STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING _____ B. WING _____	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF PRINCETON	5000 WINDROW DRIVE PRINCETON, NJ 08540

(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: 10/27/2020 CENSUS: 104 SAMPLE SIZE: 21 +2 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 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		12/4/20

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

Electronically Signed | 11/10/2020

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, medical record review, and review other facility documentation, it was determined that the facility failed to a.) ensure a care plan was developed timely for a resident who was receiving [redacted] and b.) to ensure a fall intervention was implemented after a resident had a fall. This was identified for 2 of 21 residents reviewed for care plans (Resident #30 and #89). This deficient practice was evidenced by the following: 1. According to the Admission Record, Resident #30 was admitted in [redacted] with diagnosis which included but were not limited to: [redacted]. Review of Resident #30's Admission Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that the resident had a Brief	F 656	I. What corrective action was accomplished for Residents affected by the deficient Practice? The Plan of Care for Resident #30 was updated on [redacted] reflect the use of [redacted] The Plan of Care to prevent falls for Resident #89 was updated on 1[redacted] to keep Resident in supervised area when out of bed as often as possible. The assigned CNA, RN and Unit Manager for Resident #89 were educated on the interventions in the Plan of Care to help prevent falls which included once out of bed to keep in a supervised area as often as possible. II. How will the facility identify other Residents having the potential to be	

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F 656	Continued From page 2 Interview for Mental Status (BIMS) of [redacted] which indicated that the resident's cognition was intact. The MDS also revealed that the resident used [redacted]. On 10/20/20 at 11:30 AM, the surveyor observed an [redacted] connected [redacted] in the resident's room. The resident was not in the room. On 10/21/20 at 9:05 AM, the surveyor observed the resident wearing [redacted] The resident stated that [redacted] was used as needed since admission. The surveyor has the same observation on 10/21/20 at 1:01 PM. Review of the resident's vital signs documentation indicated that the resident used [redacted] intermittently during the months of July 2020 to October 2020. On 10/21/20 at 2:19 PM, the surveyor reviewed the resident's care plan which did not include the resident's [redacted] use. During an interview with the surveyor on 10/23/20 at 9:52 AM, the Registered Unit Manager (RN/UM) #1 stated that he or the MDS nurse create and update resident care plans and that [redacted] would be on the resident's care plan. At that time, the surveyor asked to review the resident's care plan. RN/UM #1 showed the surveyor the care plan with an intervention for [redacted] dated [redacted] The surveyor questioned the date, and the RN/UM stated he needed time to look at the care plan. During a follow up interview with the surveyor on	F 656	affected by the same deficient practice? All Residents who require a Comprehensive Care Plan for [redacted] and post fall incidents have the potential to be affected by this deficient practice. III. What measures will be put in place or systemic changes made to ensure that the deficient practice will not reoccur? Nursing Unit Manager and or Nursing Supervisor will ensure all Residents receiving [redacted] will have a Plan of Care in place for these interventions. The DON/ADON, Nursing Unit Manager, Dietitian, Social Worker, MDS Coordinator will review and revise the Plan of Care for all Residents after each fall incident with an intervention to help prevent another fall and or minimize injury. The DON/ADON and or Unit Manager/Supervisor will inform the appropriate staff of the new intervention for post fall incidents during change of shift report. IV. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur? The DON and/or Nursing Designee will audit and monitor all new admissions/re-admissions that require [redacted] weekly for four (4) weeks, then	

