STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315367	A. BUILDING _____ B. WING _____	01/25/2022

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REGENCY HERITAGE NURSING AND REHABILITATION CENTER	380 DEMOTT LANE SOMERSET, NJ 08873

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F 000	INITIAL COMMENTS Standard Survey: 1/25/22 Census: 168 Sample: 33+3 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. In addition, a COVID-19 Focused Infection Control Survey was conducted.	F 000		
F 695 SS=D	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 observations, interviews, record review and review of other facility documentation, it was determined that the facility failed to implement infection control measures for the handling and storage of [redacted] equipment for 2 of 4 residents reviewed for [redacted] care, (Resident [redacted] and Resident [redacted]). This deficient practice was evidenced by the following:	F 695	Plan of correction F695 Respiratory/Tracheostomy Care and Suctioning 1. a. RN # 1 and RN # 2 were immediately counseled and re-in serviced on proper procedure for	3/25/22

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

Electronically Signed | 02/10/2022

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 695	Continued From page 1 1. On 01/04/2022 at 10:32 AM, surveyor #1 observed Resident [redacted] lying in bed with the head of the bed elevated. Resident [redacted] had a [redacted] in the area with a [redacted]) with a [redacted] (used to [redacted] , [redacted]) connected to [redacted] . On the bedside table was a [redacted] with a [redacted]), a [redacted] and a [redacted] The [redacted] was connected to a [redacted] bottle which was empty and had no water inside. There was also a [redacted] connected to an [redacted] and the [redacted] . There were no observed dates on the [redacted] , the [redacted] , the [redacted] , or the [redacted] to indicate when the [redacted] were last changed. There was also a used [redacted] connected to the [redacted] and hanging over the [redacted] . The [redacted] was observed to have dried tan substance on the top of the machine. On 01/05/2022 at 11:32 AM, surveyor #1 observed the assigned Registered Nurse (RN #1) perform [redacted] for Resident [redacted] Upon completion, RN #1 coiled the used [redacted] and [redacted] up and placed it in the top drawer of a 3-drawer bed side chest. The [redacted] was lying on top of a white paper exposed and uncovered. RN #1 then left the room after removing gloves and performing hand hygiene. The surveyor observed minimal water in	F 695	use/storage/dating of [redacted] and [redacted] supplies All nurses were re-in serviced on proper procedure for use / storage/dating of [redacted] equipment, [redacted] and [redacted] b. Resident # [redacted] water was replaced and dated accordingly. Resident # 34 [redacted] , [redacted] and [redacted] were replaced and dated accordingly. Resident # [redacted] [redacted] was immediately discarded. Concentrator was cleaned and disinfected. c. Resident # [redacted] was immediately discarded and replaced with a new one, dated accordingly and stored in a zip lock bag. 2. a. All residents with a T[redacted] or [redacted] have the potential to be affected. 3. a. A facility wide review was conducted by the Assistant Director of Nursing on all residents with a [redacted] to assure proper procedure for use/ storage/ dating was maintained. b. A facility wide Inservice was conducted by the Assistant Director of Nursing on 2/17 on proper procedure for use /storage/dating of [redacted]	

