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F 000	INITIAL COMMENTS CENSUS: 105 SAMPLE SIZE: 24 + 14 = 38 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. A. During the standard survey of 01/31/20, the facility Administration was notified of an Immediate Jeopardy (IJ) situation on [redacted] at 3:49 PM. The facility failed to ensure that the correct physician ordered mechanically altered diet consistency was provided to a resident who had a diagnosis of dysphagia, a history of [redacted] at meals and was at risk for [redacted]. The resident had an order for a puree diet and was provided a chopped consistency meal tray. The resident was fed the incorrect diet by a Certified Nurse Aide (CNA). The resident choked, became [redacted], and 911 was activated. The facility provided a removal plan on 01/27/20 at 1:56 PM. The IJ was continued at a lower scope and severity when it was identified the removal plan was not fully implemented on 01/28/20. A CNA distributed a late meal tray to a resident without having the meal checked by two staff in accordance with the removal plan. (F808) B. On 01/29/20, the facility Administration was notified of an IJ situation at 4:31 PM. The facility failed to ensure that immediate emergency treatment was administered in response to a choking incident. The resident, who was [redacted] and [redacted], was removed from the dining room where the choking occurred and taken down the hallway to the resident's room,	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/29/2020

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 000	Continued From page 1 where the Heimlich Maneuver was performed by nursing staff. The removal plan was accepted on 01/30/20 at 11:22 AM. (F684) C. On 01/29/20, the facility Administration was notified of an IJ situation at 4:31 PM. The facility failed to ensure the implementation of the removal plan, dated 1/27/20, and ensure that the correct physician ordered mechanically altered diet consistency was provided to a resident who had a diagnosis of [redacted]. The resident had an order for a puree diet. The cook plated the food incorrectly and the resident was provided a meal tray that contained ground vegetables. The resident was fed the incorrect diet by a CNA. The removal plan was accepted on 01/30/20 at 11:22 AM. (F808)	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to provide immediate emergency treatment to a resident that choked on food during the breakfast meal in the dining room. After the resident became [redacted] and [redacted] the resident was removed from the dining room by the Certified Nurse Aide (CNA) and taken back to the	F 684	The resident #58 was sent to the emergency department and admitted and treated. Resident has since readmitted to the facility. Resident remains on a pureed diet. Other residents who reside at the facility and who have an emergency will be treated via the new code response. LPN #1 was disciplined for not following	3/23/20

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resident's room, where the Heimlich maneuver (Heimlich) was performed and the food expelled. This deficient practice was identified for Resident #58, 1 of 1 resident who choked on [redacted], and a delay in emergency response placed the resident at a significant risk of death.

The facility failed to ensure that emergency treatment was provided at the time and place of the resident's choking episode. On [redacted], at 9:32 AM, under the direction of a Licensed Practical Nurse (LPN #1), the resident was removed from the dining area by a CNA and transported down the hallway to the resident's room where LPN #1 performed the Heimlich. This failure constituted immediate jeopardy (IJ) to the resident's health and safety, with the potential to affect all residents who resided in the facility. The Administrator was made aware of the IJ on 01/29/20 at 4:35 PM, and a removal plan was accepted on 01/30/20 at 11:22 AM.

The implementation of the removal plan was not verified upon completion of the survey.

This deficient practice was evidenced by the following:

On [redacted] at 9:30 AM, the surveyor began a tour of the [redacted] floor unit and introduced self to LPN #1. LPN #1 stated he was not the charge nurse and that there was not a specific charge nurse for the [redacted] floor on that day.

While the surveyor was interviewing a resident in their room on [redacted] at 9:32 AM, the surveyor overheard the shout of "code." The surveyor proceeded to the doorway of the resident's room and observed CNA #4 transporting Resident #58 in a [redacted] (wheelchair). In a clear

Provider's Plan of Correction (F 684):

the facility provided competency on November 15, 2019 related to emergency response.
All Licensed Practical Nurses and Registered Nurses will be educated on code response highlighting initial response including:
" Staying with the resident at all times
" Performing treatment on site

Facility will implement and educate all LPN□s and RN□s on the new code flow sheets. This sheet will be a reflection of the treatment provided during an emergency related to CPR and / or Heimlich.
Nursing administration including the Director of Nursing, Clinical Educator, or Unit Managers will implement random mock code drills monthly to ensure staff are following the facility policy and procedure for three months.
The Dining Room Committee will implement a new dining room schedule for oversight during mealtime.
Licensed Nursing Home or designee will educate new Clinical Educator on the correct completion of signatures for completed competencies.
The Regional Director of Operations will educate Human Resource Manager on the requirements of signatures from supervisors on the job descriptions.
The facility will roll out a new hire checklist to ensure all the necessary documents including job descriptions will be completed. This checklist includes but limited too new hire paperwork, competencies, license verification, I9 verification, job descriptions and health

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F 684	Continued From page 3 unobstructed view, the surveyor observed that Resident #58 was sitting motionless and upright. His/her face was [redacted]. The surveyor observed that Resident #58 was transported to his/her room. The surveyor proceeded to Resident #58's room and observed the door to the room was not fully closed. The surveyor overheard voices coming from the inside of Resident #58's room stating that the resident was [redacted], it is a code, they were feeding [him/her], and [he/she] wasn't eating, and [he/she] was [redacted] and [he/she] choked." (Cross refer F808). On 01/26/20 at 9:41 AM, the surveyor observed LPN #1 at the [redacted] floor nursing station. LPN #1 stated he was preparing the emergency transfer form for Resident #58. LPN #1 stated at 9:43 AM, that he performed the Heimlich and got out little particles of food. At that time, LPN #1 did not indicate where he performed the Heimlich. On 01/26/20 at 9:55 AM, the surveyor observed Resident #58 on a stretcher and was being transported out of the facility by emergency medical service (EMS). On 01/26/20 at 10:26 AM, the surveyor, in the presence of two surveyors, interviewed CNA #4 who stated the resident was drowsy and that she had to wake the resident up to start feeding the resident. She stated the resident wasn't breathing right so she left the resident to go get LPN #1. CNA #4 stated that she was instructed by LPN #1 to take the resident to his/her room. She stated when the resident was taken to the his/her room, the resident was [redacted] She stated there were two other CNAs with her in the resident's room and she was not sure who they were. She stated	F 684	file. This will be tracked through the weekly facility staff meeting. The Regional Director of Operations or designee will randomly check the new hire files monthly for three months to ensure the completion of the newly implemented check list. The facility typically has their new hire orientation class monthly. The Quality Assurance Steering Committee will be educated on the workflow of the committee understanding benchmarks and root cause analysis including implementation of Performance Improvement Projects. Results of the mock code drills will be reported to the Quality Assurance steering committee monthly x 3 months. Following 3 months the committee will decide the frequency of the audit. Results of the new hire check list will be reported the Quality Assurance steering committee monthly x 3 months. Following 3 months the committee will decide the frequency of the audit.	

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the CNAs transferred the resident to the resident's bed and LPN #1 tried to do "CPR." She stated LPN #1 then stood the resident up and did the Heimlich and a piece of pancake flew out of the resident's mouth.

On 01/28/20 at 12:14 PM, the surveyor interviewed LPN #1 regarding the incident that occurred on [redacted] with Resident #58 in the dining room. LPN #1 stated he observed CNA #4 exit the dining room as he was headed toward the unit pantry, which was across from the nurses' station. He stated CNA #4 asked him to come and see Resident #58 because the resident had [redacted], "or something like that." He stated at that time, he went into the dining room and noticed that Resident #58 had [redacted]" and was [redacted] He stated at that time he decided to remove the resident from the public and take him/her to the resident's room. He further stated the normal procedure was to start emergency care in the dining room and then take the resident to the room. The surveyor inquired if LPN #1 wrote a statement of the events and he stated that he still needed to write one. Immediately upon statement inquiry, LPN #1 changed his prior statement. LPN #1 now stated that as soon as CNA #4 showed him Resident #58, he could tell that the resident was choking. He stated that he performed the Heimlich and removed food from the resident's mouth in the dining room before the resident was taken to the room, where he performed the Heimlich again in the resident's room.

