STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315488	A. BUILDING _____ B. WING _____	06/28/2019

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CARE ONE AT MADISON AVENUE	151 MADISON AVENUE MORRISTOWN, NJ 07960

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F 000	INITIAL COMMENTS Standard Survey 6/28/19 Census: 88 Sample Size: 20	F 000		
F 641 SS=B	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 interview and record review, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 2 of 20 residents (Resident #10 and #70) reviewed. The deficient practice was evidenced by the following: 1. The surveyor reviewed Resident #10's medical records that revealed the following: Resident #10 was admitted to the facility on [redacted] with diagnoses that included [redacted] The quarterly MDS dated [redacted], revealed the facility had coded Resident #10 for a [redacted] The Universal Transfer Form dated 3/8/19 and	F 641	The MDS assessments for residents #10 and #70 were immediately corrected by the MDS Coordinator on [redacted] A review of the [redacted] history was completed on resident #10 and resident #70. MDS assessments were corrected and accurately coded. MDS of residents with wounds were reviewed with no further findings identified. The MDS Coordinator will review each MDS for residents with wounds to ensure that MDS documentation is complete, timely, and accurate. In-service was done by the Regional MDS Coordinator to MDS Assessor/nurse to ensure accurate coding. The MDS Coordinator will utilize the weekly wound rounds log on its subsequent MDS scheduled assessment	7/17/19

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

Electronically Signed | 07/19/2019

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F 641	Continued From page 1 the admission Resident Evaluation form dated [redacted], revealed there was no documentation that the resident was admitted to the facility with [redacted]. On 6/26/19 at 10:25 AM, the surveyor interviewed the Unit Manager (UM), who stated that the [redacted] that the resident currently had on the [redacted]. 2. The surveyor reviewed Resident #70's medical records that revealed the following: According to Admission Record, Resident #70 was admitted to the facility on [redacted] with diagnoses that included [redacted]. The Admission MDS dated [redacted] revealed the facility had coded Resident #70 for [redacted]. According to the Universal Transfer Form dated 5/15/19 and Resident Evaluation form dated 5/15/19, Resident # 70 ha [redacted] that was present on admission. There was no documentation of another [redacted] indicated at the time of admission. On 6/26/19 at 12:09 PM, the surveyor interviewed the UM who stated that the resident had [redacted] which was present on admission and one on the [redacted] that was not present on admission.	F 641	to validate the accuracy of coding. The MDS Coordinator will audit 5 MDS assessments for residents with wounds monthly to ensure accuracy of coding related to wounds. Results of the audit will be reported/discussed in QAPI quarterly for two quarters to ensure that interventions put in place are effective.	

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F 641	Continued From page 2 On 6/27/19 at 9:26 AM, the surveyor interviewed the MDS Coordinator who stated that she had coded the [redacted] in error. At 9:30 AM, the surveyor interviewed the Regional MDS Coordinator who stated that the [redacted] were coded in error. On 6/27/19 at 1:58 PM, the surveyor discussed the above concerns with the Administrator and Director of Nursing. There was no additional information provided. NJAC 8:39-11.2(b)	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		7/17/19

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F 656	Continued From page 3 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to develop a comprehensive person centered care for 1 of 2 residents (Resident #3) reviewed for Restorative Nursing Program services. This deficient practice was evidenced by the following: On 6/24/19 at 10:51 AM, the surveyor observed Resident #3 in bed with eyes open. The resident was leaning to the right side of the bed and had difficulty positioning themselves. The Certified Nursing Assistant assigned to the resident assisted the resident to a more comfortable position. The surveyor reviewed Resident #3's medical record that revealed the following:	F 656	A comprehensive centered plan of care for resident #3 related to restorative function was developed and a comprehensive assessment was done to reflect changes in the residents ADL function. A Rehabilitation evaluation was also completed. PT was initiated on 6-11-19 until 7-2-19. Residents with a change in functional status have the potential to be affected by the same practice. Nurses and managers were in-serviced on the resident centered plan of care. The IDC team was in-serviced on developing a restorative nursing care plan.	

