STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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: 10/7/19 CENSUS: 188 SAMPLE SIZE: 35(Pluse two closed records) The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to keep the call system within reach for a resident who was dependent on staff for transfers and able to use the call bell. This deficient practice was identified for 1 of 35 Residents (Resident #285) reviewed. The deficient practice was evidenced by: On 09/25/19 at 10:55 AM, the surveyor observed Resident #285 in bed. The resident was alert and oriented and greeted the surveyor appropriately. Resident #285 stated that he/she had [redacted] in their [redacted]. The surveyor asked the resident if they informed the nurse about their [redacted]	F 558	F558 SS=D Reasonable Accommodations Need/Preferences. Resident #285 had no negative outcome for not having [redacted] call bell within reach at the time of observation. Residents requiring call bells within reach have the potential to be affected. Staff will be in-serviced on the need to have call bells within reach of residents. Administrator and/or his/her designee will perform daily rounds with special	10/31/19

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

Electronically Signed | 10/27/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 558	Continued From page 1 Resident #285 replied that he/she had not seen the nurse for "awhile" and couldn't find the call bell. At that same time, the surveyor observed the call bell on the floor, twisted around the roommates electrical bed cord. At that same time, CNA #2 entered the room. Resident #285 informed CNA #2 of their [redacted] CNA #2 informed the Licensed Practical Nurse #4 (LPN #4) of the resident's [redacted] The surveyor observed CNA #2 had left the room and the call bell remained on the floor. On that same day at 11:00 AM, LPN #4 assessed Resident #285's [redacted] and left the room to obtain pain medication. The call bell remained on the floor out of the resident's reach. On that same day at 11:07 AM, LPN #4 medicated the Resident #285 for [redacted] The resident asked LPN #4 for the box of tissues that had fallen onto the floor. LPN #4 moved the resident's bed, picked up the box of tissues from the floor and left the call bell on the floor. On that same day at 11:47 AM, the surveyor observed CNA #4 in Resident #285's room providing care. The surveyor observed that the call bell remained on the floor. On that same day at 12:07 PM, the surveyor observed Resident #285 in bed with the call bell affixed to the right enabler within Resident #285's reach. The resident stated they were glad to finally have the call bell back and that the [redacted] had subsided.	F 558	attention to call bell placement for 14 days, then monthly for two months. Director of Nursing or designee will report audit findings to the Quality Assurance Performance Improvement Committee monthly for a period of three months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 558	Continued From page 2 On 9/30/19 at 10:50 AM, the surveyor interviewed CNA #4 who stated that on 9/25/19 she did not ensure that Resident #285 had their call bell within reach. According to CNA #4, she only delivered the resident's breakfast tray that morning. CNA #4 further stated that the night shift should have made sure that the call bell was within the resident's reach. On that same day at 11:25 AM, the surveyor interviewed LPN #4 who stated on 9/25/19 she did not notice the resident's call bell was on the floor. She further stated the resident usually had [redacted] call bell,"my mistake." On that same day at 11:30 AM the surveyor interviewed CNA #2 who stated that Resident #285 was not assigned to [redacted] on 9/25/19; she was just checking the resident so therefore did not feel it was [redacted] responsibility to see that Resident #285 had the call bell within reach. On that same day at 11:40 AM, the surveyor interviewed CNA #4 who confirmed that on 9/25/19 Resident #285's call bell was on the floor. CNA #4 stated she had to untangle the resident's call light from the roommates electrical bed cord in order to place it within the resident's reach. CNA #4 further stated that it was not solely her responsibility to ensure that Resident #285 had their call bell. The surveyor reviewed Resident #285's admission record which reflected that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted]	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 558	Continued From page 3 The surveyor reviewed the Quarterly Minimum Data Set, an assessment tool dated [redacted] which documented that the resident had [redacted] impairment and was dependent on staff for transfers and personal hygiene. On 10/3/19 at 2:00 PM, the survey team met with the Administrator and Director of Nursing and discussed the above observations and concern. No further information was provided.	F 558		
F 637 SS=D	NJAC 8:39-27.1 (a) Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a significant change assessment was completed for a total of three quarters for 1 of 37 resident's (Resident #22). Resident #22 was noted with more than two areas of improvement	F 637	F637 SS=D Comprehensive Assessment After Significant Change Resident #22 had no negative	10/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 637	Continued From page 4 with Activities of Daily Living (ADL) on the [redacted] Quarterly (Q) MDS (Minimum Data Set), an assessment tool used to facilitate the management of care. This deficient practice was evidenced by: On 9/25/19 at 9:56 AM, the Registered Nurse/Unit Manager #2 (RN/UM#2) informed the surveyor that Resident #22 was [redacted] intact, independent with ADLs and a [redacted]. On 9/27/19 at 8:21 AM, the surveyor observed the resident in his/her room independently eating breakfast. On 9/30/19 at 8:50 AM, the surveyor interviewed the Licensed Practical Nurse #5 (LPN #5) assigned to Resident #22. LPN #5 informed the surveyor that the resident was now in [redacted]. She stated that the resident was [redacted] intact and independent with ADLs. She further stated that the resident was noted with improvement with ADLs. LPN #5 stated the resident required limited assistance at the time of admission and currently the resident is independent with ADL's. LPN #5 was unable to remember the exact date the improvement was noted. On that same day at 8:55 AM, the surveyor interviewed the Certified Nursing Assistant #1 (CNA#1) assigned to the resident. CNA #1 informed the surveyor that the resident was [redacted] intact and independent with ADLs. She further stated that the resident required limited assistance when the resident was admitted to the facility and later was noted to have "a lot of improvement."	F 637	outcome for not having their MDS updated to reflect their significant improvement. [redacted] plan of care remained the same. Residents having significant changes in their plan of care can be effected by this practice. The MDS coordinator or designee will review with the Interdisciplinary Team on the RAI manual about significant changes to ensure that patients are assessed and care plans/charts are reviewed by the Interdisciplinary Team Timely. The Interdisciplinary Team will conduct an audit, led by the MDS Coordinator/s, of residents□ status on four records weekly for two weeks, then monthly for two months to ensure that the residents are accurately reflected on the MDS□s and care plans. Director of Nursing or designee will report audit findings to the Quality Assurance Performance Improvement Committee monthly for a period of three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 637	Continued From page 5	F 637		

