STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315351	A. BUILDING _____ B. WING _____	10/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	1801 OAKTREE ROAD EDISON, NJ 08820

(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: 10/25/19 CENSUS: 30 SAMPLE SIZE: 18 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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social,	F 561		12/15/19

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

Electronically Signed | 11/22/2019

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F 561	Continued From page 1 religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide a resident with a wake-up time that he/she specifically requested. This was identified for 1 of 15 residents reviewed for choices, Resident # 21. This deficient practice was evidenced by the following: On 10/23/19 at 6:50 AM, the surveyor was down the hall from the room of Resident #21 and heard a resident screaming from the private room, saying, "Get the [expletive] out of here. I told you I don't want you in here until 8 o'clock. Get out!" The surveyor observed a Certified Home Health Aide (CHHA) leave the room. The surveyor then observed the Certified Nursing Assistant (CNA) #1 go into the resident's room and talk to the resident. From outside of the room, the surveyor heard the resident say that they didn't want anyone to bother them until 8 o'clock. CNA #1 said that she would tell the [redacted] aide. The resident stated, "She won't listen to you." CNA #1 told the resident she would tell the nurse to write it down so no one would go into the resident's room before 8:00 AM. On the same day at 7:00 AM, the surveyor interviewed the [redacted] from the [redacted] provider and asked why Resident #21 was yelling at her that morning. The [redacted] stated, "I went into the room, [the resident] yell and scream. [The resident] is like that no matter what time you go	F 561	A. Residents Rights, including an emphasis on self-determination and supporting residents choice, including wake up times, were reviewed with the staff that cared for resident #21 on 10/24/19 to confirm an understanding of performance expectations. This refresher training was conducted by the Director of Nursing(DNS) In addition, the hospice provider company was contacted on 10/24/19 by the DNS, advised of the issue, and committed to re-educating their staff on resident rights. They were also informed that [redacted] is not to enter resident #21's room before 8am moving forward; and they expressed an understanding and stated that the resident's preferences will be honored by their team members. B. Residents residing in the facility have the potential of having their right to self -determination affected during care delivery. Walking rounds were made by the DNS and executive Director (ED) on 10/24/19 to observe and talk to residents and confirm they were being provided care in a manner that promotes dignity and self-determination , including honoring their wake up time preference.	

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F 561	Continued From page 2 into the room. Sometimes [the resident] is ok, sometimes not." The surveyor stated she had seen the [redacted] enter the room of Resident #21 approximately 10 minutes earlier and that [the resident] yelled and screamed to not come in until "8:00 o'clock." The [redacted] confirmed that was what the resident had said. The [redacted] stated that she was at the facility with Resident #21 for two hours a day, from 7:00 AM to 9:00 AM and that some days she arrived earlier. At 7:10 AM, the surveyor observed the [redacted] go into the resident's room with CNA #2. Resident #21 yelled again, "Get the [expletive] out of here. I am sleeping. I told you not to bother me until 8 o'clock." At 7:18 AM, CNA #3 went into the resident's room after knocking on the door. The resident yelled, "Why are you in here busting my [expletive] again. I'm asleep. Don't come in here until 8 o'clock." CNA #3 left the room. When CNA #3 came out of the resident's room, the surveyor asked CNA # 3 if she was assigned to the resident. She stated, "yes." The surveyor asked CNA #3 if the resident always yelled like that. CNA #3 replied, "He does that every day. The hospice aide [CHHA] is here until 9 o'clock, and me and the hospice aide [CHHA] get [the resident] washed and dressed. She's only here until 9 o'clock." The surveyor asked her if she got a report from the nurse that morning. CNA #3 stated, "Yes, I did, [the resident] does that every day." At about 8:05 AM, the surveyor observed the CHHA go into the resident's room. The [redacted] announced, "It's 8 o'clock. You said to come back at 8 o'clock," The resident did not yell. The [redacted]	F 561	Nurses and CNA's will receive refresher education on Residents Rights with an emphasis on Self-Determination, including honoring wake up time preferences, which will be conducted by the Social Service Coordinator. C. With respect to what systemic measures have been put into place to address the stated concern: The Social Services Coordinator/Designee will perform a monthly audit of care plan preferences and interview Residents x 3 months to confirm their care delivery preferences, audit care plans to confirm preferences are documented, and to confirm that the facility is respecting their right to self -determination with a focus on wake times an when care is delivered. D. With respect to how the plan of correction will be monitored: In order to confirm that the processes outlined above are sustained, the Social Service Coordinator will report the findings of the above audits and Resident interviews monthly to the QAPI committee for the next 90 days, during and at the conclusion of the 90 day period, the Committee will reevaluate and initiate necessary action or extend the review period. The Executive Director is responsible for confirming implementation and ongoing compliance of this POC and addressing	

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F 561	Continued From page 3 closed the door and did not come back out of the room. At 11:00 AM, the surveyor interviewed Resident #21 and asked about the [redacted] entering their room that morning. The resident stated that they never did that before but that they were angry about it that morning. Resident #21's family member was present and agreed with the resident. The family member stated that if [the resident] didn't want to be disturbed that early in the morning, that [the resident's] request should have been honored. The resident's family member added that [the resident] was confused at times, but not all the time. On 10/24/19 at 8:50 AM, the surveyor reviewed the resident's record which revealed an Admission Summary, that identified that the resident was admitted to the facility on [redacted] with diagnoses which included Personal History of [redacted]. The medical record also contained a form titled, "Informed Consent and Election of [redacted] with an effective date of [redacted]. The resident's initial Minimum Data Set (an assessment tool) dated [redacted] indicated that the resident scored an [redacted] on the Brief Interview of Mental Status (BIMS), which reflected that the resident had [redacted] impairment. At 9:18 AM, the surveyor interviewed CNA #4 about the [redacted] presence there that morning. CNA #4 stated, "Yes, she was. She comes here early, like 6:30-7:00." The surveyor explained that the day before, Resident #21 stated that they	F 561	and resolving variances that may occur.	

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F 561	Continued From page 4	F 561		

did not want anyone to go into their room until 8:00 AM. The surveyor asked if CNA #4 was aware, and they laughed and said, "Yeah, [the Resident] is grouchy." The surveyor asked if the resident yelled that morning. CNA #4 stated, "I don't know, you'll have to ask [CNA #3] because she helped the [redacted]].

At 9:43 AM, the surveyor interviewed CNA #3 and asked how Resident #21 was that morning when she and the [redacted] went in to do the care. She replied, "[The Resident] was fine this morning. Sometimes [the resident] is not, but this morning [the resident] was fine. I got here at 7:00, and she was already in there with [the resident]."

On 10/24/19, at approximately 12 PM, the surveyor spoke with the Team Leader/Registered Nurse (TL/RN) from the [redacted]. The surveyor asked if a resident wanted to be seen at a particular time by the [redacted] would they be able to honor that request. The TL/RN stated, "Absolutely" and that they did that all the time. The surveyor asked specifically about Resident #21. The TL/RN responded, that she heard something about that the day before, but that she was not the scheduler and didn't want to speak for anyone else. The scheduler was not available at that time for an interview.

At 2:00 PM, the survey team spoke with the Executive Director (ED), the Director of Nursing Services (DNS), and the Assistant Administrator. The surveyor explained the concern of the staff not honoring the wishes of a resident who didn't want to be disturbed early in the morning. The surveyor asked if that request was something they could accommodate. The ED replied, "Absolutely."