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F 656	Continued From page 4 According to the Admission Record, Resident #3 was admitted to the facility on [redacted] with diagnoses that included [redacted]. According to the Quarterly Minimum Data Set an assessment tool dated [redacted], the facility assessed Resident #3 with [redacted] The June 2019 Documentation Survey Report for Restorative Nursing revealed Resident #3 was participating in the Restorative Nursing Program for transfers to the toilet, grooming and lower body dressing, A review of Resident #3's care plans revealed there was no comprehensive person centered care plan developed to address the plan of care for Restorative Nursing Program services. On 6/26/19 at 9:21 AM, the surveyor interviewed the Registered Nurse Unit Manager (RNUM) who stated that she is responsible for developing the care plans and stated that a care plan should have been in place. On 6/26/19 at 1:33 PM, the surveyor discussed the above concern with the Administrator and Director of Nursing (DON). The DON confirmed that a care plan should have been developed. A review of the facility's policy Restorative Nursing Services under Policy Interpretation and Implementation #3 indicated the following; "Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care.	F 656	The IDC team will review the maintenance nursing program and care plan for each resident on program once a month and update or discontinue as needed. Unit Managers and the Rehabilitation Director will meet once a month to discuss residents that are appropriate for restorative Nursing and Maintenance program. Unit Managers and the ADON will audit five residents monthly on Restorative Nursing program and maintenance nursing program to ensure that they have an updated patient centered plan of care. Results of the audit will be reported/discussed in QAPI quarterly for two quarters to ensure that interventions put in place are effective.	

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F 656	Continued From page 5 NJAC 8:39-27.1(a)	F 656		
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 maintain professional standards of practice by not obtaining a physician's order for 1 of 20 residents (Resident #58) reviewed for oxygen services. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: 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	F 658	The [redacted] order was obtained immediately on 6-27-19 by the Unit Manager and the care plan was updated to reflect the use of [redacted] related to the residents medical diagnosis. A review of residents receiving [redacted] did not identify any additional findings. Nurses were in-serviced on reviewing hospital records and discharge orders from the hospital to ensure that medications and special needs/equipment are reconciled and carried out completely by the admitting Nurse. In addition to the Unit Manager who will review the residents record, the 11-7 shift Nurse will also review new admission notes and Physician orders for accuracy. Resident status will be discussed in the clinical rounds by the IDC team to identify concerns and to ensure that orders are carried out completely. Unit Managers will audit five residents	7/17/19

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F 658	Continued From page 6 casefinding; 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 6/24/19 at 11:00 AM, the surveyor observed Resident #58 seated in the wheel chair. The resident was alert and was able to respond to the surveyor. The surveyor observed Resident #58's room which had an [redacted] by the resident's bed. The resident was not using [redacted] when observed seated in the wheelchair. The surveyor reviewed Resident #61's medical record that revealed the following: According to the Admission Record, Resident #58 was admitted to the facility on [redacted] with diagnoses that included [redacted] The June 2019 physician's order Order Recap Report revealed the resident did not have an order for [redacted] Resident #58's New Jersey Universal Transfer Form dated 5/11/19 under Respiratory Needs revealed the resident required [redacted] The Resident Evaluation form under #4 "Respiratory" indicated the following; [redacted] " and under #5 "Is [redacted] ordered" indicated yes," under 5a "if yes, what frequency indicated "Routine," and under 5b "Rate of [redacted] indicated 2.	F 658	receiving [redacted] once a week for 4 weeks and ensure that the plan of care is in place. Results of the audit will be reported/discussed in QAPI quarterly for two quarters to ensure that interventions put in place are effective.	

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F 658	Continued From page 7 Resident #58's care plan related to the use of [redacted] revealed under focus area '[redacted]" that included an intervention dated 5/13/19 for [redacted] to be administer as ordered. On 6/27/19 at 11:15 AM, the surveyor interviewed Resident #58 who stated that the resident would use [redacted]. On 6/27/19 at 11:50 AM, the surveyor interviewed the Certified Nursing Assistant assigned to Resident #58 who stated that the resident was independent and would use [redacted] as needed. On 6/27/19 at 12:10 PM, the surveyor interviewed the Registered Nurse (RN) assigned to Resident #58. The RN stated that Resident #58 had an order for [redacted] as needed. The surveyor and RN reviewed the resident's physician's orders in the Order Recap Report and were unable to find an order for the use of [redacted]. On 6/27/19 at 12:20 PM, the surveyor interviewed the Unit Manager (UM) who reviewed Resident #58's physician's orders and was unable to find an order for [redacted]. The UM stated that the resident should have an order for [redacted] and that she would call the physician to get an order. On 6/27/19 at 2:20 PM, the surveyor discussed the above concerns with the Administrator and Director of Nursing. There was no additional information provided. A review of the facility's policy titled [redacted] Administration under Preparation #1 indicated the following; "Verify that there is a physician's order for this procedure. Review the physician's order	F 658		

