STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315477	A. BUILDING ______ B. WING ______	07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT WAYNE - SNF	493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470

(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: 7/15/19 CENSUS: 63 SAMPLE: 16 +3 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		7/25/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 07/24/2019

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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CARE ONE AT WAYNE - SNF	**493 BLACK OAK RIDGE ROAD** **WAYNE, NJ 07470**

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F 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. 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 that dining experience was provided in a manner to promote the dignity and respect of the residents. This deficient practice was identified on three consecutive days in the main dining room (MDR) and was evidenced by the following: On 7/9/19 at 9:30 AM, the surveyor observed that 3 of 3 residents seated in the MDR were served breakfast on plastic trays. On 7/9/19 at 12:00 PM, the surveyor observed that 5 of 5 residents seated in the MDR were served lunch on plastic trays. On 7/10/19 at 12:10 PM, the surveyor observed that 8 of 8 residents seated in the MDR were served lunch on plastic trays. On 7/11/19 at 12:19 PM, another surveyor	F 550	Residents identified in the dining room had no complaints; however, dining room supervision has been put into place for observation of meal service. Residents having meals in the dining room have the potential to be affected. Department Head/Manager on Duty schedule created to observe and assist with meal service to ensure following of the Dining Room Protocol. Beverage cart will be sent with each meal for certified aides to pour as requested by resident. The Facility Educator/ Registered Dietitian/ Designee will in-service Department Heads, Licensed nurses, Certified Aides, Speech Therapists, Dietary Aides, Dietary Director on dining room protocol including consistent homelike meal and dining service. The Director of Nursing/Designee will conduct weekly dining room observation of breakfast, lunch and dinner for	

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CARE ONE AT WAYNE - SNF	**493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470**

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F 550	Continued From page 2 observed the tables in the dining room which had been set up with drinking glasses and ceramic mugs. The surveyor observed that the staff had unloaded the trays off the carts, but only some of the 16 residents had their plates taken off the plate warmers and five residents had been served their drinks in gray plastic mugs and not the ceramic mugs placed at the tables. On 7/11/19 at 12:45 PM, a Certified Nursing Assistant (CNA) who had been feeding a resident lunch, removed the plastic wrap from the resident's dessert and placed the dessert plate on top of the residents plate with the partially eaten lunch food. The CNA proceeded to feed the resident his/her dessert while it was on top of the lunch. During an interview with the surveyor on 7/15/19 at 11:17 AM, the Director of Nursing (DON) stated the Facility Educator oversees the MDR as well as the Dietician. During an interview with the surveyor on 7/15/19 at 11:22 AM, the Facility Educator stated that the dining room process was for the staff to serve the residents at the table at the same time; to take the meals off the trays and put them in front of the resident. She stated that staff should serve the residents at the same time for dignity, and should be "just like when you go out for dinner." The Facility Educator stated that there had been staff education since she started in [redacted] and that the staff "know that's the process." Review of the undated facility, "Dining Room Program Protocol," document provided by the Facility Educator, revealed to always take all the food off the trays and place it in front of the	F 550	compliance of Dining Room Protocol. The Registered Dietician/Designee will conduct observation audits of 3 meals weekly for 3 months to verify Dining Room Protocol for meal service being followed. The findings will be reported to the Quality Assurance Committee monthly for 3 months with further follow-up action as warranted.	

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F 550	Continued From page 3 patient and residents. NJAC 8:39-4.1(a)12; 17.2(e)(g)	F 550		
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 by: Based on observation, interviews and record review, it was determined that the facility failed to ensure a fall intervention was in place after a resident had a room change. This deficient practice was identified for 1 of 2 residents reviewed for falls (Resident #44) and was evidenced by the following: According to the Admission Record, Resident #44 was admitted to the facility on [redacted] with diagnoses which included but were not limited to; [redacted] Review of an Admission Minimum Date Set (MDS), an assessment tool dated [redacted], revealed that the resident had [redacted] problems and required extensive assistance with activities of daily living. Additionally, the MDS revealed that the resident	F 689	Resident #44 is still currently admitted to Care One at Wayne, receiving skilled services. [redacted] safety intervention of stop sign utilized and present during rounds in resident #44 room. Residents identified as a fall risk with safety interventions in place have the potential to be affected. Director of Nursing/Designee will audit current residents identified as fall risk with safety interventions to ensure interventions are in place as noted in Care Plan. The Unit Manager/ Admissions Coordinator will assist with room changes to ensure all safety interventions will be moved and put in place as noted in the Residents Care Plan. The Facility Educator/ Designee will in-service Licensed Nurses, Certified Aides, Social Workers, Admissions	7/25/19