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F 561	Continued From page 5 N.J.A.C. 8:39-4.1, 12	F 561		
F 577 SS=B	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to post signage in the facility to direct residents, families, and visitors to the state survey inspection report. This deficient practice was evidenced by the	F 577	A. Residents who attended resident Council on 10/24/19 were shown where the State Survey inspection results are located and where the notice regarding the location of survey results is posted by the Social	12/15/19

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F 577	Continued From page 6 following: On 10/24/19 at 9:12 AM, the surveyor reviewed the Resident Council minutes, which showed under an Administration section that residents were reminded of the location of the state survey book. On 10/24/19 at 10:00 AM, the surveyor met with the Resident Council with five residents in attendance. During the meeting, the surveyor asked the residents if they knew where the state survey results were kept. Two of the five residents responded. One resident stated not being sure of where the results were kept. Another resident, admitted from [redacted] in the same facility, said that they kept the results at the front desk in [redacted] and assumed it would be the same. 10/24/19 2:00 PM, The surveyor interviewed the Social Work Coordinator (SWC). When asked where the state survey results were located, the SWC pointed to a binder at the front desk and stated that the location was reviewed at Resident Council meetings. The surveyor asked if a notice of the availability of the survey results was posted and in an area, "which is prominent and accessible to the public and residents." The SWC replied, "No." On 10/24/19 at 2:05 PM, the surveyor met with the Administrator. The surveyor shared the results of the Resident Council meeting, and that not all residents were able to identify where the results of the state survey were kept. The Administrator provided no additional information.	F 577	Service Coordinator. B. Residents residing in the Community have the right to Survey results A notice of the availability and where to find State Survey results was placed on the Nursing Station, which is allocation prominent and accessible to the public and residents. C. The Social Service Coordinator/Designee will confirm weekly x 3 months , and then monthly thereafter,that the notice of availability of Survey results is placed on the Nursing Station or another location which is prominent and accessible to the public and residents. D. In order to confirm that the processes outlined above are sustained, The Social Service Coordinator will report the results of the observations of the posted notice monthly to the QAPI Committee for 90 days. During the 90 dat period, the QAPI Committee will reevaluate and initiate necessary action or extend the review period as needed. The executive Director is responsible for confirming the implementation and ongoing compliance of this POC and addressing and resolving variances that may occur.	

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F 577	Continued From page 7 From 10/23/19 through 10/25/19, the surveyor did not observe any signage in the facility directing residents, families, and visitors to the state survey inspection report. N.J.A.C. 8:39-34	F 577		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F 583		12/15/19

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F 583	Continued From page 8 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure the personal privacy of a resident's body during a wound treatment. This deficient practice was identified for 1 of 15 residents reviewed for privacy (Resident #6), and was evidenced by the following: On 10/24/19, beginning at 10:11 AM, the surveyor observed the wound treatment to the right heel of Resident #6. The Registered Nurse (RN) exposed the residents' [redacted] while the resident was in their bed in their room. The door remained open, and the common hallway and unit day room were visible. At 10:17 AM, the RN continued with the treatment to [redacted] of Resident #6 as the doorway to the hallway remained opened. At 10:22 AM, as the RN continued with the [redacted] treatment, the surveyor observed that someone from the hallway closed the door to the room of Resident #6. On 10/25/19 at 8:15 AM, the surveyor reviewed the facility form titled, Admission Record, which revealed that Resident #6 most recent admission to the facility was [redacted] and identified diagnoses not limited to, [redacted]	F 583	A. With respect to the specific Resident/situation cited: The nurse who was providing the wound treatment for resident #6 was provided refresher training by the DNS on a resident's right to personal privacy and confidentiality, with an emphasis on privacy while care is being rendered. In addition, the DNS is conducting unannounced wound treatment observations of this Nurse monthly for 3 months. B. With Respect to how the facility will identify Residents/situations with the potential for the identified concerns: Residents residing in the community have the potential of having their right to personal privacy and confidentiality of records affected. CNAs and Nurses will receive refresher education on Residents Rights with an emphasis on Privacy during care and treatments. The refresher education will be conducted by the DNS or SSC. C. With respect to what systemic measures have been put into place to address the stated concern:	

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F 583	Continued From page 9 Psychosis. The surveyor then reviewed Resident #6's most recent Minimum Data Set (MDS), an assessment tool, dated [redacted] which showed that the resident's Brief Interview of Mental Status was coded as a [redacted], which indicated that the resident had [redacted] cognitive impairment. At 11:25 AM, the surveyor interviewed the RN that had completed the [redacted] treatment for Resident #6. The RN confirmed that the curtain should have been pulled around Resident #6's bed and that the door to the room should be closed to maintain the personal privacy of the resident. On the same day at 11:20 AM, the surveyor interviewed the Director of Nursing Services (DNS), who stated that the curtain and door should have been closed to maintain the personal privacy for Resident #6 and all residents. At 12:25 PM, the Executive Director (ED) stated that they did not have a specific Policy & Procedure for the maintenance of the resident's privacy, but that it was included in the Resident Rights form that was provided to the residents on admission and reviewed routinely during resident council meetings. The surveyor then reviewed the facility form titled, Resident Rights, and dated 1992, read under privacy: * Your privacy will include personal care, medical treatments, telephone use, visits, letters, and meetings of your family and resident groups.	F 583	The Social Services Coordinator/Designee will perform a monthly audit of care plans and conduct Resident interviews x 3 months to confirm their care is delivered in a manner that respects their right to privacy. In addition, the DNS will be conducting unannounced care delivery and wound treatment observations of the Nurses and CNAs monthly for 3 months to confirm privacy is maintained. D. With respect to how the plan of correction will be monitored: In order to confirm that the processes outlined above are sustained, the DNS will report the results of the wound and care treatment observations monthly and the Social Service Coordinator will report the findings of the care audits and Resident interviews monthly to the QAPI Committee for the next 90 days. During and at the conclusion of the 90 day period, the Committee will reevaluate and initiate necessary action or extend the review period. The Executive Director is responsible for confirming implementation and ongoing compliance with the is POC and addressing and resolving variances that may occur.	

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F 583	Continued From page 10 N.J.A.C. 8:39 - 4.1(a)16	F 583		
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 review of the medical records and other facility documentation, it was determined that facility nursing staff failed to maintain professional standards of clinical practice. This deficient practice was identified after facility staff left the resident's bedside during medication administration through a [redacted] for 1 of 18 residents (Resident #23) reviewed for professional standards as 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."	F 658	A. With respect to the specific resident/situation cited: Our General Dose Preparation and Medication Administration Policy and the facility's Procedure for [redacted] r Treatment were reviewed with the Nurse who administered the observed [redacted] treatment. This refresher training was conducted by the DNS B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: Residents with orders for [redacted] treatments have the potential to be affected by the observed practice. The DNS made walking rounds on 10/25/19 to confirm that the Residents who were receiving a [redacted] treatment had a nurse in attendance for the duration of the treatment. No issues were identified Nurses will receive refresher training	12/15/19