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F 656	Continued From page 3 10/26/20 at 10:26 AM, RN/UM #1 stated he was unable to locate [redacted] use on the care plan prior to [redacted]. During an interview with the surveyor on 10/27/20 at 10:26 AM, the Director of Nursing (DON) stated that the [redacted] should have been on the resident's care plan. 2. According the Admission Record, Resident #89 was admitted to the facility in [redacted] with diagnoses that included but were not limited to; [redacted]. Review of the resident's Quarterly MDS, dated [redacted] revealed that the resident had a BIMS of [redacted] which indicated that the resident's cognition was severely impaired. Further review revealed that the resident required extensive to total care with activities of daily living (ADLS). On 10/20/20 at 11:38 AM, the surveyor observed the resident alone in his/her room, in a low chair. The resident was yelling and reaching over the side of the chair. A staff member then entered the resident's room. Review of the resident's fall care plan, initiated on [redacted], identified the resident as being at risk for falls related to [redacted] and included a fall with no injury on 10/[redacted]. An intervention, dated [redacted], reflected to keep the resident in a supervised area when in wheelchair for monitoring. Review of the resident's Incident Report (IR), dated 10/[redacted] at 3:22 PM, revealed that the	F 656	five (5) new admissions/re-admissions requiring the use of [redacted] monthly for five (5) months to ensure a Plan of Care is developed for the use of [redacted] The DON and/or Nursing Designee will audit the Plan of Care of five (5) Residents with falls to ensure the Plan of Care has been updated with interventions to help prevent the fall and or injury, weekly for four (4) weeks, then will audit five (5) Residents with falls monthly for five (5) months to ensure a Plan of Care with the necessary interventions are developed post fall. The DON/ADON and/or Nursing Unit Managers and Nursing Supervisors will observe the staff of five (5) Residents with falls weekly for four (4) weeks, then monthly for five (5) months to ensure the Fall Care Plan interventions to help prevent a recurrent fall and or injury have been implemented and are being followed as directed in the Plan of Care. The DON and/or Nursing Designee will review and monitor the 24 hour Report/Change of Shift Report to ensure that the new intervention for five (5) Residents post fall is documented for staff review weekly for four (4) weeks, then will audit the report monthly for five (5) months on five (5) Residents to ensure that the 24 hour Report/Change of Shift Report were updated with the new intervention on the Plan of Care post fall. Results of all of the audits and monitoring	

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F 656	Continued From page 4 resident was found sitting on the floor in the resident's room in front of the resident's chair. Additional review of the IR revealed, that the resident had behavioral problems and would get agitated when left alone. Staff to keep resident in a supervised area when in wheelchair. The surveyor observed Resident #89 in a [redacted] wheelchair alone in their room on the following dates and times: 10/21/20 at [redacted] 10/22/20 at [redacted] 10/22/20 at [redacted]; 10/22/20 at [redacted] 10/22/20 at [redacted] 10/23/20 at [redacted] 10/23/20 at [redacted] During an interview with the surveyor on 10/22/20 at 1:54 PM, the Certified Nurses Aide (CNA) assigned to the resident stated Resident #89 was a fall risk, and was in a low chair due to the resident trying to get up. The CNA stated that the resident spends most of the time in the room watching TV and will verbalize when the resident wanted to come out of the room. During an interview with the surveyor on 10/22/20 at 2:09 PM, the RN assigned to the resident, RN #1, stated the resident was a fall risk, had a [redacted] and was unaware that the resident was to be in a supervised area when in the chair. During an interview with the surveyor on 10/23/20 at 9:35 AM, RN/UM #2 stated after a resident had a fall, IRs were reviewed during the morning falls meeting and care plans were	F 656	will be forwarded to the QAPI Committee and the Committee will meet monthly for six (6) months. The Committee will discuss the tracking, trending and recommend changes to the interventions, as necessary, of all Plans of Care monitoring.	

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F 656	Continued From page 5	F 656		

updated with the new intervention. The staff were then verbally inserviced on the intervention. RN/UM #2 stated that staff sometimes bring Resident #89 out of the room and stated that the resident could be in [redacted] chair alone in his/her room to watch TV, and that the resident was checked on frequently. RN/UM #2 stated a supervised area was an area where the resident could be seen.

During an interview with the surveyor on 10/23/20 at 10:33 AM, the DON stated that after a resident falls, IRs were reviewed the following day at the fall meeting and an intervention was put on the care plan.

During a follow up interview with the surveyor on 10/27/20 at 10:26 AM, the DON stated that the resident should have been in a supervised area when in the chair.

Review of a facility policy titled, "Falls and Fall risk Managing," revised on 07/13/20, included that the staff will identify and implement relevant interventions to try to minimize serious consequences of falling and make updates to the resident's care plan accordingly.

Review of a facility policy titled "Care Plans-Comprehensive," revised on 07/08/20, included that the individualized comprehensive care plan included measurable objectives and time tables to meet the resident's medical, nursing, needs was developed for each resident. The comprehensive care plan was based on a thorough assessment that included, but was not limited to, the MDS.

