STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315200	A. BUILDING ______ B. WING ______	12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT DELAIRE	400 W STIMPSON AVE LINDEN, NJ 07036

(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: 12/14/20 Census: 153 Sample Size: 33 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		1/13/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/24/2020

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 656	Continued From page 1 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to develop a comprehensive a care plan addressing pain management for 1 resident (Resident #101) of 30 residents reviewed for care plans. The deficient practice was evidenced as follows: On 12/08/2020 at 10:55 AM, the surveyor observed Resident #101 awake in bed. The resident stated he/she had [REDACTED] in the [REDACTED] [REDACTED] The resident further stated medication and application of [REDACTED] helped control the [REDACTED] Review of the medical record revealed the following. According to the Admission Record the resident was admitted to the facility on [REDACTED] with diagnoses including [REDACTED], and [REDACTED]	F 656	-All residents that have pain have the potential to be effected by the deficient practice. -The care plan for resident #101 was updated on [REDACTED] to include [REDACTED] management. - The nurses will be re-educated on the policy specific to the requirement of completing a comprehensive care plan. - During weekly clinical rounds the interdisciplinary team will ensure that the care plans are updated pertaining to [REDACTED] management as appropriate. Quarterly/Annually reviews will be completed to ensure care plans are appropriate in reflective of the resident's pain management. - The Health Information Management Director or designee will include the [REDACTED] management care plan on their audit. Areas not completed will be	

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The [redacted] quarterly Minimum Data Set an assessment tool, indicated the resident had [redacted] as evidenced by a Brief Interview for Mental Status interview. The resident scored [redacted] of a possible [redacted]

Additionally, a [redacted] interview was conducted that in the [redacted] days on the MDS the resident experienced almost constant [redacted] self-measured at a level of [redacted] is the [redacted]

The [redacted] Order Summary Report included physician orders for the following [redacted] management medications: [redacted] mg. [redacted] tablets every [redacted] hours as needed for [redacted] [redacted] patch every 72 hours for [redacted]; [redacted] mg. 1 tablet once daily for [redacted]; [redacted] mg. 1 capsule [redacted] times a day for [redacted] [redacted] mg. [redacted] tablets every [redacted] hours for [redacted]

The unit Licensed Practical Nurse provided a copy of the resident's current comprehensive care plans (CCP) to the surveyor on [redacted]. Upon review of the CCP, the surveyor observed there was no CCP to address the resident's [redacted] as a concern for care planning or identify goals for [redacted] management. Pharmacological and non pharmacological interventions to lessen the resident's [redacted] were not identified in any of the CCPs reviewed.

The surveyor discussed concerns regarding a pain care plan with the Director of Nursing (DON) and Administrator on 12/10/2020 at 1:50 PM. The DON confirmed a [redacted] care plan was not initiated and provided an initial [redacted] care plan on

Provider's plan of correction (F 656):

communicated to the Director of Nursing or designee.
-The results of these audits will be reviewed at the monthly Quality Assurance Steering Committee for three months. Following the three months, the committee will determine the future needs/ frequency of the audit.

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F 656	Continued From page 3 [redacted] The DON provided the facility's [redacted] Management Policy and Procedure, dated 02/18/2019. The Policy Statement indicated a plan of care for [redacted] management will be initiated to decrease or eliminate [redacted] using pharmacological and/or non pharmacological interventions. NJAC 8:39-11.2(f); 27.1(b)	F 656		
F 711 SS=B	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. 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 physician progress notes were signed and dated at each resident visit. This deficient practice was observed for 8 of 33 residents (Resident #144, #114, #141 #2, #101, #87, #30	F 711	-Residents with this MD have the potential to be effected by the deficient practice. - The physicians will be re-educated on the policy specific to the requirements of	1/13/21