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F 695	Continued From page 2 the [redacted] bottle and a small tag on [redacted] dated [redacted] that was not observed by the surveyor on 1[redacted] with no other dates on the [redacted] or [redacted]. On 1/05/2022 at 11:40 AM, RN #1 said that since she has been there, she has seen that they (other staff) place the used [redacted] attached to [redacted] in the drawer. She went on to say, "No I don't think it is the facility policy and I don't know what the policy is." She said the [redacted] were changed days during week but was unable to be more specific. According to the Face Sheet, Resident [redacted] was admitted to the facility with diagnosis including but not limited to; [redacted] encounter for attention to [redacted]. A review of the most recent Minimum Data Set (MDS), an assessment tool dated [redacted], revealed Resident #[redacted] had [redacted]. The MDS also reflected that Resident [redacted] used a [redacted] and [redacted] A review of the current Physician Orders did not include an order to change [redacted], or [redacted]. During an interview with surveyor #1 on 1/10/2022 at 9:22 AM, the Assistant Director of Nursing (ADON) and Director of Nursing (DON) stated that the [redacted] and [redacted] should be changed once a week and as needed as part of the order set for [redacted] care. The ADON further said this would be documented on the Treatment	F 695	equipment, [redacted], and [redacted] supplies to all nurses. c. The Assistant Director of Nursing will review with all nurses monthly for 6 months, annually and as needed for compliance. d. The Assistant Director of Nursing will update the policies and procedures and Inservice nursing staff as needed 4. a. The Assistant Director of Nursing will review by Observation, use/storage/dating of [redacted] equipment, [redacted] supplies of 5 nurses weekly for one month and monthly thereafter for an additional 5 months for compliance and submit report to Director of Nursing for 6 months. b. The Assistant Director of Nursing will check all rooms for proper storage and dating of [redacted] equipment, [redacted], and [redacted] supplies, weekly for one monthly then monthly for an additional 5 months and submit report monthly to Director of Nursing. c. A quarterly QAPI report will be submitted to QA committee for discussion and compliance and measure success to quarterly QA. .	

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F 695	Continued From page 3	F 695		

Administration Record (TAR). The ADON went on to say that the [redacted] order was as needed, and [redacted] was a sterile procedure, and "we" should be using kits. She also said they should throw out the [redacted] after each use as it was no longer sterile.

On 1/10/2022 at 9:28 AM, surveyor #1 reviewed the findings with the DON and ADON. The ADON stated that the [redacted] should not be hanging over the [redacted] The DON also stated the [redacted] should not be coiled up in a drawer after use.

During an interview with surveyor #1 on 01/10/2022 at 12:54 PM, the ADON said she reviewed the Electronic Medical Record for Resident [redacted] and the order to change the tubing's weekly was not checked and would not show up on the TAR. She went on to say there is no documentation to indicate that the blue [redacted] or [redacted] was changed.

A review of a facility policy titled "[redacted]" updated 2021, revealed "disconnect [redacted] from [redacted]. Wrap [redacted] around the gloved hand. Pull the glove off and over the [redacted]. Discard in designated waste." The policy did not include documentation of when the [redacted] was to be changed.

A review of a facility policy titled "[redacted]" updated 9/2021, did not include documentation of when the [redacted] was to be changed.

2. During the initial tour on 01/04/2022 at 10:56 AM, surveyor #2 observed a [redacted]

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(and , used to administer in the t, directly into the) that was connected to a (used to that are) lying directly on the overbed table. The was not in use.

On 01/06/2022 at 10:46 AM, surveyor #3 observed a attached to a lying on the nightstand. The nightstand was out of reach from the resident. The was not in a bag and was lying directly on top of a box of gloves. The resident told surveyor #3 that he/she was waiting for the nurse to administer the treatment.

According to the Face Sheet, Resident was admitted with diagnoses that included but were not limited to;

A review of Resident s MDS, dated , revealed the resident had a Brief Interview for Mental Status of which indicated that the resident was .

A review of Resident s Care Plan, dated revealed that the resident received respiratory therapy and was to be monitored while taking an effective treatment.