A review of the resident's Face sheet reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included [redacted].

A review of the Comprehensive (C) MDS with an Assessment Reference Date (ARD) of [redacted], indicated that Resident #22 had a brief interview for mental status (BIMS) score of [redacted] which indicated the resident was cognitively intact. The CMDS also indicted the resident required extensive assistance of one person for bed mobility, transfers, walking, and toileting.

A review of the QMDS with the following ARDs of [redacted], and [redacted] revealed Resident #22 required supervision with bed mobility, transfers, walking, and toileting. Thus, the resident had an improvement compared to the [redacted] Comprehensive MDS. There was no significant change assessment completed when the resident was noted with significant improvement in more than two areas of ADLs.

Review of the PT (Physical Therapy) Plan of Care dated [redacted] reflected that the current level of the resident was maximum assistance with balance, minimal assistance with bed mobility and moderate assistance with transfers. Review of the [redacted] Analysis of Functional Outcome/Clinical Impression of the PT indicated the resident made significant progress in therapy towards goals and achieved the highest level of functional mobility which was independent with bed mobility and transfers.

The surveyor reviewed the CNAs ADL log dated 9/20/18 which indicated the resident required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 637	Continued From page 6	F 637		

extensive assistance. The surveyor reviewed the 12/20/18, 4/20/19 and 6/20/19 CNA ADL logs which revealed that the resident required supervision to independent assistance.

On 9/30/19 at 10:20 AM, the surveyor interviewed the MDS Director in the presence of the survey team. The MDS Director stated that a Significant Change MDS should be done when there was two or more improvements or decline in ADLs. She further stated that the facility followed the RAI (Resident Assessment Instrument) manual as its policy for completing a Significant Change.

On 9/30/19 at 12:21 PM, the survey team met with the covering Administrator, Director of Nursing (DON), and the Assistant Director of Nursing (ADON) and discussed the above concern.

On 10/1/19 at 8:26 AM, the surveyor observed the resident seated in bed feeding themselves. There was a rollator at the bedside. The surveyor interviewed the resident. Resident #22 informed the surveyor that when he/she first came into the facility on [redacted] they were confused, unable to take care of themselves, and required extensive assistance with ADLs including transfers, toileting, bed mobility and walking. The resident further stated he/she was placed in Skilled Rehabilitation and "after more or less a couple of months of continued therapy" slowly gained strength and was able to perform daily tasks by him/herself. The resident indicated that he/she had improvement with ADLs.

On 10/1/19 at 12:43 PM, the MDS Director informed the surveyor in the presence of the survey team that the Significant Change for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 637	Continued From page 7 Resident #22 "was missed." On that same day at 1:22 PM, the survey team met with the acting Administrator, DON, and ADON. The DON informed the surveyor that the facility followed the RAI guidelines for significant change. A review of the CMS's RAI Version 3.0 Manual updated October 2019 showed that a Significant Change Assessment is appropriate when there is a determination that a significant change either improvement or decline in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and the resident's condition is not expected to return to baseline within two weeks. In addition, A Significant Change is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement, this includes two changes within a particular domain (e.g., two areas of ADL decline or improvement.) NJAC 8:39-11.1	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately assess a resident's status in the	F 641	F641 Scope and Severity D Accuracy in Assessments	10/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 641	Continued From page 8 Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for 1 of 37 residents (Resident #14) reviewed. This deficient practice was evidenced by: On 9/26/19 at 12:32 PM, the surveyor observed Resident #14 seated in a wheelchair in their room wearing [redacted] shoes. The resident informed the surveyor that the [redacted] on his/her [redacted] was being followed up by the [redacted] and healing well. On that same day at 12:35 PM, the surveyor interviewed the Registered Nurse/Unit Manager #1 (RN/UM#1) in the presence of the Licensed Practical Nurse/Unit Manager #1 (LPN/UM #1). The RN/UM#1 stated Resident #14 had a facility [redacted] to the [redacted]. At that same time, LPN/UM #1 stated the resident's [redacted] was a [redacted] and was being followed by the [redacted] The surveyor requested a timeline for the [redacted] from the RN/UM #1. A review of the resident's Face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted]). A review of the Significant Change (SC) MDS, an assessment tool, with a Assessment Reference Date (ARD) of [redacted], indicated a brief interview for mental status (BIMs) score [redacted] which	F 641	Resident #14 had no negative outcomes due to this practice. The treatment plan to the affected area remained the same. Residents that have Minimum Data Set (MDS) completed have the potential to be affected. The Interdisciplinary Team will conduct an audit, led by the MDS Coordinator/s, of up to three residents with wounds weekly, then monthly for two months to ensure that the residents wounds are accurately reflected on the MDSs and care plans. The Interdisciplinary Team will present the results of these audits to the Director of Nursing and/or his/her designee at the facilitys monthly Quality Assurance Performance Improvement Committee quarterly for a period of three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 641	Continued From page 9	F 641		