NJAC 8:39-11.2(e)

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F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and medical record review, and review of other facility documentation, it was determined that the facility failed to: a.) transcribe orders to the electronic physician's orders and medication administration record (eMAR), for 2 of 3 residents reviewed for [redacted] (Resident #25 and #30); b.) check for placement of an [redacted] e prior to a [redacted] and c.) [redacted] h for 1 of 2 residents (Resident #50) reviewed for [redacted]. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey states, "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	I. What corrective was accomplished for Residents affected by the deficient practice? A Physicians Order for oxygen was obtained and transcribed via Electronic Physician Order and eTAR for Resident #25 and Resident #30. Staff Nurse LPN #2 was re-educated on the procedure of checking the placement of the [redacted] A skills competency on the procedure for checking the placement of the [redacted] was completed for Staff Nurse LPN #2. The unlabeled jug of water for Resident #50 was disposed of. II. How will the facility identify other Residents having the potential to be affected by the same deficient practice? A Physician Order is required for all Residents receiving [redacted] and all Residents receiving [redacted] have the potential to be affected by this deficient	12/4/20

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F 658	Continued From page 7 Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. According to the Admission Record, Resident #25 was admitted to the facility in [redacted] with diagnosis which included but were not limited to; [redacted]. Review of the resident's Admission Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that the resident had [redacted] and [redacted] impairments. The MDS also indicated that the resident had a [redacted] and used [redacted] Review of the resident's care plan, dated [redacted], revealed that the resident received [redacted]. Further review of the medical record revealed that the resident was readmitted to the facility on [redacted] On 10/20/20 at 12:40 PM, the surveyor observed the resident sleeping with [redacted]	F 658	practice. Checking the [redacted] is required prior to [redacted] and all Residents who are receiving [redacted] have the potential to be affected by this deficient practice. Multi-use gallons of water that are used for [redacted] are required to be labeled and dated when opened and all Residents who are receiving [redacted] have the potential to be affected by this deficient practice. III. What measures will be put in place or systemic changes made to ensure that the deficient practice will not reoccur? The Licensed Nursing Staff will re-educated on the requirement that all Residents receiving or requiring the use of [redacted] will need an Electronic Physicians Order which is transcribed on either the eMAR or eTAR. The Unit Manager or Nursing Supervisor will ensure all new admissions and re-admissions who require [redacted] administration have an Electronic Physicians Order entered and transcribed into the eMAR and/or eTAR. The Licensed Nursing Staff will be re-educated on the procedure of checking placement of the [redacted] prior to [redacted]	

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F 658	Continued From page 8 On 10/21/20 at 11:27 AM, and 10/22/20 at 10:23 AM, the surveyor had the same observation as above for Resident #25. Review of the electronic physician's orders, which included active orders as of [redacted], did not include an order that the resident was on [redacted] Review of the October 2020 eMAR and Electronic Treatment Administration Record (eTAR) did not include that the resident was on [redacted] During an interview with the surveyor on 10/22/20 at 12:21 PM, the Registered Nurse (RN) #1 assigned to Resident #25 stated that when residents with a [redacted] were admitted to the facility, the facility nurse would receive report from the hospital with the amount of [redacted] the resident was on and then would obtain a physician's order. During a follow up interview at 10/22/20 at 1:48 PM, RN #1 stated the resident was on [redacted]. At that time, the surveyor asked to see the order on the eMAR. RN #1 was unable to locate the order on the electronic physicians orders or the eMAR. During an interview with the surveyor on 10/23/20 at 9:43 AM, the RN Unit Manager (RN/UM) #2 stated that [redacted] orders come from the hospital and would be on the eMAR or the eTAR. RN/UM #2 stated the resident was readmitted and that there must have been a "glitch" in the system. During an interview with the surveyor on	F 658	The Licensed Nurse Staff will be educated that Residents who are receiving [redacted] if and when a multi-use gallon of water is being used must be labeled and dated upon opening. IV. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur? The DON and/or Nursing Designee will audit all new admissions/re-admissions that require oxygen weekly for four (4) weeks, then five (5) new admission/re-admissions requiring the use of [redacted] monthly for five (5) months to ensure an Electronic Physicians Order has been entered and transcribed into the eMAR or eTAR. The DON/Nursing Designee will conduct a weekly audit for four (4) weeks, then monthly for five (5) months on two (2) staff members providing [redacted] to ensure the procedure for checking placement of the [redacted] is properly conducted. The DON/Nursing Designee will conduct a weekly audit for four (4) weeks, then monthly for five (5) months on two (2) Residents who require [redacted] to ensure if a multi-use gallon of water is used, it is labeled and dated.	