A review of a medication order dated , revealed that Resident was receiving

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F 695	Continued From page 5 (a medication used to treat [redacted]) [redacted] (milliliters), [redacted] vials via [redacted] from [redacted] Every Day at times: 12 am, 6 am, 12 pm, 6 pm for [redacted]. A review of the Medication Administration Records for [redacted] revealed that Resident [redacted] had received the [redacted] Solution as ordered and at the times it was scheduled. During an interview with surveyor #3 on 01/10/2022 at 10:08 AM, RN #2 stated that [redacted] would be stored in a "Ziploc bag" while not in use to prevent any type of infection and to isolate bacteria. Surveyor #3 reviewed the findings with RN #2, and she stated that was "not acceptable and that the mask should be thrown out." During an interview with surveyor #3 on 01/10/2022 at 10:43 AM, the DON stated that when [redacted] were not being used, they should be stored in a bag and dated for infection control purposes. Surveyor #3 reviewed the findings with the DON, and she stated, "it should not be stored that way." A review of a facility policy titled "[redacted] Procedure" with an effective date of 2021, revealed: Cleaning [redacted], after treatment: 2. Disassemble the [redacted]; 5. Line table surface with paper towel; 6. air dry and place on a Ziploc bag. NJAC 8:39-27.1(a)	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		3/25/22

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F 812	Continued From page 6 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 1/4/2022 from 9:53 to10:42 AM, the surveyors, accompanied by the Assistant Administrator (AA) observed the following in the kitchen: 1. In the dry storage room on a middle shelf a stack of Styrofoam bowls was removed from their original packaging. The bowls were uncovered,	F 812	F-812 completion date 3/25/22 1. -In the dry storage room; the Styrofoam bowls and the can of cut hearts of palm were removed. -in the walk-in refrigerator; the salad and hot dogs were removed. -In the produce box; the horseradish, sliced tomato, cole slaw and macaroni salad were removed. -In the Dairy refrigerator; the pears, oatmeal and soft sliced cheese were removed. -in the pantry refrigerator; the Italian	

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F 812	Continued From page 7 and the eating surface was exposed. On interview the AA stated, "I'll take those. That shouldn't be like that." 2. On a middle shelf in the dry storage room a can of Cuts Hearts of Palm had a significant dent on the upper seam. The AA removed the can to the designated dented can area. 3. On a middle shelf in the Meat Walk-In Refrigerator a half pan covered with plastic wrap contained leftover salad, per the AA. The salad had a use by date of 1/3. The AA removed the 1/2 pan of salad to the trash. 4. On a top shelf in the Meat Walk-In refrigerator two separate and opened packages of hot dogs wrapped in plastic wrap had no dates. The AA removed the hot dogs to the trash. 5. On a rear top shelf in the Produce Walk-In refrigerator a plastic container of horseradish with beets had a use by date of "1/2/22." On the same shelf a full pan contained sliced tomatoes. The pan was covered with plastic wrap and had a "use by date" of 12/31. The plastic wrap did not fully cover the tomatoes leaving them exposed. On the same shelf a container of macaroni salad and a container of Cole slaw had their lids partially opened, exposing the macaroni salad and Cole slaw to the air. The opened container of macaroni salad had no dates, and a white, unidentified liquid substance covered the lid. The AA removed both the macaroni salad and Cole slaw to the trash. 6. A half pan of diced pears covered with plastic wrap on a middle shelf of the Dairy Refrigerator had a use by date of "12/27." On the same shelf,	F 812	dressing, bags of food and Styrofoam takeout containers were removed. -In the Dish room; the rack of clean dishes were rewashed. All other areas were inspected and were found to be in compliance. 2.All residents may be affected by this deficient practice. 3.All dietary staff were re-inserviced on; labeling and dating of all foods stored in the refrigerators, proper sealed covers for all containers and pans, dented can removal from storage shelf and covering of all clean dishes, once sanitized. The dietary aides on the morning and evening shifts will inspect refrigerators daily and remove any items expected to expire and ensure all stored foods are properly covered. The dietary aides will also inspect the storage shelves for any dented cans. 4.The food service Director will inspect all refrigerators, canned food storage shelves, storage of cleaned sanitized dishes, daily for 1 week and then weekly for 6 months. A report will be submitted to the quality assurance committee quarterly with a summary of results.	