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F 711	Continued From page 4 and #52) reviewed and evidenced by the following: 1. On 12/08/20 11:46 at AM, surveyor observed Resident #144 in bed with eyes closed. The resident was lying on a [redacted] mattress. Left side of the bed was against the wall. The surveyor reviewed Resident #144's medical records that revealed the following: According to the Admission Record, Resident #144 was admitted to the facility in [redacted] and readmitted in [redacted] with diagnoses that included [redacted]. The Quarterly Minimum Data Set (MDS) an assessment tool dated [redacted], indicated that the facility performed a Brief Interview for Mental Status (BIMS) interview. The resident scored an [redacted] which indicated the resident had [redacted]. The Electronic Progress Notes (EPN) dated [redacted] through [redacted] revealed there was no documentation from the resident's primary physician. A custom search for the physician notes was done and revealed that all notes were written by the Nurse Practitioner (NP). 2. On 12/08/20 12:15 PM, the surveyor observed Resident #114 seated in a wheelchair in the resident's room participating with the exercise program. The surveyor reviewed Resident #114's medical	F 711	face to face visits, including Telemedicine visits and documentation. - The physicians completed their visits with the residents in the deficiency. - The Health Information Management Director or designee will audit physician visits on a monthly basis and for any incomplete visits. Any outstanding or incomplete visits will be communicated to the Director of Nursing or designee. -The results of these audits will be reviewed at the monthly Quality Assurance Steering Committee for three months. Following the three months, the committee will determine the future needs/ frequency of the audit.	

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F 711	Continued From page 5	F 711		

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records that revealed the following:

According to the Admission Record, Resident #114 was admitted to the facility [redacted] with diagnoses that included [redacted]

The Quarterly MDS dated [redacted] indicated that the facility performed a BIMS interview. The resident scored [redacted], which indicated the resident had [redacted].

The EPN dated [redacted] through [redacted] revealed there was no documentation from the resident's primary physician. A custom search for the physician notes was done and revealed that all monthly notes were written by the NP.

3. On 12/08/20 at 12:41 PM, the surveyor observed Resident #141 in the resident's room watching TV waiting for the lunch meal.

The surveyor reviewed Resident #141's medical records that revealed the following:

According to the Admission Record the resident was admitted in [redacted] with diagnoses that included [redacted]

The Quarterly MDS dated [redacted] indicated that facility performed a BIMS interview. Resident #141 scored a [redacted] which indicated [redacted].

The EPN dated [redacted] through [redacted] revealed there was no documentation from the

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resident's primary physician. A custom search for the physician notes was done and revealed that all notes were written by the NP. In addition, there was no documentation that either a physician or NP visited the resident in [redacted] [redacted].

On 12/10/20 at 10:30 AM, the surveyor spoke to the Registered Nurse Unit Manager and Licensed Practical Nurse (LPN) who both stated that the resident's physician does come into the facility.

On 12/10/20 at 01:45 PM, the survey team discussed the above concerns with the Administrator and Director of Nursing (DON). The team requested an interview with the physician.

On 12/11/20 between 11: 40 AM and 11:48 AM, the surveyor asked the translator to assist with questions for Resident #144, #114 and #141. The surveyor asked the residents if the doctor comes to visit and examine them. Resident #144 told the translator that he/she thinks so but doesn't know the name, Resident #141 stated to the [redacted] that he/she never sees the doctor and Resident #141 stated that someone comes but doesn't remember the name.

4. On 12/08/20 at 12:16 PM, the surveyor observed Resident #2 on seated in a wheelchair at the bedside.

The surveyor reviewed Resident #2's medical record which included the following:

According to the Admission Record Resident #2 was admitted in [redacted] with the following diagnoses, [redacted]

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F 711	Continued From page 7	F 711		

The Annual MDS reflected the resident had function as evidenced by a BIMS score of of a possible The resident was unable to be interviewed.

The EPN from through revealed there was no documentation that the primary physician performed a face to face visit with the resident at least every 60 days. Monthly face to face visits with the resident were performed by the NP.