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F 658	Continued From page 9 10/23/20 at 10:29 AM, the Director of Nursing (DON) stated that when residents were readmitted from the hospital with [redacted], an order was required and the [redacted] order should be on the eMAR or the eTAR. On 10/27/2020 at 11:05 AM, the DON and RN #2 provided the surveyor with a 24-hour nursing report, dated [redacted] which read that the resident was readmitted on [redacted]. During at interview at that time, RN #2 stated she readmitted the resident to the facility, and obtained the physician's order for the resident's [redacted] but forgot to transcribe the order to the electronic physician's orders and eMAR. 2. According to the Admission Record, Resident #30 was admitted in [redacted] with diagnosis which included but were not limited to; [redacted] Review of the Admission MDS, dated [redacted] revealed that the resident had a BIMS of [redacted] which indicated that the resident's cognition was intact. The MDS also revealed that the resident used [redacted] On 10/20/20 at 11:30 AM, the surveyor observed an [redacted] n the resident's room. The resident was not in the room. On 10/21/20 at 9:05 AM, the surveyor observed the resident wearing [redacted] The resident stated that [redacted] was used as needed since admission. The surveyor had the same observation on 10/21/20 at 1:01 PM.	F 658	Results of the audits will be forwarded to the QAPI Committee monthly for six (6) months for tracking, trending and implementation of action plans as necessary.	

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F 658	Continued From page 10 Review of the resident's vital signs record revealed that the resident used [redacted] intermittently from July to October 2020. Review of the resident's Order Summary Report for active orders as of [redacted] did not include an active physician's order for [redacted]. Review of the resident's eMAR and Electronic Treatment Administration Records (eTAR) from July 2020 to 10/21/2020 did not include that the resident was on [redacted] During an interview with the surveyor on 10/22/20 at 1:06 PM, the Licensed Practical Nurse (LPN) #1 assigned to Resident #30, stated that a physician's order was required for [redacted] use. At that time, the surveyor asked how much [redacted] Resident #30 was on. LPN #1 reviewed the electronic physician's orders, eMAR and eTAR, and stated she was unable to locate the order for [redacted] and would call the physician. During an interview with the surveyor on 10/23/20 9:52 AM, RN/UM #1 stated an order from the physician was required for [redacted] use and the order was then transcribed to the eMAR or eTAR. During a interview with the surveyor on 10/27/20 at 11:00 AM, the DON handed the surveyor handwritten orders by the resident's physician dated [redacted]. The orders included an order for [redacted]. The DON stated that the order for [redacted] was never transcribed to the electronic medical record, and it should have	F 658		

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(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 658	Continued From page 11 been on the eMAR. Review of a facility policy, titled, [redacted] Safety" revised 7/30/20, included, [redacted]." 3. According to the Admission Record, Resident #50 was admitted in [redacted] with diagnoses that included but were not limited to: [redacted]). Review of the resident's Quarterly MDS dated [redacted] included the resident's cognition was [redacted] impaired. Further review of the MDS included the resident received [redacted] Review of Resident #50's care plan, dated [redacted] revealed the resident had an [redacted] [redacted] needs and instructions to check for [redacted] per MD order. Review of Resident #50's Order Summary Report revealed an order for [redacted] dated [redacted], and an order for [redacted], dated [redacted] Review of a progress note written by the Dietician on 1[redacted] at 4:19 PM, included the resident was [redacted]) and there were no reports of [redacted] concerns. On 10/23/2020 at 10:12 AM, the surveyor observed LPN #2 administer Resident #50's [redacted]	F 658		

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	315370	A. BUILDING _____ B. WING _____	10/27/2020

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F 658	Continued From page 12	F 658		

[redacted] The LPN checked for [redacted] using an undated, unlabeled gallon jug of water, and administered [redacted]

When interviewed at that time, LPN #2 explained the process for administering a [redacted] which included [redacted] The LPN further stated she did not check for placement prior to administering the [redacted] The LPN also acknowledged the gallon water jug was not labeled or dated and that she did not know how old the water was.

During an interview with the surveyor on 10/23/2020 at 10:50 AM, the LPN/Unit Manager (LPN/UM) explained the process of [redacted] which included checking for [redacted] The LPN/UM further stated the gallon water jugs came from the supply room and the nurse was responsible for labeling the jug with the room number, date, and nurse's initials. The LPN/UM stated the water jug was good for 24 hours and the date on the jug would tell the nurse if it was still good to avoid an infection.