At 01/28/20 at 1:38 PM, in the presence of two surveyors, LPN #1 requested to speak with the surveyor. LPN #1 stated that he wanted to clarify his statement made during the previous interview at 12:14 PM. LPN #1 stated he did not perform

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the Heimlich in the dining room and that he realized that he did not do the Heimlich on the resident until the resident was brought out of the dining room and taken into the resident's room. The surveyor inquired about the resident's status when he entered the dining room. LPN #1 responded that the resident's [redacted] was turning [redacted] and that he didn't notice any breathing issues. The surveyor asked LPN #1 what he should have done. He responded that he was still trying to figure out what to do when he went into the dining room. After he looked at the resident, he stated he left to call the supervisor and 911.

On 01/28/20 at 1:56 PM, during an interview with LPN #2, LPN #2 stated she heard a "Code Blue" and went to Resident #58's room, where LPN #1 was doing the Heimlich with the resident in a standing position. LPN #2 stated she saw a "pretty big" piece of pancake come out of the resident's mouth about "this big" and motioned with her hands to show a piece approximately [redacted] in [redacted]

On 01/28/20 at 2:17 PM, the surveyor interviewed the LPN/Unit Manager (UM #1) who stated that the nursing staff were required to assess a resident at the scene of the event. If the resident was choking, the nurse was to initiate the Heimlich Maneuver and call a Code Blue with an overhead page. She stated the recertification for CPR and Heimlich with the [redacted] was just done at the facility. She stated they had a large group and when CPR certification was completed, a copy was given to the DON and she thought human resources also received a copy.

On 01/27/20 at 11:07 AM and on 01/28/20 at 1:52 PM, in the Administrator's office, two surveyors

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along with the DON and Administrator, reviewed the facility's video surveillance footage on [redacted] The two camera views reviewed were Camera [redacted] ([redacted] floor) and Camera [redacted] ([redacted] floor). The time stamp on the video footage between the two cameras differed by approximately 16-17 minutes. This was acknowledged by the DON who stated she was informed by the computer department that the time stamps that were on the videos were approximately 15 minutes ahead of the actual time. The DON stated both cameras were timed and each camera had it's own time stamp. She stated the time on the cameras had been a problem lately. The facility provided a copy of the video footage from each camera view to the survey team. The video evidenced the following on [redacted]:

Camera [redacted] ([redacted] Room): The video footage started at 09:31:53.

At 09:31:54, CNA #4 placed a meal tray on the table where resident #58 was seated in a [redacted] [redacted] (wheelchair). Resident #58 was the only resident seated at the table.
From 09:32:46 to 09:40:02, CNA #4 was observed seated in a chair located to the right side of the resident's wheelchair, feeding Resident #58.
At 09:40:05, CNA #4 stood up and walked toward the dining room entrance.
At 09:40:11, CNA #4 walked out of camera view. Resident #58 remained seated unaccompanied at the table. There was no other staff observed in the camera view at that time.
At 09:40:33, CNA #4 appeared in camera view and walked in the direction of the resident.
At 09:40:37, LPN #1 entered the camera view and walked in the direction of the resident.

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At 09:40:38, CNA #4 returned to the resident's side.
At 09:40:41, CNA #4 sat down in a chair located on the right side of Resident #58's wheelchair.
At 09:40:41, LPN #1 arrived at resident's table. LPN #1 stationed himself to the rear and right side of the resident, in between the resident's wheelchair and where CNA #4 was seated. LPN #1 placed his left hand on the grab bar located on the back of Resident #58's wheelchair and peered around the right side of resident. His right arm was positioned on the armrest of the resident's wheelchair.
At 09:40:45, LPN #1 used the grab bar to pull the resident's wheelchair backwards and away from the table. LPN #1 made a hand motion to CNA #4 who then started to stand from the chair.
At 09:45:47, LPN #1 let go of the wheelchair and walked towards dining room entrance.
At 09:45:48, CNA #4 turned the resident's wheelchair forward facing and pushed the resident towards the dining room entrance.
At 09:40:50, LPN #1 walked out of camera view.
At 09:40:56, CNA #4 walked out of camera view pushing the resident in the wheelchair.

The following was observed on Camera [redacted] ([redacted]: The video footage started at 09:56:31.

At 09:56:51-09:56:56, CNA #4 entered camera view in front of the nurses' station. At 09:56:58, LPN #1 walked out of camera view.
At 09:57:23, LPN #1 entered camera view in front of nurses' station and then immediately went out of camera view.
At 09:57:29, LPN #1 moved into camera view, behind the nurses' station, and then out of camera view at 09:57:34.
At 09:57:32, Resident #58, seated upright in a wheelchair, appeared in the camera view with

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F 684	Continued From page 8 CNA #4 in front of the nurses' station. At 09:57:36, LPN #1 entered camera view, behind resident. LPN #1 motioned with hands towards CNA #4 to follow at 09:57:37. At 09:57:43, CNA #4 transported Resident #58 down the hallway. At 09:57:56, CNA #4 entered the resident's room with the resident, followed by CNA #8. At 09:58:01, LPN #1 stepped a foot into the resident's room, then stepped back out. He motioned with his arms while looking towards the nurses' station. At 09:58:05, LPN #1 entered the resident's room. At 09:58:10, LPN #1 exited the resident's room and ran down the hallway, out of camera view. CNA #5 entered the resident's room. At 09:58:31, LPN #1 entered camera view, carrying a [redacted]. At 09:58:36, LPN #1 returned to the resident's room with the [redacted]. At 09:58:44, CNA #5 exited the resident's room. At 09:59:03, CNA #8 exited the resident room, walked down the hall, toward the nurses' station, turned around, ran back to the resident's room, and re-entered the resident's room at 09:59:25. At 09:59:32, CNA #1 entered the resident's room. At 09:59:36, LPN #2 entered the resident's room. At 09:59:38, CNA #5 entered the resident's room and exited the room at 09:59:51 and pulled the door ajar. At 10:00:26, LPN #2 exited the resident's room, followed by CNA #1 At 10:01:07, the DON entered the resident's room with a back board and LPN #3 entered the room with a code cart. At 10:04:20, RN/S #1 entered the resident's room. At 10:10:51, emergency responders entered the resident's room.	F 684		

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On 01/28/20 at 3:09 PM, the surveyor, in the presence of another surveyor and the Administrator, interviewed the DON during review of the surveillance footage. The DON stated she was called into the facility when she was notified the surveyors were in the building. She stated that she was the one that told LPN #1 to call 911 and that she also wrote a statement about the incident.

On 01/28/20 at 3:19 PM, the DON stated that if a nurse walked into a situation and a resident was blue, that meant that the resident's airway was obstructed. The DON said the nurse should automatically call a code. She stated that a nurse can yell out to get assistance and tell a CNA to call a code so the nurse could remain with the resident and start emergency care. The DON stated LPN #1 should have stayed with the resident at all times.

On 01/28/20 at 4:50 PM, the surveyor interviewed the DON in the presence of the survey team. The DON stated she was unsure of the exact time that she heard the code called overhead and went to Resident #58's room. She stated she checked the resident's [redacted]. The surveyor inquired if the DON assessed the resident. The DON stated she documented the resident assessment on the statement she completed for the investigation.

A review of the Progress Notes, dated [redacted] at 15:16 (3:16 PM), revealed a [redacted] that was completed by LPN #1. The note revealed that "around 9:30 AM, this writer was informed by a CNA that [Resident #58] is having [redacted] floor dining room." "Unfortunately, resident was choking and this nurse immediately did an

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helmrick manover [sic], sweep out the remaining food in [his/her] mouth and applie [redacted] sic]... ."

The Administrator provided the survey team with a copy the investigation for the choking incident that occurred on [redacted]. The investigation included an Individual Statement Form (ISF), completed [redacted] by the DON, which revealed the DON entered Resident #58's room and the resident was in bed with [redacted]; the resident had a pulse; was taking [redacted]; and the DON applied a [redacted] to the resident as the other nurse was checking the resident's [redacted] and [redacted]. She instructed LPN #1 to call 911. There was no evidence of a documented assessment completed by a Registered Nurse in Resident #58's medical record.

Review of the ISF, dated [redacted] and completed by LPN #1, revealed Resident #58 was having [redacted] while eating in the dining room and "unfortunately" the resident was choking and the nurse immediately performed the Heimlich Maneuver and swept the remaining food out of the resident's mouth.

