STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. BUILDING ______ B. WING ______	02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH** **BRIDGEWATER, NJ 08807**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey: 2/3/20 Census: 125 Sample Size: 31 A recertification survey was conducted to determine compliance with 42 CFR Part 483, requirements for Long Term Care Facilities. Deficiencies were cited.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		4/22/20

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

Electronically Signed | | 03/05/2020

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

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F 623	Continued From page 1 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance	F 623		

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F 623	Continued From page 2 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and review of the medical record and other facility documentation, it was determined that the facility failed to provide the resident or the resident representative written notification of a transfer to the hospital for 1 of 1 resident reviewed for hospitalizations (Resident #24). This deficient practice was evidenced by the	F 623	F623 Complete Care at Green Knoll We were deficient in practice in providing a written notification to resident and resident's representative and office of Ombudsman. Identification of others affected:	

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F 623	Continued From page 3 following: On 1/29/20, at 12:53 PM, the surveyor reviewed the progress notes for Resident #24 that revealed a re-admission note in [redacted] The surveyor then reviewed a New Jersey Universal Transfer Form (NJUTF), which revealed the resident was transferred from the local hospital and returned to the nursing facility in [redacted] The surveyor did not locate the NJUTF related to Resident #24's transfer to the hospital in [redacted] The surveyor did not observe evidence of written notification to the resident or resident representative regarding the transfer to the hospital. On 1/30/20 at 8:59 AM, the surveyor interviewed the Unit Manager (UM), who confirmed that Resident #24 had been transferred to the hospital in [redacted] and returned to the nursing facility after several days. On 1/31/20 at 7:34 AM, the surveyor interviewed the Administrator who stated that the Social Worker (SW) was responsible for the notification. On the same day at 10:33 AM, the surveyor interviewed the SW, who stated that it was her process to call and notify the resident representative. The SW then confirmed that she did not document it on the resident's chart. The SW stated that she also used to notify the Office of the Ombudsman but was told by "someone in house" that she was not required to do that anymore. The surveyor then interviewed the UM, who stated that she would have to follow-up with the	F 623	During the survey the social worker sent the incomplete discharge/transfer logs to the Ombudsman. Also, facility provided a notification to resident's representative about acute transfer. Systemic Changes: The social worker or designee will document notification of all transfers/discharges on a monthly log. Corrective action and monitoring: Administrator will perform audits biweekly x 3 months of all transfers/discharges notification to residents and resident's representative and office of Ombudsman. to ensure compliance. The results of audits will be reviewed in monthly QAPI meeting.	

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F 623	Continued From page 4 nurse and added that they may not have made a copy of the NJUTF for the medical record, but that it was sent with Resident #24 when they went to the hospital. The facility did not provide a policy related to the Acute Transfer to an acute care facility by the exit on 2/3/20. N.J.A.C. 8:39-5.3 (b)	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625		4/9/20

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F 625	Continued From page 5 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical record and other facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold policy prior to transfer to the hospital for 1 of 1 resident (Resident #24) reviewed for hospitalizations. This deficient practice was evidenced by the following: On 1/29/19 at 12:41 PM, the surveyor reviewed the facility progress notes for Resident #24, which revealed that they had been hospitalized in [redacted] and returned to the facility several days later. The surveyor did not observe evidence of written notification of the facility's bed hold policy before the transfer to the hospital. On 1/31/19 at 7:34 AM, the surveyor interviewed the Administrator who stated that they hold the beds for the residents and added that the bed hold policy was reviewed, signed, and part of the admission packet. The surveyor then requested written evidence that Resident #24 had been notified of the Bed Hold Policy before their transfer to the hospital in [redacted] On the same day at 8:45 AM, the Administrator provided the surveyor with a blank form titled, Bed Hold Notice of Policy & Authorization. The Administrator then added that she would	F 625	F625Complete Care at Green Knoll Resident #24 who had the deficient practice of not having a bed hold policy provided at the time of the discharge, had the bed hold policy provided to the responsible party and copy placed in social service file. Identification of other affected residents: All residents will not have this deficient practice happen again as all residents and/or families were provided a copy of the bed hold policy that are currently in-house. All residents were handed or mailed the bed hold policy and social services maintains a signature page which is with the social services department for in house residents. New residents are provided the Admission packet which will have included a bed hold policy for them to review and have explained. At the time of hospitalization, the discharging nurse will communicate with the resident or family and provide a note on the medical record. A copy of the bed hold policy will be physically given at the time of the discharge. Receptionist will send a copy to the responsible party. Systemic Changes: Moving forward, for the next two months the Director of Nursing or designee will be	

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F 625	Continued From page 6 follow-up to see if there was a copy in Resident #24's medical record. On 2/3/20 at 3:35 PM, the surveyor reviewed the undated facility policy titled, Bed-holds and Returns, which read under Policy Interpretation and Implementation: 1. Residents may return to and resume residence in the facility after hospitalization or therapeutic leave, as outlined in this policy. 2. current bed-hold and return policy established by the stated (if applicable) will apply to Medicaid residents in the facility. 3. Prior to the transfer, written information will be given to the residents and the residents representative that explain in detail: a. The rights and limitation of the resident regarding bed-holds; b. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents) or to hold a bed beyond the stated bed-hold period (Medicaid residents); and d. The details of the transfer (Per Notice of Transfer); and, 7. The resident will be permitted to return to an available bed in the location of the facility that he or she previously resided. If there is not an available bed in that part, the resident will be given the option to take an available bed in another distinct part of the facility and return to the previous distinct part when a bed becomes available.	F 625	weekly auditing the hospitalized residents to ensure that the resident or family has been given a copy of the bed hold policy upon transfer or discharge to the hospital. Corrective actions and monitoring: Administrator or designee will review the admissions and discharges monthly to ascertain if all received bed hold policies were provided to each resident or responsible party. Director of Nursing will review the medical record to ensure that nursing is documenting. Administrator will review that all hospital admissions on a monthly basis are sent by the social services department or designee to the Ombudsman office and will be reviewed monthly at the QAPI meetings.	

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F 625	Continued From page 7 As of exit on 2/3/20 at 4:00 PM, the facility did not provide written evidence that Resident #24 or their representative had been notified in writing of the bed hold policy for the acute transfer to the hospital in [redacted]. N.J.A.C. 8:39-5.1 (a)	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		3/18/20

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F 656	Continued From page 8 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the medical record and of other facility documentation, it was determined that the facility failed to develop a comprehensive care plan for 1 of 28 residents (Resident #50) reviewed for comprehensive care plans. This deficient practice was evidenced by the following: On 1/28/2020 at 12:32 PM, the surveyor observed Resident #50 lying awake in bed with a). The resident was awake, alert, but unable to speak to the surveyor. The resident was r. The surveyor observed that there was a supplies and an at the resident's bedside. On 1/29/2020, at 11:04 AM, the surveyor reviewed the care plans for Resident #50, which	F 656	F656 Complete Care at Green Knoll The resident #50 who had the deficient practice of not having a plan was provided a care plan which was added to the rest of the other care plans, immediately. Identification of other affected residents: Director of Nursing reviewed and revised the care plan policy to include that this baseline care plan is required for all residents with a and must be completed within 48 hours of admission and updated and revised quarterly. The Director of Nursing, the Assistant Director of Nursing and all unit managers reviewed all of the in-house resident care plans to ensure the care plans were inclusive of all of the medical diagnoses. At this point in time, no other resident care plans were found to be deficient. Systemin changes: Nursing staff were in-serviced on need for	

