| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315331 | A. BUILDING _____ B. WING _____ | 04/08/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COMPLETE CARE AT FAIR LAWN EDGE | 77 EAST 43RD STREET PATERSON, NJ 07514 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>CENSUS: 114<br><br>SAMPLE SIZE: 23 (plus 3 closed records)<br><br>A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. | F 000 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to a.) follow a Dietician's recommendation for 1 of 7 residents reviewed for nutrition (Resident #49), and b.) to set the appropriate weight in an [redacted] used to promote [redacted] healing for 1 of 4 residents (Resident #106) reviewed for [redacted] according to professional standards of practice.<br><br>This deficient practice was evidenced by the following:<br><br>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential | F 658 | I. CORRECTIVE ACTIONS FOR THOSE AFFECTED:<br>1. The orders for resident #49 were reviewed and updated immediately to include increase [redacted] to three times a day, there was no negative outcome in this deficient practice.<br>2. The orders for resident #106 were reviewed and updated immediately to include order to check placement and function of [redacted], there was no negative outcome in this deficient practice.<br>3. Staff members were in serviced on caring out orders and ensuring all orders needed for residents are obtained and carried out in a timely manner.<br>4. Resident #106 [redacted] was checked and adjusted immediately to | 4/30/21 |

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

Electronically Signed | 04/30/2021

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| F 658 | Continued From page 1<br>physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."<br><br>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."<br><br>1. On 3/30/21 at 10:00 AM, the Registered Nurse/Unit Manager (RN/UM) informed the surveyor that Resident #49 was [redacted] his/her appetite varied, was on supplements, and the weights were stable. The RN/UM stated that the resident takes their [redacted] supplement well.<br><br>On that same date at 10:33 AM, the surveyor toured with the RN/UM and both observed the resident laying on the [redacted].<br><br>A review of Resident #49's Face Sheet (an admission summary), indicated that the resident had diagnoses that included, [redacted] | F 658 | match weight.<br>II. ID OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>ALL RESIDENTS WITH ORDERS HAVE THE POTENTIAL TO BE AFFECTED.<br>1. All residents that have an order for supplements were reviewed for complete and accurate documentation. No missing supplement or incorrect supplements orders was identified.<br>2. All residents that have air mattress were reviewed to see that they have an order to check placement and function.<br>3. Dietician, Unit managers, and nurses were in-serviced on communicating with each other and following up on recommendations.<br>4. All nurses were in-serviced on checking on [redacted] for function and placement, and that the setting match the resident's weight.<br>III. SYSTEMIC CHANGES:<br>1. Copy of recommendations made by dietician will be given to Director of Nursing/Assistant Director of Nursing, they will check to ensure that recommendation is carried out and is accurate<br>2. Unit Managers will do supplements audits for residents on supplements weekly and findings will be reported to the Assistant Director of Nursing/Director of Nursing x 90days.<br>3. Dietician will audit supplement orders bi-weekly and report findings to Administrator, Director of Nursing and Assistant Director of Nursing x 90days.<br>4. Assistant Director of Nursing and Director of Nursing will audit supplements | |

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| F 658 | Continued From page 2<br>[redacted]<br><br>A review of the [redacted] Quarterly/Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, revealed a Brief Interview for Mental Status (BIMS) score of 1, which indicated that the resident's cognition was [redacted].<br><br>A review of the [redacted] Order Summary Report (OSR) showed an order dated [redacted] for the nutritional supplement [redacted] by mouth in the morning.<br><br>A review of the [redacted] electronic Medication Administration Record (eMAR) showed that the above order was signed as given daily by the nurses.<br><br>A review of the [redacted] Dietary Alert Sheet revealed a recommendation to increase the [redacted] from once a day to three times a day. Further review of the medical records showed that there was no documented evidence that the recommendation was followed.<br><br>On 4/1/21 at 11:18 AM, the surveyor interviewed the RN/UM who stated "usually" the dietician will flag and "talk to me" regarding her recommendations. The RN/UM stated "then I immediately notify the doctor about the recommendation."<br><br>On that same date and time, the RN/UM stated that she did not know about the recommendation and it was not flagged. That was why the | F 658 | monthly x 90days.<br>5. All nurses and Dietician will be in-serviced on supplement orders for accuracy to ensure that residents are getting the right order weekly and individually on specific issues as areas of necessary improvement are identified x 90days.<br>6. Unit manager will check all residents on air mattress weekly to ensure that the weight-setting match the resident's weight and report findings to Director of Nursing/Assistant Director of Nursing x 90days.<br>7. Assistant Director of Nursing and Director of Nursing will audit biweekly to ensure that all residents on [redacted] have an order and the weight setting matches resident's weight x 90days.<br><br>IV. MONITORING:<br>1. The Unit Managers will do supplements audits for residents on supplements weekly and findings will be reported to the Assistant Director of Nursing/Director of Nursing x 1month.<br>2. Dietician will audit supplement orders bi-weekly and report findings to Administrator, Director of Nursing and Assistant Director of Nursing x<br>3. The Assistant Director of Nursing and Director of Nursing will report the trends noted and related interventions to the Administrator and Quality Assurance Committee at the QA meeting monthly x 3 months.<br>4. Unit manager will check all residents | |

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| F 658 | Continued From page 3<br>recommendation to increase the [redacted] was not followed.<br><br>On 4/1/21 at 2:15 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), and discussed the above observations and concerns<br><br>On 4/6/21 at 11:35 AM, the Dietician informed the surveyors that "It was my fault, I forgot" to write the recommendations in the Food Service supplement system book that goes to the kitchen to alert them to the increase. The Dietician stated that the resident had no weight loss., The surveyor reviewed the resident's weight record which noted on [redacted] the resident's weight was [redacted] lbs and on [redacted] the weight was [redacted] lbs.<br><br>On 4/6/21 at 1:17 PM, the DON in the presence of the LNHA and ADON, informed the surveyors that "the Dietician did not put the order down" and that was why the recommended increase in [redacted] was missed and the order never instituted.<br><br>A review of the undated facility Supplements Policy, provided by the DON, included "Supplements will be recommended by MD, RD or Nursing. Order will be placed in the following MD approval. Dietitian or Nursing will notify Food Service to place order in the Food Service supplement system."<br><br>2. On 3/30/21 at 10:08 AM, the surveyor toured with the RN/UM, who informed the surveyor that Resident #106 was [redacted], required total assistance with activities of daily living (ADL) | F 658 | on air mattress weekly on Mondays to ensure that the weight-setting match the resident's weight and report findings to Director of Nursing/Assistant Director of Nursing x 4 weeks<br>5. Assistant Director of Nursing/Director of Nursing or designee will audit weekly x 4weeks to ensure that all residents on air mattress have an order and the weight setting matches resident's weight and finding will be reported at the Quality Assurance Committee at the monthly QA meeting. | |

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| F 658 | Continued From page 4 | F 658 | | |

due to [redacted]), and had non-facility acquired [redacted] She indicated that the [redacted] were getting better and that the resident is on a [redacted] to promote [redacted] healing.

On that same date and time, both the surveyor and the RN/UM observed that the resident was lying on an [redacted]. The [redacted] was set for a resident who would weigh approximately [redacted] pounds (lbs) and the [redacted] was set for [redacted] cycles. The RN/UM stated that the resident was not [redacted] lbs; the mattress was not set according to the manufacturer's specific instructions. She further stated "I don't know why it was set at [redacted] lbs. I'm not sure what was the resident's weight." The RN/UM stated that it was the nurse's responsibility to make sure that the [redacted] weight was correct. She indicated that she did not receive education about the [redacted].

Furthermore, the RN/UM informed the surveyor that there should be an order for nurse accountability to check the function of the [redacted] in the electronic Treatment Administration Record (eTAR).

On 3/31/21 at 10:05 AM, the surveyor observed a CNA reposition Resident #106 in the wheelchair and leave the room. The [redacted] was still set at [redacted] lbs. The resident informed the surveyor that their air mattress was "comfortable" and he/she had no complaints about it. The resident was unable to remember who initially set up the [redacted], it was the nurse's responsibility to check the [redacted], and "no one touches the [redacted] except the nurse."

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| F 658 | Continued From page 5<br>A review of the resident's Face Sheet indicated that the resident had diagnoses that included, [redacted].<br><br>A review of the [redacted] Q/MDS revealed a BIMS score of [redacted], which indicated that the resident's [redacted].<br><br>A review of the [redacted] OSR and eTAR did not include an order for monitoring and checking the [redacted].<br><br>On 3/31/21 at 10:14 AM, the Licensed Practical Nurse (LPN) informed the surveyor that he was Resident #106's regular nurse. The LPN stated that it was the nurse's responsibility to monitor the set weight in the [redacted] and sign the eTAR that he checked the [redacted] every shift and it was the correct inflation for the resident's weight.<br><br>On that same date and time, the surveyor and the LPN checked the resident's [redacted] and observed that it was set at [redacted] lbs. The LPN stated that "I don't know what happened" when asked by the surveyor why the [redacted] was not set for the resident's correct weight and there was no accountability ordered to check the [redacted] function. He further stated that he did not have an in-service about the [redacted].<br><br>On 3/31/21 at 2:00 PM, the surveyors met with the LNHA, DON, ADON, and discussed the above observations and concerns. The surveyor asked for additional information about the [redacted] and the DON stated that they will get back to the surveyor. The DON acknowledged that the staff should have been educated about | F 658 | | |

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| F 658 | Continued From page 6<br>the [redacted].<br><br>On 4/1/21 at 2:15 PM, the DON in the presence of the LNHA and ADON informed the surveyors that they were not sure who entered the [redacted] lbs in the [redacted]. The DON stated that "it was dropped" which was why there was no order to monitor the [redacted] and was not entered in the eTAR. The DON further stated that there was an ongoing education on the [redacted] now.<br><br>Furthermore, the DON stated that there was no negative effect on the resident. She further stated that the [redacted] were improving, and the [redacted] had resolved on [redacted].<br><br>A review of the undated facility [redacted] Policy, provided by the ADON, included "Objective: 1. To prevent and treat [redacted]. 2. To [redacted]. 3. To provide comfort for the patient. Procedure: 6. See pump based on resident's weight. 9. Nurse to check the functioning of pump every shift, if not functioning notify maintenance."<br><br>A review of the manufacturer's [redacted] specification that was provided by the ADON included "Digital adjustable setting allows for customized pressure by resident weight."<br><br>On 4/7/21 at 1:39 PM, the surveyors met with the LNHA, DON, ADON, and there was no additional information provided by the facility.<br><br>NJAC 8:39-11.2 (b) | F 658 | | |