On 01/29/20 at 9:47 AM, the surveyor, in the presence of the survey team asked the DON and Administrator regarding any policies for oversight of the dining room at meal service and any policies related to emergency procedures for resident care.

On 01/29/20 at 10:22 AM, the DON, in the presence of the survey team and Administrator, stated there were no policies regarding oversight of the dining room or related to emergency procedures related to resident care.

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On 01/29/20 at 10:47 AM, the DON provided the surveyor with a CPR policy and stated that was the only emergency policy and there was nothing specific for the dining room.

On 01/29/20 at 1:01 PM, the surveyor, in the presence of the survey team, completed a telephone interview with the Registered Nurse/Supervisor (RN/S) who worked on [redacted]. She stated she worked double shifts on the weekend and her responsibilities included to conduct rounds of residents and that she was available for emergencies. She stated she did not monitor the dining room. She stated she was available when help was needed and when a code was called. RN/S stated that on [redacted] she thought she was on the [redacted] floor in a resident's room and did not hear a code being called. She stated she thought that a CNA told her around 9:30 AM and she responded as quickly as she could but the elevator was taking time to arrive. She stated by the time she arrived at Resident #58's room, the DON and a whole bunch of people were in the room. She stated if a resident was [redacted], the nurse should have directed someone to call her, and that the nurse should have stayed with the resident until the she responded. She stated the nurse should not leave the patient. RN/S further stated that if a person was not breathing and if you knew the person was choking, the nurse should do the Heimlich on the spot.

At 01/29/20 at 2:03 PM, the surveyor measured a distance of 94 feet from the dining room table where the resident was seated, to the resident's room.

On 01/30/20 at 2:58 PM, the surveyor in the

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presence of the survey team, interviewed CNA #5. CNA #5 stated she was in the hallway when Resident #58 was brought out of the dining room. She stated CNA #4 and CNA #8 stated to her that Resident #58 was choking, and at that time, LPN #1 came down the hallway and instructed the CNAs to take Resident #58 to the resident's room. She stated when the resident was brought to the resident's room, she did not enter the room, but the door was open and she could see that LPN #1 started to stand the resident up. She stated that at that time, she left the area. She stated she wrote a statement.

An ISF, dated 01/28/20 and completed by CNA #5, revealed she observed the CNAs and Resident #58 coming out of the day room and LPN #1 told the CNAs to take the resident to the resident's room. The statement further revealed that CNA #5 went to Resident #58's room and closed the door and remained outside in the hallway.

On 01/31/20 at 10:52 AM, in the presence of the survey team, the surveyor interviewed, CNA #8. CNA #8 stated that on [redacted], during the breakfast meal, she assisted a resident to the bathroom, which was across from the dining room. She stated she then observed LPN #1 come out of the dining room with Resident #58 and stated the resident was [redacted] and to call a code. She stated the nurse pushed the resident in a wheelchair to the resident's room. CNA #8 stated that she, CNA #1 and another CNA followed LPN #1 with Resident #58 to the resident's room and during that time, CNA #1 and the other CNA were telling LPN #1 that Resident #58 was choking. CNA #8 stated at that time the resident's [redacted] was [redacted] and the resident looked like he/she was [redacted]. She stated

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LPN #1 instructed her to get [redacted] and she left and brought it in the room. She said she told LPN #1 that the resident was choking and that LPN #1 proceeded to leave the room, leaving the three CNAs alone with the resident. At that time, CNA #8 stated the resident was making a [redacted] sound, that sounded like choking, and that CNA #4 tried to hit the resident on the back. She further stated LPN #1 returned to the room and picked the resident up from the bed, performed the Heimlich and something came out.

On 01/31/20 at 11:37 AM, the surveyor reviewed LPN #1's employee file and the Licensed Practical Nurse (LPN) Job Description, provided by the Human Resources Director (HRD). A Nursing Core Competency Annual Assessments revealed a hire date of [redacted] and was signed by LPN #1. The Administrator and Director signature was blank. The HR director stated the DON and Administrator should have signed it and there should be someone's initials next to each competency to indicate that it was done. She further stated that the 2019 competencies were not done, because if they were, they would be in the file. The unsigned job description revealed specific requirements for an LPN which included thorough knowledge of principles, methods and techniques involved in performing general nursing services and adapting or modifying standard nursing practices for care of specific cases.

A Cardiopulmonary Resuscitation Initiation competency, dated [redacted], for LPN #1 revealed the competencies included critical elements to establish unresponsiveness and attempt to arouse the resident and call for help and stay with the resident. The competencies were checked off as met and there was no evaluators signature on the document.

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F 684	Continued From page 14 Review of a typed, undated letter, revealed LPN #1 successfully completed his/her CPR training course on [redacted] and was awaiting a card. The letter revealed a copy of a Basic Life Support Instructor (BLS #1) Certification card. On 02/11/20 at 4:23 PM, the surveyor interviewed BLS #1 by telephone. BLS #1 stated the typed letter was her certification that she completed a private course with LPN #1 on [redacted] and stated that she trained LPN #1 in CPR, the Heimlich Maneuver and use of an AED (automated external defibrillator that immediately diagnoses life threatening heart arrhythmia's). According to the hospital records received at the NJ Department of Health on [redacted], Resident #58 arrived at the Emergency Department with EMS for evaluation of choking. EMS reported the patient choked on pancakes that morning at the facility, the Heimlich was performed and the patient coughed up the pancakes. The resident had [redacted] of the [redacted], dated [redacted], that revealed [redacted]).	F 684		
F 808 SS=K	NJAC 8:39-27.1(a) Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may	F 808		3/23/20

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F 808	Continued From page 15 delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to provide the correct diet for 2 of 41 residents reviewed for altered consistency diets, Resident #58 and Resident #64. a.) Resident #58, who had a diagnosis of [redacted]), a history of [redacted] and was [redacted]) at meals, was fed a chopped diet instead of the physician ordered pureed diet. The resident choked on the food, became [redacted]), and required emergency treatment. On [redacted] at 3:45 PM, the facility Administrator was notified that an Immediate Jeopardy situation (IJ) had been identified. The survey team accepted the removal plan on 01/27/20 at 1:56 PM. There was a systemic failure when multiple facility staff failed to identify and provide the correct physician ordered modified consistency diets to multiple residents; b.) The facility failed to follow their removal plan, which resulted in a subsequent IJ identified on 01/29/20 at 12:10 PM, for Resident #64, who had a diagnosis of [redacted] and was identified as at risk for [redacted], and was served mechanically ground vegetables instead of the physician ordered pureed vegetables; and c.) The facility failed to follow their removal plan for 2 of 2 residents, Resident # 64 and Resident #34, who received their meal tray without the two-person point review system for meal tray accuracy at the point of service, in accordance with the facility's removal plan.	F 808	Resident #58 was sent to the emergency department and admitted and treated. Resident has since readmitted to the facility. Resident remains on a pureed diet. Resident #64 was evaluated for signs and symptoms of [redacted] and had a precautionary [redacted] completed which was negative. Resident remains on a pureed diet. It was verified by Director of Nursing that Resident #34 received the correct tray. Residents with [redacted] will be screen by speech to ensure they currently are ordered the correct diet. Certified nursing assistant #4 who served the resident the incorrect tray did not return to the nursing home and her certification was reported to the department of health. Certified nursing assistant #3 who served the wrong consistency of vegetables was terminated and her certification was reported to the department of health since she had received three previous in-services on the new policies. The dietary staff that checked the diet was from the contracted service and was asked not to return to the facility. The facility terminated the contracted service and brought the dietary department inhouse as of March 1, 2020. A seasoned dietary manager from a sister facility was transferred to the Cherry Hill	