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F 656	Continued From page 9 did not include a care plan for [redacted] care. The surveyor then reviewed the resident's significant Change Minimum Data Set, an assessment tool, dated [redacted], which indicated under [redacted] [redacted] [redacted] Care while a resident. On 1/31/2020 at 8:38 AM, during surveyor interview, the Licensed Practical Nurse confirmed that Resident #50 should have had a care plan for [redacted] care. Later that same day at 8:43 AM, during surveyor interview, the Unit Manager (UM) confirmed that there was not a care plan for [redacted] care for Resident #50 and that there should have been one created. The UM further stated that she would create one [a care plan for [redacted] care]. On 2/3/2020 at 12:30, the surveyor reviewed the facility provided policy titled; [redacted] Care with a revised date of October 2010, which did not contain information about a care plan. The surveyor then reviewed the facility provided policy titled; Care Plans-Baseline, with a revised date of December 2016 which read under: Policy Interpretation and Implementation: 1. To ensure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. 2. The Interdisciplinary Team will review the healthcare practitioner's order (e.g., dietary	F 656	inclusive care planning and documentation for all residents' medical conditions, including [redacted] care, with in the care plan. Monthly, Director of Nursing and designee will provide in-services on care planning for the next three months in the nursing monthly meeting. Corrective actions and monitoring: For the next three months, the Director of Nursing and designee will review all incoming new admissions to ensure that appropriate care planning of all medical conditions are properly written and completed on a weekly basis. Tracking and trending of careplan completion/outcomes will be reviewed at the monthly QAPI meeting.	

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F 656	Continued From page 10 needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: a. Initial goals based on admission order; b. Physician orders; c. Dietary orders; d. Therapy Services; e. Social Services; f. PASARR recommendation, if applicable. 3. The baseline care plan will be used until the staff can conduct a comprehensive assessment and develop an interdisciplinary person-centered care plan. N.J.A.C. 8:39-11.2 , 2	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the medical record and review of other facility documentation, it was determined that the facility failed to maintain professional standards of clinical practice by; a) failing to consistently perform [redacted] checks for a resident that had an unwitnessed fall for 1 of 4 residents reviewed for falls (Resident #50), and by; b) failing to assess the [redacted] risk for a resident that had an order for a [redacted] device for 1 of 1 residents reviewed for [redacted] (Resident #114).	F 658	F658 Complete Care at Green Knoll The resident #50 had the deficient practice of having a missing [redacted] check on an incident report. Once identified, resident #50 was checked and had no problems once identified. Resident #114 had the deficient practice of not having an [redacted] assessment completed when a [redacted] device was initiated. [redacted] assessment was immediately completed.	4/9/20

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F 658		F 658		

F 658 Continued From page 11

This deficient practice was evidenced by the following:

Reference: New Jersey Statues, Annotated Title 45, Chapter. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."

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."

1. On 1/28/2020 at 12:32 PM, the surveyor observed Resident #50 lying awake in bed with a [redacted] a [redacted] The resident was awake, alert, but unable to speak to the surveyor.

On 1/31/2020 at 10:26 AM, the surveyor reviewed the three incident reports for Resident

F 658

Identification of other affected residents:
All residents will not have this deficient practice happen again as all residents with [redacted] assessment flow sheets were reviewed for completion as well as accuracy in documentation. The [redacted] assessment will now be reflected in the medication administration record on our computerized medical record system.
[redacted] assessment policy was revised on 02/03/2020 to include the duration and the time that the assessment must be completed.
All residents who may be at risk for [redacted] and those residents with [redacted] devices were checked for missing [redacted] assessments immediately.

Systemic changes:
Nursing in-services were done on completion of [redacted] assessments prior to placement of [redacted] as well as the updated [redacted] assessment policy which was put in to place.
All residents with falls and [redacted] will be assessed immediately upon admission for appropriate interventions and will be discussed at the am clinical meeting with the interdisciplinary team members.

Corrective actions and monitoring:
The medication administration record and flow sheet documentation will be

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 12 #50's falls, which occurred on , and . The immediate action section for each fall indicated that checks were initiated or in progress. The surveyor then requested the documented evidence of each check. On 1/31/2020 at 10:59 AM, the Assistant Director of Nursing (ADON) provided the surveyor with the resident's Assessment Flow Sheet for and but not for . The ADON than stated that Resident #50 was sent to the hospital on before the checks were initiated. The surveyor then reviewed Resident #50's Assessment Flow Sheet dated which had a total of 14 assessments of the resident. The surveyor then reviewed Resident #50's Assessment Flow Sheet dated which had a total of 12 assessments of the resident. The surveyor then reviewed the instructions on the Assessment Flow Sheet, which indicated how many times the checks were to be performed handwritten in the right upper corner: On 2/3/2020 at 12:18 PM, during surveyor interview, the Administrator and Director of Nursing confirmed that Resident #50's l Assessment Flow Sheet was not performed correctly and that the checks should have been done according to the handwritten instructions on the form.	F 658	reviewed by the Director of Nursing or designee, upon completion of the flow sheet assessment for the next 90 days for all neuro checks. The Director of Nursing and or designee will do a monthly audit on elopement assessments for three months. Trending and tracking of outcomes will be reviewed by the Director of Nursing with the QAPI team monthly.	

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F 658	Continued From page 13	F 658		

On 2/3/2020 at 2:00 PM, the surveyor reviewed the facility provided policy titled, [REDACTED] Assessment with a revised date of October 2010 which read under
General Guidelines:

1.[REDACTED] assessments are indicated:
a. Upon physician order;
b. Following an unwitnessed fall;
c. Following a fall or other accident/injury involving head trauma; or,
d. When indicated by the resident's condition.

Under Documentation:

The following information should be recorded in the resident's medical record:
1. The date and time the procedure is performed.
2. The name and title of the individual(s) who performed the procedure.
3 All assessment data obtained during the procedure.
4. How the resident tolerated the procedure.
5. If the resident refused the procedure, the reason(s) why and the intervention taken.
6. The signature and title of the person recording the data.
The policy did not contain information of how often and for how long the neurological assessment was to be done.

2. On 1/24/2020 at 12:15 PM, the surveyor observed Resident #114 self-propelling in a wheelchair down the hallway to the facility's dayroom.

On 1/28/2020, at 10:55 AM, the surveyor reviewed Resident #114's medical record. The

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F 658	Continued From page 14 Physician Order Set included an order dated [redacted] for the [redacted] device due to poor safety awareness. Check placement at the back of the resident's wheelchair. There was no documented evidence that an [redacted] risk assessment for Resident #114 had been completed. Later that same day at 12:26 PM, the surveyor observed a [redacted] device located on Resident #114's wheelchair. On 1/31/2020 at 11:22 AM, during surveyor interview, the Unit Manager stated that she could not locate an [redacted] risk assessment for Resident #114. On 2/3/2020 at 12:17 PM, during surveyor interview, the Administrator stated that there was not an [redacted] risk assessment done for Resident #114 and that they were going to complete one now. On 2/3/2020 at 12:30 PM, the surveyor reviewed the undated facility provided policy titled, Wandering, Unsafe Resident, which read under: Highlights assessment of residents at risk of elopement; 1. The staff will identify residents who are at risk for harm because of unsafe wandering. Under Correctable risk factors 2. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. N.J.A.C. 8:39-27.1 (a)	F 658		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		3/18/20

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F 755	Continued From page 15 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to maintain accurate accountability and reconciliation for receipt and documentation of	F 755	F755 Complete Care at Green Knoll The deficient practice was not having DEA forms 222 with a received date and	