reflected that the resident's cognition was intact. The [redacted] MDS indicated that the resident had an [redacted].

Further review of the medical record revealed that the Quarterly MDS with an ARD of [redacted] documented that Resident #14 had BIMS [redacted] and a [redacted]

A review of the wound timeline provided by the RN/UM #1 revealed that the resident's [redacted] was identified as a [redacted] and treatment was ordered on [redacted]. In addition, the [redacted] timeline indicated that on [redacted] the resident was seen by the [redacted] who re-classified the [redacted] related to [redacted]. The resident was seen by the [redacted] on the following dates: [redacted], [redacted] and [redacted].

The surveyor reviewed the [redacted]9 Quarterly Conference Note which indicated Resident #14 was assessed to have an [redacted]

Review of the [redacted] Monthly Nursing Summary indicated that the resident was assessed to have an [redacted].

On 9/27/19 at 8:50 AM, the surveyor interviewed the RN/UM #1 regarding Resident # 14's [redacted] assessment discrepancy, a [redacted] vs a [redacted]. The RN/UM #1 stated that she will get back to the surveyor.

On 9/30/19 at 8:21 AM, the surveyor, in the presence of the RN/UM #1 observed Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 641	Continued From page 10	F 641		

#14's [redacted] The surveyor observed the [redacted] was clean, with no drainage or odor. The RN/UM #1 stated that the [redacted] was a [redacted] and not a [redacted]

On that same day at 10:20 AM, the MDS Director had no answer as to why the [redacted] and [redacted] MDS did not reflect that the [redacted] was re-classified as a [redacted].

On 9/30/19 at 12:21 PM, the survey team met with the covering Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) and discussed the above observation and concerns.

On 10/1/19 at 8:49 AM, the surveyor interviewed the primary care physician for Resident #14 who informed the surveyor that the resident had a [redacted] related to [redacted] and not a [redacted]

On 10/1/19 at 12:43 PM, the MDS Director informed the survey team that the [redacted] and [redacted] MDS Assessment of the [redacted] was not accurately assessed to reflect that the [redacted] was related to [redacted] The MDS Director stated that it should have been modified to reflect the accurate assessment coding of the [redacted] and not [redacted]

