STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315131	A. BUILDING _____ B. WING _____	10/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WILLOW CREEK	1165 EASTON AVE 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) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 10/5/18 CENSUS: 122 SAMPLE: 24 + 3 Closed Records	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that interventions in place to prevent accident/injury were consistently followed to prevent residents from becoming injured. The failed practice resulted in a [redacted] that was sustained during the unsafe transfer of Resident #41, [redacted] resident reviewed for care plan interventions, and was evidenced by the following: Based on observation, interview and record review, it was determined that the facility failed to ensure the implementation of care plan interventions for a resident assessed at a high risk for accident and injury. The failed implementation of the care plan resulted in a [redacted] that was sustained during the unsafe transfer of Resident #41, 1 of	F 689	1. Resident #41 is currently on [redacted] and gets out of bed by [redacted] x 2 staff. 2.Residents that are transferred OOB by a [redacted] have the potential to be affected by the deficient practice. All residents using a [redacted] to get OOB as per care plan was reviewed by DON, ADON and UM. No other resident was found affected by the deficient practice. 3.DON, ADON provided inservice and re education to all nurses and CNAs on residents' plan of care to include mode of transfers and staff assistance. Resident care information /Kardex will be provided, updated and available for staff review inside closet doors.	10/8/18

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

Electronically Signed | 10/25/2018

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F 689	Continued From page 1 24 residents reviewed for care plan interventions, and was evidenced by the following: During the initial tour of the facility on 9/27/18 at 10:15 a.m., the surveyor observed Resident #41 in bed with the head of the bed elevated. The resident was awake, alert and answered all questions appropriately. The surveyor reviewed the resident clinical record on 10/1/18 at 11:30 a.m., which revealed that Resident #41 had diagnoses that included [redacted]. The quarterly Minimum Data Set (MDS), a resident assessment tool dated [redacted], revealed that Resident #41 was awake, alert and oriented. In [redacted] of the MDS, which assessed functional status, it was documented that Resident #41 had a decline in functional capacity of the [redacted] and required extensive assistance for bed mobility and transfer. Upon further review of Resident #41's clinical record, a nurse progress note dated [redacted] revealed that the resident complained of [redacted] after being transferred to the wheelchair by two people. The nurse progress note indicated that the resident was currently on pain medications for [redacted] and that the Nurse Practioner (NP) was notified. The NP ordered an [redacted] of the [redacted]. On 5/24/18, the facility was notified of the results of the Resident #41's [redacted] which showed a [redacted]. Subsequently, Resident #41 was transferred to the Emergency Department (ED) for evaluation and treatment on [redacted].	F 689	4.DON or designee will conduct weekly audits on mode of transfer for 3 residents to determine staff compliance with plan of care for 6 months .Results will be reported at the monthly QA meeting for review, tracking and trending to determine if further interventions is needed.	

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F 689	Continued From page 2	F 689		

The hospital medical record, dated [redacted] indicated that Resident #41 sustained a "[redacted]" The hospital record further revealed that during the interview for the history of present illness, the resident stated "that while [he/she] was at the nursing home, where [he/she] is usually transported with a [redacted], a few aides came to transfer [him/her] and instead decided not to use the [redacted] and attempted to just use their own strength. The patient reports afterwards that she felt [redacted] and [redacted] that was persistent since the incident the day prior to presenting. Pt [patient] states that [he/she] was experiencing [redacted] prompting an ED visit. The patient has not stood or walked in appox 3 years, is largely [redacted] and dependent for cares [sic]." In addition the record indicated that Resident #41 and the family opted for conservative treatment due to the resident's current medical diagnoses. Resident #41 returned to the facility on [redacted] with a [redacted] and [redacted] management.

A review of Resident #41's Care Plan, initiated on [redacted], for bed mobility and transfer revealed, 1. Focus: Required maximum assistance of two person for ADL, care in bathing, bed mobility and transfer with [redacted] due to [redacted], and 2. Interventions: Bed mobility and transfer with maximum assist of two with [redacted]

The surveyor reviewed the Event Summary Report dated [redacted] that was provided by the facility on 10/3/18 at 11:45 a.m., which revealed that Resident #41 complained of [redacted] after being transferred out of bed by two facility staff. The report further indicated that the

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F 689	Continued From page 3	F 689		

resident verbalized that he/she was transferred by two Certified Nursing Assistants (CNA) who did not use a [redacted] or a [redacted]. The Event Report indicated in the summary that the CNA failed to follow the plan of care.

During an interview with the Director of Nursing (DON) on 10/3/18 at 12:15 p.m., the DON confirmed that the CNAs did not use the [redacted] during the transfer in accordance with resident's Care Plan. The DON indicated that the CNA who cared for the resident that day was in-serviced. The other CNA was not aware that the resident was a [redacted] Transfer.

