STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	09/18/2019

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OAKS AT DENVILLE, THE	21 POCONO ROAD DENVILLE, NJ 07834

(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: 9/18/19 Census: 67 Sample Size: 20	F 000		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:	F 640		10/21/19

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

Electronically Signed | 10/08/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 640	Continued From page 1 (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately complete and transmit the Minimum Data Set (MDS) for 10 of 28 residents reviewed, Residents #5, #6, #7, #8, #9, #11, #15, #54,#56, #77 as evidenced by the following: On 9/17/19 at 9:20 AM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments. The MDS is a comprehensive tool that is a federal mandated process for the clinical assessment of all residents which must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed. After transition of the MDS, it will generate a quality measure to	F 640	1. The Discharge MDS records for residents 5, 6, 7, 9, 56 and 77 were transmitted on [redacted]. The Discharge MDS record for resident #8 was transmitted on [redacted]. The Quarterly MDS records for residents 11 and 15 were transmitted on [redacted]. The Comprehensive MDS record for resident 54 was transmitted on [redacted]. 2. All residents are identified as having the potential to be affected by the deficient practice. The MDS Coordinator and Administrator designee audited all MDS records in the facility for the past 90 days to ensure the Discharge, Quarterly and Comprehensive MDS records were completed, encoded and transmitted within the required regulatory timeframe.	

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F 640	Continued From page 2 enable a facility to monitor the residents decline and progress. The following residents were identified with MDS's not completed or transmitted within the required time frame: 1. Resident #5 was observed to have a Discharge MDS with Assessment Reference Date (ARD) of [redacted], and was due to be transmitted no later than [redacted]. The MDS was noted to be open and was not transmitted when reviewed. 2. Resident #6 was observed to have a Discharge MDS with ARD of [redacted], and was due to be transmitted no later than [redacted]. The MDS was noted to be open and was not transmitted when reviewed. 3. Resident #7 was observed to have a Discharge MDS with ARD of [redacted], and was due to be transmitted no later than [redacted]. The MDS was noted to be open and was not transmitted when reviewed. 4. Resident #8 was observed to have a Discharge MDS with ARD of [redacted], and was due to be transmitted no later than [redacted]. The MDS was noted to be open and was not transmitted when reviewed. 5. Resident #9 was observed to have a Discharge MDS with ARD of [redacted], and was due to be transmitted no later than [redacted]. The MDS was noted to be open and was not transmitted when reviewed. 6. Resident #11 was observed to have a Quarterly MDS with ARD of [redacted], and was due	F 640	3. The facility MDS interdisciplinary team members will receive an in-service regarding completion, encoding and transmittal of MDS records within the required regulatory timeframes. The in-service will include but is not limited to a review of the Resident Assessment Instrument (RAI) guidelines for completion and transmittal requirements for Comprehensive, Quarterly and Discharge MDS records. 4. The MDS Coordinator and/or Administrator designee will audit all Comprehensive, Quarterly and Discharge MDS records bi-weekly to ensure resident assessments have been completed, encoded and transmitted within the required regulatory timeframes. The bi-weekly audits will be shared with the quarterly quality assurance committee who will determine the need for additional monitoring after a period of four months.	

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F 640	Continued From page 3	F 640		

to be transmitted no later than [redacted]. The MDS was noted to have been transmitted after the due date, on [redacted].

7. Resident #15 was observed to have a Quarterly MDS with ARD of [redacted], and was due to be transmitted no later than [redacted]. The MDS was noted to have been transmitted after the due date, on [redacted].

8. Resident #54 was observed to have a Comprehensive MDS with ARD of [redacted], and was due to be submitted no later than [redacted]. The MDS was noted to have been transmitted after the due date, on [redacted].

9. Resident #56 was observed to have a Discharge MDS with ARD of [redacted], and was due to be completed no later than [redacted]. The MDS was noted to be open and not completed.

10. Resident #77 was observed to have a Discharge MDS with ARD of [redacted], and was due to be completed no later than [redacted] The MDS was noted to be open and not completed.

On 9/17/19 at 10:00 AM, the surveyor interviewed the MDS Coordinator who could not provide further information.

On 9/17/19 at 1:00 PM, the Administration was informed regarding the above concern. No additional information was provided.