5. On 12/08/20 at 10:55 AM, the surveyor observed Resident #101 awake in bed.

The surveyor reviewed the resident's medical record which included the following:

According to the admission record Resident #101 was admitted in with the following diagnoses, .

The quarterly MDS reflected the resident had as evidenced by a BIMS score of of a possible

The EPN from through revealed there was no documentation that the primary physician performed a face to face visit with the resident at least every 60 days. Monthly face to face visits with the resident were performed by the NP.

6. During the initial tour of the unit on 12/08/20 at 11:40 AM, the surveyor observed Resident #30 lying in bed watching television.

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F 711	Continued From page 8	F 711		

The surveyor reviewed the resident's medical record which included the following:

According to the admission record, Resident #30 was admitted to the facility in [redacted] with diagnoses that included but not limited to [redacted]

The [redacted] Significant Change MDS reflected that the resident had an moderate impaired cognitive function as evidenced by a BIMS score of [redacted] out of a possible [redacted]. The resident was unable to be interviewed.

The EPN from [redacted] through [redacted] revealed that there was no documentation that the attending physician performed a face to face visit with the resident at least every 60 days. The monthly face to face visits with the resident were primarily performed by the NP.

7. During the initial tour of the unit on 12/08/20 at 11:21 AM, the surveyor observed Resident #87 lying in bed, eyes closed.

The surveyor reviewed the resident's medical record which included the following:

According to the admission record, Resident #87 was admitted to the facility in [redacted] with diagnoses that included but not limited to [redacted]).

The [redacted] quarterly MDS reflected that the resident had an [redacted] function as evidenced by a BIMS score of [redacted] out of a

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F 711		F 711		

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possible [redacted] The resident was unable to be interviewed.

The EPN from [redacted] through [redacted] revealed that there was no documentation that the attending physician performed a face to face visit with the resident least every 60 days. The monthly face to face visits with the resident were primarily performed by the NP.

8. On 12/11/20 at 10:32 AM, the surveyor reviewed the resident's medical record which included the following:

According to the admission record, Resident #52 was admitted to the facility in [redacted] with diagnoses that included but were not limited to [redacted].

The [redacted] Annual Minimum Data Set (MDS), a screening tool, reflected the resident had a BIMs score of [redacted] indicating the resident was [redacted].

The EPN from [redacted] through [redacted] revealed that there was no documentation that the resident's primary care physician performed a face to face visit with the resident at least every 60 days. The monthly face to face visits with the resident were performed by the NP.

On 12/11/20 at 11:54 AM, the surveyor interviewed the resident. The resident stated he/she sees the doctor every day or every other day. The resident also stated he/she is unable to recall the doctor's name.

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F 711	Continued From page 10 On 12/11/20 at 12:39 PM, the surveyors interviewed the physician who stated that he comes in and does a face to face visit with the residents and then he dictates his findings to the NP who then writes the notes. On 12/14/20 at 8:56 AM, the surveyor interviewed the NP via telephone who stated that he sees the residents most days of the of the week and writes his notes. The surveyor asked what was meant when he writes at the end of the notes "dictated for collaboration with [physician]." The NP stated that he returns to the office and discusses the residents with the physician. The surveyor asked when does the physician come in to see the residents. He stated he didn't know because the doctor rounds by himself. The surveyor asked the NP if the physician dictates his notes for him to write, he said "no I don't write his notes for him." A review of the facility's undated policy titled "Physician Visits" indicated under Policy Interpretation and Implementation #3 the following: "the Attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation." NAACP 8:39-27.1	F 711		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759		1/13/21