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F 755	Continued From page 16 controlled medications for: a) 1 of 1 back-up controlled medication storage areas; and, b) 1 of 3 narcotic shift count sheets reviewed. This deficient practice was evidenced by the following: 1) On 1/31/20 at 2:11 PM, the Director of Nursing (DON) stated that she was responsible for the completion and maintenance of the Drug Enforcement Agency Form-222 (DEA Form-222) records, as well as, the [redacted] . The DON added that if there was a discrepancy, then she would reconcile the controlled drug count of the narcotics stored in the machine by comparing the number of pills as noted by the computer with the number of pills identified on the declining inventory sheet. The DON stated that when she does complete the reconciliation, she does not physically count the number of pills in the drawer to verify that the count was correct. She added, "It [redacted] tells you how many pills are in the bin." On the same day at 2:30 PM, the surveyor reviewed the facility binder provided by the DON. In the binder were six DEA Form-222, the official order forms for Schedule I & II Narcotics (controlled substances). Upon review of the six DEA-222 Forms, the surveyor identified that the section on the Form titled, To Be Filled in By Purchaser was blank for 6 of 6 of the forms. The surveyor then reviewed the reverse side of the DEA-222 Form, and under #2 it read:	F 755	the quantity recorded, as well as the deficient practice of not signing the narcotic book prior to the end of shift. Six DEA forms were immediately completed for compliance in terms of date and quantity received by the DON. The nurse involved in the deficient practice was educated immediately. Identification of others affected: The DON and ADON reviewed all narcotic count books and DEA 222 forms for proper compliance and completion. Systemic changes: Upon receiving narcotics all DEA 222 forms will be completed with the amounts and dates received by the Director of Nursing. The copy will be kept in the narcotic book in the Director of Nursing's office. All narcotic count books will be reviewed weekly by the DON or designee. All nurses were in-serviced on signing the narcotic count book at the appropriate time which is at the beginning of the shift and also at the end of shift. Facility policy on controlled substances which entails a controlled drug count for each shift change, entitled, "Shift Change Controlled Drug Count" which was put in to place. All nursing staff were in-serviced on the new form. Corrective actions and monitoring: Narcotic book count will be audited on each floor weekly by the Director of Nursing or designee for appropriate shift change signatures for the next three months. Consultant Pharmacist will provide monthly audits as well. DON will	

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F 755 Continued From page 17

When items are received, the date of the receipt and the number of items received must be recorded in the space provided on the triplicate copy.

The surveyor then reviewed an envelope that contained one DEA Form-222 that was blank with a date issued of 11112019 and identified as order form 3 of 3. The surveyor could not locate order forms 1 of 3, or 2 of 3 in the binder provided by the DON.

On the same day at 2:25 PM, the DON provided the surveyor with order form 2 of 3 of the DEA Form-222 that had the word "VOID" written across the front of it. The DON confirmed that she was responsible for the completion of the DEA Form-222 and the binder that contained the forms. She added that she had filled out form 2 of 3 incorrectly and had to void it out.

The surveyor then asked the DON about DEA Form-222 labeled 1 of 3. The DON stated that it had been sent to the pharmacy but that they had not retained a copy for their records.

The surveyor then reviewed the reverse side of the DEA Form-222 for the Instructions, and it read under Part 1. Purchaser Information:

6. The order form must be signed and dated by the Purchaser on the day it is submitted for filling. Purchaser must make a copy of the order form for its records before mailing the original to the supplier.

The DON confirmed that she had not made a copy prior to it being submitted for filling.

F 755

audit the DEA 222 forms monthly for accuracy and completion for the next 6 months. Tracking and trending of outcomes will be reviewed at the monthly QAPI meetings.

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F 755	Continued From page 18	F 755		

On 2/3/20 at 9:00 AM, the DON provided the surveyor with a copy of the DEA Form-222 order form labeled 1 of 3 that had been previously sent to the supplier for filling.

On the same day at 3:00 PM, the surveyor completed a count with the DON, which did not reveal any narcotic discrepancies.

2) On 1/28/20 at 12:40 PM, the surveyor reviewed the facility form titled, Shift count, with the Licensed Practical Nurse (LPN) #1 assigned to the [redacted] medication cart [redacted]. Under the column; Today's Date, Line 12 had the date of 1/28/20, under the column; Time of day it read: 2:30 p (afternoon) and under the column; Is Count Correct?, contained initials under; Yes and the Going off Duty nurse's signature was present on the Form.

At that time, the surveyor then interviewed the LPN, who confirmed that it was not the proper procedure to sign off the narcotic count prior to the count taking place at the end of their shift.

On 1/29/20 at 6:55 AM, the surveyor observed the narcotic count with LPN #1 and LPN #2, who confirmed that the narcotic count was done with the incoming and outgoing nurse and that the two nurses should sign the shift count sheet at that time.

On 1/31/20 at 2:11 PM, the surveyor interviewed the DON who stated that the narcotic count took place with the incoming and outgoing nurse and confirmed that it should be completed with two nurses and not signed off before the completion of the count.

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F 755	Continued From page 19 On 2/3/20 at 11:52 AM, the Administrator and DON stated that the facility did not have a policy and procedure for the completion of the narcotic count. At the time of exit on 2/3/20 at 4:00 PM, the facility did not provide the surveyor with policy and procedures related to the narcotic count. N.J.A.C 8:39-29.1(c)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain a medication error rate below 5%. The surveyor observed 3 nurses, administer 27 doses of medication to 5 residents, and identified that there were 2 errors, which resulted in a medication error rate of 7.4%. This deficient practice was evidenced by the following: On 1/24/20 at 9:40 AM, the surveyor observed a Licensed Practical Nurse (LPN) prepare to administer medication to Resident #14. The nurse brought [redacted] [redacted] into the resident's room along with the resident's oral medication, which included [redacted] [redacted] and [redacted]	F 759	F759 Complete Care at Green Knoll The Resident #14 had the deficient practice of having received medication late and medication not being received appropriately with meal by Nurse 1. Pharmacy consultant re-educated the nurse regarding the medication cautionaries on 1/27/2020. The resident who did not receive the correct dosage of [redacted] ,only received [redacted] was re-assessed for ability to self administer medications and no longer is allowed to self -administer. Nurse 1 received med error and was then in-serviced on reviewing self administration and the need to report any changes in resident inability to self administer and our self	4/22/20

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F 759	Continued From page 20 [redacted] milligrams (mgs). At 10:00 AM, the surveyor observed the nurse hand the [redacted] to the resident. The resident inserted the [redacted] and [redacted] once (Error #1). The resident then handed the nasal spray to the LPN, and she put it away. The LPN then left all of the resident's medication whole on the resident's overbed table, including the [redacted] in a medicine cup with a separate cup of apple sauce. The resident took all of the medication, including the [redacted] (Error #2) and the [redacted]. The cautionary on the Medication Administration Record (MAR) for the [redacted]: Do not chew or crush. [redacted]. Take with food. Drink plenty of fluids. The surveyor asked the LPN what time the resident ate breakfast. The LPN stated, "She ate breakfast at 8 AM." The medication was scheduled to be given at 8:00 AM. The surveyor then reviewed the Current Physician's Order Sheet (POS) dated [redacted], which read; [redacted] in both [redacted], two times a day for [redacted]. It also had a physician's order which read: [redacted] Give 1 capsule orally three times a day for [redacted]. Do not chew or crush; Swallow whole; Take with food; Drink plenty of fluids. At 11:00 AM, the surveyor interviewed the LPN and asked about the resident being administered [redacted] into each [redacted] when the physician's order was for two sprays. The LPN stated, "Yeah, [the resident] won't let me do it. [The resident] wants to do it [independently]." The surveyor	F 759	administer assessment.. Identification of other affected residents: Pharmacy consultant completed a med pass competency and re-educated the nurse regarding the medication cautionaries on 1/27/2020. All resident medication administration records were checked for cautionary compliance, All residents receiving medications have the potential to be affected by the deficient practice of inappropriate medications being given due to not reporting changes and reviewing self administration assessment. All residents who qualified for self administration were re-assessed. New admissions will be assessed for their ability to self administer their own medications with the self administration assessment when appropriate or upon resident request. Systemic changes: All nursing staff were educated by the consultant pharmacist on the importance of following cautionaries during medication pass. On a monthly basis, the consultant pharmacist will review medication with cautionaries that are printed on the MAR as well as on the BINGO medication card and containers for accuracy. Corrective action and monitoring: Medication administration competencies will be done weekly by the Director of Nursing or designee on various shifts and monthly it will be done by the pharmacy	