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F 658	Continued From page 11 On 10/23/19 at 6:22 AM, accompanied by another surveyor, the surveyor observed Resident #23 lying in a bed low to the floor with a [redacted] on and attached to a [redacted] that was powered on. There was no staff member observed in Resident #23's room or the hallway near the resident's room. The surveyor then went to the Nurses station and interviewed the Licensed Practical Nurse (LPN) that was sitting at the desk. During the surveyor interview, the LPN stated that she was the one that had administered the [redacted] treatment and that she does not usually leave the room during the treatment, but that today when the Department of Health came in the building, she was "all over." On 10/24/19 at 11:06 AM, the surveyor reviewed Resident #23's Admission Record which revealed that the resident was admitted to the facility on [redacted] with diagnoses which included, but were not limited to, [redacted]. The surveyor then reviewed the Resident's Minimum Data Set, an assessment tool dated [redacted], which revealed the resident had [redacted] cognitive impairment. On 10/25/19 at 12:57 PM, during surveyor interview, the Director of Nursing Services (DNS) stated that the nurse should stay with the resident during a [redacted] treatment only if the resident was confused or had [redacted], but if the resident was alert and oriented, then the nurse cannot stay there for the whole 15 minutes. The DNS further confirmed that Resident #23 had [redacted] and that the nurse should have stayed with the resident during the [redacted] treatment.	F 658	conducted by the DNS on our General Dose Preparation and Medication Administration Policy and the facility's Procedure for Nurses remaining with the Resident during [redacted] Treatments. C. With respect to what systemic measures have been put into place to address the stated concern: The DNS/ADNS/Designee will conduct a random unannounced monthly audit x 3 months of a minimum of [redacted] treatment administrations to confirm that the Nurses are remaining with Residents during [redacted] treatments Refresher training and individual coaching will be initiated as needed. D. With respect to how the plan of correction will be monitored: In order to confirm that the processes outlined above are sustained, the DNS/ADNS/Designee will report the findings of the above observations to the QAPI Committee monthly for the next 90 day period, the Committee will reevaluate and initiate necessary action or extend the review period. The Executive Director is responsible for confirming implementation and ongoing compliance with this POC and addressing and resolving variances that may occur.	

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F 658	Continued From page 12 On the same day at 1:30 PM, the surveyor reviewed the facility policy titled, General Dose Preparation and Medication Administration with a revised date of 1/1/13 which read under Procedure: 3.9 - Facility staff should not leave medications or chemicals unattended. 5.9 - Observe the resident's consumption of the medication(s). At 1:40 PM, the surveyor reviewed the undated facility policy titled, Procedure for [redacted] Treatment, which read: * [redacted] is tapped occasionally to assure all medication is dropped into cup/chamber to be [redacted] *Treatment lasts between 10 to 15 minutes. *During the treatment, monitor the pulse. If the pulse increases more than 20 beats a minute, discontinue the treatment and notify physician. Otherwise, continue until the medication is used up. N.J.A.C. 8:39-29.2(d)	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		12/15/19

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F 689	Continued From page 13 by: Based on observation, interview and record review, it was determined that the facility failed to a.) provide an environment that was free from accident hazards over which the facility had control for 1 of 15 residents reviewed, Resident #11; and, b.) complete quarterly [redacted] assessments for 1 of 1 residents reviewed for smoking, Resident #10. This deficient practice was evidenced by the following: 1. 10/23/19 at 7:40 AM, the surveyor observed Resident #11 lying in bed. When interviewed, Resident #11 stated they had [redacted] about [redacted] ago and were unable to move the [redacted] f their body. Resident #11 said that they used the bedrail to move side to side in bed and that the staff provided assistance to get in and out of bed to and from a wheelchair (WC). Resident #11 also said that they could not walk and were dependent on the staff. Resident #11 informed the surveyor of having a history of falling "many times," and that the bed would move, and then they would "go down on the floor." The surveyor asked about the date of their last fall, Resident #11 could not recall. 10/24/19 at 1:15 PM, the surveyor, reviewed the medical record and progress notes that showed an investigation had been completed on [redacted] for a fall and a care plan intervention had been created to which it read, "Make sure that wheels on bed are locked at all times." 10/25/19 at 10:30 AM, the surveyor, interviewed the Director of Nursing Services (DNS) and	F 689	A. With respect to the specific residents/situation cited: The CNA who transferred resident #11 on 2/2/19 received refresher education by the DNS on confirming that bed wheels are locked before transferring a Resident in or out of bed. A smoking assessment was completed for resident #10 on 10/28 by the Social Service Coordinator. B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: Residents who reside in the community have the potential to be affected by the potential hazard of unlocked bed wheels. Beds were checked on 10/25/19 by the DNS to confirm that bed wheels are functional and were locked. No Issues identified. CNAs and Nurses will receive refresher training conducted by the Director of Nursing/Assistance Director of Nursing on confirming that bed wheels are locked before transferring a resident in or out of bed. Residents who smoke have the potential to be affected by late smoking assessments [redacted] assessments were checked for	

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F 689	Continued From page 14 obtained a Resident/General Liability Incident Report for [redacted]. The report documented under the Interview/Statement of Event that the "CNA reported to DNS that wheel on bed was unlocked." The report also indicated that the type of injury was a bruise to the [redacted] of Resident #11. The surveyor then reviewed the facility policy and procedure, titled, Accidents/Incidents, dated 2/29/16 under Action Steps it read: 1. The Licensed Nurse will complete an evaluation of the resident and the environment to identify potential risk factors. 2. The Interdisciplinary Team (IDT), based upon the identified potential risk factors, develops and implements an individualized care plan. 3. The IDT evaluates, monitors, and revises the individualized plan of care, as necessary. On the same day at noon, the surveyor interviewed a Physical Therapist (PT), a Physical Therapy Assistant (PTA), a Registered Nurse (RN), a Licensed Practical Nurse (LPN), and a Certified Nursing Assistant (CNA) separately. When asked about the proper procedure to transfer a resident from a WC to a bed, the PT and PTA both stated that the WC and the bed should be checked to make sure it was locked before transferring a resident. When interviewed, the RN, LPN, and CNA all failed to state that the bed should be checked and locked before transferring a resident. The LPN said the WC should be checked and locked, while the RN and CNA did not indicate locking the WC	F 689	timeliness by the DNS and updated as necessary by the ADNS/Staff RN Nurses will receive refresher training conducted by the DNS on the [redacted] assessment policy, schedule, and completion requirements. C. With respect to what systemic measure have been put into place to address the stated concern: The DNS/AED will make weekly unannounced rounds x 3 months to confirm that bed wheels are locked. The DNS/ADNS will complete a monthly audit x 6 months for residents who [redacted] to confirm that their [redacted] assessments are completed quarterly and as needed. Issues that may be identified will be addressed and resolved and refresher training initiated if needed. D. With respect to how the plan of correction will be monitored: In order to confirm that the processes outlined above are sustained, the DNS/ADNS/AED/Designee will report the findings of the bed wheel observations for the next 3 months and the smoking assessments audits to the QAPI Committee for the next 6 months. During and at the conclusion of the reporting periods, the Committee will	

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F 689	Continued From page 15 as part of the process when transferring a resident. When asked by the surveyor if they would agree that both the WC and the bed should be checked and locked before moving a resident, all three replied, "Yes." At 1:29 PM, the surveyor met with Administration and asked if preventative maintenance was completed for beds on the unit regularly. The Executive Director (ED) and DNS replied, "Yes." The surveyor asked if the bed for Resident #11 was functioning properly on [redacted], the day when the resident fell. The DNS replied that "the bed was not locked, and it was functioning fine." 10/25/19 at 2:59 PM, the surveyor interviewed the Maintenance Coordinator (MC) and asked if preventative maintenance was completed on the beds in the facility. He stated, "Yes" annually by an outside company. The MC said the beds were checked for proper functioning regularly, and the brakes were checked monthly. When asked if he knew if there were any problems with beds in February, he stated there were no problems. 2. On 10/23/19, during the entrance conference, Resident #10 was identified as a [redacted] by the facility. Later that same day at 12:16 PM, the surveyor reviewed Resident #10's medical record, which revealed the resident was originally admitted to the facility on [redacted] According to the Minimum Data Set, an assessment tool dated [redacted], the resident was cognitively intact. Further review of the medical record revealed that a [redacted] Risk Evaluation (a[redacted] assessment form) was done on [redacted]. There was no evidence that Resident #10 had a[redacted]	F 689	reevaluated and initiate necessary action or extend the review period. The Executive Director is responsible for confirming implementation and ongoing compliance with this POC and addressing and resolving variances that may occur.	