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| F 688 | Continued From page 7 | F 688 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate services to a resident with limited mobility. This was noted for 2 of 4 residents, Resident #95 and #73, reviewed for a limited [redacted]<br><br>This deficient practice was evidenced by the following:<br><br>1. On 3/30/21 at 10:15 AM, the surveyor observed Resident #95 seated in a wheelchair in the hallway. The resident was noted to have limitation of movement in their [redacted] and [redacted] and [redacted] in their [redacted] The resident was able to self propel the wheelchair a short | F 688 | I. CORRECTIVE ACTIONS FOR THOSE AFFECTED<br>1. Resident #95 screened by rehab and appropriate Functional Maintenance Program was put in place. There was no noted decline on the screen.<br>2. There was no negative outcome to resident #95 from this deficient practice<br>3. Resident #73 screened by rehab and appropriate Functional Maintenance Program was reestablished. There was no noted decline on the screen.<br>4. There was no negative outcome to resident #73 from this deficient practice<br><br>II. ID OTHERS WITH THE POTENTIAL | 4/30/21 |

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| F 688 | Continued From page 8<br>distance with the use of their [redacted]<br><br>On that same date and time, the RN/UM informed the surveyor that the resident was non-ambulatory and not sure if the resident was on a Functional Maintenance Program (FMP).<br><br>A review of Resident #95's Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included [redacted].<br><br>A review of the Quarterly Minimum Data Set (QMDS) assessment tool dated [redacted] reflected a brief interview for mental status (BIMs) score of [redacted] which indicated that the resident had [redacted]. The QMDS reflected that Resident #95 had limitations to the [redacted] and [redacted].<br><br>A review of the Rehab-General Quarterly note (R-GQn) dated [redacted] showed that Resident #95 should have been on [redacted] and [redacted] and [redacted] ([redacted] due to history of [redacted]<br><br>Further review of Resident #95's medical records showed there was no accountability that the [redacted] were being done according to the [redacted] R-GQn.<br><br>On 4/1/21 at 11:34 AM, the Certified Nursing Aide (CNA) informed the surveyor that the resident | F 688 | TO BE AFFECTED<br>ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED.<br>1. All resident's orders were audited for appropriate rehab orders, no missing recommendation was identified.<br>2. Nursing staff in-service about doing range of motion exercises on residents with recommendation for them and to document appropriately.<br>3. Certified Nursing Assistant were in-serviced about Active Range of Motion and Passive Range of Motion<br><br>III. SYSTEMIC CHANGES<br>1. On admission/readmission, rehab will screen the resident and their recommendation will be provided to the Director of Nursing/Assistant Director of Nursing OR designee after each screen x 30days.<br>2. The Assistant Director of Nursing/Director of Nursing or designee will put the order the electronic medical record.<br>3. The order will appear in the treatment administration record for the nurse to sign.<br>4. Therapist will in-service nursing staff of all new functional maintenance program recommendation for a resident.<br>5. The recommendation will be put on the residents Kardex for the Certified Nursing Assistant to document<br>6. Rehab recommendation will be reviewed at resident's quarterly meeting by the interdisciplinary team<br><br>IV. MONITORING<br>1. The Rehab Director will audit ten | |

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| F 688 | Continued From page 9<br>had periods of confusion, required extensive to total assists with activities of daily living (ADLs) due to [redacted] because of [redacted]<br><br>On that same date and time, the CNA stated that there was no accountability for the [redacted] exercises.<br><br>On 4/1/21 at 1:32 PM, the RN/UM informed the surveyor that the Assistant Director of Nursing (ADON) was responsible for rehab recommendations for the Functional Maintenance Program (FMP) and that there should be an order for the FMP, carried over to the electronic Treatment Administration Record (eTAR). The task of doing the FMP is assigned to the CNA. The RN/UM stated "I don't know" why there was no order for [redacted] when it was documented on the [redacted] R-GQn of the therapist.<br><br>On 4/1/21 at 1:36 PM, the ADON informed the surveyor that it was her responsibility to notify the physician with the FMP recommendations from the therapy department, transcribed it to the eTAR and assigned the tasks of the CNA. The ADON stated that she was not aware of the [redacted] R-GQn and there was no communication provided to her.<br><br>On 4/6/21 at 1:17 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the ADON, who were made aware of the above concerns. The DON informed the surveyors that "we did not get the recommendation for [redacted] that was why the order for [redacted] of Resident #95 was not placed and carried out to the eTAR and the CNA tasks." The DON stated that "it was a communication problem" between the therapy and nursing. | F 688 | resident's rehab order/recommendations weekly for accuracy and findings will be reported to the Director of Nursing and Administrator x 90days<br>2. Unit managers will audit 5 resident's rehab order/recommendations bi-weekly for accuracy and report findings to Director of Nursing and Assistant Director of Nursing x 90days<br>3. Director of Nursing and Assistant Director of Nursing will audit ten resident's rehab order monthly and will report findings to the Administrator and Quality Assurance Committee at the quarterly QA meeting. | |

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On that same date and time, the DON further stated that the resident was evaluated by Occupational Therapist (OT) on [redacted] and was picked up for rehab to re-establish the [redacted]. The DON indicated that according to the OT evaluation, there was no decline noted.

2. On 3/30/21 at 10:38 AM, the surveyor observed Resident #73 in [redacted] room sitting in a high back wheelchair and watching television. The resident was dressed and groomed and was observed eating some chips. The resident was alert but not interviewable.

A review of the resident's face sheet reflected that the resident was re-admitted to the facility on [redacted] with a diagnoses that included [redacted].

A review of the Quarterly Minimum Data Set (QMDS), an assessment tool, dated [redacted] reflected a brief interview for mental status (BIMs) score of [redacted], which indicated that the resident had [redacted]. The QMDS reflected that Resident #95 had limitations to the [redacted] and [redacted].

A review of the Rehab-General Admission note (R-GQn) dated [redacted] showed that Resident #73 should have been on [redacted] for the [redacted] and should have been on [redacted] for the [redacted]

Further review of Resident #73's medical records showed there was no accountability that the

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| F 688 | Continued From page 11<br>above [redacted] for the [redacted] and the [redacted] for the [redacted] were being done according to the [redacted] R-GQn.<br><br>On 4/1/21 at 12:00 PM, the surveyor interviewed CNA#2 who stated that the resident gets [redacted] on the [redacted] on the [redacted] She told the surveyor that FMP is usually done after getting the resident dressed in the morning. She showed where she will sign off for FMP in the Kardex. She told the surveyor that she's currently on light duty and another CNA will do the FMP for the resident.<br><br>On 4/6/21 at 9:00 AM, the surveyor reviewed the [redacted] Treatment Administration Record which revealed that Resident #73's FMP included [redacted] and [redacted] in all planes and use of [redacted] as tolerated throughout the day every shift for FMP was discontinued on [redacted]<br><br>On 4/6/21 at 8:45 AM, the surveyor interviewed a Physical Therapist who stated that Resident #73 is currently receiving no Physical, Occupational, or Speech Therapy. She was not able to tell the surveyor if the resident is currently on an FMP program but told the surveyor that if the resident was receiving therapy in the past then the resident should be on an FMP program.<br><br>On 4/6/21 at 10:15 AM, the surveyor interviewed CNA #3 who was providing care for Resident #73 and she stated that resident performed FMP during morning care. CNA #3 was unable to explain how she could sign the Kardex for FMP if the resident had no active order.<br><br>On 4/6/21 at 10:20 AM, the surveyor in the | F 688 | | |

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presence of the 3rd floor Unit Manager (UM) looked at Resident #73's electronic medical record and was unable to find an active order for FMP.

The surveyor interviewed the UM who stated that Resident #73's FMP was probably discontinued by Rehabilitation when the resident was re-admitted to the facility. The UM stated that the CNAs probably were doing FMP because they know the resident but was unable to explain how they can sign off that the resident received FMP without an active order.

On 4/6/21 at 1:05 PM, the surveyor interviewed the Director of the Rehab who stated that when the resident was screened by therapy on [redacted] the therapist didn't realize that Resident #73 was re-admitted to the facility. The therapist did not write a recommendation to continue FMP and thought it would have carried over. The Head of Rehab stated that the discontinuation of FMP was a result of lack of communication between Rehab and Nursing.

On 4/8/21 at 12:30 PM, the surveyor interviewed the DON who stated that there is no new order for FMP because the resident will need to be re-screened by the therapy department before a new order for FMP can be written.

A review of the facility's policy for Functional Maintenance Program provided by the DON with a reviewed date of 6/1/20 included "1. After completion of rehab, the rehab department will provide nursing with a FMP order for the resident. 2. Nursing will put in the order. 3. The order will appear in the TAR and the CNAs Task. 4. FMP will be done as order."