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F 759	Continued From page 21 asked the LPN why she didn't tell the resident to [redacted] in each [redacted] The LPN did not answer. The surveyor asked the LPN about giving the [redacted] without food. The surveyor then asked the LPN about the [redacted], which was to be given 1 hour before or 2 hours after a meal and the [redacted] to be given with food being given at the same time. The LPN stated, "Yeah, that should be changed then." On 2/3/20 at 10:00 AM, the surveyor reviewed the facility's policy and procedure titled, Administering Medications, number 4 read: Medications are administered in accordance with prescriber orders, including any required time frame. N.J.A.C. 8:39-29.2 (d)	F 759	consultant for the next three months. The audit will consist of medication pass observation and adherence to cautionaries on the MAR. Any variances noted during medication pass will be corrected immediately. Tracking and trending of outcomes will be reviewed at monthly QAPI meetings.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide	F 761		4/22/20

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F 761	Continued From page 22 separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to secure medication for 2 of 29 residents reviewed (Resident's #84 and #14), and for 1 of 6 medication carts observed. This deficient practice was evidenced by: 1. On 1/28/20 at 1:55 PM, the surveyor entered the [redacted] room of a resident (Resident #84) and observed a paper medication cup with pills on the resident's bedside table. The resident was sitting in a wheelchair, and the Licensed Practical Nurse (LPN #1) entered the room and stated, "I just left the room for a minute, I had to get something." When asked by the surveyor if it was proper procedure to leave medication for a resident unattended, LPN #1 stated, "No." The surveyor then observed LPN #1 take the cup of medication and leave the room. LPN #1 proceeded to pull the medication cart and placed it directly in front of the doorway. At the same time, the surveyor observed LPN #1 had removed the keys that had been left in the cart. The surveyor observed that there were no residents in the vicinity of the unlocked cart. The surveyor asked if it was the proper procedure to leave keys in a medication cart out of direct	F 761	F761 Complete Care at Green Knoll The deficient practice was that Resident #84 received medication but is not allowed to self administer and Resident #14 was not capable of self administration. Neither resident was allowed to take medications by themselves. The nurse was educated by the Director of Nursing on leaving the medication cart unlocked and unattended, as well as leaving medication at bedside with resident. Identification of other affected residents: All residents have the potential to be affected by the deficient practice and will only be able to take medication by themselves upon completion of the self medication administration assessment for self administration. All residents are affected by the deficient practice as medications could have been taken by residents from the unlocked and unattended medication cart. All staff made aware of the need to have al medication carts locked and not left unattended at any time.	

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F 761	Continued From page 23 observation. LPN #1 first stated that the keys were not in the cart and then acknowledged that they were in the cart and confirmed that this was not proper procedure. 2. On 1/24/20 at 10:00 AM, the surveyor observed LPN #2 preparing to administer medication to Resident #14. The medications included; [redacted]), and [redacted]). When LPN #2 was done placing the medication into a medicine cup, she brought them into the resident's room and placed them on the overbed table with a separate cup with apple sauce and a spoon. She administered the eye drops as prescribed, and she gave the resident the [redacted] to self administer. When the resident was done self-administering the [redacted], LPN #2 took the [redacted], and the [redacted] back to the medication cart, leaving the oral medication and the apple sauce on the resident's overbed table out of her sight. LPN #2 was observed looking at the electronic medical record on the medication cart in the hallway outside of the resident's room. The resident's [redacted] roommate was not in the room. The surveyor observed LPN #2 at the Medication Cart. While at the cart, the resident took all of the oral medication independently by dropping one	F 761	Nurse #1 and Nurse #2 were educated by Director of Nursing regarding the need to follow standard of practice requiring them to not leave medication by bedside and their need to witness medication being taken by residents. Nurse #2 was educated on leaving the medication cart unlocked and unattended at any time. All Systemic changes: Medication carts will be checked and monitored by Director of Nursing(3 carts, three times a week) and or designee upon daily rounds to ensure that nurses are in compliance with medication distribution and medication cart compliance and adherence. Checks will be made by Director of Nursing during medication pass to ensure nurses are in compliance and following the standard of practice for medication pass for the next three months.. Pharmacy consultant and Director of Nursing will continually conduct Med passes monthly and reinforce and re-educate on the locking of medication carts and ensuring medication is taken in nurses presence at all times on a monthly basis. Corrective actions and monitoring: Director of Nursing will review 3 medication carts three times a week to ensure that medications are secured and results will be audited for the next three months. Monthly med pass observations results will be reviewed in monthly QAPI	

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COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH** **BRIDGEWATER, NJ 08807**

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F 761	Continued From page 24 pill into the apple sauce at a time and spooning it into their mouth. As the resident was taking the last pill, LPN #2 returned to the resident's bedside and said, "Oh, you're taking the pills, I was going to [redacted] On the same day at 10:16 AM, the surveyor asked LPN #2 if the resident always took their medication that way. LPN #2 stated, "Yes, [the resident] is very [redacted]. [The resident] likes it in apple sauce. I watch [the resident], and [the resident] takes it." The surveyor explained to LPN #2 that she didn't watch the resident take the medicine; the surveyor watched the resident take the medicine. LPN #2 then stated, "I know, and I'm gonna get yelled at for that. I should have stayed with [the resident], but [the resident] is my most [redacted] resident, and [the resident] has never given me a problem." At 10:30 AM, the surveyor reviewed the resident's medical record which revealed the resident had diagnoses which included: [redacted] The surveyor reviewed the resident's most recent Minimum Data Set (MDS) Assessment (an assessment tool) dated [redacted]. The Brief Interview of Mental Status Assessment showed that the resident scored [redacted] which indicated the resident was [redacted]	F 761	meeting x 3 months. All QAPI members are aware of the deficient practice of unlocked medication carts and are also now responsible for checking the carts as rounds are made on a monthly basis. Results are shared for the next three months.	

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F 761	Continued From page 25 On 1/28/20 at 2:15 PM, the surveyor reviewed the facility policy titled, Storage of Medications, with a revised date of 3/15/18, which read: Store all drugs and biological's in a safe, secure, and orderly manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biological's shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. On 1/31/20 at 1:37 PM, the surveyor interviewed the Director of Nursing (DON), the Assistant Director of Nursing (ADON) and the Licensed Nursing Home Administrator (LNHA). The surveyor asked if the nurse was expected to stay with the resident while the resident took their medication. The DON stated, "She is supposed to stay with the resident until the resident takes the medication." The LNHA added, "It's a standard of practice to stay with the resident while they take their medication." On 2/3/20 at 1:00 PM, the surveyor reviewed the facility's policy and procedure titled, Administering medication. The policy did not address the nurse staying with the resident while the resident took the medication. N.J.A.C. 8:39-29.7(a) N.J.A.C. 8:39-29.2 (d)	F 761		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		4/22/20

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F 880	Continued From page 26 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions 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	F 880		

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F 880	Continued From page 27 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to: a) ensure infection control practices were followed for 2 of 29 residents reviewed for infection control precautions (Resident #13 and #25); b) notify the Local Health Department (LHD) of a [redacted], and; c) consistently follow proper standard precautions to prevent the spread of infection. This deficient practice was evidenced by: 1. On 1/29/20 at 1:10 PM, the surveyor observed Certified Nursing Assistant (CNA #1) in the room of Resident #13 with a bag in her hand. CNA #1	F 880	F880 Complete Care at Green Knoll The Resident #13 and Resident #25 had the deficient practice of the employee not wearing all of the protective equipment which was provided at the respective isolated resident room. Facility policies on Infection control of transmission based precautions (contact precautions) and PPE (the wearing of PPE prior to entering any and all resident rooms with isolation precautions) were all-re-written. Nursing assessed the risk of cohorting both Resident #13 and Resident #25 with	

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stated that the bag had her Personal Protective Equipment (PPE) in it that she had just taken off. The surveyor then observed CNA #3 place the bag near the door and go to the shared resident sink in the middle of the room and wash her hands. The surveyor observed CNA #1 to lather and scrub her hands for seven seconds outside of the running water. She then placed her hands under the water while she continued to rinse and rub her hands together.