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F 689	Continued From page 16 assessment done quarterly. On 10/24/19 at 9:59 AM, during the surveyor interview, the Licensed Practical Nurse (LPN) stated that Resident #10 could [redacted] their [redacted]. The LPN further said that Resident #10's family member brings in [redacted] but had not brought any in recently, so Resident #10 does not have any [redacted] at this time. The surveyor was unable to observe Resident #10 [redacted] during the survey. On 10/25/19 at 1:17 PM, during the surveyor interview, the ED stated that Resident #10's [redacted] assessment had not been done quarterly. On 10/25/19 at 3:02 PM, the surveyor reviewed the facility policy titled, [redacted] with an effective date of 2/29/16 which read: under Action Steps: 5. The Interdisciplinary Team ensures a [redacted] Evaluation (within SCC) is completed at the time of admission, quarterly, annually and upon significant change or when residents express a desire to start [redacted]. Residents deemed not safe may be restricted from [redacted] Interventions are entered into the resident's care plan.	F 689		
F 755 SS=D	N.J.A.C. 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records 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	F 755		12/15/19

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F 755	Continued From page 17 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 the facility failed to ensure accurate ordering and receiving of narcotic medications. The required Federal narcotic acquisition forms (DEA 222 form) were not completed with sufficient detail to enable precise reconciliation for 2 of 2 forms provided. This deficient practice was evidenced by the	F 755	A. With respect to the specific resident/situation cited: The DNS corrected the current 222 Forms and confirmed proper completion. B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:	

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F 755	Continued From page 18 following: On 10/25/19 at 9:58 AM, the surveyor requested from the Assistant Director of Nursing (ADON) to review the facility's controlled substance ordering form DEA 222 receipts. At that time, the ADON provided a binder that contained the completed DEA 222 Form #181461846, and Form #181461850. A review of these DEA 222 forms revealed the facility did not record the number of packages of controlled substances received or the date those medications were received as instructed on the reverse side of the DEA 222 form. At that time, the ADON stated she had received the medications but was unaware of the procedure for documenting the receiving of controlled substances from the provider pharmacy on the DEA 222 form. At 1:20 PM, the survey team met with the Director of Nursing Services (DNS), and the Executive Director, who confirmed that the 2 of 2 DEA 222 forms provided had not been completely filled out as required on the reverse side of the form. There were no dates recorded or quantities indicated for when medications were received. At 1:30 PM, the surveyor reviewed the instructions for submission of the DEA 222 form located on the reverse side of the form, and it revealed: When items are received, the date of the receipt and the number of items received must be recorded in the spaces provided on the triplicate copy. At 2:40 PM, the DNS stated to the survey team that the facility did not have a policy regarding	F 755	The DNS/ADNS consulted with the facility's Provider Pharmacy on 10/25/19 and received clarification/ refresher education on the completion of 222 Forms. C. With respect to what systemic measures have been put into place to address the stated concern: The Executive Director will complete an audit of 222 Forms monthly x 3 months to confirm they are completed correctly, including confirming the number of packages and the date received. D. With respect to how the plan of correction will be monitored: In order to confirm that the processes outlined above are sustained, the ED/AED will report the findings of the above audits to the QAPI Committee monthly for the next 90 days During and at the conclusion of the 90 day period, the Committee will reevaluate and initiate necessary action or extend the review period. The Executive Director is responsible for confirming implementation and ongoing compliance with this POC and addressing and resolving variances that may occur.	

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F 755	Continued From page 19 DEA 222 forms and that the facility used a guide provided by the facility's pharmacy provider to complete the form. At 2:25 PM, the surveyor reviewed the facility provided sample for completing DEA Form 222. The sample did not address the receiving of controlled medications or the documentation of quantity received, which were both required for the proper completion of the DEA 222 form.	F 755		
F 758 SS=D	N.J.A.C. 8:39-29.7(c) Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		12/15/19

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F 758	Continued From page 20 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to consistently monitor targeted behavior for a resident who received an antipsychotic medication. This deficient practice was identified for 1 of 5 resident's (Resident #6) reviewed for unnecessary medication, and was evidenced by the following: On 10/23/19 at 7:00 AM, the surveyor observed Resident #6 awake in bed and covered with blankets with the bed placed low to the floor.	F 758	A. With respect to the specific resident/situation cited: The Director of Nursing Services(DNS)conducted a root cause analysis to determine the cause of the lack of behavior monitoring on resident #6's TAR The DNS discovered that the original order for the [redacted] was entered incorrectly into the system, and therefore, a behavior monitoring sheet was not generated.	

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F 758	Continued From page 21 On 10/25/19 at 9:45 AM, the surveyor reviewed the resident's record, which revealed on the Admission Record that the resident was admitted from the Assisted Living Residence to the facility on [redacted] with diagnoses which included, [redacted] The most recent Physician's Order Sheet (POS) dated [redacted], reflected a physician's order which read: [redacted] mg give one tablet by mouth at bedtime for [redacted] Additionally, there was a physician's order which read: Behaviors-Monitor for the following: [redacted] Increase in complaints, [redacted], [redacted]n, Refusing Care. Document: "Y" if monitored, and none of the above observed. "N" if monitored and any of the above was observed, select chart code "Other/See nurses Notes" and progress note findings every shift for Risperdal. On the same day at 10:00 AM, the surveyor reviewed the behavior monitoring sheets on the Treatment Administration Record (TAR) for October 2019. There was a nurses initial for each shift, each day, except for 10/14/19, evening, and 10/24/19 evening, where nothing was entered. On the days where there was a nurse's initial, there was a checkmark. On 10/25/19 at 10:30 AM, the surveyor asked the Assistant Director of Nursing (ADON) what the checkmarks meant. The ADON stated that, "It meant the behavior was monitored and the details would be in the nurses note." There were no details found in the nurses' notes.	F 758	The nurse who took and entered the original order received refresher training on proper entering of psychoactive medication orders and checking to assure that a behavior tracking log is generated. B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: Residents who receive psychotropic medications will be reviewed monthly by the IDT team or when changes in condition or behaviors occur. The review will include a summary of targeted behaviors. Nurses will be reeducated by the Director of Nursing /Assistance Director of Nursing on the facility's policy and procedure titled "Psychotropic Medication Use" with an emphasis on behavioral monitoring and associated documentation. C. With respect to what systemic measures have been put into place to address the stated concern: The SSC/AED will conduct a random monthly audit x 3 months on a minimum of 5 Residents who receive psychotropic medications to confirm that monthly behavior monitoring summaries are completed; and with accurate coding The DNS will perform a monthly audit x 3 months of a minimum of 5 Residents who receive psychotropic medication to confirm that behavior monitoring is	