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| F 688 | Continued From page 13<br><br>On 4/7/21 at 1:39 PM, the surveyors met with the LNHA, DON, ADON and there was no additional information provided by the facility.<br><br>NJAC 8:39-27.1(a), 27.2(m) | F 688 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to a.) verify, monitor and document a resident's weights after significant weight changes, b.) consistently reassess estimated nutritional requirements in | F 692 | I. CORRECTIVE ACTION FOR THOSE AFFECTED<br>1. The Registered Dietician and the Director of Nursing reweighed resident #26 and resident's weight is currently [redacted] pounds via [redacted] Resident's | 4/30/21 |

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| F 692 | Continued From page 14<br>accordance with facility policy, and c.) modify nutritional interventions. This was identified for 1 of 7 residents reviewed for nutrition (Resident #26).<br><br>This deficient practice was evidenced by the following:<br><br>On 3/31/21 at 12:31 PM, the surveyor observed Resident #26 in bed with the head of the bed elevated. There was a [redacted] at the bedside. The resident's eyes were open but the resident did not respond to the surveyor.<br><br>A review of the Admission Record for Resident #26 revealed that he/she was initially admitted [redacted] and readmitted [redacted] with diagnoses that included [redacted] ) .<br><br>A review of an Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated [redacted]. The MDS further indicated that the resident was [redacted] pounds (Lbs), had a significant weight gain and had a [redacted] which was the sole source of [redacted] and [redacted] delivery.<br><br>A review of the Order Summary Reports reflected the following [redacted] Order's" which provide the residents nutrition: | F 692 | weight is stable.<br>2. Resident nutritional needs was reassessed by Registered Dietician.<br>3. There was no negative outcome by this deficient practice.<br>4. All of resident's lost weight were regained, and [redacted] resolved.<br>5. Registered Dietician was educated by the Director of Nursing on assessment, documentation, and reweigh.<br><br>II. ID OTHERS WITH THE POTENTIAL TO BE AFFECTED<br>ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED.<br>1. All resident weight were reviewed by Registered Dietician, and no other resident was identified<br>2. All residents' weight will be documented in resident's medical record.<br>3. Registered Dietician in-serviced nursing staff about the importance of obtaining accurate weights.<br>4. Registered Dietician and Unit Manager will oversee that weights are done and are accurate.<br><br>III. SYSTEMIC CHANGES:<br>1. New admission/readmission residents will be weighed on admission, then daily for three days, then weekly for four weeks.<br>2. Registered Dietician will check weight and all necessary recommendation will be made<br>3. Monthly weight meeting will be held and residents with unplanned weight gain, or weight loss will be discussed.<br>4. Registered Dietician and Unit | |

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| F 692 | Continued From page 15<br>[redacted]) for a [redacted] hrs which provided [redacted].<br><br>[redacted] in 24 hrs which provided [redacted].<br><br>[redacted] ml in 24 hrs which provided [redacted]<br><br>Further review of the [redacted] Order Summary Reports reflected the same [redacted] Order's continued to present.<br><br>[redacted] ml in 24 hrs which provided [redacted]<br><br>A review of the "Weights & Vitals" section in the electronic medical record revealed the following weights entered by the Registered Dietitian with calculated weight changes:<br><br>3/1/202[redacted] [redacted] Lbs<br>2/26/2021 [redacted] Lbs weight gain of [redacted] Lbs [redacted]<br>1/12/2021 [redacted] Lbs<br>12/3/2020 [redacted] Lbs<br>11/9/2020 [redacted] Lbs<br>10/14/2020 [redacted] Lbs<br>9/13/2020 [redacted] Lbs<br>9/3/2020 [redacted] Lbs<br>8/24/2020 [redacted] Lbs<br>8/3/2020 [redacted] Lbs weight loss of [redacted] Lbs [redacted])<br>7/11/2020 [redacted] Lbs weight gain of [redacted] Lbs [redacted])<br>6/6/2020 [redacted] Lbs weight loss of [redacted] Lbs [redacted]<br>5/11/2020 [redacted] Lbs weight loss of [redacted] | F 692 | Manager will write a note in resident's medical record.<br><br>IV. MONITORING:<br>1. Registered Dietician will reviewed all new admission/readmission weight and will report and discrepancy to Assistant or Nursing and Director of Nursing weekly x 4weeks<br>2. Dietician will provide a copy of her recommendation to nursing administration to make sure recommendations are carried out.<br>3. Unit Manager will notify primary care physician of any changes to resident's weight<br>4. Registered Dietician will notify families or responsible party.<br>5. Residents on weekly weights will be reviewed weekly during clinical meeting by the clinical team. The outcome of the audits will be reported to the Administrator and the QAPI Committee monthly for further review and discussion. | |

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| F 692 | Continued From page 16<br>Lbs [redacted]<br>4/29/2020 [redacted] Lbs<br><br>There was no documented evidence of reweighs or weekly weights to verify the accuracy of the gains and losses<br><br>A review of the RD's nutrition notes reflected the following:<br><br>[redacted]: Readmission note indicated a [redacted] hospital weight of [redacted] Lbs and did not reflect a readmission weight nor a significant weight loss. The note acknowledged the resident had a pressure ulcer that increased his/her nutritional needs. Based on this information the RD reassessed the resident's nutritional needs to be [redacted] of body weight); [redacted] The resident did not eat anything [redacted] The RD indicated that she recommended to increase the formula to [redacted] which would have provided [redacted] and [redacted]<br><br>[redacted]: Late entry note acknowledged a significant weight loss after hospitalization of [redacted] Lbs/[redacted] over a [redacted] week period, that the current [redacted] order was inadequate to meet the residents nutritional needs and recommended an increase to [redacted] with a [redacted] as stated in the [redacted] note. There was no evidence of the RD reassessing the resident's nutritional needs after acknowledging a significant weight loss.<br><br>[redacted]: Weight note reflected a significant weight | F 692 | | |

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loss of [redacted] over a [redacted] period noting a [redacted] weight of [redacted] Lbs. The RD indicated that the resident had increased nutritional needs due to [redacted]. Based on this information the RD reassessed the resident's nutritional needs to be [redacted]). The [redacted] order remained [redacted] which provided [redacted]. The RD did not recommend any further interventions or modifications of existing interventions.

[redacted]: Weight follow-up note reflected a significant weight gain of [redacted] over a [redacted]-day period noting a [redacted] Lbs. There was no evidence of the RD reassessing the resident's nutritional needs after acknowledging a significant weight gain. The RD again acknowledged that the resident had increased nutritional needs due to [redacted] and the [redacted] remained [redacted] which provided [redacted]. The RD further indicated that there were no additional nutritional needs identified at that time.

[redacted]: [redacted] nutrition review and weight note reflected a significant weight loss of [redacted] over a [redacted]-day period and a current weight of [redacted] Lbs. There was no evidence of the RD reassessing the resident's nutritional needs after acknowledging a significant weight loss. The RD again acknowledged that the resident had increased nutritional needs due to [redacted] and the [redacted] remained [redacted] which provided [redacted] and [redacted]. The RD further indicated that there were no additional nutritional needs identified at that time.

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| F 692 | Continued From page 18<br><br>From [redacted] through [redacted], the residents weights were stable and ranged from [redacted] Lbs. The [redacted] weight was noted to be [redacted] Lbs.<br><br>[redacted]: Annual note reflected a significant weight gain of [redacted] Lbs [redacted]. The RD entered a weight of [redacted] Lbs and estimated the residents nutritional needs to be [redacted]). [redacted] status remained noted and with improvement. The [redacted] order remained the [redacted] with a [redacted] which provided [redacted]<br><br>During an interview with the surveyor on [redacted] at 11:20 AM, the [redacted] floor Registered Nurse/Unit Manager (RN/UM) stated that she was not aware that Resident #26 experienced significant weight changes. The surveyor and RN/UM reviewed the weights documented in the electronic medical record. She further stated that the RD entered the weights and had not notified her of the weight changes we reviewed. The RN/UM further stated that the resident had a history of [redacted] to the [redacted] and that his/her [redacted] were almost healed.<br><br>During an interview with the surveyor on 4/07/21 at 1:21 PM, in the presence of the Director of Nursing (DON) and the survey team, the RD stated that Resident #26 had been meeting his/her nutritional needs due to guaranteed nutrition delivery via the [redacted]. She further stated that she kept track of resident weights, including reweighs and weekly weights but on her "own papers" which she doesn't always keep. In addition, she stated that she did not enter reweighs or weekly weights in the electronic | F 692 | | |

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medical record. The RD also stated that if a reweight was done she would have documented that in her notes. She could not speak to the resident's significant weight changes at this time.

During an interview with the surveyor on 4/08/21 at 10:45 AM, and in the presence of the Licensed Nursing Home Administrator (LNHA), DON, the Assistant Director of Nursing (ADON) and two surveyors, the RD presented an undated facility policy "Guidelines for Calculating Nutrition Needs". In accordance with the policy presented, the RD stated she would calculate energy or kcal requirements for [redacted] and [redacted] for [redacted] and gave an examples of [redacted] to include medical issues and significant or insidious weight loss. She then stated that if a resident had weight loss she would start assessment for nutrition needs at [redacted] and would increase if there was further weight loss. The RD further stated that if a resident had [redacted] through [redacted], she would calculate kcal requirements at [redacted]. In addition, she stated that she would have modified nutritional interventions as needed based on the information discussed above. The surveyor reviewed the significant weight changes Resident #26 experienced and the RD's documentation in the presence of the survey and facility team. The RD could not speak to why she had not, a.) documented and could not provide evidence of reweights or weekly weights, b.) documented reassessment of kcal needs after there were significant changes in weight status and in accordance with facility policy, c.) modified the [redacted].

During an interview with the surveyor on 4/08/21 at 11:15 AM, and in the presence of the LNHA,

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DON, the RD and two surveyors, the ADON stated that weights were obtained upon admission and readmission and were taken for four weeks afterwards as well as after significant weight changes.

During an interview with the surveyor on 4/08/21 at 11:18 AM, in the presence of the LNHA, DON, the ADON and two surveyors, the RD she should have increased the residents [redacted] (kcal's) due to weight loss and increased nutritional needs due to impaired [redacted] status.

A review of the undated facility policy "Guidelines for Calculating Nutrition Needs", reflected the following:

Condition: Energy Requirements (kcal's/kg)

Normal: 25-30
Stress mild: 30-35
Stress moderate to severe: 35-45

A review of the undated facility policy "Weight Policy", reflected that as part of the assessment process each resident would be weighed upon admission and readmission. It also reflected that weekly weights would be taken per the physician or at the RD's discretion. All residents would be weighed monthly and if a weight varies by "+/- 5" Lbs from the previous months weight, the resident would be reweighed for verification. It further reflected that the RD's notes should be completed no later than the 20th of the month or five days from the date the weight was obtained. In addition, significant weight changes were defined as 5% over a 30-day period, 7.5% over a 90-day period and 10% over a 180-day period.