At the same time, the surveyor observed a precaution sign outside Resident #13's room and PPE (gowns, gloves, and masks) near the door. The surveyor observed that Resident #13 shared a two-person room, and the room had a bathroom with only a toilet, which was connected to another two-person room. The surveyor interviewed CNA #1, who stated that the resident had an [redacted]" and was on Transmission Based Precautions (TBP).

The surveyor asked CNA #1 if Resident #13 used a [redacted] for both [redacted], and she stated, "Yes." CNA #1 further stated that the resident lets them know when to use the [redacted] but that they sometimes had accidents. CNA #1 added that she provided a [redacted] lined with an [redacted] to collect the [redacted], and then the [redacted] is placed into a plastic bag and discarded.

The Medical record for Resident #13, documented that a [redacted] was taken on [redacted] and showed [redacted]) in the resident's [redacted] and that the physician ordered contact precautions. [redacted]

their respective roommates and documented it in the medical record. The deficient practice of employees not wearing proper PPE was discussed with employees and education was provided on proper useage.

Identification of other affected residents:

All in house residents with transmission based precautions and cohorting have the potential to be affected by this deficient practice. All in house residents with infection were assessed and evaluated to ensure proper cohorting of a resident. The interdisciplinary team assessed and evaluated the in-house residents receiving [redacted] therapy for specific infection to ensure that no other residents were affected by the same practice. Any resident who is admitted or re-admitted with an infection are reviewed by the Director of Nursing or designee and placed in an appropriate room for prevention of transmission of any infection. Any employee who did not obtain a flu vaccine was identified and requested to wear a mask while working.

Systemic changes:
There will be two separate bins for garbage and linen in all isolation rooms Donning and Doffing of PPE (such as gowns, gloves, mask and goggle) education will be provided to all staff upon orientation and annually. All employees who refusesd influenza vaccine will be required to wear a mask

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[REDACTED]

On 1/30/20 at 2:00 PM, the surveyor reviewed the physician order sheet, which revealed an order dated [REDACTED] at 15:00 (3:00 PM) that read: Contact Isolation x 7 days every shift for [REDACTED] [REDACTED]

The surveyor then reviewed the medical record of Resident #13 which revealed a care plan created on [REDACTED] with the focus: I am on an [REDACTED]) for [REDACTED] contact isolation for [REDACTED] that included the following interventions:

* [REDACTED] per MD orders
* Check and change every two hours and as needed
* Monitor temps, follow up with MD fever change in color consistency odor urine
* Give extra PO (by mouth) fluids

On 2/13/20 at 9:50 AM, the Unit Manager (UM) confirmed that [REDACTED] had been discontinued for Resident #13 and that the [REDACTED] report was negative.

The surveyor then reviewed a [REDACTED] report dated [REDACTED] that confirmed the UM's statement and read: No growth two days.

2. a). On 1/24/20 at 9:30 AM, the surveyor observed a stop sign on the door of Resident #25, which read to see the nurse before entering the room; PPE was next to the door entrance.

The surveyor then interviewed the Unit Manager (UM), who stated the resident was on contact precautions for [REDACTED]

Provider's Plan of Correction (F 880, continued):

during the flu season.All linens from isolation rooms will be transported to laundry directly in double bags by staff.
Staff development nurse or designee will perform handwashing competencies for all employees upon orientation and annually.
Meals will be served in disposeable trays for all residents in isolation rooms.
Staff development nurse or designee will perform [REDACTED] care competency for all nurses during orientation and as needed
All employees were in-serviced on the need to don gowns, gloves and masks when entering ANY resident room which is an isolation room. Those employees who were not given influenza vaccine will be mandated to wear masks at all times in accordance with our policy and will wear them appropriately throughout their shifts.
Use of cohorting residents will be assessed prior to resident placement and reviewed with the Director of Nursing and Infection Preventionist. The IP will review and ensure that medical records of those cohorting will be documented in the medical record for all new transmission based infections
Linen chute was marked with signage that denoted what linens were not appropriate: "Linen with the following clinical conditions are not to be placed in the laundry chute and must be double bagged and physically brought down to the laundry room---[REDACTED]

All employees were in-serviced on proper

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F 880	Continued From page 30 is a [redacted] On the same day at 12:45 PM, the surveyor observed a Regional Food Service Worker who entered Resident #25's room without wearing PPE and removed a lunch tray from the resident's overbed table. The resident was sitting in front of the table near the door. The surveyor interviewed the worker and asked if she knew that the resident was on [redacted]. The worker confirmed she did not know the resident was on [redacted] and should have asked a nurse about it before entering the room. On 1/27/20 at 8:45 AM, the surveyor observed CNA #2 enter the room of Resident #25, without wearing PPE, and delivered a non-disposable breakfast tray to the resident and assisted the resident with meal set-up. The surveyor then observed CNA #2 leave the room without washing her hands. The surveyor interviewed CNA #2 and asked about the resident being on TBP, and she stated that since there was no contact with the resident, there was no need for PPE. At that same time, the surveyor then interviewed CNA #2 regarding the process for the return of meal trays to the kitchen. CNA #2 stated that the trays are returned to the meal cart, and then the cart was brought down to the kitchen. She confirmed this was the process for all residents, including those on precautions and that the facility did not use disposable trays. The surveyor asked CNA #2 if she had been educated on the use of PPE, and she stated,	F 880	method of handling isolation and garbage and non-use of the chute for specific linens. All bedpans and urinals were marked with residents' room number and placed in plastic bags for each room. All employees were re-in-serviced on proper hand washing technique, before and when exiting a resident room. Competencies were also done on handwashing and infection control (ppe included). Meal trays are sanitized appropriately via water temperatures as well as chemical processing during tray sanitization. Isolation precaution of providing a disposable tray and plate ware policy was developed and supplies provided to the facility. All employees were in-serviced on the sanitation process. Meal carts are sanitized in-between mealtimes as necessary. Resident water fountains were removed on 02/02/2020. Facility provided hydration stations to all three floors which is situated in the locked pantries. Nursing staff were in-serviced specifically on cleaning the bed side table upon completion of [redacted] dressing, in addition to using or removing paper towel as a barrier. For all residents admitted to the facility with active infections, a physician order for isolation precaution will be	