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a half pan covered with plastic wrap contained what appeared to be oatmeal. The pan had no dates. On an upper shelf an opened package of soft, sliced cheese was wrapped in plastic wrap. The cheese had a use by date of "dec 23/21." The AA removed all food products to the trash.

On 1/10/2022 from 9:44 to 10:01 AM, the surveyor, accompanied by the Unit Secretary (US) and an Executive Administration (EA) member observed the following on the G1 unit pantry refrigerator designated for outside food:

1. On the inside shelf of the refrigerator door, an opened bottle of Light Zesty Italian Dressing & Marinade had a "Best if used by date" of "SEP 25, 2020." On a lower shelf of the door, a brown paper bag was labeled with a resident name and room number. The bag contained what appeared to be an Asian style take out container with unidentified food. The bag had no dates.

2. On an upper shelf in the refrigerator, the surveyor observed (2) brown paper bags labeled with a resident name and room number. One bag stated, "Please use for Monday 1/3" and the second brown paper bag was labeled with a resident name and room number and stated, "Please use for Sunday 1/9." In addition, on the same shelf a plastic bag contained unidentified food. The bag was labeled with a resident name and room number. The bag had no dates.

3. On a middle shelf of the refrigerator a plastic take out style container with a clear plastic lid appeared to contain leftover beef. The container had no name, room number, or dates.

4. On a bottom shelf of the refrigerator, a white

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F 812	Continued From page 9	F 812		

Styrofoam take out style container contained unidentified food. The container had no name, date, or room number. On the same shelf a plastic clear sealable bag contained what appeared to be 3 pieces of loaf style bread. The plastic clear sealable bag had no name, or dates. The following sign was observed to be posted on the outside of the freezer door: "Attention Residents and Families Please remember to label any items placed in this refrigerator with resident's name and date. Unlabeled items will be discarded. All food will be discarded after 72 hours." On interview with the US concerning the above observations the US stated, "Ok, they are not labeled properly." The surveyor then questioned who was responsible for monitoring the refrigerator designated for outside food. The US deferred to the EA and the EA stated, "I believe that nursing management monitors the refrigerator for expired food but I'm not certain."

On 1/10/2022 at10:32 AM in the L2 Pantry, the surveyor interviewed a Dietary Aide (DA) who was observed to be cleaning the refrigerator upon entry to the pantry. The DA stated, "I am responsible for maintaining the nourishment refrigerator for the dietary supplies from the facility and the refrigerator and freezer that is used to store resident food from outside. I don't like to do the resident refrigerator because they put stuff in there and don't label it."

On 1/11/2022 from 10:01 to 10:20 AM, the surveyor, accompanied by the AA observed the following in the kitchen:

1. In the dish room, a (4) wheeled mobile cart contained cleaned and sanitized plates used for resident meals. The cart was under a wet metal

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shelf adjacent to the clean end of the high temperature dish machine. The plates were stacked with the food contact surface facing upward and not in the inverted position. The food contact surface was exposed. The high temperature dish machine was in operation at the time by the AA, as staff had gone on break. The AA was loading the dish machine with plastic racks used to hold dirty dishware so that the surveyor could observe the wash and rinse temperatures. The dish machine was observed to emit steam in the direction of the cart of cleaned and sanitized plates. The AA stated, "They need to be covered. They shouldn't be left in that location." The AA instructed staff to rewash all plates on the cart.

A review of a facility policy titled Dietary Services/Outside Food with effective date: 06/2009, revealed under the heading Policy Interpretation and Implementation:

6. "Non-perishable foods permitted to be retained in the resident's room must be stored in plastic containers with tight-fitting lids, except fruit. Perishable, prepared foods stored in refrigerators @ 40 F or below must be discarded after 72 hours."

A review of a facility policy titled "Dented Cans" with effective date: 09/20/2021, revealed under the heading Purpose: "To assure all cans are dent free, in good condition, maintaining contents wholesome integrity." The following was revealed under the heading PROCEDURE:

1. "Upon discovery, all dented cans shall be removed to a designated space to prevent use and return to vendor."