A review of the facility policy regarding Resident Assessment Instrument with a revised date of 9/2010 provided by the DON indicated "The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity," and "All persons who have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 641	Continued From page 11 completed any portion of the MDS Resident Assessment for must sign such document attesting to the accuracy of such information." NJAC 8:39-11.2(e)1; 27.1(a)	F 641		
F 658 SS=D	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 record review, it was determined that the facility failed to follow a physician's order for the use of [redacted] which was identified for 1 of 35 residents (Resident # 17) reviewed. 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 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." On 9/26/19 at 12:00 PM, the surveyor observed	F 658	F658 SS=D Services Provided Meet Professional Standards Resident #17 had no negative outcome for not having [redacted] on during the duration of the observation. Medical Records indicate that resident #17 had a [redacted] reading of [redacted] shortly after the Nurse was notified of the observation. Residents receiving continuous oxygen have the potential to be affected. Unit Manager or designee will review care plans for residents on [redacted] ensure the residents needs are being met. Nurse Staff will be in-serviced on checking residents with care plans for	10/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 12 Resident #17 sleeping in his/her room seated in a [redacted] wheel chair. Resident #17 was wearing an [redacted] that was connected to an [redacted]. The surveyor observed that the [redacted] was off. On that same day at 12:26 PM, the surveyor observed that the concentrator remained off. On that same day at 12:37 PM, the surveyor asked the License Practical Nurse #4 (LPN #4) who was assigned to Resident #17 why the resident was wearing an [redacted] connected to an [redacted] that was turned off. LPN #4 replied that the Certified Nursing Assistant #2 (CNA #2) probably turned it off when she gave Resident #17 morning care. LPN #4 turned the [redacted]r on and stated the resident should have been receiving [redacted]. On that same day at 1:05 PM, the surveyor interviewed the [redacted] Aide who stated she had provided care to Resident #17 at approximately 10:30 AM, but she did not turn off the [redacted] On 10/1/19 at 12:00 PM, the surveyor interviewed CNA #2 who was assigned to care for Resident #17. CNA #2 stated that she never turned off Resident #17's [redacted] Review of the September 2019 Physician's Order Form reflected an order dated, [redacted] for [redacted] to be administered at [redacted] every shift for [redacted]. The corresponding physician's orders were transcribed onto the resident's September 2019	F 658	continuous oxygen, on a regular basis. Administrator and/or his/her designee will be assigned to check residents with physician orders for continued [redacted] on their daily rounds for a period of two months. His/ her finding will be reported to the Director of Nursing at the facilities Monthly Quality Assurance Meetings. The Director of Nursing or designee will present the results of these audits to the facility□s quarterly Quality Assurance Performance Improvement Committee quarterly for a period of three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 13 Treatment Administration Record (TAR) and signed by the nurse as administered. The surveyor reviewed the medical record for Resident #17. According to the admission record, the resident was admitted to the facility on [redacted] and had diagnoses which included [redacted] Further review of the medical record revealed the resident was admitted on [redacted] on [redacted] for [redacted]. Review of the Quarterly Minimum Data Set (MDS), an assessment tool with an assessment reference date of [redacted] reflected that the resident had [redacted] impairment. On 10/3/19 at 2:00 PM, the survey team met with the Administrator and Director of Nursing and discussed the above observations and concern. No further information was provided by the facility.	F 658		
F 677 SS=D	NJAC 8:39-11.2 (b) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide oral care and personal hygiene to a resident who was dependent on staff for	F 677	F677 SS=D ADL Care Provided for Dependent Residents	10/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 677	Continued From page 14 grooming and hygiene for 1 of 35 residents (Resident #17), reviewed for care. This deficient practice was evidenced by the following: 1. On 9/26/19 at 12:00 PM, the surveyor observed Resident #17 in his/her room seated in a [redacted] wheel chair. The resident was not interviewable. On that same day at 12:37 PM, the surveyor observed Resident #17 awake. The resident smiled at the surveyor. The surveyor observed that the resident was missing teeth and had poor oral hygiene with food particles and residue in his/her mouth. On that same day at 12:48 PM, the surveyor interviewed the Licensed Practical Nurse #4 (LPN #4) who was assigned to Resident #17. LPN #4 stated that the Certified Nursing Assistant #2 (CNA #2) and the [redacted] were usually responsible for the resident's oral hygiene. LPN #4 then attempted to provide oral care by using two dry oral care sponges. LPN #4 removed a moderate amount of food particles and residue from the resident's mouth. At that same time, the surveyor asked LPN #4 why she was using dry sponges. LPN #4 stated Resident #17 was on [redacted] liquids, couldn't swallow water and was not supposed to have his/her teeth brushed and that oral care sponges should be dry. On that same day at 1:05 PM, the surveyor interviewed the [redacted] who stated that she had provided oral care to Resident #17 at	F 677	Resident #17 had oral care completed immediately and had no negative impact on their status. Residents on [redacted] have the potential to be affected. An audit was completed and no other residents affected. Speech Therapists and Facility Educator will continue to educate staff on proper oral care for patients with swallowing impairments who need assistance with oral care. Unit Managers will audit current residents on [redacted] liquids. UM/Supervisors will conduct daily observation of two residents on thickened liquids x 4 weeks then monthly x 3 months. The Director of Nursing or designee will present the results of these audits to the facility□s quarterly Quality Assurance Performance Improvement Committee quarterly for a period of three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 677	Continued From page 15	F 677		

approximately 10:30 AM, by using oral care sponges dipped in mouth wash. The [redacted] Aide further stated that she never brushed the resident's teeth because s/he was on [redacted] liquids.

On 9/30/19 at 11:01 AM, the surveyor interviewed CNA #2 who was routinely assigned to care for Resident #17. CNA #2 stated that she was not responsible for providing care to Resident #17 that morning because the resident had a [redacted] aide who had not arrived yet. CNA #2 further stated she was assigned to care for Resident #17 on the weekends.

At that same time, CNA #2 stated that when she provided oral care she brushed the resident's teeth with toothpaste then used an oral swab moistened with mouth wash to remove the toothpaste from the resident's mouth. CNA #2 stated that the [redacted] in-serviced staff with specific instructions for brushing Resident #17's teeth and explained that the resident could get pneumonia or become very sick if his/her teeth weren't brushed properly.

On 9/30/19 at 11:50 AM, the surveyor interviewed the [redacted] Therapist [redacted] who stated that [redacted] #2 who treated Resident #17 was out on holiday for a few days.