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F 880	Continued From page 31 "Yes" but could not remember a date. The surveyor asked CNA #2 about the handling of laundry, and the disposal of PPE for residents on TBP. CNA #2 stated that separate containers were not used for residents on precautions. On the same day at 8:50 AM, the surveyor observed LPN #1 put on gloves and entered the room of Resident #25. LPN #1 went to the resident's bedside and picked up the call light and placed it near the resident on the bed. The surveyor interviewed LPN #1 and asked if that was an appropriate use of PPE for someone on [redacted] with [redacted], and she replied, "No." The surveyor then observed LPN #1 put on a gown and don new gloves at the doorway and re-entered Resident #25's room. LPN #1 then removed the PPE and placed it in a trash can that was overflowing with garbage, and the tie from the PPE gown extended out the door. The surveyor asked LPN #1 if that was appropriate disposal of PPE, and she stated, "No." She further stated that there should be separate covered containers for both PPE and laundry disposal. The surveyor then observed LPN #1 leave the room without washing her hands. At 9:36 AM, the surveyor observed CNA #2 outside Resident #25's room with two small plastic garbage bags, which CNA #2 confirmed to be garbage. The surveyor interviewed CNA #2 regarding the disposal of the garbage, and she stated she was going to bring it to the soiled utility room. There was a blue bag in the one bag, which she stated was used as a liner for Resident #25's bedside commode to collect and dispose of [redacted].	F 880	documented in the medical record. Monitoring will be conducted each day for all residents being admitted to the facility. Any changes with a residents condition (ie infection) after admission, will be assessed and evaluated immediately for an appropriate room change and the implementation of the infection prevention control program. Corrective actions and monitoring: Infection Control Committee reviewed and updated isolation policies as well as PPE policies. Infection Preventionist was enrolled in the Association for Professionals in Infection Control and Epidemiology certification course and is responsible with team members to review and develop infection control practices on a monthly basis. The IP will provide 10 staff with proper handwashing competencies, 2 resident room checks for correct PPE and 2 room audits which will be completed on a weekly basis for compliance for three months. Chart audits encompassing a review of admission or re-admission of residents with active infection will be conducted by the IP. The audits will ensure proper room assignments and staff observation to ensure infection control procedures have been followed. Whenever there are two or more residents infected with infection there will be a reporting to the local department of health for tracking and trending purposes by the IP. The IP will report these findings on a daily basis at our daily AM meetings.	

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F 880	Continued From page 32 The surveyor then observed CNA #2 enter the room of Resident #25 carrying a gown and placed it on while in the room. She then went to the sink in the middle of the room and put on gloves. The surveyor then observed CNA #2 leave the room and carry a tray to the meal cart in the hallway. The surveyor then observed CNA #2 re-enter the room of Resident #25 with the same PPE (gown and gloves). At 10:04 AM, the surveyor observed Resident #25's meal tray wrapped in plastic. The surveyor interviewed CNA #2 regarding the tray being wrapped in plastic, and she stated that it was wrapped in plastic and placed on top of the resident's wastebasket because it was going to be thrown away. At 10:07 AM, the surveyor observed CNA #2 carrying a large plastic bag of laundry in the hallway. The surveyor interviewed CNA #2, who confirmed that it was the laundry of Resident #25, and she was placing it down the laundry chute. When asked how the laundry staff would know that it was from a resident on precautions, she stated, "they would know when they open the bag because we double bag it." At 12:42 PM, the surveyor observed CNA #2 enter Resident #25's room without wearing PPE and carrying a non-disposable lunch tray. The surveyor interviewed CNA #2 and asked if she should have worn PPE, and she stated she was not required to wear PPE, and that PPE was only required when providing care. At 1:01 PM, the surveyor observed CNA #3 enter Resident #25's room without PPE and remove	F 880	Infection Preventionist or designee will audit 5 employees daily during flu season who didn't receive flu vaccine for proper use of face mask. The results of audits will be reviewed in the monthly QAPI meetings.	

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the resident's tray from the overbed table and placed it in the meal cart in the hallway. The surveyor interviewed CNA #3 and asked if he knew why Resident #25 was on [redacted]. He stated, "No." When asked if it would be good to know, he stated, "Yes." When asked if they usually put the non-disposable tray from a resident on precautions back on the meal cart, he stated, "Yes."

The surveyor then interviewed a Dietary Aide (DA) who was picking up the meal cart outside of Resident #25's room. The surveyor asked the DA if the facility ever used disposable utensils and trays for people on precautions. The DA replied, "They used to, but they don't do that anymore." She further stated the CNA's used to write on a form and dietary would know who was on [redacted].

The surveyor asked CNA #5 what she did with meal trays for residents on [redacted] CNA #5 stated that she put the tray in a plastic bag and then places it on the meal cart. CNA #5 further stated that this was her process, and she was not sure what others did. The surveyor asked why she placed the meal tray in a plastic bag, and she stated that she did that to alert the kitchen that the tray was from an isolation room. CNA #5 added that this should be done in the facility, "so not to spread infection."

On 1/28/20 at 9:28 AM, the surveyor interviewed the Food Service Director, who stated that disposable trays were not used because of dignity concerns and that the tray delivery carts were hosed down daily and sometimes after each meal. He added that it was the assigned job of one of the foodservice workers and that he would routinely oversee the process. He also

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stated that Residents on TBP were identified every day in the morning meeting, and then he would make his staff aware.

On 2/3/20 at 10:00 AM, the surveyor reviewed a General Note dated [redacted] 15:30 (3:30 PM) and the Note Text read: Resident seen by [The Physician] order placed to d/c contact isolation for [redacted] resident no longer has [redacted] noted for the past week. Will continue [redacted] ([redacted]. Housekeeping notified, room has been thoroughly cleaned, and shower given to resident. Will continue to monitor.

The surveyor then reviewed the active care plan for Resident #25 which read:

The resident exhibits or is at risk for complications of infection related to C.Diff with interventions identified as;

·I will remain free ofcomplications/infection X 30 days

·Administer medication as ordered

·Assist resident with hand washing throughout the day as needed

·Contact Precautions

·Encourage resident to consume all fluids during meals

b). On 1/29/20 at 11:01 AM, the surveyor observed a Maintenance Assistant (MA) in the room of Resident #25. The MA removed the resident's TV and placed it on a cart outside of

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the room. The MA was not wearing any PPE. His pant leg was touching the garbage can in the doorway. The garbage can contained used gloves draped over the rim and his pants were touching the used gloves. He then, leaned against the resident's dresser and brushed against the resident's wheelchair.

The MA did not wear any gloves when he picked up the resident's TV and placed it on his cart outside the room. The surveyor then asked the MA if he was aware that the resident was on transmission-based precautions. He said, "I am sorry, I am on the move. I should have asked the nurse first." He added that he would be throwing the TV away and would use a bleach wipe to clean the top of his cart. He then walked away and got on the elevator with the cart holding the TV.

On 2/3/20 at 12:00 PM, the surveyor spoke with the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Licensed Nursing Home Administrator (LNHA). The surveyor described the situation where the MA entered the room of a resident on contact transmission-based precautions without wearing any PPE and the observation of his clothing coming into contact with things in the resident's immediate environment. The DON stated that he didn't have to wear any PPE because he was not touching the resident.

The surveyor then reviewed the facility policy titled; Infection Control Guidelines for All Nursing Procedures, with a revised date of October 2010 which read under General Guidelines:

Standard Precautions will be used in the case of

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all residents in all situations of suspected or confirmed presence of infectious disease. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, nonpintact skin, and/or mucus membranes.

Transmission-based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection, and,

Wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials.

The surveyor then reviewed the facility policy titled; Isolation-Categories of Transmission-Based Precautions, with a revised date of October 2018, read under Contact Precautions;

Contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact or indirect contact with the environmental surfaces or resident -care items in the resident's environment.
The decision on whether contact preautions are necessary will be evaluated on a case by case basis.
The individual on contact precautions will be placed in a private room if possible.
If a private room is not available, the infection preventist will assess various risk associated with

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the other resident placement options (e.g., cohorting, placing with a low-risk roommate.)
Staff and visitors will wear gloves (clean, non-sterile) when entering the room.
Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room, and will avoid touching contaminated surfaces with clothing after the gown is removed.

The surveyor then reviewed the facility policy titled, Sanitization, with a revised date of October 2008 which read:

14. Dumbwaiters or carts may be used to transport food to dining areas, and soiled dishes back to the dietary department provided that the compartment is santitized between the transportation of soiled dishes and food.