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| F 692 | Continued From page 21<br>A review of the undated facility job description for the "Dietitian", reflected the following:<br>The dietitian should identify dietary needs, plan and implement appropriate interventions and medical nutrition therapy for residents to help them achieve the highest levels of health, wellness and quality of life.<br>Duties and responsibilities included assess residents' anthropometric indicators (i.e. weight as a measure of health), food and nutrition intake adequacy, nutrition diagnoses with interventions, monitor progress and adjust interventions and plans of care based on required needs.<br><br>NJAC 8:39-17.1(c); 17.2 (d); 27.2 (e), (k) | F 692 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of | F 761 | | 4/30/21 |

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| F 761 | Continued From page 22<br>the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to properly label and dispose of medications in 3 of 5 medication carts and 1 of 2 medication refrigerators inspected.<br><br>This deficient practice was evidenced by the following:<br><br>On 4/6/21 at 9:00 AM, the surveyor inspected the 3rd floor low-side medication cart in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed an opened bottle of [redacted] that was not dated. The surveyor interviewed LPN #1 who stated that an opened bottle of [redacted] should have been dated.<br><br>On 4/6/21 at 9:20 AM, the surveyor inspected the [redacted] floor [redacted] medication cart in the presence of LPN #2. The surveyor observed two opened [redacted], an opened [redacted], an opened [redacted] vial, an opened [redacted] vial, and an opened bottle of [redacted]. None had been dated when opened.<br><br>The surveyor interviewed LPN #2 who stated that all the opened medications and [redacted] listed above should have been dated when opened. LPN #2 also stated that an opened bottle of [redacted] | F 761 | I. CORRECTIVE ACTIONS FOR THOSE AFFECTED<br>1. The undated bottle of [redacted] were disposed of accordingly.<br>2. The two opened [redacted] that were not dated were also removed from the med cart and was disposed of accordingly.<br>3. The expired [redacted] suspension, which the resident was no longer on was removed from the fridge and disposed of accordingly<br>4. The undated [redacted] were removed from the med cart and were disposed of accordingly.<br>5. The medications were reordered and were delivered to the facility STAT<br><br>II. ID OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents who are on [redacted], and have medication have the potential to be affected.<br>1. Primary nurses checked all med carts with Unit Managers to see if there were any unlabeled medications, there was none found.<br>2. Nurses and unit managers checked all med carts and refrigerators to see if there were any other expired medication, there was none found | |

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| F 761 | Continued From page 23<br>[redacted] and an opened [redacted] should have been dated.<br><br>On 4/6/21 at 9:45 AM, the surveyor inspected the [redacted] floor medication refrigerator in the presence of LPN #3. The surveyor observed two bottles of [redacted] suspension that had an expiration date of 4/5/21 and was still stored in the medication refrigerator. The surveyor interviewed LPN #3 who stated that the medication was discontinued and should have been removed from the refrigerator.<br><br>On 4/6/21 at 10:00 AM, the surveyor inspected the [redacted] floor [redacted] medication cart in the presence of LPN #4. The surveyor observed an opened bottle of [redacted] that was not dated. The surveyor interviewed LPN #4 who stated that an opened bottle of [redacted] should have been dated.<br><br>A review of the Manufacturer's Specifications for the above medications indicated the following:<br><br>1. [redacted], once opened, had an expiration date of 90-days.<br>2. [redacted] vial, once opened, had an expiration date of 28-days.<br>3. [redacted], once opened, had an expiration date of 42-days.<br>4. [redacted], once opened, had an expiration date of 42-days.<br>5. [redacted] vial, once opened, had an expiration date of 28-days.<br><br>A review of the facility's policy titled Medication Labeling, Storage and Distribution following under 10. "All medications dispensed and or provided | F 761 | 3. In-serviced nurses on dating [redacted] vials and bag with the open date and the expiration date immediately a new vial is open.<br>4. In serviced nurses on dating [redacted] immediately, they are opened, with date opened.<br>5. In-serviced nurses on dating [redacted] by using a tape to write the open and expired date.<br><br>III. SYSTEMIC CHANGES:<br>1. Nurses will audit med carts daily and report findings to Unit Managers, and Supervisors x 90 days.<br>2. Unit Managers will audit the med carts weekly and report findings to Assistant Director of Nursing and Director of Nursing x 90 days.<br>3. Assistant Director of Nursing and Director of nursing will audit med carts bi-weekly and report findings to Administrator x 90 days<br>4. Pharmacy Consultant will audit med carts monthly and report findings to Director of nursing and Administrator.<br>5. Individual in-service will be done with nurses<br><br>IV. MONITORING:<br>1. The Unit Managers will report their audit findings to Assistant Director of Nursing and Director of Nursing on issues found when med carts are checked.<br>2. Assistant Director of Nursing and Director of Nursing will report trends and interventions to Administrator and Quality Assurance Committee meeting monthly. | |

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| F 761 | Continued From page 24<br>by the Provider Pharmacy will have expiration date in accordance with all federal and state regulations and discarded as per manufactures recommendation."<br>"a. Staff will check to ensure no expired medications are in their carts."<br>"b. Expired medications will be removed and discarded." | F 761 | | |
| F 804 SS=E | NJAC: 8:39-29.4 (a) (h) (d)<br>Nutritive Value/Appear, Palatable/Prefer Temp<br>CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of cold food and drink served to the residents. This deficient practice was identified for 5 of 5 residents interviewed during the Resident Council meeting and confirmed during the lunchtime meal service on 4/7/21 for 2 of 2 nursing units tested for food temperatures by four surveyors and was evidenced by the following: | F 804 | I. CORRECTIVE ACTION<br>All cold items will be placed in the freezer 45 minutes before the line begins and then it will be kept on ice on the tray line.<br><br>II. OTHERS WITH POTENTAIL TO BE AFFECTED<br><br>All residents and other staff have the potential to be affected. The Food Service director with the dietician have completed a comprehensive inspection of all cold | 4/29/21 |

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| F 804 | Continued From page 25<br>On 4/01/21 at 10:33 AM, the surveyor met with the residents for council meeting.<br>five out of five residents stated that they were displeased with food temperatures and that cold food items were not consistently served cold enough.<br><br>On 4/7/21 at 10:30 AM, the surveyors calibrated four thermometers in ice water to 32 degrees Fahrenheit (F) in the presence of the team coordinator.<br><br>On 4/7/21 at 11:25 AM, Surveyor #1 observed food [redacted] arrive on the [redacted] floor. The surveyor observed that Certified Nursing Assistants (CNA) began to delivery meal trays to residents at 11:30 AM. After the last meal tray was delivered to a resident at 11:46 AM, the surveyor took the temperatures of the following items (regular consistency) in the presence of CNA #1:<br><br>4-ounce (oz) cup of creamy coleslaw 53.1 degrees F<br>4 oz cup of peach cobbler 63.9 degrees F<br>4 oz container of whole milk 52.1 degrees F<br><br>On 4/7/21 at 11:35 AM, Surveyor #2 observed food [redacted] arrive on the [redacted] floor. The surveyor observed that Certified Nursing Assistants (CNA) began to delivery meal trays to residents. After the last meal tray was delivered to a resident at 11:45 AM, the surveyor took the temperatures of the following items (regular consistency):<br><br>4 oz cup of creamy coleslaw 59.2 degrees F<br>4 oz cup of chilled peaches 62.9 | F 804 | items in the kitchen to make sure all cold food items are delivered to the residents at the proper temperature and to ensure all policies and procedures are properly being adhered to.<br><br>III. SYSTEMATIC CHANGES<br>In service was done with the Director, supervisor and cooks to ensure that all temperatures are being logged properly and that all cold food items proper temperatures are being maintained.<br><br>IV. MONITORING<br>The Food service director will do daily monitoring for 4 weeks to ensure proper temps on all food items are being done. The food service director will be responsible to report his findings to the administrator weekly for 4 weeks, then bi weekly for a quarter or until 100% compliance is met. The FSD will report all findings and reports to the Administrator and Quality Assurance Committee and the Quarterly QA.<br><br>The Food Service Director will be responsible for the ultimate completion of education, accuracy of the audits and the overall compliance of the plan of correction | |

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| F 804 | Continued From page 26 | F 804 | | |

degrees F
4 oz container of whole milk 51.9 degrees F
4 oz container of diet ice cream 32 degrees F (soft to touch)

On 4/7/21 at 11:51 AM, surveyor #3 and #4 observed food truck ([redacted] arrive on the fourth floor. The surveyors observed that Certified Nursing Assistants (CNA) began to delivery meal trays to residents at 11:53 AM. After the last meal tray was delivered to a resident at 12:00 PM, the surveyors took the temperatures of the following items (regular consistency):

4 oz cup of creamy coleslaw 54 degrees F
4 oz cup of chilled peaches 53 degrees F
8 oz container of whole milk 45 degrees F
4 oz container of apple juice 48 degrees F

On 4/7/21 at 12:02 PM, Surveyors #3 and #4 observed food [redacted] arrive at on the [redacted] floor. The surveyors observed that Certified Nursing Assistants (CNA) began to delivery meal trays to residents at 12:03 AM. At that same time, they took the temperatures of the following items (regular consistency):

4 oz cup of creamy coleslaw 52 degrees F
4 oz cup of chilled peaches 57 degrees F
4 oz container of whole milk 42 degrees

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| F 804 | Continued From page 27 F | F 804 | | |

On 4/07/21 at 12:24 PM, the surveyor requested today's tray line temperature log from the Food Service Director (FSD). There was no documented evidence that temperatures were taken and monitored for any of the cold food/fluid items for the lunch meal. The surveyor interviewed the cook that served lunch that day. He stated that he only took and documented the hot food items at 11:20 AM. The FSD stated that the Registered Dietitian (RD) took the temperatures of cold foods (I.e. milk, juice, Cole slaw and dessert) in his and the FSD's presence before the lunch meal. The FSD acknowledged that none of these items were documented on the "Daily Food Temperatures" form. He stated that the "kitchen got busy and they never logged the temps". The FSD acknowledged and stated that he could not ensure that the cold food items were held at proper temperatures in the kitchen to ensure they were not in the danger zone (41-135 degrees F).