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F 808	Continued From page 16 During the standard survey of 01/31/20, the facility Administration was notified of the IJ situation on [redacted] at 3:49 PM. The facility failed to ensure that the correct physician ordered mechanically altered diet consistency was provided to a resident who had a diagnosis of [redacted], a history of [redacted] and was at risk for [redacted] Resident #58 had an order for a puree diet and was provided a chopped consistency meal tray. A Certified Nurse Aide (CNA #4) fed the resident the incorrect diet. The resident choked, became [redacted] and 911 was activated. The facility provided a removal plan on 01/27/20 at 1:56 PM. The IJ was continued at a lower scope and severity when it was identified the removal plan was not fully implemented. On 01/28/20, a CNA #6 distributed a late meal tray to Resident #34 without having the meal checked by two staff in accordance with the facility's removal plan. On 01/29/20, the facility Administration was notified of a subsequent IJ situation at 4:31 PM. The facility failed to ensure the implementation of the removal plan, dated 01/27/20, and ensure that the correct physician ordered mechanically altered diet consistency was provided to Resident #64 who had a diagnosis of [redacted]. The resident had an order for a puree diet. The cook plated the food incorrectly, and the resident was provided a meal tray that contained ground vegetables. CNA #3 fed the resident the incorrect diet. The removal plan was accepted on 01/30/20 at 11:22 AM. The implementation of the removal plan was not verified upon completion of the survey.	F 808	facility as the new dietary manager. Facility will have nursing screen each resident for recent behaviors during meals to identify if any have showed signs or symptoms of lethargy or difficulty with swallowing. " Those residents will be screened by the Speech Therapist to ensure appropriate diet is in place for each resident. The Administrator and Director of Nursing will implement a two person point of contact for review of meal tray at point of service. This new policy and procedure (Tray Identification) will be in-serviced to all nursing staff. " Appropriate identification/coding shall be used to identify various diets. " The Food Services department will check trays for correct diets before the food carts are transported to their designated areas. " Two trained nursing staff shall check each food tray for the correct diet before serving the residents. Some of the items to verify on the food tray are as follows: o Name (First and Last) o Diet o Adaptive Equipment " If there is an error, the Nurse Supervisor will notify the Dietary Department immediately by phone so that the appropriate food tray can be served. Administrator and Director of Nursing will educate all staff including scheduled agency staff by end of day on the following: " Therapeutic Diets	

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Part A. Resident #58

This deficient practice was evidenced by the following:

While the surveyor was interviewing a resident in their room on [redacted] at 9:32 AM, the surveyor overheard the shout of "code." The surveyor proceeded to the doorway of the resident's room and observed CNA #4 transporting Resident #58 in a wheelchair. In a clear unobstructed view, the surveyor observed that Resident #58 was sitting motionless and upright. His/her [redacted] was [redacted] in [redacted] and the resident was [redacted].

The surveyor observed that Resident #58 was transported to his/her room. The surveyor proceeded to Resident #58's room and observed the door to the room was not fully closed. The surveyor overheard voices coming from the inside of Resident #58's room stating that the resident was [redacted] it is a code, they were feeding [him/her], and [he/she] wasn't eating, and [he/she] was [redacted], and [he/she] choked."

The surveyor reviewed Resident #58's medical record and noted the following:

An Admission Record revealed the resident was admitted to the facility with diagnoses that included [redacted].

A Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care dated [redacted] revealed the resident had a Brief Interview for Mental Status Score of [redacted] which indicated the resident was [redacted]. The MDS revealed the resident required extensive assistance of one person to

F 808

" Meal tickets
" Tray Identification
" Name (First and Last)

Administrator and Director of Nursing will have all nursing staff including agency complete the Health Care Academy course prior to their shift on Feeding and Eating Assistance.
The Director of Nursing or designee will complete a random audit to verify newly implemented policies during meal time.
The facility is changing their tray ticket system to go with a system that is integrated with their current electronic medical record. This will allow the following:
" Avoid confusion with the layout of ticket and description of diet consistencies
" Pictures of residents to allow for the verification of correct tray delivery.
" Highlight in colors and font diet consistencies, allergies, adaptive equipment

With this change a onetime audit completed by the Food Service Director or designee will be completed on each resident□s meal ticket to ensure the correct information is reflected into system.
The policy and procedure (Tray Identification) will be revised to include the new color-coded identifications noted above.
Visual guides will be printed for the color-coded tickets and pictures of diet consistencies. These will be posted in the kitchen and on the inside door of the meal carts.

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F 808	Continued From page 18 eat meals and was totally dependent on staff for personal hygiene. The MDS indicated the resident had a [redacted], loss of [redacted], and was on a mechanically altered diet. The Care Plan revealed a Focus, initiated [redacted], that indicated the resident was on an altered diet texture due to his/her diagnoses of [redacted] and [redacted]. A goal, initiated [redacted] revealed the resident would be free from signs and symptoms of [redacted] or [redacted]. A Medication Review Report, dated [redacted] revealed the resident had a physician order for a NAS (No Added Salt) diet Pureed Texture, dated [redacted]. A review of the Progress Notes, dated [redacted] at 15:16 (3:16 PM), revealed a [redacted] that was completed by LPN #1. The note revealed that "around 9:30 AM," LPN #1 was informed by CNA #4 that Resident #58 was choking in the dining room and LPN #1 immediately did the Heimlich maneuver and swept out the remaining food in the resident's mouth and applied [redacted]. A review of a quarterly Nutrition/Dietary Note, dated [redacted] at 10:57 AM and completed by the Dietitian, revealed Resident #58 continued on a NAS, puree diet which was appropriate and tolerated well. Resident was dependent for eating, weight was gradually trending downward due to decreased food intake, and that the	F 808	This revised policy will be re in-serviced to all nursing, all activity staff and all dietary staff by the Administrator, Director of Nursing, Dietary Manager and or the AristaCare home office staff. The dietary staff will implement a tray line checklist to be completed during each meal for the next 30 days by a member of the dietary team. The tray line checklist will audit the tray line for palatability, portion size and consistency. The dietary schedule will accommodate the changes to the tray line policy which include identifying the personnel expected to be on tray line. " Starter o Will put the following items on the meal tray: ¿ Placemat, napkin, silverware, condiments, hot plate and pellet ¿ Places on beltline " Cook o Plates up food and places on pellet plate " Middle o Will put on cold items and extra items " End o Check accuracy of tray o Correct name, room number and diet order o Accuracy of following the therapeutic diet extension o Proper portion sizes o Special requests (food preferences) o Neatness of tray and attractiveness of the food served " Runner o Delivers the carts to the units All the dietary staff will be in-serviced on	

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F 808	Continued From page 19 resident was [redacted] during meals. A review of the Census List (a listing of the resident's diets and used by dietary and nursing), dated [redacted], revealed that Resident #58 was on a NAS (no added salt), Pureed Diet (smooth textured diet). On [redacted] at 9:37 AM, the surveyor observed a meal tray at an unoccupied table with a meal ticket that reflected Resident #54's name and an order for a chopped diet consistency which also allowed soft sandwiches and soft snacks. The tray contained approximately 16 one-inch pieces of pancake, which appeared dry, and approximately six one-inch pieces of sausage patty with a plastic fork stuck into the pancakes. A four-ounce container of orange juice, an unopened container of pancake syrup, an unopened package of butter, an unopened package of cereal and unopened container of farina was also observed on the tray. The surveyor observed the first name printed on Resident #54's meal ticket was the same first name as Resident #58. During this observation, CNA #4 entered the dining room and approached the surveyor during the surveyor's observation of Resident #54's meal tray. CNA #4 held up the meal ticket that was located on Resident #54's meal tray and stated to the surveyor that she fed Resident #58 that meal tray. She stated she fed Resident #54's meal tray to Resident #58 and stated, "I was feeding [Resident #58] and something must have gotten stuck in [his/her] throat." She further examined Resident #54's meal tray ticket and stated that wasn't Resident #58's tray, and that the resident received the wrong tray. She continued to state that she fed Resident #58 pancakes.	F 808	the roles of the employees on the tray line. The Dining Room Committee will implement a new dining room schedule for oversight during mealtime Following 3 months of the reported audits to the Quality Assurance Steering Committee, the committee will decide the frequency and type of the audits that will be monitored monthly ongoing through the dining room committee.	

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On 01/26/20 at 9:40 AM, the surveyor continued the interview with CNA #4 in the dining room. CNA #4 stated, "I accidentally gave [Resident #58] the wrong tray, I am not sure what [Resident #58] gets." CNA #1 stated that she was employed through an agency and had been at the facility for a while. CNA #1 stated she had taken care of Resident #58 in the past.