3. On 1/24/20 at 10:32 AM, the surveyor identified during the medication pass observation that there were residents on the [REDACTED] that had symptoms of [REDACTED] [REDACTED] The surveyor then asked the DON about the complaints of [REDACTED] issues [REDACTED] on the [REDACTED]. The DON confirmed that there had been multiple residents that had the above-noted [REDACTED]. The DON further stated they had put precautions in place to prevent the spread of infection that included; closure of the main dining room, requested residents that had symptoms remained in their rooms. Residents were also provided with their meals in their rooms, additional hand sanitizers were placed on all the units, staff had completed handwashing in-services, no group activities were held. The facility also completed a tracking

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form for surveillance and the tracking of infection.

On the same day at 11:10 AM, the DON stated that the [redacted] had started with [redacted] residents on the [redacted] and then with [redacted] to [redacted] residents on the [redacted] a few days later. The DON added that they had in-services and re-educated staff and residents on infection control practices, handwashing and that was the reason that the main dining room had been closed. The surveyor then requested the list of residents that had been identified with [redacted] symptoms.

The DON provided the surveyor with a list of [redacted] Residents. The top of the paper was handwritten: [redacted] Outbreak labeled "[redacted] and the date of onset was noted as [redacted]. The surveyor then asked the DON if she had notified the Local Health Department (LHD). The DON informed the surveyor that she did not notify the LHD because the symptoms only lasted 24 hours, and the residents did not have a fever. The DON added that she would be required to report the outbreak to the LHD when "50%" of the residents were symptomatic.

On 1/28/20 at 11:54 AM, the DON provided the surveyor with an email dated [redacted] at 6:02 PM from the LHD to the DON. The email requested a line list be filled out daily from when the outbreak began until it was over. The DON then provided the line listing of the [redacted] residents that had been identified initially and included an email with the name of an additional resident that reported symptoms on [redacted]

On 2/3/20 at 3:00 PM, the surveyor reviewed the

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Infection Control Track and Trending for [redacted] and [redacted]. The Infection Control Monthly Line Listing for [redacted] had eight residents identified. The list revealed symptoms and diagnosis but did not list the causative infectious organism.

The surveyor then reviewed the Infection Control Monthly Line Listing for [redacted] had eight residents identified. The list revealed the symptoms and diagnosis but did not list the causative infectious organism.

On the same day at 3:30 PM, the surveyor interviewed the DON who confirmed that the causative infectious organism should have been included on the line list report.

4. On 1/28/20 and 9:03 AM, the surveyor interviewed two staff members in the laundry room. The female staff member was in the soiled utility room, with the door to the chute room opened. She was wearing PPE of a gown and gloves while she removed bagged laundry from a bin marked dirty. There were also three garbage cans with lids that were also identified as dirty that the staff stated they used to transport the soiled linen to the washing machine after it had been sorted. The male laundry staff member stated that the door to the chute and soiled utility room remained closed. The male laundry staff member confirmed that the machines had pre-programmed settings and that bleach was used for the linen, and there was also a heavily soiled option on the machine. The laundry staff stated that linen from a resident on [redacted] was placed into red bags, however, confirmed that they had not recently observed any linens in red

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bags.

On 2/02/20 at 9:00 AM, the surveyor observed the laundry chutes on the [redacted] floors of the facility. Each chute had a sign posted outside that read: All linen, which is exposed to the following, must be double bagged and physically brought down to the laundry and not placed in the laundry chute. The surveyor noted the list included [redacted].

On 2/03/20 at 9:10 AM, the surveyor interviewed CNA #4 on the first floor about the resident trash and laundry process. CNA #4 stated that dirty incontinent briefs were wrapped in garbage bags and placed into a large bin in the soiled utility room along with all garbage and that it was picked-up every hour. CNA #4 further stated that all laundry goes down the chute.

On the same day at 9:25 AM, the surveyor interviewed CNA #5 on the [redacted] about the resident trash and laundry process, and she stated all laundry goes down the chute, and all trash goes in the garbage room (soiled utility room). CNA #5 further stated that if a resident was on isolation, they used red bags if they are available. If red bags were not available, then they sometimes "tag the bag" to let the laundry room know a resident was on isolation. CNA #5 stated they were not told to do this, but it is something she does and was not sure what others did.

At 9:35 AM, the surveyor interviewed CNA #6 on the [redacted] about the resident trash and laundry process. CNA #6 stated that they, "Just put dirty [incontinent briefs] in the soiled utility room and housekeeping takes care of emptying

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trash from the room." CNA #6 further stated that all laundry went down the chute. The surveyor asked CNA #6 about the process for a resident on isolation. CNA #6 stated that on their floor, if someone were on isolation, they would put the laundry in a red bag and bin in the soiled utility room. CNA #6 continued to state that if the red bags were not available, they would double bag the laundry and carry it down to the laundry room. She further stated that no one on the third floor was on isolation, and no one recently was on isolation.

The surveyor then asked CNA #6 if she could show her where she would find the red bag and bin. CNA #6 stated there was one in the soiled utility room if needed, and she brought the surveyor to the soiled utility room and pointed to a bin with a red bag.

On 1/29/20 at 1:05 PM, the surveyor interviewed the Director of Maintenance who stated, that it was the responsibility of housekeeping to clean and disinfect the chute.

On 2/3/20 at 9:30 AM, the surveyor reviewed the undated facility form titled, Policy statement that read: Ensure that the facility laundry chute is cleaned and disinfected to maintain infection control standards. Under Interpretation, it read:

Procedure:
I. Maintenance Director will inspect the chute on an as-needed basis.
III. The laundry will:

A. Coordinate with the contractor and/or maintenance for the cleaning.
B. Ensure that the laundry chute room entrance

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door is locked
IV. Cleaning Contractor and/or in-house personnel involved with the cleaning are instructed to:
A. Comply with confined space requirements, including:
1. Use special protective equipment identified, such as:
a. Splash-proof gown
b. Gloves
c. Protective eyewear
d. Submicron Mask

5. On 1/27/20 at 12:50 PM, the surveyor observed Resident # 67. The resident used a personal cup with a plastic top dispense water from a unit water cooler located near the nurse's station and between a shower room and medical supply room. The surveyor observed the cup had touched the spigot to the dispenser.

On 1/28/20 at 10:28 AM, the surveyor observed Resident #33 with a large Styrofoam covered cup and straw. The resident took the cover off and touched the spigot and water spilled on the floor. The surveyor then interviewed the Director of Housekeeping, who said that the water dispenser was not for residents' use, only the staff. The surveyor asked it was good practice to touch a personal cup to the spigot of the dispenser he stated, "No, it would contaminate the system."

On 1/29/20 at 12:40 PM, the surveyor observed Resident #67 obtain water from the water cooler, and the cup touched the water dispenser spigot. At that time, the surveyor asked CNA #6 who could use the water dispenser, and she stated both residents and staff. The surveyor asked

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F 880	Continued From page 43 CNA #6 about infection control and if this could be a potential concern with residents using the dispenser and the recent [redacted] outbreak, and she stated that Resident #67 was on the other side of the floor away from the area that residents' were sick from the [redacted] infection. 6. On 1/29/20 at 11:15 AM, the surveyor observed LPN #2, had removed his gloves after administering medications to Resident #64, washed his hands with soap and water for 10 seconds outside the flow of water and then 10 seconds under the flow of water. Upon surveyor interview conducted at that time, LPN #2 stated that this was the way he was taught to wash his hands. On 2/3/20 at 1:35 PM, the surveyor reveiwed the facility policy titled, Handwashing/Hand Hygiene, with a revised date of 2015 read under Procedure, Washing Hands: Vigourously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature. Rinse hands thoroughly under running water. Hold hands lower than the wrist. Do not touch fingertips to inside of sink. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. Discard towels in trash.	F 880		