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F 759	Continued From page 11 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 all medications were administered without error of 5% or more. During the medication pass on 12/10/20, the surveyor observed two (2) nurses administer medications to four (4) residents. There were 26 opportunities and two errors observed which calculated to a medication administration error rate of 7.6 %. This deficient practice was identified for 2 of 2 nurses administering medications to 2 of 4 residents, (Resident #49 and #139), and was evidenced by the following: 1. On 12/10/2020 at 8:04 AM, the surveyor observed the Licensed Practical Nurse (LPN#1), during the medication pass, administer eight (8) medications including one [redacted] milligram (MG) tablet of [redacted]. The surveyor with the LPN #1 observed Resident #49 sitting in a wheelchair and the LPN #1 stated that the resident had already had breakfast. Upon returning to the medication cart, the surveyor asked the LPN #1 to review the medication label for [redacted] which revealed a cautionary warning to "Take on an empty stomach." The LPN #1 then stated that she was unaware of the cautionary because the [redacted] had an administration time of 9 AM in the electronic medication administration record (EMAR). The LPN #1 added that the 9 AM time had not triggered her to administer the medication on an empty stomach. The LPN #1 also stated that the	F 759	-Residents receiving medications have the potential to be effected by the deficient practice. -LPN #1 was re-educated on reading medication cards completely; including the cautionaries listed on the card. Nurses will receive re-education regarding the distribution of medication; including to observe the cautionary listed on both the medication card and in the EMAR. -LPN # 2 was re-educated and received a disciplinary related to following medication administration policies and procedures to ensure that all residents receive their medications as ordered. Nurses will receive re-education regarding the distribution of medication to ensure that they are administering according to the physician orders. -Pharmacist/DON or designee will complete one medication pass observation weekly per shift for 12 weeks. -The results of these audits will be reviewed at the monthly Quality Assurance Steering Committee for three months. Following the three months, the committee will determine the future needs/ frequency of the audit.	

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resident had medications including [redacted] and [redacted] that were administered at 9 AM that had cautionary warnings to administer with food or after a meal and she was following those cautionary warnings. The LPN #1 stated that she would have to check why the [redacted] had an administration time of 9 am. (ERROR#1)

The surveyor reviewed the medical records for Resident #49.

A review of the resident's current Order Summary Report reflected a physician's order (PO) dated [redacted] for "[redacted] tablet [redacted] MG, give one tablet by mouth two times a day for [redacted]."

A review of the resident's EMAR reflected the PO dated [redacted] with a time of administration for 9 AM and 5 PM. In addition, the EMAR indicated a time of 7:30 AM and 4 PM that was blocked out.

On 12/10/2020 at 10:20 AM, the surveyor interviewed LPN #1 who stated that she spoke with the Nurse Practitioner and the time of administration for the [redacted] was changed to accommodate an empty stomach. The LPN #1 added that "Take on an empty stomach" was added to the EMAR.

On 12/10/2020 at 1:37 PM, the facility administrative team met with the survey team. The Director of Nursing (DON) stated that she would have to check why the [redacted] was not timed according to the cautionary warning. The DON acknowledged that cautionary warnings for medications were to be followed.

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On 12/10/2020 at 2:10 PM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone. The CP stated that according to her records she had made a recommendation that the [redacted] be administered on an empty stomach. The CP could not speak to whether the recommendation had been followed. The CP acknowledged that [redacted] manufacturer specifications indicated that [redacted] be administered on an empty stomach and has done in-services for the nurses regarding following the cautionary warnings on the label of the medications. The CP could not speak to whether the EMAR would have cautionary warnings in place but stated that the nurses were instructed to read the cautionary warnings on the medication label.

On 12/14/2020 at 9:55 AM, the surveyor interviewed the DON who stated that when the CP made the recommendation for the [redacted] to be administered on an empty stomach there was an order entry change sent to the provider pharmacy indicating to change the time of administration. The DON added that she had spoken with the provider pharmacy liaison and there was a glitch in the computer system and the change in administration time had not occurred. The DON also stated that the administration time had been resolved and the administration time was now reflecting the medication be administered on an empty stomach.

A review of an undated facility policy for "Administering Medications" provided by the DON reflected that "Medications must be administered in accordance with the orders, including any required time frame." In addition, "The individual

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administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time and right method of administration before giving the medication."

A review of the manufacturer's specifications for administration of [redacted] indicated to "Take on an empty stomach, at least 30 minutes before or 2 hours after breakfast or dinner."