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F 758	Continued From page 22 On 10/25/19 at 1:15 PM, the surveyor asked the Director of Nursing Services (DNS) and the Executive Director (ED) for the behavior monitoring sheets for the previous three months. On 10/25/19 at 2:45 PM, the surveyor reviewed the facility's policy and procedure titled, Psychotropic Medication Use, with a revised date of 11/28/16, which read: under Number 12: Facility staff should monitor the resident's behavior pursuant to Facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication for organic mental syndrome with agitated or psychotic behaviors. Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff interventions. On the same day at 3:11 PM, the surveyor reviewed the behavior monitoring sheet on the TAR for [redacted],which read, "Behavior-Monitor for the following: Restlessness [redacted], Increase in complaints, [redacted], [redacted], Refusing Care. Document "Y" if monitoring and none of the above observed. "N" if monitored and any of the above observed, select chart code "Other/See Nurses Notes" and progress note finding every shift for [redacted]" The surveyor noted that [redacted]h, there was an "X" for every day and every shift. There was also an "X" noted from the 21st to the 30th day of the month. From the 11th to the 20th, there were mostly "Y's" listed with two "N's" listed on the evening shift of the 19th and 20th. From	F 758	completed upon medication administration and progress notes initiated as needed. D. With respect to how the plan of correction will be monitored: In order to confirm that the processes outlined above are sustained, the SSC/AED and the DNS will report the findings of their respective audits to the QAPI Committee monthly for the next 90 days. During and at the conclusion of the 90 day period, the Committee will reevaluate and initiate necessary action or extend the review period. The Executive Director is responsible for confirming implementation and ongoing compliance with this POC and addressing and resolving variances that may occur.	

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F 758	Continued From page 23 the 21st to the 30th, there were all "X's", no "Y's" or "N's" noted. The surveyor then reviewed the behavior monitoring sheet on the TAR for [redacted], which read, "Behavior: Monitor for [redacted] Indicate the number of episodes, intervention code and outcome, and side effects observed every shift for the use of [redacted]" There were all zeroes entered from the 1st to the 14th - day shift. There was either nothing entered or "X's" from September 14th to the 31st except for the 20th, evening shift, in which, zeroes were entered. Lastly, the surveyor reviewed the behavior monitoring sheet on the TAR for [redacted], which read, "Behavior: Monitor for [redacted] Indicate the number of episodes, intervention code and outcome, and side effects observed every shift for the use of [redacted]." In every box, every day there was an "x" entered, except for September 31st, night shift, where there were all zeroes entered. The surveyor could not locate any documentation that showed that data of the resident's behavior was being collected or analyzed. On 10/25/19 at 3:36 PM, the surveyor asked the DNS and the ED for any monthly summaries that addressed the behavior monitoring for Resident #6 for the use of the [redacted] medication, [redacted]. The ED stated, "There is none, it is what it is. We're not gonna lie; we're gonna fix it." N.J.A.C. 8:39-27.1 (a)	F 758		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		12/15/19

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F 812 SS=D	Continued From page 24 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 determined that the facility failed to maintain proper kitchen sanitation practices and food service equipment in a safe and sanitary environment to prevent the development of foodborne illnesses. This deficient practice was evidenced by the following: On 10/23/19 beginning at 6:41 AM, the surveyor observed, in the presence of Food Service Worker (FSW) #1, the following during the initial kitchen tour.	F 812	A. With respect to the specific resident/situation cited: The covered bins labelled with a "use by" date of 10/20 or 10/18 were immediately disposed of by the Dining Services Coordinator. The items observed on the gray two shelved cart were rewashed by the Dishwasher The sunken bowl built into the countertop in the juice room was drained and sanitized	

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F 812	Continued From page 25 The walk-in refrigerator revealed the following: 1. A bin covered with clear plastic wrap and labeled pudding that had a use-by date of 10/20. 2. A bin covered with clear plastic wrap and labeled icing had a use-by date of 10/20. 3. A bin covered with clear plastic and labeled feta cheese had a use-by date of 10/18. At that time, FSW #1 stated that the above-identified items would have to be thrown away. At 7:02 AM, the surveyor observed a gray two shelved cart that contained the following; a plastic bin of loose utensils, ten small silver-colored coffee creamer pitchers, two large silver-colored bowls, and a pair of blue handled scissors. The blue handled scissors were placed directly under the paper towel dispenser on the left-hand side of the handwashing sink. FSW #2 stated that the items on the cart were considered clean and that they should have been put away by the prior shift. At 7:04 AM, the surveyor observed about a half-inch of cloudy water at the bottom of a sunken bowl built into the countertop in the juice room of the kitchen near the doorway to the Assisted Living Dining Room. At 7:07 AM, the surveyor observed FSW #1 place strips of bacon that he had removed from a box onto a baking sheet. One piece of bacon fell and landed on the stainless-steel countertop that FSW #1 identified as a "prep area." FSW #1 then	F 812	FSW #1 was reeducated by the Dining Services Coordinator on infection control during food preparation, food preparation, and food storage FSW #3 was reeducated by the Dining Services Coordinator on proper hand hygiene with an emphasis on hand washing after handling dirty items and before handling clean items, including a focus on hand washing during the dish washing process. B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: Food Service Workers will be reeducated on food service safety including storing, preparing, distributing, and serving food. This refresher training will be conducted by the DSC. C. With respect to what systemic measures have been put into place to address the sated concern: The DSC/AED will make weekly unannounced kitchen rounds x 3 months to observe food service workers and confirm that the facility stores, prepares, distributes, and serves food in accordance food service safety standards. D. With respect to how the plan of correction will be monitored: In order to confirm that the processes outlined above are sustained, the	

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F 812	Continued From page 26 picked up the piece of bacon and placed it on the baking sheet and placed the full tray of bacon in the oven to be served for that day's breakfast meal. On the same day at 10:57 AM, the surveyor observed FSW #3 operating the hot temperature dishwasher. FSW #3 stated that they were responsible for the management of the dishwasher and was seen placing dirty dishes onto racks and then put the racks into the dishwasher to be cleaned. FSW #3 was then observed after she had placed a rack into the dishwasher, began wiping down the dirty side of the dishwasher with a soapy cloth. At the same time, FSW #1 was observed to be at the handwashing sink, so FSW #3 pulled the rack of clean dishes out of the dishwasher without conducting hand hygiene. On 10/25/19 at 1:50 PM, The Executive Director (ED) confirmed that hand hygiene should have been performed between the handling of dirty and clean dishes. The surveyor then reviewed the facility form titled, Sanitation Tip of the Month - Use-by Date, with a revised date of 9/26/18, read under Introduction: Using food products before their "Use by" date is critical to a safe foodservice operation. Under Labeling & Dating Standards, it read: *All products should be dated upon receipt. *Use "Use-by-dates on all food once opened and stored under refrigeration.	F 812	DSC?AED will report the findings of the above observations to the QAPI Committee monthly for the next 90 days During and at the conclusion of the 90 day period, the Committee will reevaluate and initiate necessary action or extend the review period. The Executive Director is responsible for confirming implementation and ongoing compliance with this POC and addressing and resolving variances that may occur.	