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F 689	Continued From page 4 had a fall in the last month and 6 months prior to admission. On 7/9/19 at 12:00 PM, Resident #44 was observed in his/her room seated in a wheelchair. Review of the resident's care plan reflected that the resident was at risk for falls related to [redacted] and had a fall on [redacted] while attempting to transfer self. The goal was to minimize the risk for falls and interventions included but were not limited to; "stop sign reminder placed in room to call for assistance able to demonstrate proper use" which was dated [redacted] Review of the Certified Nurses Aide (CNA) "Kardex" (a plan of care for the resident) revealed, under "safety," "stop sign reminder placed in room to call for assistance able to demonstrate proper use." Review of the Progress Notes (PN), dated [redacted] at 1:07 AM, reflected that a CNA found the resident sitting on the floor in his/her room. There were no injuries and the physician was notified. Review of an Incident Report (IR), dated [redacted] at 11:50 PM, revealed that the resident was found sitting on the floor in the resident's room and had no injuries. The IR reflected a section titled, "Notes," dated [redacted] and revealed there was no injury after the fall and that a stop sign reminder was in place to call for assistance. The note also included that the resident was participating in therapy, focusing on strength, endurance and fall safety.	F 689	Coordinator, Unit Clerks, Housekeepers, Rehab Therapists on identification of residents that are at risk for falls and maintaining fall safety interventions as noted in the Care Plan, inclusive of resident with a room change. Unit Manager, Designee will conduct weekly audits of residents identified as a fall risk with room changes to ensure safety interventions are in place in the new room as noted in Care Plan. The Director of Nursing will conduct audits of 3 residents weekly for 3 months for fall safety interventions in place as per Care Plan. The findings will be reported to the Quality Assurance Committee monthly for 3 months with further follow up action as warranted.	

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F 689	Continued From page 5 On 7/11/19 at 9:45 AM, there was no stop sign observed in Resident #44's room. During an interview with the surveyor on 7/12/19 at 9:51 AM and 10:06 AM, the Licensed Practical Nurse (LPN), assigned to Resident #44, stated that the resident was a fall risk and was not aware that a stop sign should have been in the resident's room. During an interview with the surveyor on 7/12/19 at 9:57 AM, the Registered Nurse Unit Manager (RN/UM) stated that after a resident falls, rehab and nursing would meet by the following day to discuss the fall and interventions. The interventions would be placed on the care plan and the CNA plan of care. The RN/UM stated that after Resident #44 had fallen, a stop sign was placed in the resident's room as an intervention to remind the resident to call for assistance. On 7/12/19 at 10:06 AM, the surveyor and the RN/UM went into Resident #44's room and the RN/UM confirmed that the stop sign was not in the room. The RN/UM stated while in the room that the resident had a prior room change. At that time, the surveyor and the RN/UM went to the previous room where the resident resided and observed the stop sign on the wall in front of a bed. The RN/UM stated that the stop sign should have been moved when the resident's room was changed. The RN/UM placed the stop sign in the resident's current room. During an interview with the surveyor on 7/12/19 at 10:12 AM, the CNA who was assigned to Resident #44 stated that she was not aware that the resident was a fall risk or had any interventions in place.	F 689		