2. On 12/10/2020 at 8:37 AM, the surveyor observed the LPN #2, during the medication pass, preparing to administer six (6) medications to Resident #139, which included one 100 MG tablet of [redacted] obtained from an over the counter (OTC) stock bottle. The LPN #2 stated that the [redacted] was a house stock medication meaning that the facility purchased a supply of OTC medications that were not resident specific. The LPN #2 also stated that the drug name for [redacted] The LPN #2 also stated that she was ready to administer the six (6) medications to Resident #139.

At that time, the surveyor stopped the LPN #2 and asked the LPN #2 to review the EMAR with the medications that had been prepared. The surveyor with the LPN #2 reviewed the EMAR which indicated that there was no PO for [redacted] MG tablet to be administered. (ERROR#2)

At that time, the surveyor with the LPN #2 further reviewed the EMAR which indicated a PO dated [redacted] for [redacted] tablet [redacted] micrograms (MCG), give one tablet by mouth one time a day for [redacted] The LPN #2 again

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stated that the drug name for [redacted] was [redacted]. The surveyor with LPN #2 read the label of the house stock bottle for [redacted] tablets that was in the medication cart. The [redacted] OTC house stock bottle label had the ingredient name of [redacted]. In addition, the surveyor with the LPN #2 reviewed the OTC house stock bottle for [redacted] which indicated the drug name of [redacted]. The LPN #2 stated that she got confused and thought [redacted] was the name for [redacted] and had not realized the doses were different.

At that time, the surveyor with the LPN #2 observed in the medication cart two OTC house stock [redacted] bottles, one had a dose of [redacted] MCG and the other had a dose of [redacted] MCG. The LPN #2 then removed the [redacted] MG tablet from the prepared medications for Resident #139 and stated that she did not have [redacted] MCG tablets and would have to get that medication.

The surveyor reviewed the medical records for Resident #139.

A review of the resident's Order Summary Report reflected a PO dated [redacted] for "[redacted] tablet [redacted] give one tablet by mouth one time a day for [redacted]"

On 12/10/2020 at 11:32 AM, the surveyor interviewed the LPN #2 who stated that she was aware that the drug name for [redacted] was Thiamine and the drug name for [redacted] was [redacted]. The LPN #2 also stated the [redacted] MCG tablets were being delivered.

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F 759	Continued From page 16 On 12/10/2020 at 1:37 PM, the facility administrative team met with the survey team. The DON stated that she had called the provider pharmacy and the [redacted] MCG tablets were currently being delivered. The DON also stated that she would review why the medication was not in house. On 12/10/2020 at 2:10 PM, the surveyor interviewed the CP via telephone who stated that she was aware that the facility obtained OTC medications as house stock. The CP added that she has completed in-services and med passes with the nurses and stressed that the OTC medications must match the PO. The CP could not speak to whether the EMAR would generate that [redacted] but thought that could be added to the EMAR. On 12/14/2020 at 9:55 AM, the surveyor interviewed the DON who stated that the [redacted] MCG house stock bottle was found in the facility's central supply and that LPN #2 had been in serviced. A review of a facility policy revised 9/16/19 for "OTC Medication Policy" reflected that the facility maintains a supply of commonly used OTC medications considered floor stock or house stock medications which are not resident specific that are permitted to be administered upon receipt of an order from an authorized prescriber. NJAC 8:39-11.2(b), 29.2(d), 29.4(c)	F 759		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		1/13/21