On 01/26/20 at 9:41 AM, the surveyor observed Licensed Practical Nurse (LPN #1) at the second-floor nursing station. LPN #1 stated he was preparing the emergency transfer form for Resident #58. At that time, CNA #4 approached LPN #1, in the presence of the surveyor, and stated to LPN #1 that she accidentally gave Resident #58, Resident #54's tray. At that time, the surveyor interviewed LPN #1 about Resident #58's diet and LPN #1 stated that Resident #58's diet "is a puree, full puree."

On 01/26/20 at 9:42 AM, the surveyor brought CNA #1 into the dining room to observe Resident # 54's meal tray and the corresponding meal ticket located on the meal tray. CNA #1 observed the meal tray and meal ticket and stated that this was not Resident #58's name on the meal ticket and the the meal was the wrong diet. She stated, "this was the wrong diet, this was not [Resident #58's name] and this was not even [Resident #58's] food at all." CNA #1 stated she was a full-time employee of the facility.

On 01/26/20 at 9:43 AM, the surveyor interviewed LPN #1 who stated he performed the Heimlich maneuver on Resident #58 and "got out little pieces of food."

On 01/26/20 at 9:55 AM, the surveyor observed

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F 808	Continued From page 21 Resident #58 on a stretcher and was transported out of the facility by Emergency Medical Service (EMS). On 01/26/20 at 10:06 AM, the surveyor interviewed the [redacted] unit manager (UM #1) who stated Resident #58 had been on a puree diet for a while and she showed the surveyor a book of recent diet orders. A review of the book revealed that there were no recent diet order changes for Resident #58. At that time, UM #1 provided a copy of Resident #58's CNA Kardex (resident specific care report used by nurse aides) information. The Kardex did not include information regarding the type of diet Resident #58 consumed. UM #1 also provided a copy of the [redacted] "Daily Assignment Sheet," which revealed that CNA #4 was assigned to Resident #58 to provide care. On 01/26/20 at 10:26 AM, the surveyor, in the presence of two surveyors, interviewed CNA #4 who stated that she worked at the facility often and stated that she thought Resident #58 was on a puree diet. She stated she didn't pay attention to the resident's last name on the tray ticket. She stated the resident was drowsy and she woke the resident to feed him/her. She stated that she fed Resident #58 a piece of pancake and then noticed the resident was not breathing right. She stated she left the resident alone in the dining room to get the nurse. CNA #4 stated that she observed that the resident's meal was not puree; however, she thought the tray was correct because it matched the diet printed on the meal ticket. She further stated she did not cut the pancake or sausage any more than the way it was served on the tray. She fed Resident #58 pancake first and then sausage. She stated the	F 808		

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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

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diet Resident #58's was prescribed was not listed on her assignment sheet and she would have to ask the nurse if she needed to know. She stated that she would know the resident's diet by reading what was printed on the resident's tray ticket.

On 01/26/20 at 10:41 AM, the interview continued, and CNA #4 stated Resident #58 was taken to the resident's room and during that time the resident was [redacted] She stated there were two other CNAs with her in the resident's room and she was not sure who they were. She stated the CNAs transferred the resident to the resident's bed and the nurse tried to do "CPR," and after that the nurse stood the resident up and did the Heimlich maneuver and a piece of pancake flew out of the resident's mouth.

On 01/26/20 at 11:07 AM, the surveyor interviewed the Food Service Director (FSD) who stated that a puree consistency diet was the consistency of baby food or applesauce with no lumps. He further stated that regular pancakes and sausage were not provided on a puree diet because a resident could choke.

On 01/26/20 at 11:24 AM, the surveyor, in the presence of the survey team, interviewed the Director of Nursing (DON) and facility Administrator. The DON stated the aides know their assignments and which residents need to be fed. The DON stated that the CNAs have access to the information in the kiosk (computer CNA assignment). The DON showed the surveyor the [redacted] "Daily Assignment Sheet" where CNA #4 was assigned to the [redacted]" to feed residents. The DON further stated that when the trays arrived on the floor, CNAs were supposed to check the meal ticket and the diet to make sure the tray was accurate. She stated that they

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should also check the name of the resident and the meal ticket to ensure that the resident received the correct tray. The DON stated the CNAs were trained on the dining process and how to properly feed a resident during orientation and that the training was part of their annual competencies. The DON was interviewed regarding agency staff being included in the facility orientation training or annual competencies. The DON stated that she was not aware of the agency staff being provided with education at the facility.

On 01/26/20 at 1:09 PM, the surveyor interviewed LPN #1 who stated that the CNAs should check that the resident's name band matched the meal ticket and that they should check even when they are familiar with the residents. He stated that the CNAs were also supposed to confirm the accuracy of the tray for the correct diet and check for missing items.

A review of Resident #58's Speech Therapy Encounter Note, dated [REDACTED] and signed by the speech clinical fellow (SCF), revealed that the SCF examined Resident #58's [REDACTED]. The patient was unsafe to continue feeding by mouth at that time and the nursing and the aides verbalized understanding and agreement.

A review of Resident #58's Speech Therapy Encounter Note, dated [REDACTED] and signed by the Speech Clinical Fellow (SCF), revealed that the resident was on a puree consistency diet.

On 01/26/20 at 2:57 PM, the surveyor, interviewed the Regional Manager of Speech Therapy (RMSP) who stated she cosigned the

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SCF notes and stated she had seen Resident #58 "a handful of times." She stated the resident was not always arousable and that the resident was known to nursing for [redacted] food. She stated any education would have been done with staff at that time and that there wasn't any documentation. She stated the strategies should be on the care plan and stated that she should not have been fed regular sausage and pancakes.

On 1/26/20 at 12:30, the DON provided a copy of an undated "Serving of Food" policy, which revealed food shall be prepared and served in a manner that prevents foodborne illness and meets the individual needs of each resident. The policy further revealed that nursing staff and feeding assistants would serve resident trays and would help residents who require assistance with eating. Residents who could not feed themselves would be fed with attention to safety, comfort and dignity.

Part B. Resident #64

There was a systemic failure when multiple facility staff failed to follow the removal plan accepted on 01/27/20 at 1:56 PM, which indicated a two person point of contact for review of meal tray at point of service. The facility served a resident a ground diet instead of a physician ordered puree diet.

The facility's failure to ensure the resident, who had difficulty swallowing and was at risk for aspiration, received the appropriate altered diet. Serving the wrong consistency constituted an Immediate Jeopardy (IJ) to the resident's health and safety.

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This IJ was identified on 01/29/20 at 12:10 PM, in the main dining room, after the surveyor observed CNA #3 feeding Resident #64 a spoonful of ground Italian mixed vegetables. Resident #64 ingested the ground mixed vegetables and swallowed the mixture. The IJ was reported to the Administrator and the Director of Nursing (DON) on 01/29/20 at 4:31 PM and the removal plan was requested. The removal plan was accepted on 01/30/20 at 11:22 AM.

This deficient practice was evidenced by the following:

The surveyor reviewed Resident #64's medical record and noted the following:

The Admission Record revealed the resident was admitted to the facility with diagnoses which included: [redacted] [redacted].

The Quarterly Minimum Data set (MDS), an assessment tool dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) of [redacted] which indicated that the resident's cognition was [redacted]. The MDS also indicated that the resident was on a mechanically altered diet (change in food or liquids texture).

The Care Plan [redacted], dated [redacted], revealed the resident had a history of [redacted] The goal was for the resident to be free from signs and symptoms of [redacted] or [redacted]. The intervention listed was for staff to serve the resident's diet as ordered.

A Physician Order sheet, dated [redacted] revealed the resident was prescribed a puree diet with nectar thickened liquids.

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A review of the Nutrition/Dietary Note, dated [redacted] at 02:49, revealed the resident required a puree diet with nectar thick liquids.

A Speech Therapy (ST) (SLP Evaluation & Plan of Treatment) report, dated [redacted], revealed the resident was referred to ST for an [redacted]. The evaluation was done to assess the least restrictive oral intake and to restore the resident's oral function. The report also revealed the resident had a past medical history [redacted].

On 01/29/20 at 11:53 AM, the surveyor conducted a dining room observation to ensure the removal plan of 01/27/20 was implemented. At that time, the surveyor observed Resident #64 seated in his/her wheelchair being fed ground Italian mixed vegetables by CNA #3.

