or changed her gloves or washed her hands. The staff member proceeded to another resident's room where she made the residents bed and provided hands on assistance while helping the resident back to bed. The staff member never washed her hands between rooms nor did she change her gloves. On 3/24/17 at 12:30 p.m. the surveyor asked the owner of the facility what the job responsibilities for RHK were and if training included infection control. The owner told the surveyor that RHK (Residential HouseKeeping) staff filled water pitchers, made beds and provided laundry services. He told the surveyor that RHK staff did not provide direct care to the residents. The surveyor then requested the job description for RHK staff. Review of this document indicated that staff provided non-direct resident assistance and environmental maintenance. The surveyor also requested a copy of the training the staff member received. The staff member signed that she received Infection Control training on 1/16/17. The training included that the staff member wash hands before and after performing any service for	F 441	procedures are being followed. 3. Findings will be reported during the daily clinical meetings and presented to the QA Committee. 2.Plan of Correction for 483.80(a)(1)(2)(4)(e)(f) Infection Control, Prevent Spread, Linens ID Prefix Tag 441 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice? 1. All the resident rooms in the Agripina unit were cleaned and sanitized. This includes sanitizing all the furniture, fixtures, bed rails, over bed tables, call bell cords and resident restrooms with a disinfectant solution by 3/27/2017 2. All beddings were replaced with a clean fresh set of linens and pillow cases in the Agripina unit by 3/27/2017. II. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 441	Continued From page 29 the resident. 3. Resident #3 was admitted to the facility on 7/15/16 and readmitted to the facility on 1/25/17. Resident #3 had multiple medical diagnoses that included a history of Urinary Tract Infection, Benign Prostatic Hyperplasia, Neuromuscular Bladder Disorder, Dementia, Sepsis, and Acute Cystitis, among others. On 3/20/17 at 8:10 a.m. the Registered Nurse told the surveyor that Resident #3 had recurrent urinary tract infections and had a Suprapubic (S/P) Catheter for urinary drainage. The surveyor observed the resident in bed with a urinary drainage bag inside a privacy bag at bedside. The Unit Manager/RN (UM/RN) told the surveyor at 12:30 p.m. that the resident had a history of chronic urinary tract infections and the physician wrote an order to irrigate the S/P catheter with Gentamicin Sulfate Solution to prevent further infection. On 3/22/17 at 8:15 a.m. the surveyor observed the Resident #3 in the resident's room washing at the sink. The resident conversed with the surveyor about various topics. The resident was alert but at times forgetful. The resident said he was in the hospital for an infection but was not sure when. On 3/22/17 at 11:55 a.m. the surveyor reviewed an Admission Minimum Data Set (MDS), an assessment tool dated 7/23/16 and a Quarterly MDS dated 12/4/16. The Interdisciplinary Team (IDT) assessed the resident in both MDS assessments as the resident having an indwelling bladder catheter for urinary drainage. The IDT also documented in the Quarterly MDS that the	F 441	1. All residents in the Agripina unit have the potential of being affected by the same deficient practice. 2. The identified RHK was given coaching by the ESD Supervisor regarding Hand washing and Linen Handling policies. III. What measures will be put into place or what systemic changes will be made to ensure deficient practice will not continue? 1. All housekeepers, residential housekeepers, and laundry staff were given an in-service regarding Hand Washing and Linen Handling policies. 2. The ESD Supervisor will conduct quarterly in-services to all his staff regarding Hand Washing and Linen Handling policies. 3. The ESD Supervisor will conduct and in-service regarding Hand Washing and Linen Handling policies to all new employees in his department. IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1. The ESD Supervisor will provide a copy of all completed in-service records to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 441	Continued From page 30 resident had a urinary tract infection within the last 30 days. The surveyor reviewed the Physician's Order Sheet and noted that on 2/2/17 the Physician ordered Gentamicin Sulfate Solution 40 mg/ml, use 2 ml via irrigation one time a day related to bladder disorder, irrigate S/P catheter with 80 mg. of Gentamicin with 100 ml of normal saline solution daily, then clamp for 1 hour. On 3/23/17 at 1:30 p.m. the surveyor observed Resident #3's urinary catheter drainage bag contained inside a plastic bag hanging in the resident's bathroom. The catheter drainage tube tip was uncapped. The plastic bag was observed to have urine in the bottom of it and the uncapped drainage tube tip was in contact with the urine. 