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F 812	Continued From page 17 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 observation, interview and review of documentation provided by the facility, it was determined that the facility failed to maintain proper kitchen sanitation practices to prevent the development of food borne illness. This deficient practice was identified during the kitchen tour and was evidenced by the following: On 12/08/20 at 10:40 AM, during the initial tour of the kitchen in the presence of the Food Service Director (FSD), the surveyors observed the following: 1. There were several silver trays/pans and clear plastic bins nested on top of each other on the drying rack. The surveyor asked the FSD to separate the silver trays/pans and the clear plastic bins. There was moisture observed between four of the silver trays/pans and two of	F 812	-Residents have the potential to be effected by the deficient practice. -The DA applied the beard guard immediately and was disciplined accordingly to the policy. -The dietary was educated about the beard guard policy. - All silver tray/pans and clear bins removed from service immediately. Properly washed, rinsed, sanitized and air dried. - FSD completed staff education for Dietary Supervisors and employees on Policy &Procedures for Pot & Pan Process. Copies have been provided to Administrator and remain on file in the Dietary Department. - FSD, Supervisors or designee will	

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the clear plastic bins. The FSD stated that they should not be stacked until they were completely dry to avoid wet nesting because bacteria could form in the moisture.

On 12/09/20 at 10:03 AM, during a tour of the kitchen in the presence of the Food Service Director (FSD) and the Regional Food Service Director (RFSD), the surveyors observed the following:

2. There were several serving silver trays/pans nested on top of each other on the drying rack. The surveyor asked the FSD to separate the silver trays/pans. There was moisture observed between two of the silver trays/pans. The FSD stated that the trays should have been separated to allow proper drying. The RFSD stated that they should not be stacked while drying to avoid wet nesting.

3. A Dietary Aide (DA) was separating silverware into clear plastic bags. The DA had a mask on with facial hair curling around the bottom of the mask. The DA stated that he should have had a beard net on so that his facial hair does not contaminate the food. The FSD stated that the DA should have had a beard guard to keep his facial hair from falling in food. The RFSD stated that facial hair should be covered "1000%" of the time.

Review of the facility's policy "Wet Nesting of Kitchen Wares Policy" with a revision date of 9/5/2018 revealed "Policy: Kitchen will wash, rinse, sanitize and air dry (when wet) all pots, pans, cook ware, service wares and small wares following each meal". "Procedure: 2. When using pot and pan 3 compartment sinks; a ...items will

F 812

monitor daily during department rounds to ensure appropriate beard guards are worn and policy is followed.
-FSD, Supervisors or designee will complete Wet Nesting Prevention / Beard Guard Audit daily for initial 30 days and submit to both Administrator and Regional Director.
-FSD, Supervisor or designee will complete Wet Nesting Prevention / Beard Guard Audit Mon- Wed – Fri for additional 30 days and submit to both Administrator and Regional Director.
-The results of these audits will be reviewed at the monthly Quality Assurance Steering Committee for three months. Following the three months, the committee will determine the future needs/ frequency of the audit.

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F 812	Continued From page 19 be stacked or angled in such a way on a designated clean "air drying" rack so they may completely dry prior to usage without any pooling or nesting water visible or to touch. Review of the facility's policy "Uniform Policy" with a revision date of 5/27/2020 revealed "Procedure: Facial hair coverings will be worn to cover any and all facial hair." NJAC 8:39-17.2 (g)	F 812		
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	F 880		1/13/21

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procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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F 880	Continued From page 21 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 the facility nurse failed to adhere to acceptable standards of infection control practices during the administration of a [redacted] treatment. The deficient practice was identified for 1 of 1 resident (Resudent #43) and was evidenced by the following: On 12/08/20 at 11:45 AM, the surveyor interviewed Resident #43. The resident stated he/she had a [redacted] on the [redacted]. The resident voiced a concern that the [redacted] was not consistently cleansed according to the physician's order. The resident gave permission to the surveyor to observe the [redacted] treatment. A review of the medical record revealed the following information: The Admission Record indicated the resident was admitted to the facility in [redacted] with diagnoses including [redacted]. The 9/13/20 annual Minimum Data Set (MDS), an assessment tool, identified the resident as having no cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of [redacted] of a possible [redacted]. The resident was care planned for [redacted] of the [redacted]. The [redacted] Order Summary Report included a [redacted] physician's order for a [redacted] treatment to the [redacted] as follows: [redacted], gently pack with [redacted], and cover with	F 880	-Residents with [redacted] have the potential to be effected by the deficient practice. -The LPN Unit Manager was disciplined on [redacted] for not following the facility policy related to [redacted] treatment. -The LPN Unit Manager was re-educated on [redacted] treatment policy and procedures and finger nail length. -The Clinical Educator completed competencies with the LPN Unit Manager on hand hygiene, [redacted] treatments, and proper PPE use during [redacted] treatments. - The Clinical Educator or designee will re-educate the nursing staff on [redacted] [redacted] management, privacy, and hand hygiene. -The clinical educator or designee will perform a [redacted] competency audit on a designated nurse monthly for 3 months including the LPN Unit Manager. -The results of these audits will be reviewed at the monthly Quality Assurance Steering Committee for three months. Following the three months, the committee will determine the future needs/ frequency of the audit.	