On 9/17/19 at 10:10 AM, the surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDS), who stated that she was the one responsible to ensure that the MDS assessments were to be submitted in a timely manner. The

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F 640	Continued From page 4 RN/MDS Coordinator could not provide any further information to explain the transmission discrepancies. The Administrator and the Director of Nursing were informed regarding the above concern. They could not provide any further information regarding the transmission discrepancies. NJAC 8:39 - 11.1	F 640		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		10/11/19

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F 656	Continued From page 5 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 plan for a resident on contact precaution diagnosed with an infection. This deficient practice was identified for 1 of 21 residents (Resident #279) reviewed for comprehensive care plans and was evidenced by the following: On 9/12/19 at 10:45 AM, the surveyor observed Resident #279 in the room seated on the bed. The surveyor observed personal protective equipment including gloves, gown and mask placed in a drawer unit prior to entering the resident's room door. The surveyor reviewed Resident #279's medical record. Resident #279 was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted].	F 656	1. Resident 279 had comprehensive person-centered care plans developed and implemented reflecting contact precautions and the infection. 2. All residents receiving antibiotic therapy and requiring transmission-based precautions were identified and had their comprehensive person-centered care plans reviewed by the Director of Nursing or designee to ensure their development and implementation. 3. The Director of Nursing or designee will provide in-service education on the required policy, procedures and processes for developing comprehensive resident-centered care plans to all contributing members of the interdisciplinary team. 4. All residents receiving antibiotic	

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F 656	Continued From page 6 On 9/12/19 at 11:15 AM, the surveyor interviewed the Registered Nurse assigned to the resident who stated that Resident #279 was currently on contact isolation due to a [redacted] The surveyor reviewed the resident's care plan which did not reflect a care plan for Resident #279's infection and isolation. The Administrator and the Director of Nursing (DON) were informed regarding the above concern, and both agreed, that there was no care plan implemented regarding the [redacted] The DON stated that there should have been a care plan implemented for a resident that's on contact isolation. NJAC 8:39-11.2(e)(1)(2)	F 656	therapy and requiring transmission-based precautions will have their comprehensive person-centered care plans reviewed by the Director of Nursing or designee for a period of 16 weeks to ensure compliance. The weekly audit findings will be shared with the quarterly quality assurance committee who will determine the need for additional monitoring after a period of four months.	
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician;	F 710		10/11/19

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F 710	Continued From page 7 §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to implement a Physician's Orders (PO) for 1 of 21 residents reviewed, Resident #279. This deficient practice was evidenced by the following: On 9/12/19 at 10:45 AM, the surveyor observed Resident #279 in the room seated on the bed. The surveyor observed personal protective equipment including gloves, gown and mask that was placed in the cart prior to entering the resident's room door. The surveyor reviewed Resident # 279's medical record. The resident was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted] The surveyor reviewed the September 2019 Physician Order Sheet (POS) which revealed that there was no PO for Resident #279 to be placed on contact isolation due to the [redacted] A review of the Policy and Procedure titled [redacted] Documented under section #6 "Decolonization requires a physician order." On 9/17/19 at 12:45 PM, the surveyor interviewed	F 710	1. Resident 279 obtained a physician order for contact precautions and it was transcribed in the medical record. 2. All residents placed on decolonization and/or isolation will have their corresponding physician orders reviewed by the Director of Nursing or designee. If warranted, the attending physician will be notified of the required order and it will be transcribed in the medical record to ensure compliance. 3. The Director of Nursing or designee will provide in-service education to all RN's and LPN's regarding the policies, procedures and processes related to physician orders. 4. The Director of Nursing or designee will audit all physician orders for residents placed on decolonization and/or isolation for a period of 16 weeks to ensure compliance. The weekly audit findings will be shared with the quarterly quality assurance committee who will determine the need for additional monitoring after a period of four months.	

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F 710	Continued From page 8 the Director of Nursing (DON) who stated that any resident who is placed on any type of isolation must have a PO written whether it's verbal or via telephone order. The Administrator and the DON were made aware of the above concern and both agreed that Resident #279 should have had an order for their contact isolation. NJAC 8:39-27.1 (b)	F 710		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to maintain an effective tracking system in order to ensure that all Certified Nursing Assistants (CNA) received 12 hours of mandatory inservice training and perform Annual Performance Reviews of CNAs as required. This was identified for 5 of 5 employee files reviewed for inservice training and 2018 Annual Performance reviews. The 5 files did not contain documented evidence that each CNA had definitively received the 12 hours of inservice training including 1 of the 5, who had not received any inservice training for the year 2018.	F 730	1. C.N.A #1, C.N.A. #2, C.N.A. #3, and C.N.A. #4 will receive 12 hours of mandatory in-service training and annual performance reviews. C.N.A. #5 has had their employment status placed on inactive status and will be furnished an annual performance review and 12 hours of in-service training upon return to active employment status. 2. The facility will identify all nurse aide annual performance review(s) and in-service education hours. Any outstanding requirements will result in the required mandatory in-service training	10/25/19