On 9/30/19 at 12:00 PM, the surveyor asked LPN #4 if [redacted] #2 provided in-services regarding Resident #17's oral care. LPN #4 replied, "I get a lot of in- services from PT/OT [Physical Therapy/Occupational Therapy] and [redacted]" LPN #4 further stated all she remembered was it had something to do with oral care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 677	Continued From page 16	F 677		

Review of a dental exam progress note dated [redacted] reflected: "poor oral hygiene. Lots of food pocketing, recommend oral hygiene by staff. [redacted] #26 mobility recommend extraction upon MD clearance. Per nurse, pt on [redacted] Nurse to speak to family to see if they want extraction done."

On 10/1/19 at 1:30 PM, the survey team met with the Acting Administrator and Director of Nursing (DON) and discussed the above observations and concerns. The surveyor requested a copy of the Facility's policy on oral hygiene. The Acting Administrator stated that the facility did not have a policy on oral care/hygiene but that all residents with teeth should have them brushed and complete oral care should be provided for residents with and without teeth.

On 10/3/19 at 10:07 AM, the surveyor interviewed [redacted] in the presence of the survey team, who stated that she had in-serviced both CNA #2 and LPN #4 on proper oral care for resident #17. ST #2 further stated she felt it was very important that staff were given on going training because Resident #17 "needed a little more TLC as he/she had a lot of residue in his/her mouth and had trouble clearing it."

The surveyor reviewed a Speech Therapist Patient/Caregiver Training progress note dated [redacted] which reflected Resident #17, CNA #2 and LPN #4 were all educated on safe swallowing strategies, posture, and strict oral care, using toothbrush and moist swabs.