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F 812	Continued From page 27 N.J.A.C. 8:39 - 17.2(g)	F 812		
F 880 SS=F	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; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		12/15/19

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F 880	Continued From page 28 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 review of facility documentation, it was determined that the facility failed to maintain infection control practices to reduce the risk of infection for; a.) 2 of 2 [redacted] treatment observations (Resident's # 3 and #6), b.) storage of [redacted] or 2 of 2 residents reviewed for [redacted] (Resident #3 and #6), c.) conduct an	F 880	A. With respect to the specific resident/situation cited: The nurse who rendered [redacted] care to residents #3 and #6 - (RN#1) - received refresher education on 10/25 by the DNS on proper hand washing techniques, including completion of a hand washing	

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F 880	Continued From page 29 annual review of the infections prevention and control practices policies and procedures, and d.) for the storage of clean housekeeping equipment. This deficient practice was evidenced by the following: 1. On 10/24/19 at 10:11 AM, the surveyor observed Registered Nurse (RN) #1 complete the [redacted] treatment on the [redacted] of Resident #6. RN #1 reviewed the Treatment Administration Record (TAR) for Resident #6. RN #1 then gathered the needed supplies; an open package of woven 4x4 gauze sponges, tongue depressor, five individual plastic [redacted]), tube of [redacted] (used to [redacted], bottle of hand gel, box of gloves, and a tub of sanitizing wipes) from the treatment cart and placed them on the top of the cart. On the same day at 10:15 AM, the surveyor observed RN #1 pick up all the supplies and carried them into the room of Resident #6 and placed them on to the left side of the resident's overbed table. At 10:16 AM, the surveyor observed RN #1 washed her hands for 20 seconds under the flow of water, then dried her hands with a paper towel. RN #1 put on a pair of gloves and cleaned off the right side of the overbed table with the sanitizing wipes. At 10:17 AM, the RN washed her hands for 16 seconds under the flow of water.	F 880	competency and return demonstration. RN #1 also received refresher education on the facility's Skin Care [redacted] Management Program, with an emphasis on infection control during treatments. Residents #3 and #6 were observed by the DNS to confirm proper storage of their [redacted], and specifically that [redacted] and storage bags were not touching the floor. RN #1 received refresher training by the DNS on 10/25 re: proper storage and positioning of [redacted] bags and [redacted] The Executive Director confirmed on 10/25 that the DNS is proficient in proper storage and positioning of [redacted] bags and [redacted] The Treatment Cart, and its contents, with which Nurse #1 treated resident #6 with on 10/24/19, were cleaned and disinfected on 10/24/19 by the DNS. The QAPI Committee will review and approve infection prevention nd control practices policies and procedures at the next QAPI meeting on 11/25/19 The clean mops heads observed in the soiled linen room of the laundry room were removed from that room and sanitized.	

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F 880	Continued From page 30 RN #1 then put on a pair of gloves and placed a poly-lined barrier on the right side of the overbed tabletop. The RN then moved the garbage can to the end of Resident #6's bed, removed her gloves, gelled her hands, and then washed them with soap and water under the flow of water for 16 seconds. At 10:20 AM, RN #1 put on gloves and removed some 4x4's from the open package of dressings, and along with the five [redacted] dressing, tongue depressor placed them on to the clean barrier on the right side of the table. At 10:22 AM, RN #1 put on a clean pair of gloves and removed the padded [redacted] and non-skid sock from the [redacted] of Resident #6. After she removed her gloves, RN #1 gelled her hands and put on a clean pair of gloves. RN #1 then placed a barrier on the bed and under the [redacted] of Resident #6. RN #1 then removed her gloves and gelled her hands. At 10:23 AM, RN #1 removed the optifoam dressing from Resident #6's [redacted] and discarded the dressing and gloves in the garbage can. At 10:25 AM, RN #1 washed her hands with soap and water for seven seconds outside the flow of water, followed by 10 seconds under the flow of water. RN #1, assisted by the resident, lifted their [redacted] while RN #1 placed a barrier under the residents' [redacted]. RN #1 then used a [redacted] to clean the [redacted]d while holding a 4x4 gauze	F 880	No additional clean mops heads will be stored in the room. They will be stored in the clean utility room. B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: Residents receiving wound care may have the potential for increased risk of infection related to protocols not being followed during wound care treatment Nurses will receive refresher education on proper hand washing technique, including completion of a hand washing competency and a return demonstration, an on the facility's Skin care an [redacted] Management program. This refresher training will be conducted by the DNS Residents with indwelling urinary catheters may have the potential for increased risk of infection related to improper storage of their [redacted] supplies. CNAs and Nurses will be reeducated by the DNS on the proper storage and positioning of [redacted] and [redacted] Housekeeping Staff will be reeducated by the Maintenance Coordinator on the proper stage of clean mop heads, and the separation of soiled and clean supplies.	

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F 880	Continued From page 31 dressing under the [redacted] of Resident #6. Some of the [redacted] went onto the barrier that had been placed under the residents [redacted]. The resident then lowered their [redacted], and it rested on the wet spot on the barrier. At 10:29 AM, RN #1 removed her gloves, gelled her hands, put on a clean pair of gloves, and returned the [redacted] sock and [redacted] to the [redacted] of Resident #6. At 10:34 AM, RN #1 completed the [redacted] treatment, tied the bag of garbage closed, and left it in the garbage can in the room. RN #1 then removed the opened package of 4x4 gauze dressings, tube of [redacted], and tub of sanitizing wipes from the overbed table and returned them to the treatment cart. RN #1 returned the hand gel and gloves to the top of the medication cart. At 10:50 AM, the [redacted] treatment garbage remained in Resident #6's garbage can in the room. At 11:01 AM, Resident #6 was out of their room, and the [redacted] treatment garbage remained in the garbage can in the room. At 11:37 AM, the [redacted] treatment garbage had been removed from the garbage can in Resident #6's room. On 10/25/19 at 8:15 AM, the surveyor reviewed the facility form titled, Admission Record, which revealed that Resident #6 most recent admission to the facility was [redacted] and identified diagnoses not limited to, [redacted]	F 880	C. With respect to what systemic measures have been put into place to address the stated concern: The AED/DNS/Designee will make weekly Infection control Rounds x 90 days, to confirm Infection Control Standards are. Observation emphasis will be placed on placement and storage of [redacted] bags and [redacted] the separation of soiled and clean housekeeping supplies, and hand washing observation. D. With respect to how the plan of correction will be monitored: In order to confirm that the processes outlined above are sustained, the AED/DNS/Designee will report the finding of the above infection control observations to the QAPI Committee monthly for the next 90 days. During and at the conclusion of the 90 day period, the Committee will reevaluate and initiate necessary action or extend the review period. The Executive Director is responsible for confirming implementation and ongoing compliance with this POC and addressing and resolving variances that may occur.	

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F 880	Continued From page 32	F 880		

[redacted].

The surveyor then reviewed Resident #6's most recent Minimum Data Set (MDS), an assessment tool, dated [redacted], which showed that the resident's Brief Interview of Mental Status was coded as a [redacted], which indicated that the resident had [redacted] cognitive impairment.

2. On 10/25/10 at 9:58 AM, the surveyor observed RN #1 prepare the needed supplies for the [redacted] treatment on Resident #3. RN #1 washed her hands with soap and water for 18 seconds under the flow of water.