During an interview with the surveyor on 10/23/20 at 11:16 AM, the DON explained the process for [redacted] which included [redacted] prior to administering the [redacted]

During a follow up interview on 10/23/20 at 12:11 PM, the DON stated the facility used one bottle of water for each resident and it should have the date and resident's name on it. She also stated

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F 658	Continued From page 13 that once the jug was opened, it was good until the expiration date on the bottle. Review of the facility's [redacted]-Safety Precautions" policy, revised 11/2018, included "Preventing aspiration, Check [redacted] prior to [redacted] or administration of medication." The facility was unable to provide a policy regarding the multi-use water jugs. NJAC 8:39-27.1(a)	F 658		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution	F 761		12/4/20

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F 761	Continued From page 14 systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined the facility failed to remove an expired medication and maintain a clean, orderly medication cart for 2 of the 3 carts inspected. This deficient practice was evidenced by the following: On 10/23/2020 at 12:27 PM, in the presence of the Unit Manager (UM), the surveyor inspected the [redacted] medication cart ([redacted] and observed the following: in the first bin of the third drawer, there was one pink tablet and one green tablet which were unwrapped and unmarked. In the second bin of the third drawer, there were two orange tablets, one pink tablet, one yellow tablet, two white tablets, and one-half white table which were unwrapped and unmarked. When interviewed at that time, the UM stated the med cart drawers were cleaned before and after every shift and as needed for spills. The UM further stated loose medications were destroyed by the nurse using a drug destroyer and that the nurse checked expiration dates for safety to avoid an adverse reaction or complication. On 10/23/2020 at 12:43 PM, in the presence of the UM and Registered Nurse Supervisor, the surveyor inspected the [redacted] medication cart [redacted] and observed the following: in the first bin of the second drawer, there was one unopened [redacted], one pink pill, one white pill, one yellow pill, and two pink/dark pink	F 761	I. What corrective action was accomplished for Residents affected by the deficient practice? The expired medication bottle of [redacted] in the medication cart labeled #1 was removed from the medication cart and destroyed. All loose pills that were unwrapped and unmarked in the medication cart labeled #1 & #2 were removed and destroyed. Medication cart labeled #1 & #2 were cleaned. All medication carts in the facility, totaling six (6), were inspected for expired medications and cleaned including removing any loose, unmarked and unwrapped medications for destruction. The unopened [redacted] in the medication cart labeled #1 was disposed of. II. How will the facility identify other Residents having the potential to be affected by the same deficient practice? Medication carts should be clean, free of unwrapped or unmarked medication and expired medications. All Residents have the potential to be affected by this deficient practice.	

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F 761	Continued From page 15 capsules. All medications were unwrapped and unmarked. In the second bin of the second drawer, there was one tan pill, which was unwrapped and unmarked. The surveyor also observed a bottle of [redacted] spray, sealed, with an expiration date of 9/2020. The RN acknowledged the expired med and removed it from the cart. During an interview with the surveyor on 10/23/20 at 1:08 PM, the Licensed Practical Nurse (LPN) stated the medication carts were cleaned nightly. The LPN further stated she checked meds for expiration because they may not be effective if they were expired. During an interview with the surveyor on 10/27/20 at 10:27 AM, the Director of Nursing (DON) stated the nurses cleaned the med carts before and after each shift. The DON further stated the nurses check each cart to make sure the proper meds were available and not expired to prevent an adverse reaction. Review of the facility's undated "Medication Storage in the Facility, Storage of Medications," undated, revealed "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier" and "All medications dispensed by the pharmacy are stored in the container with the pharmacy label." The policy also included "Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal if a current order exists."	F 761	III. What measures will be put in place or systemic changes made to ensure that the deficient practice will not reoccur? The Nursing Staff will be re-in serviced and educated that the assigned Shift Nurse to a medication cart is responsible for cleaning the medication cart at the beginning and end of each shift. Cleaning includes ensuring that any loose, unwrapped and unlabeled medications are destroyed according to facility policy. The Nursing Staff will be re-in serviced and educated that the assigned Shift Nurse to a medication cart is responsible for checking for expired OTC medication at the beginning and end of each shift. Expired OTC medications will be destroyed according to facility policy. The Nursing Staff will be re-educated to store unopened insulin pens in the refrigerator. IV. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur? The DON/Nursing Designee will inspect three (3) medication carts weekly for four (4) weeks, rotating medication carts weekly to ensure all medication carts in the facility have been inspected at least twice in a 3o-day period, then each medication cart will be inspected once a	