2. On 9/30/19 at 10:43 AM, the surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 677	Continued From page 17 observed Resident #17 laying in bed awake. On that same day at 11:01 AM, the surveyor interviewed CNA #2 who stated she was not responsible for Resident #17's care that morning. The resident had a [redacted] aide who should be "here" soon. CNA #2 further stated if she was responsible for Resident #17's care she would have had the resident washed, dressed and up in the chair "by now." The surveyor asked if the resident had breakfast. CNA #2 replied that another CNA (CNA #3) who was on light duty fed the resident but did not give any personal care. CNA #2 stated that since the [redacted] aide wasn't "here yet" she would provide incontinence care to Resident #17. CNA #2 then checked the resident's incontinence pad which was [redacted] with [redacted]. On that same day at 11:20 AM, LPN #4 told the surveyor that CNA #2 was still responsible for the care of Resident #17 even though the resident was receiving [redacted] services. On 10/3/19 at 1:00 PM, the surveyor interviewed CNA #3 who was on light duty who stated that on 9/30/19 she fed Resident #17 his/her breakfast. She did not provide incontinence care, personal hygiene or any other care because she was on light duty and not capable of turning, lifting or changing residents. She further stated, "I already told the Director of Nursing and the other lady that I didn't change or turn the resident." On 10/3/19 at 2:00 PM, the survey team met with the DON who stated that on [redacted], CNA #3 was on light duty and provided Resident #17 incontinence care and helped to reposition the resident.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 677	Continued From page 18 The surveyor reviewed the medical record for Resident #17. According to the admission record, the resident was admitted to the facility on [redacted] and had diagnoses which included [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool with an assessment reference date of [redacted] reflected that the resident had [redacted] impairment, was dependent on staff for eating, toileting and personal hygiene and was incontinent of bowel and bladder. Review of the September 2019 Physician's Order Form reflected an order dated [redacted] for a [redacted] Diet with [redacted] Liquid Consistency. No further information was provided by the facility. NJAC 8:39-27.2 (f) (h)	F 677		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 726		10/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 726	Continued From page 19 accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure nursing competencies related to medication administration were performed for 2 of 3 nurses reviewed (LPN #1, LPN #6) for nurse competencies. The deficient practice was evidenced by: On 10/2/19 at 9:30 AM, the surveyor randomly selected three nurses to review competencies for a 12 month period (2018). Two of the three nurses selected did not have a medication administration observation competency for the 12 month period. The two nurses in question were Licensed Practical Nurse #1 (LPN #1) with a date of hire [redacted] and LPN #6 with a date of hire	F 726	F726 SS=D Competent Nursing Staff No residents were affected by this practice. Residents receiving medication have the potential to be affected. Education records for professional staff will be reviewed by the Facility Educator with attention to ensure nursing competencies related to medication administration were performed. Two randomly selected nurses	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 726	Continued From page 20 [redacted] On 10/2/19 at 10:00 AM, the surveyor interviewed the facility educator who stated she was responsible for nurse competencies at the facility. She further stated she performed the initial medication pass audit and the consultant pharmacist did subsequent medication pass audits. On 10/2/19 at 11:17 AM, the surveyor interviewed the Director of Nursing (DON) who stated the two nurses remembered having had a medication pass audit in the past, however, the DON said there was no record of those audits on file. On 10/2/19 at 11:50 AM, the surveyor interviewed the DON and the Pharmacy Consultant (CP). The CP stated the facility gives her a list of nurses to be observed during medication administration. The DON stated the facility educator asks the CP to observe the medication pass for specific nurses who are on shift at the time. The surveyor requested the DON and Consultant Pharmacist provide evidence of medication pass observations for the two nurses in question. No further documentation of medication pass observations was provided to the surveyor. A review of the Facility Assessment - 2019 Education Plan, provided by the Administrator on [redacted] at 9:45 a.m., revealed "Medication Administration Competency" was scheduled for the month of [redacted]	F 726	competencies will be reviewed weekly for a period of four weeks, then monthly for two months. Director of Nursing or designee will report audit findings to the Quality Assurance Performance Improvement Committee monthly for a period of three months.	
F 755	NJAC 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		10/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 755 SS=D	Continued From page 21 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to dispose of medication according to facility policy. This deficient practice was identified for 1 of 5	F 755	F755 SS=D Pharmacy Services/ Procedures/	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 755	Continued From page 22 residents (Resident #114) observed during the medication observation pass. This deficient practice was evidenced by the following: On 9/26/19 at 8:16 AM, the surveyor observed the Licensed Practical Nurse #1 (LPN#1) administer medications to Resident #114. At that time, the resident declined the prepared [redacted] (a medication used to treat or [redacted]) and the resident tossed the medication into the garbage receptacle in the presence of LPN #1 and the surveyor. On that same day and time, the resident informed LPN #1 and the surveyor that he/she did not need the [redacted] because his/her bowel movement was regular. LPN #1 then left the room and signed the Electronic Medical Record (eMAR) without removing the medication from the garbage receptacle. On 9/26/19 at 9:58 AM, the surveyor interviewed the Registered Nurse/Unit Manager #1 (RN/UM #1) who informed the surveyor that there should be two nurses to witness the medication disposal for regular and controlled medications. RN/UM #1 further stated that medications are disposed by using the drug buster which was available in the medication carts and the nurses should fill out a form titled "Wasted Routine Medication Sheet" (WRMeds). On that same day and time, RN/UM #1, in the presence of the surveyor checked the garage receptacle inside Resident #114's room. RN/UM #1 stated that LPN #1 "should have picked it up" and disposed of the medication properly.	