On 4/07/21 at 1:04 PM, the surveyor interviewed the RD in the presence of the survey team and the Director of Nursing (DON). She stated that before the lunch meal was served, she observed the FSD take the temperatures of the cold food/fluids and acknowledged that he had not document them on the temperature log. The RD stated that the FSD should have documented the temperatures for accountability and to ensure the items were held at safe temperatures. She further stated, "if it's not documented, it's not done".

A review of the facility document "Daily Food Temperatures", the temperatures for the vegetable, dessert, milk, juice and other were not

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recorded. There were guidelines for acceptable cold item temperatures, however this information had been cut off the form.

A review of the facility policy "Food Preparation" signed 4/2/21, reflected that cold foods should be maintained at a temperature of 40 degrees F or below.

A review of the undated facility job description for the "Food Service Director", reflected the following:
The FSD was responsible for coordinating quality food service and overseeing all phases of food production, service, sanitation and safety.
The FSD was responsible to oversee supervisors, production staff and food service workers.
The FSD's duties and responsibilities included ensuring menus adhere to standards including safety and palatability; and oversees that food was served at appropriate temperatures.

Review of the undated facility job description for the "Food Service Supervisor",reflected the following:
The FSS was responsible for coordinating quality food service, including sanitation and safety with the goal to provide excellence in quality food service.
The FSS's duties and responsibilities included ensuring completion and accuracy of required records and reports; records daily temperatures; and to ensure proper standards of safety and sanitation were maintained.

Review of the undated facility job description for the "Cook" , reflected the following:
The Cook's duties and responsibilities included to obey and enforce all safety and sanitation

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| F 804 | Continued From page 29<br>regulations.<br><br>Review of the undated facility job description for the "Food Service Worker", reflected the following:<br>The food service worker was supervised by the FSD or the FSS.<br>The food service workers were responsible to provide quality meal service; maintain sanitation and safety standards in the kitchen, as well as recognize and use safe food handling practices.<br><br>NJAC 8:39-17.4(e) | F 804 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and review of | F 812 | I. CORRECTIVE ACTION | 5/15/21 |

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documentation provided by the facility, it was determined that the facility failed to maintain proper kitchen sanitation practices and properly label, date and store potentially hazardous foods in a safe and sanitary environment to prevent the development of food borne illness. This deficient practice was evidenced by the following:

On 3/30/21 at 9:36 AM, during a tour with the Food Service Director (FSD) the surveyor observed the following:

The diamond plate (a steel or stainless steel non porous metal of industrial strength) was pulled away from the wall behind the handwashing sink which exposed the damaged wall.

In the walk-in refrigerator the following was observed:

There were multiple closed cases of 4-ounce health shakes that had received dates but no thaw dates including an opened case which had a variety of 4-ounce health shakes which were not individually labeled. The FSD stated the cases were pulled from the freezer yesterday but stated unless a pull or thaw date was indicated on the case he could not be sure how long the health shakes were good for because they were only good for 14 days once thawed.

There were two opened - five-pound packages of sliced American cheese that had a received date of 3/24/21 but no open date. The FSD stated that the cheese was good for seven days once opened but could not be sure if the cheese was still good since there was no open date.

There were six raw eggs on an egg crate on a

A. All opened, undated, and raw food items, including but not limited to health shakes, American cheese, raw eggs, grated cheese, Italian dressing, and mayonnaise cited by the surveyor as deficient practices were immediately removed and discarded by the Food Service Director.
B. All items in the kitchen that did not have a date as to when they were received from the vendor were immediately discarded.
C. All debris found by the surveyor on the plastic storage racks, on the dollie, on the clean side of the machine, on the wall behind the machine was cleaned. New dollies were immediately purchased, and the old ones were discarded.
D. The wall behind the machine was fixed the same afternoon.
E. The two fans with a buildup of dust were immediately removed and taken out of circulation.
F. The three-door reach-in freezer, which was not operating correctly, was immediately taken out of service; all frozen products were moved to an alternate freezer. The same afternoon qualified technicians came to the facility to make the necessary repairs. The reach-in freezer was repaired and functioning on the same day.
G. Unopened bags of frozen sliced zucchini, chopped spinach, and broccoli florets did not have delivery dates and, the premade items that were undated were discarded.
H. The baffles, oven hood, steamer gasket, and lights under the hood were

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| F 812 | Continued From page 31<br>sheet pan stored on a shelf above prepared food. The FSD stated the raw eggs should not have been stored there and removed the eggs.<br><br>There was an opened five-pound bag of grated cheese with a received date of 3/24/21 with no opened date.<br><br>There was an opened 1-gallon container of Italian salad dressing with a received date of 11/25/20 with no opened date.<br><br>There was an opened 1-gallon container of mayonnaise with a received date of 3/23/21 with no opened date.<br><br>There were two fan covers coated with a heavy buildup of a blackish substance. The FSD stated "its mold and needs to be cleaned".<br><br>All 12 of the refrigerator metro style plastic storage racks had a heavy buildup of debris on the top and a blackish substance on the undersides. The FSD stated the racks needed to be cleaned. He stated they were cleaned every two months and should have been cleaned as needed.<br><br>The three-door reach in freezer temperature was 15 degrees, had ice buildup by the fans and the fans were not working. The temperature log indicated the freezer was at 5 degrees Fahrenheit at 5 AM. The freezer had an opened and undated bag of stuffed shells, tater tots, and sweet potato fries. The FSD could not state when they were received nor opened and discarded the products. The surveyor observed that the freezer held premade food products and frozen vegetables which were solid to the touch. The FSD stated he | F 812 | cleaned and replaced.<br>I. The residents were served on disposable paper and utensils while the dishwasher was being repaired.<br>J. The repair company serviced the dishwasher<br>K. All dietary staff was re-educated, and re-in serviced regarding the policies and procedures for proper logging of dishwasher temps and proper machine cleaning.<br>L. The diamond plate and food debris on top of the dish machine was cleaned immediately.<br><br>II. OTHERS WITH POTENTIAL TO BE AFFECTED<br>All residents and other staff have the potential to be affected.<br>The Food Service Director, Administrator, and Dietician performed a comprehensive inspection of the whole kitchen to ensure that proper food safety, sanitation, storage, meal service, and proper temperatures are being adhered to.<br><br>III. SYSTEMATIC CHANGES<br><br>All dietary staff were re-educated, and re-in serviced regarding the policies and procedures for food safety, sanitation, storage, proper logging of temperatures, and meal service.<br><br>IV. Monitoring | |

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| F 812 | Continued From page 32<br>would move the product into the walk-in freezer and placed the reach in freezer out of order.<br><br>There were multiple undated unopened bags of frozen sliced zucchini, chopped spinach, and broccoli florets. The FSD stated that without indication of dates he could not be sure when they were received and could not effectively ensure "first in first out (FIFO)" for food quality and safety.<br><br>There were 12 baffles in the hood over the cooking equipment that had a heavy buildup of a brownish/reddish sticky substance. There were five lights not working under the hood, and the metal light covers had a black sticky fuzzy substance hanging from each of them.<br><br>The steamer gasket was in disrepair.<br><br>There were two of three dollie racks which were covered with food debris and a thick pink substance. One rack held clean mugs and cups mouth side down. The FSD removed that rack and acknowledged the dollie had debris and stated they needed to be cleaned.<br><br>There was food debris on the clean side of the stainless-steel dish machine table where the clean dishware was placed. The FSD acknowledged this and stated that area should have been clean.<br><br>There was food debris on top of the dish machine. The FSD stated that should not have been there.<br><br>There were blackish dots on the wall behind the dish machine and on the grout. The FSD stated | F 812 | The Administrator or designee will perform a weekly audit of<br>the dietary department to monitor sanitation, food safety,<br>proper logging of temperatures, storage, and meal<br>service for 3 months. The Administrator will report the outcome of the audits to the QAPI Committee for further discussion and<br>consideration monthly | |

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that "it was dust" and should not be there.

At 10:13 AM, the breakfast dishware had been cleaned. The FSD stated the dish machine was a high temperature machine and that the temperatures for the wash and rinse water should be 145 degrees and 180 degrees Fahrenheit, respectively. He then stated that the wash temperature should be 165 degrees. The FSD was unaware that the manufacturer water temperature specifications were etched on the machine which indicated that the wash temperature should be 160 degrees and the rinse temperature 180 degrees.

After the FSD made eight attempts of running dish racks through the dish machine, the temperatures were unable to reach 160 for the wash nor 180 for the rinse. The machine had a heat booster that was observed to be set at 185 degrees.

At 10:27 AM, the surveyor reviewed a black binder that had temperature logs for refrigeration and the dish machine. The log sheets were not in any order. The dish machine temperature log for March was not readily available. The FSD stated that "the logs are all mixed". The FSD found the dish machine log for March 2021 and it was reviewed with the surveyor. There was no documented evidence of the rinse temperature for the morning. In addition, the rinse temperatures recorded for breakfast, lunch, and dinner from 3/1/21 through 3/29/21 were between 170-174 degrees. The FSD could not speak to this observation and further stated that the supervisor was responsible for monitoring this process and that he should have monitored her. The FSD stated that he was ultimately

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responsible to ensure the dish machine was working properly and that the correct temperatures were logged. The FSD stated that going forward until the dish machine could be fixed the residents meals would be served with disposable dishware and silverware.

During an interview with the surveyor on 3/30/21 at 10:35 AM, Dietary Aide (DA) #1 stated that he did not know and was not trained as to what the temperatures were supposed to be for the wash and rinse on the dish machine. He further stated that he did not monitor temperatures and was never told to document the temperatures on a log/form.