The surveyor reviewed Resident #64's meal ticket that was lying on the table next to the resident's meal plate. The surveyor compared the resident's meal ticket to the meal the resident was being fed by CNA #3. The meal ticket revealed the resident was to be served puree ham, mashed sweet potatoes and puree Italian mixed vegetables; however, the resident's lunch meal plate contained, pureed ham, mashed sweet potatoes and ground consistency Italian mixed vegetables.

CNA #3 immediately stopped feeding the resident and asked the surveyor if Resident #64's meal was incorrect. When interviewed by the surveyor, CNA #3 stated the vegetables were puree consistency.

The surveyor requested for a nurse to come to the dining room. CNA #3 stated there was no

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nurse inside the dining room during meals.

The surveyor observed the Nurse Consultant (NC #1) walking down the hallway and requested for her to come inside the dining room. NC #1 reviewed the resident's lunch meal and stated the vegetables looked to be either chopped or ground and were not a puree consistency. When interviewed by the surveyor at that time, NC #1 stated the resident was supposed to have been served a puree diet. NC #1 stated that if the resident was to ingest the ground vegetables, the resident could "choke" on the food.

During an interview on 01/29/20 at 12:11 PM, in the presence of four surveyors, the FSD and Regional Manager, Cook/Supervisor #1, stated that he had worked at the facility as the PM (evening) Cook/Supervisor for 30 days. Cook/Supervisor #1 stated that he had a " certification, but his certification had expired. When Cook/Supervisor #1 was asked to describe the difference in the consistency of a pureed meal verses a ground meal, Cook/Supervisor #1 stated a pureed consistency was like "baby food" and the ground consistency diets had "little pieces" inside.

The surveyor showed Cook/Supervisor #1, Resident #64's lunch meal plate. Cook/Supervisor #1 stated the ham and sweet potatoes were pureed consistency and the Italian vegetables were ground consistency.

Cook/Supervisor #1 stated that he was responsible for reviewing the resident's meal ticket prior to plating the resident's food. Cook/Supervisor #1 stated the Food Service Workers (FSWs) provided the second check to ensure residents received the correct diets. Also,

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F 808	Continued From page 28 the FSWs were responsible for comparing the meal tickets to what was on the plate. Cook/Supervisor #1 reviewed Resident #64's meal ticket in the presence of the surveyor and stated the resident's entire meal should have been a pureed diet and not ground vegetables. Cook/Supervisor #1 stated, "it is my mistake and the mix-up occurred because the tray line wasn't set up properly." Cook/Supervisor #1 stated he could not remember which FSW checked Resident #64's plate because the kitchen was very busy. Cook/Supervisor #1 stated the mix-up was all his fault and he had just "messed up." During an interview on 01/29/20 at 12:40 PM, in the presence of four surveyors, Activity Aide (AA #1) and CNA #3 stated they were trained by the facility on how to identify altered diets and to serve the residents their meal trays. AA #1 stated she removed Resident #64's meal tray from the cart and compared the meal ticket to what was on the plate. AA #1 stated that she did not see anything wrong with the meal on the plate. CNA #3 stated she also compared the meal ticket to the plated meal and did not find anything wrong with the meal she fed to the resident. CNA #3 stated the facility was giving them more and more responsibility and she was finding it difficult to remember everything she had been taught. A review of a Speech In-Service titled, "Diet Textures," dated [redacted], revealed the second-floor staff were provide an in-service on all diet consistencies: pureed, ground, chopped, and regular. The in-service also included modified liquid level consistencies: nectar, honey and pudding. According to the attendance register, CNA #3 attended this in-service and another in-service on 01/28/20.	F 808		

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A review of the undated Pureed Diet guidelines revealed the facility provided pureed diets meats, and that starches and vegetables were pureed to a smooth consistency without lumps or solid materials.

A review of the Tray line Service policy, updated 01/2019, revealed the tray line positions and set up procedure were planned for efficient and orderly delivery. All meals were to be checked by food service personnel for accuracy, and the employee serving the meals prior to serving to the individual. Each meal will be checked for: correct name, room number, diet order, accuracy of the following therapeutic diet extension, and proper portion size.

On 01/30/20 at 11:13 AM, the Chief Operating Officer (COO) provided the surveyor with a new tray line policy, dated 01/30/20. The policy implemented a color coded meal ticket to increase awareness for diets that were altered food and liquid consistencies.

Part C. Resident #34:

The deficiency continued at a level "D" and was evidenced by the following:

The facility staff did not follow the removal plan accepted on 01/27/20 at 1:56 PM which indicated a two person point of contact for review of meal tray at point of service.

On 01/28/20 at 9:12 AM, the surveyor was at the [redacted] floor nursing station and observed a dietary staff member place a meal tray at the nursing station. The dietary staff stated to CNA #6, who was working at the computer, that the

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F 808	Continued From page 30 tray was for Resident #34. CNA #6 lifted the lid of the meal tray and looked at the meal. The surveyor followed CNA #6 to Resident #34's room where CNA #6 placed the meal tray in front of the resident on the bedside table which was located next to the resident's bed. At that time, the surveyor interviewed CNA #6, who stated she brought the resident the meal tray and confirmed that the tray was placed in front of Resident #34 without another staff member checking the tray. On 01/28/20 at 9:16 AM, the surveyor interviewed LPN #1 who was observed at the medication cart directly outside of Resident #34's room. The LPN stated that two CNAs were supposed to double check the meal trays with the nurse prior to giving the tray to the resident. He stated that was for any resident and any tray. On 01/28/20 at 9:24 AM, the surveyor interviewed CNA #6 who stated if she removed the tray from the cart, then she would be the one who would check the tray. She stated the tray for Resident #34 was a late tray and that she checked the tray to ensure everything was on it. A review of the Quarterly MDS, dated [redacted] revealed Resident #34 had a BIMS score of [redacted] which indicated [redacted] impairment. The MDS did not indicate that the resident had a swallowing disorder or was on a specialized diet. The Census List, dated [redacted], revealed Resident #34 was on a CCD/NCS, NAS diet (low carbohydrate, no concentrated sweets, no added salt). NJAC 8:39-17.4(a) (1-2); 27,1(a)	F 808		

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F 812 SS=F	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 document review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to ensure items are not beyond safe use by dates, b.) maintain and reheat hot food items in a manner to minimize the potential for food borne illness, c.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination. This deficient practice was evidenced by the following: On 01/26/20 at 8:24 AM, the surveyor toured the kitchen during the breakfast meal tray line preparation with a cook (Cook #1), who stated they were short a staff person because someone	F 812	The undated and uncovered items were discarded. The slicer was cleaned. The staff will be educated at the all staff meeting regarding sanitation as it relates to entering the kitchen with the proper head coverings. The water on the floor and pipe will be cleaned up and will be positioned correctly by maintenance. Staff will be educated in the kitchen how to handle the equipment in the kitchen. The facility terminated the contracted service and brought the dietary department inhouse as of March 1, 2020. A seasoned dietary manager from a sister facility was transferred to the Cherry Hill	3/27/20

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called out.

On 01/26/20 at 8:26 AM, Cook #1 stopped the tray line, went to the dirty dish area and began cleaning a large blender. Cook #1 stated she ran out of the ground food and needed to make more food. At that time, a Speech Therapist (ST #2) entered the kitchen without a head covering and requested a tray from the kitchen staff.

The surveyor observed the slicer was observed uncovered and was soiled with food shavings on the base and blade area. Cook #1 stated the slicer was not used for the breakfast meal preparation. A Diet Aide (DA #1) stated it was used yesterday and that "they did not clean it, but are supposed to."

The surveyor observed a large puddle of dirty waster that was adjacent to the tray line. DA #1 stated that a pipe was not properly placed in a drain and it leaked all over the floor.

On 01/26/20 at 8:54 AM, the surveyor observed the Cook #1 stop the tray line. Cook #1 washed hands, put on gloves, removed frozen pancakes from the freezer, and placed them in a pan that was then put into the into the steamer.