F 755	Pharmacist/Records Resident #114 had no negative outcome, no other residents were affected. Residents receiving medication have the potential to be affected. Nurses will be in-serviced on the process for proper documentation Medication destruction with special attention to issues of resident refusing and the process for deposing of medication once prepared. Unit Manager or designee will observe the wasting of up to two medications weekly for a period of two months for medications that were prepared, but then required deposing. Wasted medication documentation will be reviewed weekly for four weeks by the Administrator and/or his designee and the results will reported to the Director of Nursing Director of Nursing or designee will report audit findings to the Quality Assurance Performance Improvement Committee monthly for a period of three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 755	Continued From page 23 At that same time, RN/UM #1 asked LPN/UM #1 to witness the disposal of the [redacted] and co-signed the WRMeds. On 9/27/19 at 9:12 AM, the surveyor conducted a telephone interview with LPN/UM #1 who stated she was not aware of the facility's medication disposal policy. On 10/7/19 at 11:33 AM, the survey team met with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). There was no additional information provided. A review of the facility's Policy titled Disposal of Medications provided by the Regional Nurse with a revised date of 1/2015 indicated that "Authorized personnel only will handle disposal of medications in the facility;" and "the facility will maintain a record of all medications that have been disposed, and the record will contain the information of the resident, med name and strength, quantity of med disposed, signature of person destroying/disposing med and date and the signature of person witnessing the destruction and date." NJAC 8:39-29.4 (i)	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		10/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 756	Continued From page 24 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the Consultant Pharmacist (CP) reported irregularities of a drug regimen to the physician and the facility for 1 of 5 residents, (Resident #143) observed during medication administration,	F 756	F756 SS=D Drug Regimen Review, Report Irregular, Act On Resident #143 medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 756	Continued From page 25 and act upon the CP's recommendations and report of irregularities for the Interim Medication Regimen Review (IMRR) for 1 of 37 residents (Resident #123). This deficient practice was evidenced as follows: 1. During the medication administration on 9/26/19 at 8:59 AM, the surveyor observed the Licensed Practice Nurse #3 (LPN #3) administer medications to Resident #143 which included [redacted]. The surveyor reviewed the September 2019 electronic Medication Administration Record (eMAR) which revealed an order for [redacted] dated [redacted]. This medication was scheduled on the MAR to be administered at 9:00 AM and 5:00 PM. However, further review of the eMAR revealed that the [redacted] had special instructions to administer the [redacted] at 12:00 PM and 5:00 PM and separate from [redacted] by at least two hours. At that same time, the surveyor observed LPN #3 change the physician's order by deleting the special instructions in the electronic medical record during the medication observation pass without consulting the physician. LPN #3 did not follow the above special instructions and did not administer the supplement at 9:00 AM. The surveyor interviewed LPN #3 who stated, "I should have called the doctor first" to clarify the 9:00 AM and 5:00 PM plotting for the [redacted] and the special instructions to administer at 12:00 PM and 5:00 PM.	F 756	administration time was changed the same day and had no negative impact on their status. Resident #123 continued on the same dose per the physician and no negative impact has been observed. A review of residents with cautionary statements related to time administration was completed and no other residents were identified. Pharmacy consultant reports were reviewed related to supportive consultants and no other residents were identified. Residents□ drug regimen will continue to be reviewed on admission by the Consultant Pharmacist at the time of admission and monthly for any irregularities. Medical Director, DON, ADON, Unit Managers will receive and review Pharmacy recommendations report, communicate with the physician, and document changes or additional interventions in the medical record. DON, ADON, and Unit Managers will review admission and monthly Consultant Pharmacist□s Medication Regimen Review corrections and recommendations weekly x 4 weeks then monthly x 2 months. Findings to be reported to the QAPI Committee monthly for further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 756	Continued From page 26 Further review of the September 2019 eMAR revealed an order dated 5/17/18 for [redacted] by mouth in the morning scheduled to be administered at 6:00 AM with special instructions not to give within four hours of [redacted] or [redacted] A review of the [redacted] orders Audit Report dated [redacted] indicated the order for [redacted] twice a day and was revised by LPN#3 on [redacted] to include the special instruction to give at 12:00 PM and 5:00 PM. The surveyor reviewed the August and September 2019 Consultant Pharmacist Review/MRR (Medication Record Review) report for Resident # 143. The 9:00 AM and 5:00 PM incorrect scheduled administration time for the [redacted] was not identified. On 10/2/19 at 11:44 AM, the survey team met with the Director of Nursing (DON), Consultant Pharmacist #1 (CP #1) and CP #2. The DON informed the surveyors that the order for [redacted] was changed by LPN #3 on [redacted] and that the [redacted] should have been given at 12:00 PM and 5:00 PM and was erroneously scheduled for administration at 9:00 AM and 5:00 PM. The DON further stated that she was thankful to the surveyor that the irregularity was identified. On that same day and time, CP #2 stated the order for the [redacted] "was not addressed on our part" in the August and September 2019 MRR. CP #2 further stated that the [redacted]	F 756	recommendations and or action plans as needed for a period of three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 756	Continued From page 27 should have been scheduled for administration to provide at least 4 hours separation from [redacted] according manufacturer's specifications. In addition, CP #1 stated that upon investigation, there was no negative effect on the resident and the [redacted] (laboratory report used to check the [redacted] medication) was normal. A review of the facility's undated Interim Medication Regimen Review (IMRR) Policy provided by the DON indicated that "The CPs Medication Regimen Review shall include, but not be limited to the following area: 1. Identification of irregularities, including unnecessary drugs and adverse consequences; 2. Any other areas deemed appropriate by the consultant pharmacist." 2. A review of the Admission Record revealed Resident #123 was admitted on [redacted] with diagnosis of [redacted] A review of the Admission Minimum Data Set (MDS), an assessment tool with an Assessment Reference Date (ARD) of [redacted]9, indicated that Resident #123 had a brief interview for mental status (BIMS) score [redacted] which indicated that	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 756	Continued From page 28 resident had [redacted] impairment On 9/27/19 at 10:35 AM, the surveyor reviewed the Interim Medication Regimen Review (IMRR) dated [redacted] which revealed "Resident receiving [redacted] [every day]. Per Manufacturer Doses of [redacted] mg are not recommended in the elderly due to increased risk of adverse effects. If the above dose is to continue have MD [medical doctor] document the benefits and why this dose is appropriate for this resident." Further review of the [redacted] IMRR revealed a handwritten note which indicated "admit [redacted] e medication dose-F/U [follow-up] [redacted]] MD [doctor]." Further review of Resident #123 medical record did not reveal a [redacted] consult or that the primary care physician addressed the Consultant Pharmacist's recommendation for the [redacted] mg. There was no documented evidence that the doctor documented the benefits of the [redacted] mg until after surveyor inquiry. Review of the August and September 2019 Physician Order Sheet revealed a Physician's order for [redacted] mg by mouth daily for [redacted]. On 9/27/19 at 11:35 AM, the surveyor interviewed LPN #3 who stated, "the pharmacy consultant comes and makes recommendations monthly and then the nurse will review the recommendations and call the doctor for orders." At that same time, LPN #3 in the presence of the surveyor reviewed the resident's medical chart	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 756	Continued From page 29	F 756		