During an interview with surveyor on 3/30/21 at 10:35 AM, DA #2 stated that a former employee trained him and that the wash temperature should be 145 degrees and 180 degrees for the rinse temperature. He further stated that he was never instructed to document the temperatures on a log/form. In addition, DA #2 stated that he could not recall the last time he received training as to how to use the dish machine.

During an interview with surveyor on 3/30/21 at 10:41 AM, the FSD stated that he had trained DA #1 and #2 on the dish machine process but could not recall when. He could not produce any documentation to verify said training. He further stated that they should have known the correct dish machine temperatures and to document the temperatures on the log/form. The FSD stated that their chemical company recently serviced the dish machine when the new heat booster was installed.

During an interview with surveyor on 3/30/21 at

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10:42 AM, the Food Service Supervisor (FSS) stated that the temperatures for the wash and rinse water should be 145 degrees and 180 degrees Fahrenheit, respectively. She then stated that the wash temperature should be 165 degrees. The FSS stated that she had trained DA #2 on the dish machine process but could not recall when. She could not produce any documentation to verify said training.

On 3/31/21 at 10:39 AM in the presence of the surveyor, the FSD, and Director of Maintenance, the Licensed Nursing Home Administrator (LNHA) observed the dish machine running, however, the wash temperature did not reach 160 degrees and the rinse temperature did not reach 180 degrees. This observation was after the dish machine received service and the heat booster was set to 192 degrees. The dish machine had not been used for china and reusable dishware and silverware; the residents still received disposable items for their meals and snacks.

A review of the facility policy "Preventing Cross Contamination" dated 4/2/21, reflected that raw foods should be stored separately from ready to eat foods. It further reflected that ready to eat foods should be stored above raw foods. In addition, the document reflected that employees should be educated in preventing cross contamination.

A review of the facility policy "First-In First-Out" signed 4/2/21, reflected that all foods will be labeled and dated upon receipt. It further reflected that items opened that will be reused will be dated upon opening for first use. In addition, the document reflected that food items with the oldest received date would be used first and that

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stock would be rotated daily to ensure older food items were most easily accessible.

A review of the facility policy "Receiving" signed 4/2/21, reflected that all incoming cases of items shall be dated by the person receiving them to ensure first in /first out rotation.

A review of the facility policy "Storage - Refrigeration and Freezers" signed 4/2/21, reflected that the goal was to provide safe and sanitary storage of food items received to provide the safest, freshest and most palatable meals possible to the residents. It further reflected that frozen storage should be maintained below 0 degrees Fahrenheit and that the first-in, first-out system for stock rotation should be observed. In addition, the document reflected that containers of food should be stored on clean shelves and racks in a manner protected from contamination.

A review of the facility policy "Cleaning and Sanitizing" signed 4/2/21, reflected that the goal was to provide a safe and sanitary kitchen environment to provide the safest and freshest food possible. It further reflected that cleaning and sanitizing of the Food Service department was conducted on a routine basis to reduce the risk of foodborne illness. In addition, the document reflected that cleaning removed visible solids and sanitizing reduced pathogens to safe levels. The policy indicated that walk-in refrigerators were to be cleaned and sanitized daily, that walk and roll refrigerator interiors were to be cleaned and sanitized weekly and that the hood was to be cleaned and sanitized monthly.

A review of the facility "Daily Dietary Cleaning List P.M." dated 3/27/21, reflected that the "Pot

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washer" position was responsible for cleaning the dish machine; however, the task was not initialed to indicate completion. There was also no indication that a staff member was assigned to the "Special Cleaning" task for "Oven Hoods & Vents" and subsequently, no initialization that the task was completed.

A review of the undated facility policy "Proper Dishroom and Sanitizing Procedures", reflected the following procedures:
Know and be aware of dishwasher temperatures.
Temperature logs should be kept at the dish machine.
Temperatures will be recorded prior to using the dish machine.
The wash temperature should be 160 degrees.
The rinse temperature should be 180 degrees.
When finished, the dish washer screens, wash arms, nozzles and walls should be scrubbed with detergent.

A review of the undated facility job description for the "Food Service Director", reflected the following:
The FSD was responsible for coordinating quality food service and overseeing all phases of food production, service, sanitation and safety.
The FSD was responsible to oversee supervisors, production staff and food service workers.
The FSD's duties and responsibilities included daily operations, oversees delivery of food and sanitation of the kitchen.

A review of the undated facility job description for the "Food Service Supervisor", reflected the following:
The FSS was responsible for coordinating quality food service, including sanitation and safety.

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| F 812 | Continued From page 38<br>The FSS's duties and responsibilities included ensuring completion and accuracy of required records and reports; records daily temperatures; ensures proper standards of safety and sanitation were maintained; oversees and/or maintains temperature and inspection logs; conducts inspection rounds as required; oversees cleaning and sanitation of refrigerators and oversees cleaning of walls behind equipment.<br><br>A review of the undated facility job description for the "Cook" , reflected the following:<br>The Cook's duties and responsibilities included to obey and enforce all safety and sanitation regulations; cleans all equipment that was used; cleans and sanitizes all refrigerators; and cleans walls behind equipment.<br><br>A review of the undated facility job description for the "Food Service Worker", reflected the following:<br>The food service worker was supervised by the FSD or the FSS.<br>The food service workers were responsible to maintain sanitation and safety standards in the kitchen, as well as recognize and use safe food handling practices.<br><br>NJAC 8:39-17.1(a);17.2(g) | F 812 | | |
| F 842 SS=B | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent | F 842 | | 4/30/21 |

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agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained

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| F 842 | Continued From page 40<br>for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to maintain complete, accurate, and readily accessible medical records (monthly Physician Progress notes from [redacted] until [redacted]). This deficient practice was identified for 1 of 23 residents reviewed, Resident #20, and was evidenced by the following:<br><br>This deficient practice was evidenced by the following:<br><br>On 3/30/21 at 10:52 AM, during the tour, the surveyor observed Resident #20 seated in a wheelchair watching television. The surveyor attempted to interview the resident. The resident refused an interview. | F 842 | I. CORRECTIVE ACTIONS FOR THOSE AFFECTED:<br>1. The physician assigned to resident #20 was called and he brought in all the notes<br>2. Notes were filed in resident's chart<br>3. There was no negative outcome to resident #20 from this deficient practice<br>4. Nurses were in-service that Director of Nursing and Assistant Director of Nursing must be notified when physicians are not documenting<br><br>II. ID OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED<br>1. All residents charts were audited for | |

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| F 842 | Continued From page 41<br><br>A review of the resident's Face sheet (an admission summary), disclosed that the resident had diagnoses that included, [redacted].<br><br>A review of the Quarterly Minimum Data Set (QMDS) assessment tool used to facilitate care management dated [redacted], indicated a Brief Interview for Mental Status (BIMS) scored at [redacted], which indicated that the resident had [redacted].<br><br>On 3/31/21 at 10:00 AM, the surveyor reviewed Resident #20's electronic medical record which revealed they were no monthly physician progress notes in the electronic medical record. A Nurses Note from [redacted] at 12:59 PM, revealed that the physician visited the resident and had no new orders.<br><br>On 3/31/21 at 10:30 AM, the surveyor reviewed Resident #20's medical chart which revealed the last monthly Physician Progress Notes (PPN) in the chart was from [redacted]. The medical chart also revealed that the physician signed the monthly physician orders, responded to the Consultant pharmacist recommendations, the physician asked for a [redacted] evaluation to discontinue [redacted] and an order for the resident to be seen by the [redacted] to have a [redacted].<br><br>On 3/31/21 at 11:30 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that since the pandemic that Resident | F 842 | any missing physician progress notes and none were identified.<br>2. Nurses were in-serviced on calling physicians and asking them for their notes.<br>3. Electronic medical record access and training provided to physicians.<br><br>III. SYSTEMIC CHANGES:<br>1. Unit managers will audit specific physician's chart weekly for missing documentation and will notify Assistant Director of Nursing and Director of Nursing x 90days.<br>2. Unit managers will audit resident's chart as they are coming up for quarterly review for any missing physician's documentation.<br>3. Assistant Director of Nursing and Director of Nursing will audit charts of specific physician's progress notes, and signatures bi-weekly x 90days.<br>4. Physician will be called and notified if any documentation is missing by Director of Nursing or Administrator.<br><br>IV. MONITORING<br>1. The unit manager will audit resident's chart of specific physician for missing documentation weekly and report findings to Assistant Director of Nursing and Director of Nursing.<br>2. Assistant Director of Nursing and Director of Nursing will audit residents chart bi-weekly and will report findings to Administrator and Quality Assurance Committee monthly. | |

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#20's physician has been using Telemedicine (Face-Time medical visits). The surveyor asked the ADON if she can supply him with all the monthly PPN's.

On 4/1/21 at 9:00 AM, the ADON provided the surveyor with a monthly PPN dated [redacted] and stated that Resident #20's physician will be sending all of the resident's monthly PPN which are stored in his laptop.

On 4/1/21 at 11:35 AM, the surveyor in the presence of a third floor Registered Nurse (RN) reviewed Resident #20's medical chart which revealed the last monthly PPN was from [redacted].

On 4/1/21 at 11:42 AM, the surveyor interviewed the RN who stated that Resident #20 was seen by the physician, but he usually comes in the off hours when she's not working. The RN stated that the physician will call the nurse if he wants to order a new medication, lab or if the resident needs an evaluation. The RN stated that there is good communication between the physician and the nursing staff.