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F 658	Continued From page 8 or the facility protocol." NJAC 8:39-27.1 (a)	F 658		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 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 documentation of monitoring for complications related to [redacted] and b.) schedule administration of medications on [redacted] treatment days from 5/24/19 through 6/24/19. This deficient practice was identified for 1 of 2 residents (Resident #55) reviewed for [redacted]. The deficient practice was evidenced by the following: 1. On 6/25/19 at 9:28 AM, the surveyor observed Resident #55 seated in the wheelchair at the bedside watching television. The surveyor reviewed Resident #55's medical record that revealed the following: According to the Admission Record, Resident #55 was admitted to the facility on [redacted] with diagnoses that included [redacted]	F 698	Resident #55 was discharged home after their successful rehabilitation stay. Residents on [redacted] have the potential to be affected. No other residents were identified after a clinical record review was completed. Nursing staff were in-serviced on order entry, plotting times for [redacted] days, and medication administration. Education also included the protocol for communication books to ensure that pre and post treatment activity has been captured. The Director of Nursing and/or designee(s) will audit orders of up to three [redacted] patients weekly for four weeks. Audit items will include communication, order plotting, and order entry for residents receiving [redacted]. The results of these audits will be submitted quarterly for two quarters to the	7/17/19

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F 698	Continued From page 9 [redacted] Resident #55's care plan (CP) related to the resident's need for [redacted] with a focus of [redacted]," included the following intervention; 1. "Check [redacted] per facility guidelines. Report abnormalities to physician." 2. "Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-[redacted] as needed." According to the Order Recap Report dated 5/23/19 to 6/30/19, revealed the following physician's orders: 1. [redacted] every Monday, Wednesday, Friday, pick up at 10:00 AM. 2. Check [redacted] every shift with a start date of 6/25/19. 3. [redacted] before meals and at bedtime with a start date of 5/24/19. The [redacted] monitoring was indicated to check the resident's [redacted] levels and determine whether the [redacted] should be administered.	F 698	QAPI committee for review to determine if further action to the plan is needed.	

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F 698	Continued From page 10 4. [redacted] with meals, with a start date of 5/23/19. 5. [redacted] three times a day with a start date of 5/31/19. The May 2019 and June 2019 Electronic Medication Administration Record's (EMAR) for Resident #55 revealed the following: 1. From 5/23/19 through 6/24/19 there was no documentation that the resident's [redacted] 2. [redacted] was scheduled for administration at 7:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM. On 5/24/19, 5/27/19, 5/29/19, 5/31/19, 6/3/19, 6/5/19, 6/7/19, 6/10/19, 6/12/19, 6/14/19, 6/17/19, 6/19/19, 6/21/19, and 6/24/19, the resident did not have a [redacted] check at 11:30 AM because the resident was out to [redacted]. 3. [redacted] was scheduled for administration at 8:00 AM, 12:00 PM and 5:00 PM. On 5/24/19, 5/27/19, 5/29/19, 5/31/19, 6/3/19, 6/5/19, 6/7/19, 6/10/19, 6/12/19, 6/14/19, 6/17/19, 6/19/19, 6/21/19, and 6/24/19 the resident did not receive [redacted] at 12:00 PM. 4. [redacted] was scheduled for administration at 9:00 AM, 1:00 PM, and 5:00 PM. On 6/3/19, 6/5/19, 6/7/19, 6/10/19, 6/12/19, 6/14/19, 6/17/19, 6/19/19, and 6/21/19 the resident did not receive [redacted] at 1:00 PM. The documentation on the EMAR for these	F 698		

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F 698	Continued From page 11	F 698		

medications was coded as being held, with an explanation in the EMAR and Progress Notes (PN) that the resident was at [redacted] and not in the facility. The medications times and [redacted] monitoring were not adjusted for the days the resident was out of the facility for [redacted]

A review of the PN's from 5/23/19 through 6/24/19, revealed no consistent documentation that the nurses checked the resident's [redacted].