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bordered gauze.

The surveyor observed the Licensed Practical Nurse Unit Manager (LPN UM) administer [redacted] on [redacted] beginning at 11:00 AM. The LPN UM began assembling treatment supplies on the top of the sanitized treatment cart. The LPN UM donned and doffed gloves twice while assembling the supplies without hand hygiene after glove removal.

The LPN UM left the supplies unattended on top of treatment cart while she walked down the hallway to obtain an additional supply item. The LPN UM returned to the treatment cart and placed the additional item on top of the cart. The LPN UM entered the resident's room and proceeded to the far side of the bedroom and stepped behind the privacy curtain. The treatment cart was out of her view in the hallway with unsecured supplies on top of the cart.

The LPN UM began to prepare the clean treatment field on the over bed table (OBT) at the resident's bedside. She moved the resident's four drink containers to one side of the OBT and sanitized the other half of the OBT. She placed a three-fold paper towel down as a clean field on the sanitized half of the OBT.

The surveyor observed the LPN/UM's initial hand hygiene since beginning the procedure. She washed her hands satisfactorily for 20 seconds outside of running water. Her fingernails were noted to extend well beyond the fingertip.

The treatment supplies were transferred from the treatment cart in the hallway to the OBT at the resident's bedside. The LPN UM washed her

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F 880	Continued From page 23 hands for 5 seconds outside of the running water before rinsing. She proceeded to the doorway and touched the doorknob with her bare hand and closed the door. She donned clean gloves. A plastic trash bag was placed on the bed next to the resident's [redacted] The soiled dressing was removed from the [redacted] and placed in the plastic trash bag on the bed. Gloves were removed and clean gloves were donned without performing hand hygiene. The [redacted] was cleansed, packed, and covered with bordered gauze according to the physician's order. The LPN UM removed her gloves, handwashed satisfactorily, and donned clean gloves. She documented the date and initialed with a ballpoint pen directly on the gauze covering the [redacted] The surveyor discussed the infection control breaches with the Director of Nursing (DON) and the Administrator on 12/20/20 at 1:50 PM. On 12/11/20 from 9:30 AM to 10:30 AM the DON provided to the surveyor the following documentation: the facility [redacted] Care Policy and Procedure (P&P), the Treatment Competency Checklist, the facility Dress Code: Professional Attire and Grooming Policy (Dress Code) and the Corrective Action Plan for the LPN UM. The [redacted] Care P&P, updated 5/28/2015, indicated hand hygiene is performed after removing gloves. The P&P also indicated the date and nurse's initials are to be written on tape and attached to the dressing topper. The Treatment Competency Checklist, dated [redacted] was documented by the DON to indicate the LPN UM had passed the competency on	F 880		

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F 880	Continued From page 24 [redacted] The checklist included hand hygiene after glove removal as a criterion for successful completion of the competency. The Dress Code, dated March 1, 2017, indicated nails are to be no longer than a quarter inch from the tip of the finger to tip of the nail. NJAC 8:39-19.4(n); 27.1(a) (e)	F 880		