and was unable to locate a [redacted] consult and/or documentation from the primary care physician addressing the Consultant Pharmacist's recommendation for the [redacted] mg. She then stated, "I know the [redacted] saw the resident, because there was a change to her medication. Let me call the Unit Manager, maybe she knows where the [redacted] consult is."

On that same day at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager #2 who stated "the [redacted] Nurse is responsible to respond to the Pharmacy Consultant's MRR. I am not sure if the writing on the consultation report is hers."

On 10/1/19 at 11:30 AM, the surveyor interviewed LPN #1 who stated, she was responsible for following up on the pharmacy consultant drug regimen reviews. "I remember doing the recommendation follow-up for this resident, but I only did the ones I wrote 'done' in the front of the recommendation. I don't recall writing on the consult form, I don't recall calling the doctor for the [redacted] recommendation.

On 10/1/19 at 1:57 PM, the survey team met with the DON, ADON and the Administrator and discussed the above concern. The DON stated, "I am sorry, I was the one who wrote on the pharmacy consultant's report that the resident will be followed up by the [redacted] after I spoke to the medical director, but I did not document that in the resident's progress note or anywhere about my conversation with the doctor. We called the [redacted] and the resident was seen on [redacted] after you left, the [redacted] wants the resident to continue with all the medications."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 756	Continued From page 30 10/2/19 at 12:17 AM, the surveyor interviewed CP #1 in the presence of the survey team. CP #1 stated, "I come once a month to do the review of the residents' medications; the report is then sent to the Director of Nursing, ADON and other designees. For the new admissions, the lists of medications are faxed by the nurses to our office for the IMRR. After reviewing them, the recommendations are sent to the DON, ADON and the designees for them to address any recommendations made. The nurses then put their initials on the forms with the recommendations to indicate that the recommendations are done or physician refused or agreed to the recommendations." The surveyor reviewed the facility's undated Medication Regimen Reviews policy provided by the DON. The policy indicated the following, #3. Reviews for short stay individuals (those who are expected to stay for 30 days or less) are done upon admission (or as close to admission as possible) and as needed to identify individuals with potential medication-related issues and for those who may be experiencing adverse consequences from their medications and #12. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it" (#12). NJAC 8:39-29.1 (b) NJAC 8:39-29.3 (a) (1)	F 756		
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	F 880		10/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 31	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 32 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to a) maintain adequate infection control standards of practice for 1 of 35 residents (Resident #17) and b) failed to follow appropriate handwashing practices for 1 of 4 nurses (LPN #2) observed during the medication observation pass. This deficient practice was evidenced by the following: On 9/30/19 at 11:10 AM, the surveyor observed CNA#2 prepare to provide [redacted] care to Resident #17. The surveyor observed CNA #2	F 880	F880 SS=D Infection Prevention and Control Resident #17 and #178 had no negative outcome due to this practice. Residents receiving care in the facility have the potential to be affected. Staff will be in-serviced on the topic of Infection Control and proper handwashing during care of a resident as well as during medication pass	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 33 wash her hands for five seconds under running water. CNA #2 opened the resident's [redacted] pad that was [redacted]. After touching the soiled [redacted] pad and without removing her gloves, CNA #2 picked up the roommates call bell from the floor and placed it on top of the Roommates bed. CNA #2 then removed the soiled gloves and washed her hands for eight seconds. CNA #2 then left the resident's room to obtain [redacted] products. On that same day at 11:18 AM, the surveyor observed CNA #2 wash her hands for five seconds and don two pair of gloves (double gloved). CNA #2 stated, "I sometimes wear two pairs of gloves, I don't think I'm wrong." After providing [redacted] care to Resident #17, CNA #2 removed both pair of gloves and washed her hands for 10 seconds. On that same day at 11:30 AM, the surveyor asked the CNA #2 what the facility's policy was on handwashing. The surveyor also asked CNA #2 why she handled the roommates call bell with soiled gloves. CNA #2 replied she should have washed her hands for 30 seconds but she washed them so often she forgot to count. CNA #2 further stated that she had not realized she handled Resident #17's call light with soiled gloves but she shouldn't have. Review of the Facility's Handwashing/Hand Hygiene Policy reflected: "Wet hands first with water, apply soap and vigorously rub hands together creating friction to all surfaces for a minimum of 20 seconds (or longer.) The surveyor reviewed the medical record for Resident #17. According to the admission record,	F 880	Facility Educator and Unit Manager will observe handwashing for up to fifteen employees a week for two months and report his/her findings to the Director of Nursing weekly. Director of Nursing or designee will report audit findings to the Quality Assurance Performance Improvement Committee monthly for three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 34 the resident was admitted to the facility on [redacted] and had diagnoses which included [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool with an assessment reference date of [redacted] reflected that the resident had [redacted] impairment, was dependent on staff for eating, toileting and personal hygiene and was incontinent of bowel and bladder. On 10/3/19 at 2:00 PM, the above observations and concerns were discussed with the Administrator and Director of Nursing (DON). No further information was provided by the facility. On 9/26/19 at 8:44 AM, the surveyor observed the Licensed Practical Nurse #2 (LPN#2) wash her hands for 55 seconds under the stream of running water during the medication administration for Resident #178. At that time, the surveyor asked LPN #2 what was the facility protocol on the proper way of performing hand washing. LPN #2 stated that "handwashing should be done for 20 seconds." She further stated, "yes, it should be done under running water." On 10/1/19 at 1:22 PM, the survey team met with the covering Administrator, DON, and Acting	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 35 Director of Nursing (ADON). The DON informed the surveyors that hand washing should not be done under running water. NJAC 8:39-19.4 (a) (1)	F 880		