4. On 3/20/17 during the initial tour of the facility, the Certified Nursing Assistant (CNA) told the surveyor that Resident #8 was alert with confusion. On 3/22/17 at 9:45 a.m. the surveyor observed Resident #8's urinary catheter drainage bag hanging from the shower knob in the resident's bathroom. The drainage bag was not contained in a bag and the drainage tube tip was uncapped. On 3/22/17 at 11:55 a.m. the surveyor reviewed the medical record for Resident #8 which revealed that the resident was admitted on 6/2/16 with diagnoses that included benign prostatic hyperplasia and retention of urine and readmitted on 3/11/17 with diagnoses that included urinary tract infection. A Quarterly MDS, an assessment tool, dated 3/3/17 revealed that the IDT assessed Resident #8 to need extensive assistance of one person for toileting and utilized an indwelling	F 441	Administrator. 2. The ESD Supervisor will provide a copy of the quarterly in-service record to the Administrator. 3. Plan of Correction for 483.80(a)(1)(2)(4)(e)(f) Infection Control, Prevent Spread, Linens ID Prefix Tag F441 I. What corrective action(s) will be accomplished for those residents affected by the deficient practice? 1. Resident #3, #8, #2 - All their urinary bags were replaced on the morning of 3/24/17. All tubing tips were capped aseptically and contained in a clean plastic bag and hanged in the resident's bathroom. II. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken? 1. All residents with Foley Catheters are identified as of having the potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 441	Continued From page 31 catheter for bladder elimination. On 3/23/17 at 11:10 a.m. the surveyor observed Resident #8's urinary drainage bag hanging from the shower knob in the resident's bathroom. The drainage bag was contained inside a plastic bag and the drainage tube tip was uncapped. On 3/20/17 the Unit Manager (UM) told the surveyor that Resident #20 was alert and oriented, had diagnoses of urinary retention, utilized an indwelling "Foley" catheter, and had a history of urinary tract infections. On 3/23/17 at 1:30 p.m. the surveyor observed Resident #20's urinary catheter drainage bag hanging in the resident's bathroom and the drainage tube tip was uncapped. On 3/24/17 at 10:11 a.m. the surveyor reviewed the medical record for Resident #20 which revealed that the resident was admitted on 2/4/16 with diagnoses that included Alzheimer's disease. An Annual Minimum Data Set MDS dated 2/9/17 revealed that the Interdisciplinary (IDT assessed Resident #20 to need extensive assistance of one person for toileting and utilized an indwelling catheter for bladder elimination. On 3/24/17 at 10:00 a.m. the surveyor received from the Director of Nursing (DON) the facility's Infection Control policy for "Urinary Drainage Bag Care." The policy contained the following directions: "Observe aseptic techniques;" "NEVER leave drainage tube tip uncapped when it is not inserted into the catheter;" "When not in use, drainage bag is to be emptied, capped, and hung in resident's bathroom;" "Bag MUST be	F 441	2. All nursing staff was in-serviced regarding proper aseptic technique and proper storage of urinary catheter bags. III. What measures will be put into place or what systemic changes will be made to ensure deficient practice will not continue? 1. All Unit Nurses and Unit Managers will do daily rounds/ inspections on all residents who have Foley catheters to ensure the urinary drainage bags are properly stored to prevent contamination. IV. How will corrective actions be monitored to ensure the deficient practice will not recur? 1. The Director of Nursing as the Infection Control Officer will review all documentation/findings of the daily rounding and report to the QA committee on a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART OF BOONTON TOWNSHIP	199 POWERVILLE ROAD BOONTON, NJ 07005

(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 441	Continued From page 32 covered at all times;" and "Disconnect catheter bag tubing from insertion site of catheter and DO NOT let hands or soiled items come in contact with tip." N.J.A.C. 8:39-19.4(a)5, (c), (d)	F 441		