On 6/28/19 at 9:27 AM, the surveyor interviewed the Registered Nurse (RN) assigned to Resident #55 who stated that the resident returns to the facility from [redacted] at 4:30 PM and that she assessed the resident's [redacted] daily. She also reported that according to the facilities protocol, it should be assessed every shift by the nurse. The RN also stated that the [redacted] should be assessed when the resident returns from [redacted] for any complications and the assessment should be documented on the EMAR as well as in the PN.

The RN further stated that there should be a physician's order to check the [redacted] every shift and if there was not an order, the nurse should call the physician and obtain one.

The RN stated she was not aware that from 5/23/19 to 6/24/19 there was no order to check the [redacted]. The RN stated that all medication orders should be scheduled to accommodate the resident's [redacted] dates and times. The RN stated that she held Resident #55's medications

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F 698	Continued From page 12 on the resident's [redacted] days because the resident was out of the facility at [redacted]. The RN was aware that this practice was not the facility's policy and that she should have called the physician to receive orders to change the administration times to accommodate the resident's [redacted] schedule. On 6/28/19 at 9:30 AM, the surveyor interviewed the Unit Manager (UM) who stated that the facility's protocol for assessing an [redacted] was to [redacted] every shift, there should be a physician's order for this, and the assessment should be documented on the EMAR and in the PN. The UM stated that if there was no physician's order, the nurse is expected to call the physician to obtain one. The UM reviewed the physician's orders with the surveyor and stated Resident #55 did not have an order to assess the [redacted]. The UM further stated that all medications must be scheduled to accommodate the resident's [redacted] schedule to ensure that no medications are missed when the resident was out of the facility at [redacted] The UM was not aware that the resident had missed any medications while out of the facility at [redacted], stating that the nurses should not have held the medication, they should have called the physician and received new orders adjusting the administration times around the resident's [redacted] schedule. On 6/28/19 at 10:37 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the nurses should have obtained a physician's orders	F 698		

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F 698	Continued From page 13 to assess the [redacted] and [redacted]. The DON also stated that all medications administration times should be reviewed with the physician and scheduled to accommodate the resident's [redacted] schedule so that no doses are missed. A review of the facility's policy titled [redacted] Pre and Post Care," revealed, under General Information; "Routes of [redacted] treatments will be monitored for potential complications of infections. Routes may include but not limited to [redacted]. Treatment sites are to be assessed regularly; including upon admission to the center and each shift, upon complaint of pain, pre and post [redacted] treatment and more frequently is complications arise. Treatment sites should be inspected for signs and symptoms of inflammation or infectious process; [redacted] NJAC 8:39-11.2 (b), 27.1 (a)	F 698		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		7/17/19

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F 761	Continued From page 14 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to properly label, store and dispose of medications. The deficient practice was observed in 4 of 9 medication carts on 3 of 4 units and 1 of 4 medication refrigerators inspected and evidenced by the following: On 6/24/19 at 9:25 AM, the surveyor inspected the [redacted] floor medication cart #1 in the presence of a License Practical Nurse #1 (LPN). The surveyor observed an opened bottle of [redacted] that was not dated. The surveyor interviewed the LPN #1 who stated that an opened bottle of [redacted] should have been dated. On 6/24/19 at 9:35 AM, the surveyor inspected the [redacted] floor medication cart in the presence of LPN #2. The surveyor observed an opened [redacted] and an opened bottle of [redacted]	F 761	The Opened bottle of [redacted] that were in the [redacted] floor medication cart #1 was discarded. In the [redacted] floor medication cart, the undated, opened [redacted] was discarded and replaced with a dated one. The undated,opened bottle of [redacted] was also discarded and replaced with a dated one. In the other [redacted] floor medication cart, the undated, opened [redacted] was discarded and replaced with a dated one. The unlabeled, [redacted] was discarded. The Pharmacy delivered a new [redacted] which was labeled with the residents name and dated. The undated, opened [redacted] on the [redacted] floor medication cart was discarded and replaced with a dated one. On the [redacted] floor the undated,opened bottle of [redacted] was	