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F 761	Continued From page 16 NJAC 8:39-29.4(a),(h)	F 761	month for five (5) months. Medication cart inspection includes checking for cleanliness, loose, unwrapped and unlabeled medications and for expired medications. This inspection will also include checking for unopened insulin pens stored in the medication carts. Results of the audits will be forwarded to the QAPI Committee monthly for six (6) months for tracking, trending and implementation of action plans as necessary.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 812	I. What corrective action was	12/4/20

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F 812	Continued From page 17 documentation provided by the facility, it was determined that the facility failed to maintain proper kitchen sanitation practices and properly store dry foods in a safe and sanitary environment to prevent the development of food borne illness. This deficient practice was evidenced by the following: On 10/20/20 at 9:35 AM, during the initial tour of the kitchen, the surveyor who was accompanied by the Food Service Director (FSD), observed the following in the kitchen: In the dry storage room: 1. A 20-pound opened bag of Jasmine Rice was not labeled with a received or opened date. 2. A 10-pound opened bag of Tri-Color Rotini was not labeled with a received or opened date. In the walk-in freezer: 1. An opened bag of potato skins was not labeled with a received or opened date. 2. A 10-pound opened undated box of precooked lasagna sheets in an opened plastic bag opened and not dated as to when the bag was opened. The FSD stated that all food that came into the building needed to be labeled with a received date. The FSD stated the unlabeled foods should have been labeled and he took "full blame" because he was the FSD. The FSD stated the AM and PM supervisors were responsible for labeling and dating the food in the kitchen and that all of the staff should also	F 812	accomplished for Residents affected by the deficient practice? The 20 pound bag of jasmine rice, 10 pound bag of tri-color rotini and the bag of potato skins that were opened and not labeled and dated were disposed of. The unlabeled/not dated pre-cooked lasagna sheets were also disposed of. An in-service was conducted to all Dietary Staff on the proper labeling and use by dating of all stored food items II. How will the facility identify other Residents having the potential to be affected by the same deficient practice? All Residents have the potential to be affected by this deficient practice III. What measures will be put in place or systemic changes made to ensure that the deficient practice will not reoccur? The Dietary Staff will be re-educated on the labeling and use by dating procedure when opening any food item. Labeling includes the date the food item was opened for both dry food and frozen food. The Dietary Staff will be educated to dispose of any dry or frozen food that is not labeled or dated with a use by date. The Dietary Supervisors will be educated to check all food items for proper labeling and dating and dispose of any food items	

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F 812	Continued From page 18 be checking the labels. During an interview with the surveyor on 10/23/20 at 10:41 AM, the FSD stated the protocol for the rice and the pasta would be 90 days from the open date and all frozen foods must be dated with a received date. On 10/26/20 at 12:35 PM, the Administrator and the Director of Nurses (DON) were made aware of the surveyor's findings. During a follow up interview with the surveyor on 10/27/20 at 10:26 AM, the Administrator and Corporate Chef stated the items should have been dated when they were opened because the facility had a protocol with used by dates. The Administrator stated that he understood that the labels were not on the items when they were opened and would not know how long the items were good for. Review of the "Food Safety Requirements Policy and Procedure" with an implementation date of 12/12/17, revealed, Procedure...4. proper labeling and dating of each item. Review of the undated "Labeling and Dating System Protocol" revealed bagged goods that are opened are good for 90 days. All food in freezer storage are good for 6 months. Review of the undated labeled "Food Service Director Duties" revealed the FSD ensures correct labeling and dating of all food products in kitchen. Review of the undated "AM/PM Cook Supervisor Job Flow" revealed the supervisors should	F 812	that are not labeled and or not dated with a use by date. IV. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur? The Director of Dining Services and/or Designee will conduct an audit twice (2) weekly for four (4) weeks, then once weekly for one (1) month, then once (1) monthly for four (4) months checking both the dry good storeroom and the freezer to ensure that all stored dry food and frozen food items are labeled with a use by date. Results of the audits will be forwarded to the QAPI Committee monthly for six (6) months for tracking, trending and implementation of action plans as necessary.	

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F 812	Continued From page 19 perform a daily walk through to make sure all food items are labeled and dated properly NJAC 8:39-17.2(g)	F 812		