On 01/26/20 at 8:56 AM, DA #1 left the tray line and went to an uncovered deep pan, located on top of the stove. There was no flame observed. DA #1 proceeded to scoop hot cereal into burgundy bowls and placed a plastic lid on top. He placed the bowls in a pan on the tray line. DA #1 stated he usually put the oatmeal in the steam table to heat it up and that this was okay. During this observation at 8:58 AM, the surveyor interviewed Cook #1 regarding the hot cereal that DA #1 scooped into bowls and placed in a pan on

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facility as the new dietary manager.
New AristaCare policies will be rolled out and educated to the staff including:

- Meal temps
- Labeling food
- Food storage
- Food prep
- Procedures if you run out of food
- Sanitation of kitchen

New job duties will be implemented with specific accountability. These new job duties will be in-serviced to the staff.
With the change in department the administrative team is hiring additional staff for the dietary department. When new staff is on board a serve safe class will be scheduled and the new dietary manager will select the staff that will complete the necessary training.
A sanitation audit will be completed by Food Service Director or designee weekly for 3 months and reported monthly to the Quality Assurance Steering Committee.
Following 3 months the committee will decide the frequency of the audits that should be reported to the dining room committee, which meets monthly on an ongoing basis.

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F 812	Continued From page 33 the tray line. She stated the cereal was farina (a hot cereal) and the temperature of the farina was checked when it was cooked. Upon surveyor inquiry, Cook #1 proceeded to take a thermometer and took the temperature of the farina in the steam table pan locate on top of the stove. The temperature was 98 degrees Fahrenheit (F). She stated the farina should have been 140 degrees (F). She then removed all of the bowls of farina from the tray line and placed them inside of the steamer. she stated since they were uncovered, they needed to be reheated. The cook further stated that it was not okay to reheat foods on the tray line and that was why she put the farina back into the steamer. She further stated the white digital thermometer she used was calibrated and that was the thermometer that she used at 7:30 AM to take the food temperatures. She further stated she did not have a "Serve Safe" certification (nationally accredited food safety certification); however, "our head boss had that and he was called in because of the survey team being in the building." On 01/26/20 at 9:09 AM, the Food Service Director (FSD) entered the kitchen and resumed the tour with the surveyor. The refrigerated walk-in box contained a plastic pan with two packages of wrapped cold cuts, sitting in water. One item was undated and one item had a date of open of 01/14/20 and expiration date of 03/14/20. The FSD stated the item was ham and they were taken out of the freezer and were missing a pull date. He stated he will throw them out right away. The surveyor interviewed the FSD regarding the large puddle on the floor. The FSD stated the floor shouldn't have been left like that.	F 812		

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F 812	Continued From page 34 On 01/26/20 at 9:13 AM, a Regional Food Service Director (RFSD #1) joined the tour. A package of shredded cheese was located on a shelf in the walk-in refrigerator and was open to air. The RFSD #1 stated the cheese should be sealed. On 01/31/20 at 9:27 AM, the Chief Operating Officer (COO) stated during interview that the FSD was the only person in the kitchen who was "Serve Safe Certified." A review of an undated Labeling and Dating System Protocol revealed that all fresh and frozen foods must be dated with the date it was received into the kitchen, unless it has a purveyor shipping label on it. Opened sliced deli meat has a three day expiration when it is sliced. A review of the Trayline Service Policy, updated January 2019, revealed the food service manager or designee was responsible to assure that all foods needed for meal assembly were present at the appropriate time. All foods would be covered and hot foods would be kept hot (greater than 135 degrees Fahrenheit). A review of an undated Meal Temperature Policy revealed that if hot foods were not greater than or equal to the standards, or cold temperatures were not less than or equal to the standards, respond accordingly. Do not serve food at unacceptable temperatures. Record temperatures for all replacement pans. A review of the Slicer Cleaning Instructions, updated January 2020, revealed the slicer would be cleaned and sanitized after each use. NJAC 8:39 17.2(g)	F 812		
F 842	Resident Records - Identifiable Information	F 842		3/23/20

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F 842 SS=D	Continued From page 35 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 36 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain complete and accurate documentation for 1 of 1 resident reviewed for [redacted] care and medical record completion (Resident #42). This deficient practice was evidenced by the following: On 01/30/2020 at 10:41 AM, the surveyor observed the Licensed Practical Nurse (LPN #2) irrigate Resident #42's [redacted] and noted the following:	F 842	The physician will be contacted to review the residents plan of care as it relates to their [redacted] and to inquire what type of information they would like reflected in the medical record. LPN #2 is no longer employed at facility. Residents with [redacted] will have their medical records reviewed to audit the documentation of the care provided specific to their [redacted]. Any changes that are needed to the resident's orders to enable the correct documentation will be adjusted.	

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F 842	Continued From page 37 During an observation of Resident #42's cognition prior to the [redacted] care, the resident demonstrated lack of awareness to the environment and was unable to respond to the surveyor. The surveyor observed [redacted] in the [redacted] and [redacted] that was uncovered and secured to the side of the bed. LPN #2 proceeded to perform the [redacted] procedure. Once the [redacted] was flushed, LPN #2 reconnected the [redacted] to the [redacted] and [redacted] began to drain into the [redacted] that was secured to the bed. The surveyor observed that the resident remained non-verbal and demonstrated a lack of awareness to the environment during the [redacted] procedure. The surveyor also observed that the resident exhibited no facial grimacing, elevation in mood or tone of voice, or other behaviors of intolerance. According to the Admission Record, the resident was admitted to the facility with diagnoses which included, but were not limited to, [redacted] infection [redacted]. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], revealed that the resident was in a [redacted]. A review of the [redacted] Order Summary Report (OSR) revealed a physician order with a start date of [redacted] to '[redacted]	F 842	Administration will review the [redacted] policy via an ad hoc Quality Assurance Steering Committee to identify any changes that are needed. The nurses will be educated via in-servicing and competencies specific to [redacted] care and documentation of [redacted] care. This will include documentation of outcome and resident response to procedure. The Director of Nursing, clinical educator or designee will complete a random audit via [redacted] competency monthly for three months to ensure the appropriate documentation is completed. Results of the [redacted] competency audit will be reported the Quality Assurance steering committee monthly x 3 months. Following 3 months the committee will decide the frequency of the audit.	

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F 842

) every shift for prevention of , every shift for prevention of The OSR also showed a physician's order with a start date of that revealed Care] and record the amount every shift."

A review of the Treatment Administration Record (TAR) reflected the above physician orders.

A review of the Care Plan, revised on indicated that the resident required an indwelling catheter related to . The interventions included to monitor the for patency every shift and to monitor, record and report to the physician signs and symptoms of patterns.

A review of the Progress Notes on at 2:48 PM, revealed there was no documentation by the LPN that reflected Resident #42's response following the procedure or documentation regarding .

On 01/31/2020 at 3:17 AM, the Director of Nursing (DON) provided a copy of the Medication Administration Audit Report and confirmed, in the presence of the surveyor, that LPN #2 had documented on the TAR that the was performed on 01/30/2020 at 11:29 AM. The DON stated that LPN#2 should

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F 842	Continued From page 39 have documented the [redacted], and the resident's response to the procedure immediately following the irrigation procedure in the progress notes. The DON confirmed that there was no documentation of this information in the progress notes. During an interview with the surveyor on 01/30/20 at 10:50 AM, LPN #2 stated that the indication for Resident #42 [redacted] was that he/she was unable to [redacted] on his/her own. The LPN stated that she observed that Resident #42 was passing [redacted]. LPN #2 stated that she does not document an assessment in the progress note before and after the procedure and that she only documents on the TAR that the procedure was completed. The facility's undated "Intermittent Irrigation of [redacted]" policy indicated to document in the clinical record the [redacted] before and after procedure, type and amount of [redacted] instilled, and the client's tolerance of the procedure. NJAC 8:39-35.2	F 842		
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.	F 880		3/23/20

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F 880	Continued From page 40 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: (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.	F 880		

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F 880	Continued From page 41 §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: Based on observation, interview, and record review, it was determined that the facility failed to follow appropriate infection control protocols for hand hygiene (hand washing or use of an alcohol-based hand rub) and [redacted] This deficient practice was identified for 1 of 1 nurse observed during catheter care on 1 of 1 resident (Resident #42) reviewed for [redacted] and was evidenced by the following: On 01/30/20 at 10:23 AM, the surveyor entered Resident #42's room and observed the resident's bedside table with white debris scattered across the top. There was also two individual packets of ointment, a nail clipper, and a bottle of [redacted] skin cleanser observed stored on the table. On 01/30/20 at 10:34 AM, the surveyor observed the Licensed Practical Nurse (LPN #2) perform [redacted] of Resident #42's [redacted] as follows:	F 880	LPN #2 is no longer employed at the facility. An [redacted] competency will be completed with each of the residents that have an active physician order. The nurses will be educated via in-servicing and competencies on [redacted] care including infection control techniques. The nurses will be educated via in-servicing and competencies on hand hygiene. The Director of Nursing, clinical educator or designee will complete a random audit on [redacted] care specific to infection control monthly for three months. The Director of Nursing, clinical educator or designee will complete a random audit on hand hygiene monthly for three months. Results of both audits will be reported the Quality Assurance steering committee monthly x 3 months. Following 3 months the committee will decide the frequency of the audit.	