On 10/4/18 at 10:00 a.m., the surveyor interviewed Resident #41 regarding the incident of [redacted]. Resident #41 told the surveyor that on that day, two CNAs came to the room to assist with the transfer. The resident stated that he/she informed the CNAs that he/she could not stand and the one CNA verbalized, "We got you." Resident #41 stated that in the process of standing and turning to sit on the chair, he/she [redacted] the [redacted].

That same day at 10:15 a.m., the surveyor again interviewed the resident with the Director of Nursing (DON) present and the resident repeated the same statement.

On 10/4/18 at 10:20 a.m., the surveyor interviewed the nurse who cared for Resident #41 on [redacted] the day of the incident. The nurse told the surveyor that Resident #41 was on routine [redacted] medications which consisted of [redacted] and [redacted]. The nurse further stated that on [redacted], the resident did not get relief after being medicated

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F 689	Continued From page 4	F 689		

and that the resident complained of excruciating pain after the transfer. The nurse called and informed the NP. The NP ordered an [redacted] that was positive for a right distal femur fracture.

On 10/4/18 at 10:40 a.m., the surveyor interviewed CNA #1 who cared for the resident during the 7:00 a.m. - 3:00 p.m. shift on [redacted] CNA#1 stated that she was aware that Resident #41 was a [redacted] Transfer. CNA #1 went on to state that she could not locate a [redacted] in the hallway and decided to enlist CNA #2 to assist with the transfer. A [redacted]) was executed that day. CNA #1 indicated that she received report from the nurse in the morning and was aware that the mode of transfer was posted inside the resident's closet door. CNA #1 escorted the surveyor to the room and we both noted that the transfer method was posted as followed: "[redacted] with 2 assists." CNA #1 further stated that she was excited that the resident agreed to get of bed so she wanted to get Resident #41 out of bed right away.

On 10/4/18 at 11:15 a.m., the surveyor interviewed CNA #2 who stated that CNA #1 asked her to assist with the transfer and that she (CNA #2) was not aware that Resident #41 was a [redacted] Transfer.

The surveyor interviewed the Physical Therapist on 10/4/18 at 12:25 p.m., who indicated that Resident #41 was downgraded from a [redacted] transfer to a [redacted] transfer and did not provide any documentation regarding the [redacted] transfer.
During a second interview on 10/4/15 at 1:30 p.m., the therapist indicated that Resident #41 was [redacted].

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F 689	Continued From page 5 On 10/5/18 at 10:05 a.m., the surveyor interviewed the UM who completed the assessment for the [redacted] transfer dated 11/2017. The UM stated that in November of 2017, she was called to the room to assist with transferring the resident from the bed to the chair where she discovered that the resident was unable to stand. The UM reassessed the resident and the resident had been a [redacted] transfer since then. The UM further stated that the Care Plan was revised that same day and staff were made aware that Resident #41 had a decline in functional limitation and should be a [redacted] for all transfer. The surveyor reviewed CNA #1's file on 10/5/19 at 10:30 a.m., which revealed the description of the event dated [redacted] as followed: On [redacted], an investigation was conducted after Resident #41's [redacted] revealed a [redacted]. The [redacted] was ordered on [redacted] because the resident had complained of [redacted] in the [redacted] On [redacted], Resident #41 was assisted out of bed to a wheelchair by two CNAs. According to the resident, he/she verbalized to CNA #1 that he/she cannot stand up and the CNA responded, "We got you." It was after the transfer that resident stated he/she was experiencing more discomfort and [redacted] which she then complained to the nurse who then scheduled the [redacted]. The CNA denied the resident complained of [redacted] or hit the [redacted] on anything during the transfer. CNA #1 failed to get information on the mode of transfer from the nurse or the plan of care. Consequently, by the CNA's failure to follow the care plan this may have led to the adverse outcome of the resident.	F 689		

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F 689	Continued From page 6 A review of the facility policy for Fall Management, dated 9/15/01 and last revised 3/15/16, reflected that residents would assessed for falls risks as part of the nursing assessment process and determined to be at risk would receive appropriate interventions to reduce risk and minimize injury. NJAC 8:39-27.1 (a)	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		10/8/18