On 4/1/21 at 2:30 PM, the surveyor interviewed the Director of Nursing (DON), Administrator and ADON who stated that the physician comes to the facility too see the resident and will enter his progress notes in his laptop. The DON did not now why the progress notes were not in the medical record which included the electronic and paper medical record. She told the surveyor that the physician will provide the facility all the progress notes from [redacted] till [redacted] They also presented the surveyor with a Quality Assurance and Performance Improvement (QAPI) which addressed issues

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| F 842 | Continued From page 43<br>with physician not leaving medical information in the chart which included Resident #20's physician.<br><br>On 4/6/21 at 9:30 AM, the surveyor reviewed Resident #20's medical chart which revealed that all missing PPN's were added to the chart.<br><br>A review of the facility's policy titled Physician Services Policy and Procedures under II. "Physician Visits. The physician must: B. Write, sign and date progress notes at each visit."<br><br>NJAC 8:39-35.2 (d)(5) | F 842 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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 | F 880 | | 5/31/21 |

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| F 880 | Continued From page 44 | F 880 | | |

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
(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

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| F 880 | Continued From page 45<br>infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to: a) to follow transmission-based precautions (TBP) for 1 of 2, Resident #3 reviewed for infection; b.) follow appropriate infection control practices during the wound treatment observation for 1 of 1, Resident #49 to prevent the spread of infection; c.) ensure designated containers to dispose personal protective equipment (PPE) were inside 5 of 9 PUI rooms; d.) ensure PPE was discarded in accordance with nationally accepted guidelines for infection prevention and control; e.) perform hand hygiene according to CDC and facility guidelines; f.) ensure TBP signs were posted for 9 of 9 rooms on the person under investigation (PUI) unit and f.) ensure transport personal wore the appropriate PPE on the PUI unit.<br><br>This deficient practice was evidenced by the following:<br><br>According to the U.S. CDC guidelines Precautions to Prevent Transmission of Infectious Agents, page last reviewed 7/22/19 included "Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient of patient's environment as described in 1.B.3.a. Contact Precautions also apply where the presence of excessive wound drainage, fecal | F 880 | 1. Isolation sign and personal protective equipment (PPE) box was placed outside of residents #3 door alerting staff.<br>2. Staff were in-serviced about the contact precaution.<br>3. Licensed Practical Nurse and Certified Nurse□s Assistant were rein-serviced about the correct way to do hand washing by Infection Preventionist.<br>4. Handwashing competency/in-service weekly.<br>5. Monthly treatment pass by Infection Preventionist.<br>6. Each Patient on the Patient under Observation (PUI) were provided with a PPE bin in front of each door.<br>7. A PPE disposal trash bin was placed inside of each room.<br>8. Housekeeper was in-serviced through a translator on importance of hand hygiene, donning and duffing of PPE.<br>9. Transmission Based Precaution sign were placed at each door.<br>10. A sign was placed at the nurses station alerting everyone that came on the unit about the PUI unit.<br>11. N95 mask and face shield were provided at the front desk for transporters/ or anyone going to the PUI unit<br><br>ll. ID OTHERS WITH THE POTENTIAL TO BE AFFECTED | |

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| F 880 | Continued From page 46<br>incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination.<br><br>According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. Immediately after glove removal." It further specified the procedure for hand hygiene which included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times."<br><br>1.On 3/30/21 at 10:00 AM, the Registered Nurse/Unit Manager#1 (RN/UM#1) informed the | F 880 | ALL RESIDENTS, STAFF, AND TRANSPORTERS HAVE THE POTENTIAL TO BE AFFECTED.<br><br>III. SYSTEMIC CHANGES:<br>1. Prior to receiving an admission that will be in the PUI unit, housekeeping or designee will set up the room with a PPE bin in front of the room and transmission based sign at the door.<br>2. Infection Control Preventionist will in-service nurses to read the lab results entirely and follow all necessary precaution recommended.<br>3. Nurses will be in-service on reading lab results and follow appropriate isolation as recommended.<br>4. Unit Manager will bring copy of lab result to clinical meeting for review.<br>5. One to one re-education done with staff on hand hygiene<br>6. Prior to an admission/readmission housekeeper or designee will place a disposal bin in the room for PPE disposal.<br>6. One to one education with housekeeper through an interpreter with return demonstration.<br>7. Nurses will be in-service about placing appropriate transmission based precaution sign at the door of any resident that is on isolation.<br>8. In-serviced receptionist to inform anyone going to the [redacted] floor that the PUI unit is on that floor.<br>9. Log for N95, and face shield placed at receptionist desk for anyone going to the PUI unit to sign that they received proper PPE.<br>Directed Plan of Correction was | |

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| F 880 | Continued From page 47<br>surveyor that there were no residents on the [redacted] floor that were currently on isolation or precaution. RN/UM #1 stated that Resident #3 was [redacted] with some [redacted] and had a [redacted].<br><br>On that same date at 10:29 AM, the surveyor toured with the RN/UM #1, and both observed the resident asleep with [redacted] dressing intact. There was a [redacted] hung on a pole and dated today. The RN/UM#1 stated, "I forgot to mention that the resident was on [redacted] infection."<br><br>Furthermore, the RN/UM#1 stated that she "forgot" what kind of infection and that she will get back to the surveyor. There was no isolation sign and PPE box outside the resident's room.<br><br>A review of the resident's Face Sheet (an admission summary), indicated that the resident had diagnoses that included, [redacted]).<br><br>A review of the 2/18/21 Comprehensive/Minimum Data Set (C/MDS), an assessment tool used to facilitate the management of care, revealed a Brief Interview for Mental Status (BIMS) score of | F 880 | completed with Root Cause Analysis and in-services on [redacted]. It has been identified through the root cause analysis performed by the Director of Nursing and Assistant Director/Infection Preventionist and the QAPI team that although the staff involved in the deficient practice were in-serviced multiple times on proper hand hygiene, they stated that when they were being observed directly by the surveyor, they got confused or nervous thus making a mistake. Most of the staff stated that they know how to properly wash their hands. The topline staff listed below and Infection Preventionist completed recommended training,<br>ADMINSTRATOR<br>DIRECTOR OF NURSING<br>ASSISTANT DIRECTOR OF NURSING/INFECTION PREVENTIONIST<br>DIRECTOR OF SOCIAL SERVICES<br>SOCIAL WORKER<br>DIRECTOR OF ADMISSIONS<br>BUSINESS OFFICE MANAGER<br>MDS COORDINATOR<br>DIRECTOR OF ACTIVITY<br>FOOD SERVICE DIRECTOR<br>MAINTENANCE DIRECTOR<br>ASSISTANT DIRECTOR OF MAINTENANCE<br>HOUSEKEEPING DIRECTOR<br>UNIT MANAGER<br>REGISTERED DIETICIAN<br>DIRECTOR OF REHAB<br><br>Nursing Home Infection Preventionist Training Course Module 1- Infection Prevention and Control Program on: https://www. | |

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| F 880 | Continued From page 48<br>[redacted] which indicated that the resident's cognition was [redacted]<br><br>A review of the [redacted] laboratory report was positive for the [redacted]) and contact precautions were indicated.<br><br>A review of the [redacted] Order Summary Report (OSR) did not include an order for contact precaution.<br><br>Further review of the [redacted] OSR revealed orders dated [redacted] 1 for the [redacted] s [redacted] every [redacted] hours (hrs) and [redacted] every [redacted] hrs for [redacted] days for [redacted] infection. There was an order for the [redacted] milligram 1 tablet twice a day for [redacted] infection that had been discontinued on 3/18/21.<br><br>On 3/31/21 at 11:18 AM, the surveyor and the Licensed Practical Nurse#1 (LPN#1) went to the resident's room. There was no contact precaution sign and PPE box outside the room. LPN#1 informed the surveyor that Resident #3 had an [redacted] in the [redacted] and was currently treated with an [redacted]. LPN#1 stated that even though [redacted] was considered a contact precaution, it does not apply to [redacted] in the [redacted] that was why there was no contact precaution sign and PPE box outside the resident's room.<br><br>On that same date and time, the LPN stated that contact precaution [redacted] "only applies" to [redacted]. She further stated that staff does not need to wear an isolation gown when caring for a resident because [redacted] infection was | F 880 | train.org/main/course/1081350.<br>All Full-Time and Part-Time staff including topline staff completed the Nursing Home Infection Preventionist Training Course Module 6a- Principles of Standard Precautions. Anticipated Completion date is May 31 2021.<br>All Full-Time and Part-Time staff including topline staff completed the Nursing Home Infection Preventionist Training Course Module 6b - Principles of Transmission Based Precautions<br>Per Diem staff are going through the education as they are scheduled for work. Anticipated Completion date is May 31, 2021.<br>In-service on hand hygiene was completed on individuals who were deficient in their practice during Survey.<br><br>IV. MONITORING:<br>1. Infection Preventionist/Designee will be responsible for the following monitoring measures:<br><br>a. Five (5) Transmission-Based Precaution (TBP) room assessments will be conducted weekly x4 weeks, and monthly x2 months thereafter to ensure that:<br>" A clean PPE cart/bin is located outside resident room<br>" A soiled PPE bin is located inside resident room<br>" Appropriate Transmission-Based Precaution (TDP) signage is posted on/outside resident room<br>2. Infection Control Preventionist/Designee will check lab | |

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| F 880 | Continued From page 49<br>in the resident's [redacted].<br><br>On 3/31/21 at 12:58 PM, the Infectious Disease Doctor (IDD) called back and informed the surveyor that Resident #3 should be on contact precaution for positive [redacted] in the [redacted] and "the facility should know better" to use proper PPE i.e. isolation gown, gloves when caring for the resident and before entry to the room. He further stated that "I was on assumption" that the facility was following the contact precaution "already."<br><br>On 3/31/21 at 2:00 PM the surveyors met with the Licensed Nursing Home Administration (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), and made aware of the above concerns.<br><br>On 4/1/21 at 2:15 PM, the DON informed the surveyors in the presence of the LNHA and ADON that "we should have called and confirmed with the doctor the order for isolation" when the nurse relayed the lab results reported on [redacted] for positive [redacted]. The DON stated that there should have a contact precaution sign and PPE box outside the resident's door.<br><br>On 4/7/21 at 1:39 PM, the surveyors met with the LNHA, DON, ADON, and there was no additional information provided by the facility.<br><br>2. On 3/30/21 at 10:00 AM, the RN/UM informed the surveyor that Resident #49 had a facility acquired "[redacted] and was currently on [redacted] for an infection in the | F 880 | results of residents started on [redacted] to ensure all necessary transmission based precaution are in place, and to include appropriate signage is posted on or near resident door weekly x4 weeks, and monthly x2 months thereafter.<br>3. Infection Control Preventionist/Designee will conduct (10) random health-care personnel hand hygiene competency weekly x4 weeks, and monthly x2 months thereafter.<br>4. Infection Control Preventionist/Designee will conduct (5) random audits of employees weekly x4 weeks, and monthly x 2 months thereafter for compliance with use of the N95.<br><br>5. Negative findings will be reported to the DON and/or Administrator immediately for further education, competency and/or disciplinary action leading up to and including termination, as applicable. All findings will be reported in the monthly Quality Assurance meeting. | |

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A review of the lab results report date of [redacted] showed a [redacted] identification of [redacted] is a [redacted] contamination.