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F 761	Continued From page 15 [redacted] that were not dated. The surveyor interviewed LPN #2 who stated that both an opened [redacted] and an opened bottle of [redacted] should have been dated. On 6/24/19 at 9:45 AM, the surveyor inspected the [redacted] floor medication cart in the presence of LPN #3. The surveyor observed an opened [redacted] that was not dated and an opened [redacted] that had no resident's name on the pen. The surveyor interviewed LPN #3 who stated that an opened [redacted] should have been dated and she also stated that any medication without a resident's name should be remove from the medication cart. On 6/24/19 at 10:00 AM, the surveyor inspected the [redacted] floor medication cart in the presence of a Registered Nurse (RN). The surveyor observed an opened [redacted] that was not dated. The surveyor interviewed RN #1 who stated that an opened [redacted] should have been dated. On 6/24/19 at 10:10 AM, the surveyor inspected the [redacted] floor medication room refrigerator in the presence of RN #1. The surveyor observed an opened bottle of [redacted] that was not dated. The surveyor interviewed RN #1 who stated that an opened bottle of [redacted] should have been dated. A review of Manufacturer's Specifications for the above medications revealed the following: 1. [redacted] once opened have a 90-day expiration date. 2. [redacted] once opened have a 42-day expiration date. 3. [redacted] once opened have a	F 761	discarded. Any resident receiving identified medication has the potential to be affected. Upon review, no residents with untoward effects. In-service on storing, dating, and labeling of medication, supplements, and supplies was done on 6-24-19. The Unit Manager, ADON and Facility educator will monitor the refrigerators once per week and ensure that all medications that are opened are properly labeled with the resident name and dated when it was opened. The Director of Nursing and/or designee(s) will audit three medication carts weekly for four weeks to ensure compliance with dating,and storage of items. The results of these audits will be submitted quarterly for two quarters to the QAPI Committee for review to determine if further action to the plan is needed.	

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F 761	Continued From page 16 90-day expiration date. 4. [redacted] once opened have a 90-day expiration date. A review of the facility's policy titled Labeling of Medication Containers under #3 indicated the following; "Labels for individual resident medications include all necessary information, such as: a. The resident's name and h. The expiration date when applicable." NJAC: 8:39-29.4 (a) (h) and (d)	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of documentation provided by the facility, it was	F 812	On 6-24-19 staff cleaned and sanitized the two coffee carafes, the small metal	7/17/19

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F 812	Continued From page 17 determined that the facility failed to prepare and store potentially hazardous foods in a safe and sanitary manner to prevent food borne illnesses. This deficient practice was evidenced by the following: On 6/24/19 at 9:00 AM, in the presence of the Director of Culinary Services (DCS), the surveyor observed the following: 1. Two coffee carafes were stored upright on a shelf with the covers on them. The DCS removed the tops and there was standing water in each carafe. 3. One small metal pot and one large metal pan stored on an open cart were wet nesting. 4. Thirty five clean food trays were stacked with bottom side up and all of the trays were wet nesting. 5. There were plastic dish warmers stored on a dry rack and 12 of the plastic dish warmers were placed two together between each metal separator. All 12 of the plastic dish warmers that were not individually separated were wet nested. 6. In the reach in refrigerator there was one large plastic bowl that contained a prepared green salad that was covered with plastic wrap. The salad did not have a use by date. 7. The back splash behind the food prep area was soiled with multiple dried red and brown particles on it. 8. The back splash behind the oven and the	F 812	pot, the large metal pan, the 35 food trays, and the 12 plastic dish warmers. The salad was removed from the refrigerator and discarded. Staff cleaned the back splash behind the food prep area,and behind the oven. The oven glass door, the inside of the oven base, as well as the top and sides of the oven were also cleaned. The glass doors, base, top, and sides of the two convection ovens were also cleaned. Food stored in the refrigerator and freezer were labeled and dated in accordance with center policy. The wax paper on the spice container was discarded. The Center recognizes that other residents have the potential to be affected. On 6-24-19 the food service staff were in-serviced on the proper operation of the 3 compartment sink, the dish machine, recording of temp logs, label and dating of refrigerated items, and proper stacking of dishes, pans, pots, to allow air flow and prevent wet nesting. An in-service was also conducted on the daily cleaning schedule. The Food Service Director will conduct audits weekly for four weeks, then monthly to ensure cleanliness and to prevent wet nesting. The Food Service Director will report the results at the quarterly QAPI meeting. The Administrator will evaluate the results from the quarterly QAPI meeting and take	