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F 880	Continued From page 7 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 8 Based on observation, interview and record review, it was determined that the facility failed to ensure that staff followed appropriate infection control practices for handwashing, and the cleaning and disinfecting of medical equipment prior to resident use for 2 of 3 residents (Residents #115 and #111) by 2 of 2 nurses observed during the medication pass. This deficient practice was evidenced by the following. On 9/28/18 at 9:30 a.m., the surveyor observed Nurse #1 administer medications to Resident #115. The nurse entered the room and informed the resident that she needed to monitor the resident's [redacted] before administering [redacted] (a medication that [redacted]. While the nurse spoke to the resident, she dropped the stethoscope on the floor. At 9:42 a.m., the nurse picked the stethoscope up from the floor and, without sanitizing the stethoscope or performing hand hygiene, placed the stethoscope on the resident's chest to assess the sounds. After the procedure, the nurse returned to the medication cart, placed the stethoscope on top of the medication cart, and then prepared Resident #115's medication. Nurse #1 returned to the room and administered medications to the resident without having performed handwashing. The surveyor interviewed Nurse #1 at 9:55 a.m., regarding the above mentioned practice. The nurse stated, "I see your point, I should have sanitized the stethoscope and washed my hands." On 9/28/18 at 10:00 a.m., the surveyor observed Nurse #2 administer medication to Resident #111. Nurse #2 went into the room and monitored	F 880	1. Resident #115 and #111 were monitored for signs and sypmtoms of infection after the deficient practice was obeserved. Both residents did not exhibit any after effects from deficient practice. 2. All residents have the potential to be affected by this deficient practice. No other resident was found affected by the deficient practice. 3.DON, ADON and UM provided an inservice and reeducation to all nurses and CNAs on facility policy on ifection control to include handwashing, sanitizing and disinfecting equipments before and after resident use. 4.Unit Managers will conduct weekly random audit checks on 2 unit Nurses to determine compliance with infection control policy to include handwashing and sanitizing/disinfecting equiments before and after resident use. Results of the weekly random audit checks will be submitted to the monthly QAPI committee for tracking and trending and will be completed until 100% compliance is achieved.	

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F 880	Continued From page 9 Resident #111's [redacted]. After the procedure, the nurse used the hand wipes to sanitize her hands, prepared Resident #111's medications, and then returned to the room and administered the medications to the resident. The nurse left the room, parked the medication cart near the Nurses' Station and placed the blood pressure cuff on top of the medication cart without cleaning it first. At 10:20 a.m., Nurse #2 told the surveyor that she had to monitor the [redacted] for the resident in Room [redacted] before medication administration. The nurse retrieved the blood pressure cuff that she placed earlier on top of the medication cart and proceeded to enter Room [redacted] The nurse was about to open the door when the surveyor stopped her and reminded her that she did not sanitize the blood pressure cuff after the last use. Nurse #2 returned to the medication cart and used a sanitizer wipe to sanitize the blood pressure cuff. The surveyor asked Nurse #2 if she was aware of the facility's policy for disinfecting equipment. Nurse #2 replied, "The blood pressure cuff should be sanitized after each resident, I just forgot." The facility was made aware of the above concerns on 10/1/18 at 12:45 a.m. The Director of Nursing (DON) stated that the nurses reported to her what had happened during the medication administration pass. The DON further stated that the nurses were in-serviced regarding infection control prevention. On 10/4/18 at 12:15 p.m., a review of the facility policy titled, "Infection Prevention and Control Program Description" dated 9/1/14 and revised on 3/1/18 revealed, "Implementation of Control	F 880		

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F 880	Continued From page 10 Measures and Precautions which includes basics such as hand hygiene, Standards and Transmission Based Precautions, cleaning /disinfecting equipment and measures to protect persons (as listed above) from communicable disease or infections." NJAC 8:39 -19.4 (a) (l) (n)	F 880		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, it was determined that the facility failed to ensure that all Certified Nursing Assistant (CNA) received the mandated 12-hours annual competency training as required by the State agency. This deficient	F 947	1. CNA #1,#2, # 3 and #4 has completed their quarterly mandatory inservices for year [redacted] to include abuse prevention, emergency preparedness, dementia training.	10/12/18

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F 947	Continued From page 11 practice was identified in 4 of 4 CNAs reviewed and was evidenced by the following: On 10/4/18, the facility was made aware of quality care issues found during the survey. The surveyor provided a list of four CNAs to evaluate their competency training. CNA #1 was hired [redacted] CNA #2 was hired [redacted] CNA #3 was hired [redacted] CNA #4 was hired [redacted] Upon request at that time, the facility could not provide the in-services completed from the CNAs' hiring date to their anniversary date. On 10/5/18 at 11:30 a.m., the Assistant Director of Nursing (ADON) told the team that she could not find documentation that the 12 hours of competencies were completed. In addition, the ADON stated that she reviewed the in-service training book and that information documented in the book did not meet the 12-hour requirements. NJAC 8:39-43.10	F 947	2. All CNAs have the potential to be affected by this deficient practice. 3 ADON / Educator inserviced and reeducated all CNAs on the importance of completing mandatory inservices. ADON devised a calendar schedule for mandatory inservices for all CNAs to comply with 12 hours of mandatories before the year end. 4.ADON or designee will perform quarterly audit checks on CNAs compliance with scheduled mandatory inservices. Result of the audit will be reported monthly to QAPI committee for tracking and trending.	