At 10:00 AM, the surveyor observed RN #1 washed her hands for 21 seconds and then rinsed them under the flow of water. RN #1 then picked up a garbage bag that had been sitting on the floor of the bathroom in the resident's room and carried it over and placed it on top of Resident #3's wheelchair.

At 10:01 AM, RN #1 washed her hands for 11 seconds, then rinsed them under the flow of water. RN #1 stated that the paper towel dispenser was empty and picked up a loose paper towel from the countertop and dried her hands, and used the same paper towel to shut off the faucet.

At 10:02, RN #1 gelled her hands and informed the housekeeper that paper towels were needed in the bathroom of Resident #3.

At 10:20 AM, RN #1 informed the surveyor that

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housekeeping had filled the paper towel dispenser and that they had also cleaned off the wheelchair because of the garbage bag that had been placed on it.

Immediately following, the surveyor interviewed the housekeeper, who confirmed that she had cleaned Resident #3's wheelchair and disposed of the garbage bag in the soiled utility room.

At 10:25 AM, RN #1, with the assistance of RN #2, explained to Resident #3 that they would be completing the [redacted] treatment. Resident #3 consented to the treatment.

At 10:31 AM, the surveyor observed that RN #1 reviewed the TAR and gathered the supplies; one opened package of 4x4 woven gauze dressings, one package of a gauze bandage roll, seven packages of individually wrapped tongue blades, a clear bag that contained a bottle of [redacted] and a tube of [redacted], a tub of sanitizing wipes, a bottle of hand gel, a box of gloves, two packages of [redacted] dressings (a non-adhering dressing) and three packaged sterile covers. RN #1 then removed a pair of bandage scissors and a marker from the pocket of her shirt and placed them on the top of the supplies that were on the top of the treatment cart.

RN #1 then gathered the supplies from the top of the cart and carried them into the room, and placed them on the left side of the overbed table of Resident #3.

At 10:34 AM, the surveyor observed RN #1 wash her hands with soap and water for 12 seconds and then rinsed them under the flow of water.

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F 880	Continued From page 34 RN #1 then put on a pair of gloves and wiped the right side of the overbed table with a sanitizing wipe. RN #1 then washed her hands with soap and water for seven seconds and then rinsed them under the flow of water for 10 seconds. RN #1 then placed a barrier to the right side of the overbed table and moved the [redacted] treatment supplies from the left side of the table and placed them on the clean barrier that had been placed on the right side of the table. RN #1 then removed her gloves and gelled her hands. After putting on a pair of gloves, RN #1 removed the bedspread from the bed of Resident #3. At 10:44 AM, RN #1 removed her gloves and washed her hands for 25 seconds under the flow of water, added more soap, and rubbed her hands for an additional five seconds under the flow of water. At 10:45 AM, RN #1 put on a pair of gloves and removed multiple 4x4's gauze dressings from the opened package and placed them on the clean barrier. RN #1 then washed her hands for 10 seconds under the flow of water. RN #1, with the assistance of RN #2, placed a barrier on top of the sheet and under the [redacted] of Resident #3. RN #1 then washed her hands for 15 seconds	F 880		

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under the flow of water.

RN #1, then put on a pair of gloves, removed the [redacted]) from the clear bag and cleaned the [redacted] on the [redacted] on Resident #3's right foot. RN #1 then placed the bottle of [redacted] onto the clean barrier and patted the two [redacted] dry with a separate 4x4 gauze dressing.

RN #1 used a separate tongue blade and placed a small amount of [redacted] used to treat [redacted]) onto the open areas on the [redacted] with a different tongue blade.

At 10:51 AM, RN #1 washed her hands for 12 seconds outside of the flow of water before she rinsed them off under the stream. The clear bag that held the bottle of [redacted] and tube of [redacted] was empty and lying on the clean barrier on the overbed table.

RN #1 then put on a clean pair of gloves and prepared the resident for the treatment on their left foot.

RN #1 then washed her hands with soap and water for five seconds outside of the flow of water and then rinsed them under the flow of water for 10 seconds.

At 10:56 AM, RN #1 put on a pair of gloves, and with the assistance of RN #2, lifted the [redacted] of Resident #3. RN #1 then placed a clean barrier under the [redacted] of Resident #3.

At 10:58 AM, RN #1 picked up the scissors that had been on the clean barrier and then returned

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them to the barrier.

At 11:02 AM, RN #1 washed her hands for eight seconds and then rinsed them under the flow of water.

RN #1 then put on a clean pair of gloves and after cleaning the [redacted] with the bottles of [redacted] and patted them dry with a different 4x4 gauze dressing and with the same gloved hands, picked up the [redacted] tube and placed a small amount of the gel onto a tongue blade and repeated the process five more times using a different tongue blade to apply the [redacted] to the [redacted]. RN #1 then recapped the tube of [redacted] and returned it to the barrier on the right side of the table.

RN #1 then removed her gloves and gelled her hands.

RN #1 then put on a pair of gloves and removed the [redacted] dressing from its packaging.

RN #1 picked up the scissors and used them to cut the adaptic dressing and placed a piece on each of the [redacted] of the [redacted]

RN #1 then removed her gloves, gelled her hands before putting on a new pair of gloves and wrapped the [redacted] of Resident #3.

At 11:00 AM, RN #1 informed Resident #3 that the [redacted] treatment had been completed and removed the barrier from the bed and then removed the supplies from the right side of the overbed table.

RN #1 returned the bottle of [redacted] and

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tube of [redacted] to the clear plastic bag and placed it on the left side of the table, along with the scissors and marker.

RN #1 then placed the used treatment supplies into the garbage can and tied the two garbage bags off and left them in the garbage can. RN #1 told RN #2 that she would inform housekeeping that the garbage needed to be removed from Resident #3's room.

RN #1 then lowered the bed of Resident #3 and touched the [redacted] that was secured to the right side of the bed before she placed the call bell into the right hand of Resident #3.

At 11:14 AM, RN #1, washed her hands for 10 seconds before rinsing them under the flow of water.

RN #1 then picked up the supplies from the left side of the overbed table and returned the bag with the [redacted] to the treatment cart, as well as the pair of scissors, a package of 4x4's and tub of sanitizing wipes.

RN #1 then returned the box of gloves and hand gel to the medication cart.

Immediately following the treatment, the surveyor interviewed RN #1 about the [redacted] treatment observations they had completed on Resident #6 and Resident #3. RN #1 confirmed that they had been inserviced on proper handwashing technique and that the wound treatment was not a sterile technique. RN #1 stated that she had cleaned the scissors before the treatment and added that she would clean them after the

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interview.

On the same day at 11:25 AM, the surveyor interviewed the Director of Nursing Services/Infection Preventionist (DNS/IP) and informed them of the [redacted] treatment observations that had been made on 10/24/19 and 10/25/19. The DNS/IP stated that the proper technique for handwashing was to turn on the water, not hot or cold, and gather soap and wash between your fingers, scrubbing outside the flow of water for at least 20 seconds, and added that she told them 30 seconds with friction. She continued, that staff should then rinse their hands, holding them downward to rinse, grab and dry their hands with a paper towel, discard, grab another paper towel and use it to turn the faucet off.

The DNS/IP stated that hand hygiene should take place between wounds and that the nursing staff were told to tie off the bag of garbage after the treatment and have the housekeeper, or the nurse themselves, remove it from the residents' room.