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F 689	Continued From page 6 During an interview with the surveyor on 7/12/19 at 11:17 AM, the Director of Nursing (DON) stated that after a fall, IRs are reviewed by herself and the interdisciplinary team, the CP is updated, and interventions are put into place. The DON stated report is given to the nurses, the CNAs and that nursing supervisors and the nurses ensure the interventions are put into place by checking during daily rounds. The DON stated that when the resident's room was changed, the stop sign intervention should have moved to the new room. During an interview with the surveyor on 7/15/19 at 9:40 AM, the RN/UM stated the resident's room was changed on 7/5/19. Review of the facility's "Falls-Clinical Protocol" document, revised March 2018, included that the staff and physician would identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. NJAC 8:39-27.1(a)	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		7/25/19

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F 880	Continued From page 7 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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F 880	Continued From page 8 (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 follow hand hygiene practices and to consistently offer residents hand hygiene during meals. This deficient practice was identified on three consecutive days in the main dining room (MDR) and was evidenced by the following: On 7/9/19 at 12:18 PM, the surveyor observed the staff serve lunch to the residents seated in the MDR with no hand hygiene offered to the residents. On 7/10/19 at 12:16 PM, another surveyor observed the staff serve a table of three residents with no hand hygiene offered to the residents. At 12:26 PM, the surveyor observed a basket of moist towelettes on the counter but the staff had not offered them to the residents.	F 880	Residents identified in the dining room with inconsistent hand hygiene. Dining room supervision in place for observation for compliance with resident hand hygiene. Residents unable to provide independent hand hygiene have the potential to be affected. The Facility Educator/ Designee will in-service Department Heads, Licensed Nurses, Certified Aides, Speech Therapists, Dietary Aides on hand hygiene at meals. The Director of Nursing/Designee will conduct weekly dining room observations for resident and staff hand hygiene practices. The Director of Nursing/ Designee will conduct observation audits of 3 meals weekly for 3 months to verify hand hygiene practices for residents and staff. The findings will be reported to the Quality	

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F 880	Continued From page 9 On 7/11/19 at 11:49 AM, another surveyor observed 11 residents seated in the MDR who were offered hand wipes. At 12:15 PM, five more residents entered the MDR but were not offered hand wipes. At 12:15 PM, one of the residents left the MDR and returned at 12:18 PM. This resident had been touching the wheels of his/her wheelchair and had not been provided with hand wipes prior to eating. On 7/11/19 at 12:45 PM, the surveyor observed a Certified Nurses Aide (CNA) leave a resident they were assisting with feeding and go to another resident to assist. While with the other resident, the CNA touched the resident's back and bare arm, table and wheelchair. The CNA next retied her scrub pants and then returned to the original resident she had been assisting, sat down and proceeded to feed the resident without performing hand hygiene. On 7/11/19 at 12:49 PM, the same CNA scratched her nose and then touched her hair before placing a lid on a coffee cup. The CNA then handed the coffee cup to a resident that was leaving the dining room. The CNA did not perform hand hygiene after touching her hair and nose. During an interview with the surveyor on 7/15/19 at 10:56 AM, the Director of Nursing (DON), who is also the facility's infection control nurse, stated that handwashing should be done before and after serving food, and that the staff is to clean residents hands before and after eating. The DON stated that staff should also perform hand hygiene after touching their own hair, clothes and in between residents.	F 880	Assurance Committee monthly for 3 months with further follow-up action as warranted.	

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F 880	Continued From page 10	F 880		

During an interview with the surveyor on 7/15/19 at 11:22 AM, the Facility Educator stated that staff are to perform hand hygiene prior to and after feeding, serving, touching their uniforms, and between residents.

Review of the undated "Dining Room Program Protocol" revealed to use hand wipes before and after meals for each resident. The protocol indicated to practice appropriate hand hygiene and use hand sanitizer three times before hand washing if hands are not visibly soiled.

Review of a policy titled, "Handwashing/Hand Hygiene," dated 8/15, revealed all personnel shall follow the handwashing/hand hygiene procedures and use an alcohol-based hand rub for the following situations: before and after direct contact with residents, before and after handling food and before and after assisting a resident with meals. The policy also indicated that residents will be encouraged to practice hand hygiene

NJAC 8:39-19.4(a)(1)