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F 730	Continued From page 9 This deficient practice was evidenced by the following: On 9/13/19 at approximately 9:30 AM, the surveyor requested a list of the facility's CNAs which was provided to the surveyor by the facility's Administrator. The surveyor reviewed the list and randomly selected 5 CNAs for review of performance evaluations and inservice training. Upon receiving the 5 files, the surveyor reviewed the sheets documenting the inservices received by each CNA. The inservice dates included on the sheets were from the CNAs anniversary date of hire (2017 or 2018) to the following anniversary year (2018 or 2019). The surveyor calculated that CNA#1 with a date of hire (DOH) [redacted], only had 3 hrs 45 minutes (mins) of inservicing. CNA #2 DOH [redacted]7, only had 2 hrs 20 mins of inservicing. CNA#3 DOH [redacted], only had 2 hrs 15 mins of inservicing. CNA#4 DOH [redacted], only had 5 hrs 5 mins of inservicing and CNA#5 DOH [redacted] only had 2 hrs 10 mins of inservicing. The surveyor requested required Annual Performance Reviews (APR) from the Administrator (Admin) for the CNA's reviewed. The Admin supplied APRs for CNA #1 dated 4/14/2017, CNA#2 dated 5/2016-3/2017, CNA #3 dated 3/2017, CNA#4 dated 3/2017-3/1/2018 and CNA#5 dated 3/1/18. The surveyor interviewed the Admin on 9/17/19 at 10:46 AM who could not provide any further information regarding the lack of CNA required inservices and required Annual Performance Reviews. NJAC 8:39 - 43.17 (b)	F 730	following the annual performance review(s) to ensure compliance. 3. The Director of Nursing or designee will initiate a master tracking schedule for all nurse aide staff to timely complete the annual performance review with mandatory 12 hour in-service education and to ensure compliance. 4. The Director of Nursing or designee will audit all 12-hour mandatory in-service training and annual performance reviews for nurse aide staff monthly for four months. The -monthly audit findings will be shared with the quarterly quality assurance committee who will determine the need for additional monitoring after a period of four months.	

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F 755 SS=D	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 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to properly remove expired and discontinued medications. for use by the Physician. This	F 755	1. The bottle o [redacted] opened on 6/2/19 was removed from the [redacted] unit [redacted] medication cart. The bottle	10/11/19

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F 755	Continued From page 11 deficient practice was observed in 1 of 4 medication carts inspected, as evidenced by the following: On 9/12/19 at 11:10 AM, the surveyor inspected the [redacted] floor unit [redacted] medication cart. The following was identified: 1 [redacted] documented by nursing as opened on 6/2/19. The surveyor reviewed the "Storage Recommendations and Expiration Dates" (SRED) sheet that was posted in the [redacted] floor medication room bulletin board. The SRED documented, [redacted] Date container after removing from the refrigerator-discard after 28 days." 2. [redacted] ocumented by nursing as opened on 7/29/19. The bottle of [redacted] as ordered by the Physician with directions '[redacted]" and received on 7/29/19 for Resident # 54. The order was discontinued on 8/15/19. The opened bottle remained in the medication cart. 3 [redacted] documented by nursing as opened on 7/31/19. The bottle of [redacted] was ordered by the Physician with directions, [redacted] and received on 7/29/19 for Resident # 54. The order was discontinued on 8/15/19. The opened bottle remained in the medication cart. The surveyor interviewed the Director of Nursing (DON) on 9/16/19 at 1:24 PM who explained that	F 755	of [redacted] opened on 7/29/19 was removed from the [redacted] floor unit [redacted] medication cart. The bottle of [redacted] opened on 7/31/19 was removed from the [redacted] floor unit [redacted] medication cart. 2. All residents have the potential to be affected. All facility medication carts will be audited for discontinued and expired medications by the Director of Nursing to ensure compliance. Any discontinued or expired medications will be removed from the medication cart and destroyed. 3. The Director of Nursing or designee will provide in-service education to all RN's and LPN's on the facility's policies and procedures for expired medications and discontinued medications. 4. The Director of Nursing or designee will audit all facility medication carts for discontinued and expired medications weekly for sixteen weeks. The weekly audit findings will be shared with the quarterly quality assurance committee who will determine the need for additional monitoring after a period of four months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT DENVILLE, THE	**21 POCONO ROAD DENVILLE, NJ 07834**