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F 812	Continued From page 18 glass door of the oven was soiled with drippings of charred, dried black particles. The inside of the oven base was soiled with a large area of dried beige, white substance and the remaining base, top and sides of the oven were soiled with dried black, charred particles. 9. The glass doors of the two convection ovens were soiled with charred dried black, brown particles and the inside of the convection ovens base, top and sides had charred, dried black particles. 10. A cart containing spices had multiple brown and beige particles on the wax paper that the spices were stored on. The DCS told the surveyor that the dietary staff used a Weekly Cleaning Assignment (WCA) form that they sign after completing their cleaning tasks. The DCS further stated that the WCA was kept posted in the prep area. When the DCS went to get the form it was not there. The DCS stated, "Someone must have removed it from the wall." The surveyor reviewed the facility's Sanitation policy that indicated in section #1 titled, Policy Interpretation and Implementation," All kitchens, kitchen areas and dining areas shall be kept clean" and under #11 in the section titled Procedure, "Food preparation equipment and utensils that are manually washed will be allowed to air dry." The surveyor reviewed the facility's Food Receiving and Storage policy that indicated, "Foods stored in the refrigerator or freezer will be stored using food service standards."	F 812	corrective action as needed.	

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F 812	Continued From page 19 The facility did not have a policy for the labeling and dating of prepared refrigerated items. NJAC8:39-17.2(g)	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and 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;	F 880		7/17/19

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F 880	Continued From page 20 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain proper infection control procedures to minimize the risk of the spread of infection for 1	F 880	Employees that were observed not utilizing PPE were immediately educated on infection control general practice, which included isolation protocols, the use	

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F 880	Continued From page 21 of 1 resident's (Resident #329) reviewed for transmission-based precautions. The deficient practice was evidenced by the following: On 6/25/19 at 9:47 AM, the surveyor observed Resident #329 laying in bed watching TV. There was a bin of personal protective equipment (PPE) and a "Stop Report to Nurse Before Entering" sign on the resident's door. The Unit Manager (UM) reported that the resident was on contact isolation for a diagnosis of [redacted] requiring a gown and gloves to be worn whenever anyone enters the resident's room. The surveyor reviewed Resident #329's medical record that revealed the following: According to the Admission Record, Resident #329 was admitted to the facility on [redacted], with a diagnosis that included [redacted] The June 2019 physician's orders revealed an order for contact isolation for a diagnosis of [redacted] " Resident #329's care plan dated 6/22/19, identified a focus area indicating the resident had an [redacted] On 6/25/19 at 10:00 AM, the surveyor observed the Licensed Practical Nurse (LPN) assigned to the resident, enter the residents room wearing	F 880	of PPE and hand-washing. Residents on isolation precautions have the potential to be affected. No other residents were impacted after clinical record review of antibiotic trends were completed. In-service was completed with employees related to infection control which included use of PPE, hand-washing, identification and communication of residents on specific precautions. Hand-washing in-services and individual hand-washing competencies to employees was also completed on 6-25-19. The Director of Nursing or designee(s) will interview and observe five employees for competency regarding isolation practice and hand-washing every two weeks for two months. The results of the observations/competency evaluation will be submitted quarterly for two quarters to the QAPI committee for review to determine if further action to the plan is needed.	

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gloves, the LPN left the room removing her gloves, no handwashing was observed.

On 6/25/19 at 11:44 AM, the surveyor interviewed the LPN who reported that Resident #329 was on isolation for [redacted]. When leaving the room, the PPE must be removed, and handwashing must be performed prior to leaving the room. The LPN stated that she did not follow the procedure when entering the room earlier because she did not touch the patient. She further stated that PPE should always be worn when entering the room for any reason and that she should have donned all the PPE before entering the resident's room earlier.

On 6/25/19 at 11:55 AM, the surveyor observed the Occupational Therapist (OT) approach the resident's room, apply a gown and a mask and went into the resident's room. The OT stood at the bedside talking with the resident. While walking back to the resident's door the OT began removing the gown, then she removed the mask and threw the items in the trash can. The OT walked to the nurse's station. The surveyor did not observe the OT apply gloves or perform handwashing prior to leaving the residents room.