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LPN #2 entered the resident's room carrying catheter care supplies, which included, a [redacted] milliliter (mL) [redacted]) container, [redacted] mL [redacted] one black sharpie marker, multiple individual alcohol pads, [redacted] kit with [redacted] [redacted] mL [redacted] bag, and one box of medium gloves. LPN #2 placed the catheter care items directly on the resident's uncleaned bedside table, without barrier. LPN #2 also brought in a [redacted] tray which she placed directly on the bed, at the foot of the bed. She donned gloved (put on), adjusted the resident's [redacted], and then removed and discarded her gloves.

At 10:38 AM, after glove removal, the survey observed LPN #2 perform handwashing as followed: LPN #2 turned on the water, applied soap to dry hands and rubbed hands together with friction for three seconds. She placed both hands under running water to wet hands and washed hands with a lather of soap and water for 20 seconds outside the flow of water. She rinsed her hands and then dried her hands with paper towels that were bunched together. She used those same paper towels to turn off the water.

At 10:39 AM, LPN #2 opened the [redacted] mL container of [redacted] and the [redacted] mL [redacted] container. LPN #2 poured the [redacted] into the [redacted] ml [redacted] container. LPN #2 then performed handwashing as followed: LPN #2 turned on the water, applied soap to dry hands, and rubbed hands together with friction for three seconds. She placed both hands under running water to wet hands and washed hands with a lather of soap and water for 10 seconds outside the flow of water. She rinsed her hands and then dried her

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hands with paper towels that were bunched together. She used those same paper towels to turn off the water.

At 10:41 AM, LPN #2 applied gloves, opened an alcohol pad, placed the pad on top of the alcohol pad wrapper, and then placed the wrapper directly onto the bedside table that was covered with white debris. She used the She opened the plastic bag from the kit and placed it on the bedside table. She placed the container and on top of the plastic bag. Without changing gloves and performing hand hygiene, LPN #2 started the irrigation procedure as followed:

LPN #2 removed an unopened alcohol pad from the bedside table, and walked towards the resident. She unfastened the in place), opened the alcohol pad and wiped the catheter port that was located on the tubing. She disconnected the catheter from the and of . Once the , LPN #2 immediately reconnected the to the and began to drain into the that was secured to the bed. She secured the to the

Following the procedure, LPN #2 removed her gloves, and without performing hand hygiene, she used the black marker that was on the bedside table to date the . At that time, LPN #2 stated that she needed to return the unused and tray to the medication room, and return the container to the treatment cart.

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At 10:47 AM, the surveyor observed LPN #2 exit the resident's room without performing hand hygiene. LPN #2 walked to the treatment cart and placed the [redacted] container in the drawer. LPN #2 then walked to the medication room where she placed the [redacted] and the [redacted] in the cabinets. LPN #2 walked out of the medication room to the nurse's desk and stated that she was finished. LPN #2 did not perform hand hygiene.

During an interview with the surveyor on 01/30/20 at 10:50 AM, in Resident #42's room, LPN #2 stated that the outside packaging of the [redacted] care items were not [redacted]; however, the inside packaging was [redacted] She also stated that the [redacted] was a [redacted] procedure ([redacted]) because [redacted] was used. LPN #2 confirmed that the bedside table was not cleaned and stated she should have cleaned the table before placing the items on the table. LPN #2 stated that a drape (protective covering to prevent contamination) was not available to place on the table as a barrier. LPN #2 also confirmed that she did not clean the bedside table before leaving the resident's room. She stated that she forgot to wash her hands before leaving the resident's room and confirmed that she touched the treatment cart and then went into the medication room to return items.

On 01/30/20 at 11:15 AM, after the interview with LPN #2, the surveyor observed LPN #2 perform handwashing in the resident's room as followed: LPN #2 turned on the water, applied soap to dry hands, and rubbed hands together with friction for three seconds. She placed both hands under

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running water to wet hands and washed hands with a lather of soap and water for 20 seconds outside the flow of water. She rinsed her hands and then dried her hands with paper towels that were bunched together. She used those same paper towels to turn off the water.

The surveyor resumed the interview with LPN #2 on 01/30/20 at 11:17 AM. LPN #2 stated that she was last in-serviced on handwashing one week ago and did not recall the educator's name. LPN #2 stated that the facility policy and procedure for handwashing was to turn on the water, put soap on both hands, wet hands, scrub hands with soap and water for 20 seconds between fingers, rinse hands in a downward motion, use paper towels to dry hands, and turn off the water with the paper towel. She stated that soap to scrub time was 20 seconds out of the flow of water. She also stated that she used the same paper towel to dry her hands and turn off the faucet and that it was alright to use the same paper towels to turn off the water.

On 01/30/20 at 1:35 PM, the Director of Nursing (DON) provided a copy of the Handwashing in-service, dated [redacted], that confirmed LPN #2 had attended the education training. The DON also provided the surveyor with the facility handwashing policy. The surveyor reviewed the documents and noted that the in-service education differed from the handwashing policy. The in-service education included a diagram titled, "How to Handwash?" which contained instructions to wash hands outside of the running water. The facility policy titled, Handwashing/Hand Hygiene" included instructions to wash hands under a moderate stream of running water.

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F 880	Continued From page 46 On 01/31/20 at 3:38 PM, in the presence of the survey team, the DON confirmed that the facility's handwashing policy and the in-service diagram on handwashing did not correlate with each other. She also stated that the policy did not match what was taught to the facility staff. The DON stated that staff were educated on the procedure for handwashing in accordance with in-service diagram and not the handwashing policy as followed: wet hands, apply soap to hands, lather hands for 30 seconds all surfaces, rinse hands under running water, use a paper towel to dry hands, use another clean paper towel to turn off the faucet, and then discard the paper towel in the trash receptacle. The DON stated that the facility policy was incorrect. During an interview with the DON on 01/31/20 at 4:14 PM, the DON stated that she oversees the Infection Control education and made sure that it was done monthly. The DON stated that she would provide the Infection Control Policy (ICP) which would include any additional information related to infection control with handwashing and keeping residents equipment clean. She also confirmed that the bedside table was to be cleaned with antiseptic wipes (disinfecting cloths used to prevent the spread of infection) before and after a procedure to prevent the spread of infection. During an interview with the DON and the Regional Director of Operations on 01/31/20 at 4:23 PM, in the presence of the survey team, the DON did not provide the Infection Control Policy. The DON and the Regional Director of Operations had no comment when asked by the surveyor for the ICP Policy. The facility's undated "Handwashing/Hand	F 880		

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ARISTACARE AT CHERRY HILL	**1399 CHAPEL AVE WEST** **CHERRY HILL, NJ 08002**

(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 880	Continued From page 47 Hygiene" policy, indicated that handwashing must be performed before and after direct contact with residents; after contact with blood, body fluids, secretions, mucous membranes, or nonintact skin; and after removing gloves. The procedure for handwashing included, vigorously lather hands with soap and rub them together, creating friction to all surfaces, for 20-30 seconds under a moderate stream of running water, at a comfortable temperature. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. The facility's undated "Intermittent Irrigation of [redacted]" policy indicated to open the sterile [redacted] tray and establish sterile field. Place waterproof drape under the [redacted] Place sterile basin next to the client's [redacted] Don sterile gloves. Cleanse connection site of [redacted] and [redacted] with antiseptic swab. Disconnect [redacted] from [redacted]. Keep end of [redacted] Cap or position [redacted] [redacted] to maintain sterility. Remove the syringe and allow the solution to drain into the basin. Cleanse open end at adapter site with alcohol prep pad and reconnect with end [redacted]. NJAC 8:39 19.4 (a)	F 880		