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F 812	Continued From page 11	F 812		

2. "All dietary staff, have/will receive proper training to recognize and remove dented cans to "The Dented Can Rack.""

A review of a facility policy titled Food Labeling/Dating, with effective date: 04/01/2016, revealed under the heading POLICY:

"All food items must be labeled and dated."

In addition, the following was revealed under the heading PROCEDURE:

"All food items shall be labeled and dated with a USE BY date once opened, not to exceed the manufacturer's expiration, best by or use by date according to the following parameters:

All cooked food: 72 hours following preparation.
Hard and Sliced Cheese: 14 days
Cottage Cheese/Sour Cream: 7 days
Purchased, prepared salads; Potato, Macaroni, Cole Slaw: 7 days

In addition, the policy revealed under the heading RESPONSIBILITY:

"Food Service Director, Cooks, Food Service Staff"

N.J.A.C. 8:39-17.2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061801	A. BUILDING: _____ B. WING _____	01/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABILITATIO	380 DEMOTT LANE SOMERSET, NJ 08873

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: This is a repeat deficiency. Based on observations, interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 11 of 14 day shifts and 1 of 14 overnight shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	Plan of Correction S560 Mandatory Access to Care 1. a. Immediate movement of ancillary staff to unit to assist with tasks: call bells, trays, phones, transports, to enable nursing staff to concentrate on direct patient care. b. No negative outcomes were observed. 2. a. All residents have the potential to be affected. 3. a. Administrator/designee will review staffing for the week and utilize available resources to assure mandatory staffing is	3/25/22

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

Electronically Signed | 02/10/22

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for weeks of 12/19/2021, and 12/26/2021. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 11 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -12/19/21 had 16 CNAs for 173 residents on the day shift, required 22 CNAs. -12/20/21 had 18 CNAs for 173 residents on the day shift, required 22 CNAs. -12/21/21 had 16 CNAs for 173 residents on the day shift, required 22 CNAs. -12/22/21 had 16 CNAs for 173 residents on the day shift, required 22 CNAs.	S 560	maintained, as needs change, immediate response by adjusting schedules and use of other departments to answer phones, call bells, deliver trays and transport b. Administration to focus on mandatory staffing requests and hiring by: - Utilizing agency to increase staffing - Ads placed on several job sites and job fairs - Facility to use Entry level Care Givers - Facility to offer incentives, increase rates, bonuses - Facility to utilize other departments to answer call bells, deliver trays and transport patients. 4. a. The administrator will review staffing ratios and acuities monthly for 6 months to determine efficacy of interventions to increase staff and adjust as needed, results will be submitted to QA committee quarterly for review and discussion.	

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S 560	Continued From page 2 -12/23/21 had 19 CNAs for 174 residents on the day shift, required 22 CNAs. -12/24/21 had 19 CNAs for 166 residents on the day shift, required 21 CNAs. -12/25/21 had 18 CNAs for 165 residents on the day shift, required 21 CNAs. -12/26/21 had 17 CNAs for 165 residents on the day shift, required 21 CNAs. -12/29/21 had 18 CNAs for 172 residents on the day shift, required 22 CNAs. -12/30/21 had 14 CNAs for 172 residents on the day shift, required 22 CNAs. -12/31/21 had 12 total staff for 170 residents on the overnight shift, required 13 total staff. -01/01/22 had 17 CNAs for 168 residents on the day shift, required 21 CNAs. During an interview with the surveyor on 01/10/22 at 10:10 AM, the staffing coordinator stated she was aware of the state staffing ratios and the facility had hired more staff but there had been call outs. During a interview with the surveyor on 01/10/22 at 12:42 PM the Administrator stated he was familiar with the state staffing ratios and that the ratios were being met however, recently staffing had been difficult with the recent COVID-19 virus.	S 560		