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F 755	Continued From page 12 all resident's medications that are expired or discontinued must be removed from storage and destroyed/discarded. The DON stated that the three medications found (1 expired and 2 discontinued) should have been removed from the resident's active medications. NJAC 8:39- 29.4(b)2	F 755		

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	061424	A. BUILDING: _____ B. WING _____	09/18/2019

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OAKS AT DENVILLE, THE	21 POCONO ROAD DENVILLE, NJ 07834

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to have a	S1405	1. C.N.A. Employee #1 will be given a new physical examination by a MD.	10/21/19

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

Electronically Signed | 10/08/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1405	Continued From page 1 physician or advanced practice nurse perform employee physical examinations (PE) within 2 weeks prior to the first day of employment or upon employment for 5 of 5 employee files reviewed. This deficient practice was evidenced by the following: On 09/17/19 at 10:30 AM, the surveyor reviewed the health records for 5 employees hired within the last 4 months. 1. Certified Nursing Assistant (CNA) Employee #1's date of hire (DOH) was [redacted]. The PE was performed by the physician on 7/2/19. 2. Licensed Practical Nurse (LPN) Employee #2's DOH was [redacted]. The PE was performed by the physician on 4/1/19. 3. LPN Employee #3's DOH was [redacted] The PE was not performed by the physician. 4. LPN Employee #4's DOH was [redacted]. The PE performed by the physician on 3/19/19. 5. CNA Employee #5's DOH was [redacted]. The PE was performed by the physician 5/9/19. On 9/18/19 at 11:00 AM, the surveyor interviewed the Administrator and Director of Nursing who could not provide any further information.	S1405	LPN Employee #2 will be given a new physical examination by a MD. LPN Employee #3 will be given a new physical examination by a MD. LPN Employee #4 was terminated from employment on 05/22/2019. C.N.A. Employee #5 will be given a new physical examination by a MD. 2. All residents have the potential to be affected by the same deficient practice. The administrator or his designee will track all employee candidates bi-weekly to ensure timely completion of the new employee health history and physical examination. 3. The human resource policy for hiring will be updated to reflect the regulatory requirements for mandatory staff qualifications and an in-service education on the updated hiring policy and procedure will be provided by the administrator to each department head and executive director. 4. The administrator will audit all prospective employees and new employees bi-weekly to ensure facility compliance with the requirements for new employee health history and physical examinations. The weekly audits will be shared with the quarterly quality assurance committee who will determine the need for additional monitoring after a period of four months.	
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation	S1410		10/21/19

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S1410	Continued From page 2 (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on the review of employee files and interview, it was determined that the facility failed to perform a 2 step Mantoux tuberculin skin test (PPD) as required for new employees hired. This deficient practice was identified for 2 of 5 employees reviewed as evidenced by the following: The Mantoux tuberculin skin test is done in order to identify any potential carriers of Tuberculosis. Typically, the first step activates the disease and the second step, done 1 to 3 weeks later, shows the existence of a potential problem via a small	S1410	1. LPN Employee #3 will be administered a 2-Step Mantoux tuberculin skin test. C.N.A. Employee #5 will be administered a 2-Step Mantoux tuberculin skin test. 2. All residents have the potential to be affected by the same deficient practice. The administrator or his designee will track all employee candidates bi-weekly to ensure timely completion of the first and second step Mantoux tuberculin skin test, or a negative test screening for tuberculosis.	

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S1410	Continued From page 3 skin reaction at the site of the test. 1. LPN Employee #3's Date of Hire (DOH) was [redacted]. The facility performed the first PPD on 8/20/19 with no follow up of a second PPD. 2. CNA Employee #5's DOH was [redacted]. The facility performed the first PPD on 5/11/19 with no follow up of a second PPD. On 9/18/19 at 11:00 AM, the surveyor interviewed the Administrator and Director of Nursing who could not provide any further information.	S1410	3. The human resource policy for hiring will be updated to reflect the regulatory requirements for the two-step Mantoux tuberculin skin test and, an in-service education on the updated hiring policy and procedure will be provided by the administrator to each department head and executive director. 4. The administrator will audit all prospective employees and new employees bi-weekly to assure the facility is in compliance with the requirements for two-step Mantoux tuberculin skin test and/or negative tuberculosis test screening. The weekly audit findings will be shared with the quarterly quality assurance committee who will determine the need for additional monitoring after a period of four months.	