A review of the [redacted] OSR showed an order dated [redacted] for the [redacted] suspension, give [redacted] mg by mouth [redacted] times a day for [redacted] days to treat the [redacted] infection

During the wound treatment observation on 3/31/21 at 10:26 AM, the surveyor observed LPN#1 and the Certified Nursing Aide#1 (CNA#1) wearing a mask and gloves. Both LPN#1 and the CNA#1 were not wearing an isolation gown. CNA#1 performed handwashing under the stream of running water. Later on, during the wound treatment, the surveyor observed CNA#1 performed handwashing twice for 13 and 8 seconds respectively.

On that same date and time, LPN#1 removed the old dressing, did not perform handwashing after removing the contaminated gloves, immediately went to her treatment cart to get an adhesive dressing, dated the dressing with a pen that she took from her uniform pocket.

Then LPN#1 performed handwashing, put on gloves, cleansed and dried the [redacted] applied [redacted], and covered the [redacted] with an adhesive dressing. LPN#1 did not change gloves and or perform hand hygiene when she soiled her gloves after cleaning the wound and

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immediately applied the ointment and the clean dressing.

On that same date at 11:03 AM, LPN#1 stated "I probably forgot" to wash my hands after removing her gloves when she disposed of the old dressing to the treatment cart. LPN#1 further stated "I don't' know" when the surveyor asked LPN#1 why she did not change gloves and performed hand hygiene in between cleaning of [redacted] and applying a new dressing. CNA#1 was present and acknowledged that he observed LPN#1 did not change gloves and perform hand hygiene after soiling her gloves when she cleaned the [redacted] and when she applied a new clean dressing.

CNA #1 also stated, "I should wash my hands outside the water."

LPN#1 stated that they do not need to wear an isolation gown during wound treatment even though the resident had a [redacted] infection and currently on [redacted] treatment.

On 3/31/21 at 2:00 PM, the surveyors met with the LNHA, DON, ADON, and were made aware of the above concerns.

On 4/1/21 at 2:15 PM, the ADON in the presence of the LNHA and DON informed the surveyors that the staff was provided an in-service regarding handwashing, use of isolation gown during [redacted] treatment, and the proper wound treatment. The ADON further stated that the CNA acknowledged that he was not washing his hands appropriately during the wound observation of the surveyor. The ADON indicated that there was no negative effect on the resident and that the [redacted] was healing.

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| F 880 | Continued From page 52<br><br>On 4/7/21 at 1:39 PM, the surveyors met with the LNHA, DON, ADON, and there was no additional information provided by the facility.<br><br>3. On 3/30/21 during the entrance conference, the ADON informed the surveyor that the facility's dedicated PUI unit was on the [redacted] of the [redacted] floor. She provided the survey team with the facility's updated floor plan which indicated that rooms [redacted] through [redacted] were PUI rooms.<br><br>On 3/30/21 at 11:15 AM, the surveyor toured the dedicated PUI unit with RN/UM#2. The surveyor observed two PPE disposable trash bins in the hallway. One bin was observed in the hallway near room [redacted] and the second bin was observed in the hallway near room [redacted]. The RN/UM #2 stated that the PPE disposable trash bins should not be in the hallway and instructed CNA #2 to place them back into the rooms. Neither RN/UM #2 or CNA #2 could not speak to why the bins were in the hallway. The surveyor observed both PPE bins half filled with used yellow disposable gowns.<br><br>On that same date and time, the surveyor observed there was no designated container to dispose of PPE inside five PUI rooms (rooms [redacted], and [redacted]). The RN/UM could not speak to why those rooms had no designated containers for disposal of contaminated PPE.<br><br>4. On 3/30/21 at 11:45 AM, the surveyor observed a housekeeper in the doorway of room [redacted] remove her gloves and discard the gloves into the housekeeping trash bin. She then took off her | F 880 | | |

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yellow disposable gown, rolled it up and discarded the gown into the PPE trash bin in the hallway near room [redacted]. The housekeeper did not perform hand hygiene after disposing the yellow gown. The surveyor interviewed the housekeeper with the assistance of a translator. The housekeeper stated that is where she was supposed to put the disposable gown. She further stated she always washes her hands.

On 3/31/21 at 1:52 PM, the survey team met with the LNHA, DON, and the ADON and discussed the above observations and concerns. Both the DON and the ADON acknowledged that the PPE bins to dispose PPE should not have been in the hallway and could not speak to how that happened. They also acknowledged that each room on the dedicated PUI unit should have a designated container to dispose PPE. They further acknowledged that the housekeeper should have noticed that room [redacted] did not have a designated container to dispose PPE and she should have performed hand hygiene after removing her gloves and gown.

5. On 3/30/21 at 11:15 AM and on 3/31/21 at 10:45 AM, the surveyor toured the dedicated PUI unit and observed that rooms [redacted] through room [redacted] did not have any TBP signs posted on or near the door to indicate stop and see nurse before entering or droplet precautions signs.

On 3/31/21 at 12:30 PM the surveyor interviewed LPN #3. She stated that all the staff members know that the low side hallway are PUI rooms and everyone knows to put on gown and gloves before going into these rooms. The surveyor inquired how would any outside vendor such as a lab technician, medical transport or physician

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| F 880 | Continued From page 54<br>know that the [redacted] hallway was the dedicated PUI rooms. LPN #3 stated "we would tell them what they would have to put on before going inside the room." LPN #3 did acknowledge that each room should have a sign indicating that it is a TBP room.<br><br>On 3/31/21 at 1:52 PM, the survey team met with the LNHA, DON, and the ADON and discussed the above observations and concerns. The DON stated it was facility policy to have signs on the door for any TBP room so that staff knows what kind of precautions to take before entering the rooms.<br><br>6. On 3/30/21 at 12:15 AM, during the tour of the dedicated PUI unit, the surveyor in the presence of RN/UM #2 and LPN #2 observed two transport company individuals on the unit near room [redacted]. The two individuals were not wearing eye protection or an N-95 mask. They did not enter any PUI rooms. The one individual was observed wearing a black cloth mask and the other individual was observed wearing a blue surgical mask.<br><br>On that same date and time, the RN/UM stated "they should know what to wear. It's not our job to tell them what to wear." The surveyor interviewed both individuals who stated that they were screened downstairs in the lobby before coming upstairs but that no one told them they had to wear eye protection or an N-95 mask.<br><br>On that same date at 1:00 PM, the surveyor interviewed a male receptionist who stated that everyone who comes into the facility is screened for COVID-19 and if a transport company comes | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315331 | A. BUILDING _____ B. WING _____ | 04/08/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMPLETE CARE AT FAIR LAWN EDGE | 77 EAST 43RD STREET PATERSON, NJ 07514 |

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| F 880 | Continued From page 55 | F 880 | | |

into the facility, he always asks what unit they are going onto and ensures they are wearing the proper PPE. The receptionist could not speak to why the two transport company individuals on the PUI unit wear not wearing eye protection or an N-95 mask.

On 3/31/21 at 1:52 PM, the survey team met with the LNHA, DON, and the ADON and discussed the above observations and concerns. The DON and the ADON acknowledged that the transport company individuals should have worn eye protection and an N-95 mask on the PUI unit.

A review of the undated facility Isolation Precautions Policy and Procedure, provided by the ADON, included "Contact Precaution: for residents with known or suspected infections that represent an increased risk for contact transmission: Ensure appropriate patient placement. Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens."

A review of the undated facility Handwashing/Hand Hygiene Policy, provided by the DON, included "Use an alcohol-based rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: f. before donning sterile gloves; g. before handling clean or soiled dressing, gauze pads, etc.; h. before moving from a contaminated body site to a clean body site during resident care; j. after contact with blood or bodily fluids; k. after handling used dressings, contaminated

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| F 880 | Continued From page 56 | F 880 | | |

equipment, etc.; m. after removing gloves. Washing hands: 6. Rub hands together using full friction for twenty seconds (20 sec) (Not under running water) singing happy birthday song."

A review of the undated facility Nursing Services Policy and Procedure Manual for Long-Term Care Infection Control provided by the DON included "5. Wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials."

A review of the undated facility Dressing Change Policy that was provided by the ADON included "Procedure: #12. Put on clean gloves and remove soiled dressing #13. Remove gloves and wash hands. #14. Put on a clean pair of gloves. #15. [redacted] with prescribed solution and sterile/clean gauze pads/sponges. Remove gloves and wash hands. #16. Put on another pair of sterile gloves. #17. Apply ointment/medication and sterile dressing. Secure dressing with tape as necessary."

A review of the facility's Isolation-Categories of Transmission-Based Precautions undated policy provided by the DON indicated that transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected ...the signage informs the staff of the type of CDC [Centers for Disease Control and Prevention] precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room ...Droplet precautions may be implemented for an individual documented or suspected to be infected with microorganism transmitted by droplets (large-particle droplets[larger than 5 microns in

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| F 880 | Continued From page 57<br>size] that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning) ...masks will be worn when entering the room ...gloves, gown and goggles should be worn if there is risk of spraying respiratory secretions.<br><br>A review of the facility's Infection Control Patient's Under Investigation (PUI) policy reviewed 2/1/20 indicated to enter the PUI unit goggles or face shield and an N-95 mask is required ...when leaving the room, gown, gloves are to be removed and discarded in the rooms in the containers provided, followed by washing hands.<br><br>NJAC 8:39-19.4 (a) (1) (n) (2) | F 880 | | |