The DNS/IP said that she started working at the facility in [redacted] and that she had not conducted a [redacted] treatment competency with the nursing staff. The DNS/IP added that a hand hygiene inservice and competency was conducted upon hire, annually and at any time, a breach was observed. She said, "We do it a lot."

On 10/25/19 at 11:44 AM, The DNS/IP provided the surveyor with a completed competency for the proper handwashing technique that had been completed with RN #1 on [redacted] and the facility form titled, Transcript Report - Individual Team

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F 880	Continued From page 39 Member for RN #1 which included the successful completion of web-based training of Infection Control Essentials on March 16, 2019. On the same day at 12:25 PM, the surveyor reviewed the facility Wellness Program titled, Skin Care & [redacted] Management Program which included: 1. Assessment of identifying resident that were at risk for developing wounds. 2. Plan - An Individualized Plan which included Infection Control and read: * Current Recommendations specific to [redacted] care: * Wash/decontaminate hands prior to contact with a resident * Wash/decontaminate hands after contact with intact skin * wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur * Wash/decontaminate hands when moving from a contaminated-body site to a clean body site during patient care * Remove and discard gloves after caring for a resident and wash/decontaminate hands 3. Implement - Putting the Plan into Action 4. Evaluate - Evaluating Outcomes At that time, the Executive Director (ED) and RNS/IP confirmed that the Wellness Training Program identified above was the procedure used for the management and treatment of wounds. The DNS/IP confirmed that the facility did not have a [redacted] treatment competency or a specific [redacted] treatment policy. At 1:52 PM, the surveyor reviewed the facility provided form from the World Health	F 880		

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Organization titled, How to Handwash, dated May 2009, read as follows:

Wash hands when visibly soiled! Otherwise, Use hand rub. Duration of the entire procedure: 40 - 60 seconds.
Wash hands with water; Apply enough soap to cover all hand surfaces; Rub hands palm to palm; Right palm over left dorsum with interlaced fingers and vice versa; Palm to palm fingers interlaced; Backs of fingers to opposing palms with fingers interlocked; Rotational rubbing of the left thumb clasped in right palm and vice versa; Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa; Rinse hands with water; Dry hands thoroughly with a single use towel; Use towel to turn off faucet; Your hands are now safe.

3. On 10/23/19 at 7:00 AM, the surveyor observed Resident #6 in bed and covered with blankets. There was a visible [redacted] bag secured to the bed, and the [redacted] was half on the floor and half on the mat that was on the floor next to the resident's bed.

On 10/25/19 at 10:11 AM, the surveyor observed Resident #6 in bed with the head of the bed elevated. The [redacted] emptied into a large [redacted] bag secured to the right side of the bed. The [redacted] bag had a [redacted] cover and was resting on the floor.

On the same day after the [redacted] treatment at 10:31 AM, as identified in example #1, RN #1 lowered the bed, and the [redacted] bag again rested on the floor.

4. On 10/23/19 at 7:45 AM, the surveyor

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F 880	Continued From page 41 observed Resident #3 in a low bed in the resident's room. There was a [redacted] bag attached to the bed frame. The collection bag was resting on the floor. There was a privacy drape covering the front of the bag. On 10/24/19 at 9:00 AM, the surveyor reviewed the Admission Record, which revealed that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted]. There was also a lab report which indicated that the resident was diagnosed with a [redacted] On 10/24/19 at 9:14 AM, the resident was in the dining room in a wheelchair. The [redacted] bag was under the wheelchair. The back of the bag was covered by a [redacted] plastic drape. The [redacted] plastic drape was touching the floor. On 10/24/19 at 9:32 AM, the DNS wheeled the resident down the hall and stopped in front of the surveyor. The DNS went into another resident's room and left Resident # 3 in the wheelchair next to the surveyor. The surveyor observed the [redacted] bag attached to the underside of the wheelchair, was touching the floor as well as the [redacted] drape covering the front of the [redacted] bag. At 9:35 AM, the DNS came back to the resident and wheeled the resident to therapy with the [redacted] bag dragging along on the floor under the wheelchair. On 10/24/19 at 12:04 PM, the surveyor observed the resident in the day room at a table during an activity. The [redacted] bag was attached to	F 880		

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F 880	Continued From page 42 the underside of the wheelchair and was touching the floor. At that time, the Assistant Director of Nursing (ADON) approached the surveyor. The surveyor asked the ADON if anything was wrong with the way the catheter was positioned under the wheelchair. The ADON first said it's too far back, then asked about the [redacted]. The surveyor then asked if the [redacted] bag should have been touching the floor. The ADON stated, "Oh, that, No." The surveyor asked her why it shouldn't be touching the floor. The ADON said, "Infection." The ADON further stated, "It's usually not like that." The ADON then took the resident to the resident's room and positioned the [redacted] bag, so it was hooked onto a higher bar under the wheelchair and not onto the floor. On 10/24/19 at 2:00 PM, the surveyor spoke with the DNS, the ED, and the Assistant Administrator about the observation of Resident #3's [redacted] bag viewed on the floor multiple times. The surveyor asked them if the [redacted] should have been on the floor. The DNS stated, "No." The DNS further said, "When the bed goes low, it is a challenge to find a spot, so they are not on the floor. A lot of the wheelchairs are different, and so we really have to crawl on the floor and find a spot to put the bag, so it's not on the floor." On 10/24/19 at 2:00 PM, the survey team asked for the policy and procedure for the care of resident's with [redacted]. The DNS said that they didn't have a policy and procedure; they had a Wellness Program. The surveyor reviewed the Wellness Program titled, Continence Management Program Forms and Tools, which did not address the positioning of [redacted] bags.	F 880		

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5. On 10/23/19 07:13 AM, the surveyor observed two housekeepers standing at the doorway of the soiled linen room of the laundry room. Upon entrance to the room, on the right side, there was a bucket with mop heads. A housekeeper stated that was where they placed the dirty mop heads. In addition to the mop heads, two covered bins were used for the placement of soiled linen. On the opposite side of the small, soiled linen room, was a large gray garbage can with mop heads. The housekeepers confirmed that was where the clean mop heads were stored.

6. On 10/23/19, during the entrance conference, the surveyor requested the Infection Prevention and Control Program Policy (IPCP), [redacted] Program, and the [redacted] and [redacted] Policy and Procedures (P&P's).

The surveyor reviewed the IPCP that had an effective date of [redacted]

The surveyor then reviewed the facility policy titled [redacted] Stewardship Program had a date of August 2018.

The [redacted] Immunizations policy had an effective date of 11/28/16.

On 10/25/19 at 10:52 AM, the surveyor interviewed the DNS/IP on IPCP. The DNS/IP stated that she would have to look into when the annual review of the IPCP policies and procedures took place.

On the same date at 3:00 PM, the surveyor interviewed the ED and DNS/IP regarding the annual review of the IPCP P&P's. The DNS/IP

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F 880	Continued From page 44 stated that she had spoken to the Regional Representative and confirmed that the policies had been reviewed annually but did not provide any evidence as to the last time they had been reviewed. The ED stated that the policies and procedures were reviewed on the Corporate Level and that those provided were the active and current policies and procedures. The ED added that they were made aware of new policies and procedures, as well as revisions when they were sent out by Corporate, and then they would be reviewed, accepted, and the staff would be in-serviced on them. The ED confirmed that they do not review and sign off on the P&P's at the individual facility level. N.J.A.C. 8:39- 19.4 (a)(e)(f)	F 880		