On 6/25/19 at 12:00 PM, the surveyor interviewed the OT who stated she knew she needed to put on a gown, gloves, and mask to enter this residents' room. She stated that the procedure for leaving an isolation room was to remove the gloves, gown, mask and discarded them in the trash and come out of the room and wash her hands with soap and water. She was unaware

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that she should have washed her hands prior to leaving the residents room.

On 6/25/19 at 12:05 PM, the surveyor interviewed the facilities Infection Preventionist (IP) who stated that the Resident #329 was on contact precautions requiring putting on a gown and gloves before entering the room. The IP reported that the procedure for exiting the room was to remove the PPE in the bathroom and wash hands before leaving the room.

On 6/25/19 at 12:13 PM, the surveyor observed two staff members enter Resident #329's room, the Registered Occupational Therapist (OTR) put on gloves and the Physical Therapy Assistant (PTA) did not put on any PPE. They both proceeded to the residents beside. Once at the bedside, the PTA was observed leaning on the footboard of the resident's bed while the OTR had a conversation with the resident. The OTR removed her gloves discarded them in the trash and they both left the room. The surveyor did not observe the PTA any PPE and OTR wash their hands to leaving the residents room.

On 6/25/19 at 12:14 PM, the surveyor interviewed the PTA who stated that she knew that Resident #329 was on contact precautions requiring staff to put on a gown, gloves, and mask before entering the room. The PTA further stated that when leaving the room all PPE should be removed and then handwashing should be done immediately after coming out of the room. The PTA stated that they should have put on a gown, gloves, and mask when entering the room and then washed their hands. The PTA was not aware that they had to wash their hands before leaving the resident's room.

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F 880	Continued From page 24	F 880		

On 6/25/19 at 12:19 PM, the surveyor interviewed the OTR who stated, that Resident #329 was on contact precautions and that when entering the room, a gown, gloves, and mask must be worn. The OTR stated that PPE should be removed prior to leaving the room and then handwashing should be done immediately after coming out of the room. The OTR further stated that they did not put all the required PPE or wash their hands because they only had a conversation and did not provide any treatment.

On 6/25/19 at 12:45 PM, the surveyor interviewed Resident #329 who stated when the staff enter the resident's room for a quick conversation they do not wear a gown or gloves but, if they perform care they always put on a gown and gloves.

On 6/25/19 at 1:10 PM, the surveyor spoke to the administrator, Director of Nursing (DON) and the IP of the above observations and interviews.

The DON stated that he was aware that Resident #329 was being admitted to the facility with active [redacted]. The DON stated that the staff were then notified and that a physician's order for contact precautions/isolation should have been obtained. The DON further stated that staff were expected to follow the facility policy for contact precautions.

A review of the facility's policy titled [redacted] under "Policy Interpretation and Implementation" numbers three, four, five, nine and 14 revealed the following: "#3. The primary reservoirs for [redacted] are infected people and surfaces. [redacted] can persist on resident-care items and surfaces for several months and are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315488	A. BUILDING _____ B. WING _____	06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT MADISON AVENUE	151 MADISON AVENUE MORRISTOWN, NJ 07960

(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 25 [redacted]. #4. [redacted] is transmitted via [redacted]. Therefore, any resident-care activity that involves contact with the resident's mouth when hands or instruments are contaminated may provide an opportunity for transmission. #5. Steps toward prevention and early intervention include: d. Frequent hand washing with soap and water by staff and residents; e. Wearing gloves when handling [redacted] or articles contaminated with [redacted]; f. [redacted]) using a disinfecting agent recommended for [redacted] (e.g., household bleach and water solution or an EPA registered germicidal agent effective against [redacted]). #9. Residents with [redacted]) are placed on Contact Precautions. #14. When caring for residents with [redacted], staff is to maintain vigilant hand hygiene." A review of the facility's policy titled Isolation - Categories of Transmission - Based Precautions under "Contact Precautions" numbers four and five revealed, #4. "Staff and visitors will wear gloves (clean, non-sterile) when entering the room. b. Gloves will be removed and hand hygiene preformed before leaving the room. c. Staff will avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. #5. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed." NJAC 8:39-19.4 (a)1	F 880		

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