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F 880	Continued From page 44 Use lotions throughout the day to protect the integrity of the skin. 7. On 1/29/2020 at 10:03 AM, the surveyor observed the [redacted] treatment of Resident #50's sacrum. The overbed table had been cleaned prior to the treatment, but upon completion of the [redacted] treatment, LPN #5 removed the used supplies from the bedside table and did not clean the bedside table. On 1/30/2020 at 9:38 AM, the surveyor observed the wound treatment to the [redacted] for Resident #326. The overbed table had been cleaned prior to the treatment, but after the completion of the [redacted] treatment, LPN #6 removed the used supplies from the bedside table but did not clean the bedside table. On 2/3/2020 at 9:00 AM, the surveyor reviewed the facility provided policy titled, Dressings, Dry/Clean, with a revised date of October 2010 which read under: Steps in the Procedure; Discard disposable items into the designated container. Clean the bedside stand. 8. On 1/27/2020 at 9:01 AM, the surveyor observed the Business Office Manager (BOM) walk into the facility's conference room wearing a blue face mask (used to prevent the spread of any infectious liquid droplets) that was under her chin, not covering her mouth or nose.	F 880		

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On that same day at 12:39 PM, the surveyor observed the BOM sitting at the facility's receptionist desk, talking to three other facility staff members, wearing a blue mask that was under her chin, not covering her mouth or nose.

Later that same day at 1:12 PM, the surveyor observed the BOM sitting at the receptionist's desk wearing a blue mask that was under her chin, not covering her mouth or nose. The BOM then proceeded to pull up the mask to cover her mouth and nose after she observed the surveyor.

On 1/28/2020 at 9:12 AM, in the presence of another surveyor, the surveyor observed the BOM standing at the receptionist desk wearing a blue mask that was under her chin, not covering her mouth or nose.

On that same day at 10:23 AM, the surveyor observed the BOM walk into the conference room [to enter her office] and pulled down the blue mask from her mouth and nose and walked into her office. Less than a minute later, the surveyor observed the BOM walk out of her office wearing a blue mask that was under her chin, not covering her mouth or nose.

On that same day at 12:35 PM, the surveyor observed the BOM at the receptionist's desk talking on the phone wearing a blue mask that was under her chin, not covering her mouth or nose.

Later that same day at 1:35 PM, the surveyor observed the BOM standing at the receptionist's desk wearing a blue mask that was under her chin, not covering her mouth or nose. The surveyor then asked the BOM the reason the

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mask was under her chin and not covering her mouth and nose. The BOM stated that she did not get the flu shot and that she will pull up the mask up [to cover her mouth and nose] in the patient care areas or when a resident comes by.

On 1/29/2020 at 11:34 AM, during the surveyor interview, the DON stated that if the staff does not receive the influenza vaccination that they are required to wear a mask covering their mouth and nose when they step in the building until the end of March.

Later that same day at 12:00 PM, the surveyor reviewed the facility provided policy titled, Influenza Vaccine, with a revised date of December 2007 that did not contain information regarding wearing a mask if a staff member did not receive the influenza vaccine.

The surveyor then reviewed the facility provided form titled; Employee Declination for Influenza Vaccine, which read under:

Section III Refusal/Declination of vaccine:

[Facility] may require that I wear a mask during the influenza season in the interest of patient safety.

On 2/3/20 at 3:06 PM, the surveyor interviewed the DON who stated that the ADON that left the past month had been the Infections Preventionist (IP) and that she had recently reviewed information online, but had not obtained any specialized certifications related to infection control. She added that the ADON that started last month would take the role of IP and that he

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F 880	Continued From page 47 had started the online training. The DON stated that the proper procedure for handwashing was: Turn on the faucet, wet their hands, get soap and lather, scrub between finger and nails for 20 seconds, then rinse their hands, then dry their hands. The DON added that hand washing should not be under the flow of water. The DON further stated that all staff were in-serviced on infection prevention, including the use of PPE and handwashing. The DON also stated that when a resident was on [redacted], a sign was placed on the door and PPE placed outside the room. This information is then passed onto the nursing staff, CNAs, other facility staff, vendors and visitors as well. N.J.A.C. 8:39-19.4(a)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061806	A. BUILDING: ______ B. WING ______	02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN KNOLL	**875 ROUTE 202-206 NORTH BRIDGEWATER, NJ 08807**

(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) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S1360	8:39-19.4(f) Mandatory Infection Control and Sanitation (f) The facility shall have a system for investigating, evaluating, and reporting the occurrence of all reportable infections and diseases as specified in Chapter II of the State Sanitary Code (N.J.A.C. 8:57-1). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to notify the Local Health Department (LHD) of a gastrointestinal outbreak identified for 2 of 3 units; [redacted]. This deficient practice was evidenced by the following: On 1/24/20 at 10:32 AM, the surveyor identified, during the medication pass observation, that there were residents on the [redacted] that had symptoms of [redacted] and	S1360	S1360 Complete Care at Green Knoll The deficient practice was that the local health department was not notified until [redacted] regarding the twenty four hour [redacted] symptoms of 14 affected residents. Identification of other affected residents: All residents have the potential to be affected by this deficient practice. A line listing of all residents affected was completed and reported to the local and	3/18/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/05/20

New Jersey Department of Health

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S1360	Continued From page 1	S1360		

[redacted]. The surveyor then asked the DON about the complaints of [redacted] issues [redacted] on the [redacted]. The DON confirmed that there had been multiple residents that had the above-noted [redacted]. The DON further stated they had put precautions in place to prevent the spread of infection that included; closure of the main dining room requested residents that had symptoms remained in their rooms. Residents were also provided with their meals in their rooms. Additional hand sanitizers were placed on all the units, and staff had completed handwashing in-services, no group activities were held. The facility also completed a tracking form for surveillance and the tracking of infection.

On the same day at 11:10 AM, the DON stated that the [redacted] had started with [redacted] residents on the [redacted] and then with [redacted] to [redacted] residents on the [redacted] a few days later. The DON added that they had in-services and re-educated staff and residents on infection control practices, handwashing and that was the reason that the main dining room had been closed. The surveyor then requested the list of residents that had been identified with [redacted] symptoms.

The DON provided the surveyor with a list of 14 Residents. The top of the paper was handwritten: [redacted] Outbreak labeled "Jan [January] 2020," and the date of onset was noted as [redacted]. The surveyor then asked the DON if she had notified the LHD. The DON informed the surveyor that she did not notify the LHD because the symptoms only lasted 24 hours, and the residents did not have a fever. The DON added that she would be required to report the outbreak to the LHD when "50%" of the residents were

state DOH. Residents were monitored and refrained from dining and group activities, post the incubation period.

Systemic changes:
[redacted] residents with symptoms in the same room or wing will be reported with line listing to the local and or state department of health immediately in accordance with all mandated regulations. They will remain in their rooms for at least 24-48 hours after symptoms have resolved. The Infection Control Preventionist and the Infection Control Committee were all in-serviced on the need to report any and all outbreaks that involve two or more residents to the local health and state departments and line list the occurences.

Education on infection control and handwashing techniques was completed on nursing staff.

The infection control nurse will continue to maintain a line list for all infected residents and employees and this listing will be reviewed at monthly Infection Control and meetings.

Dining room and recreation group activities will be suspended when an outbreak of 2 or more is suspected within 24 hours and will remain in effect until three days after symptoms are cleared.

Corrective actions and monitoring:
Director of Nursing will review all line listings weekly for 90 days. New outbreaks will be reported to the local

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S1360	Continued From page 2 symptomatic. The surveyor then reviewed a State Department of Health (DOH) Form titled; Guidelines for the Control of [REDACTED] Outbreaks in Long-Term Care and Other Institutional Settings, dated July 2016, which read under Reporting: Immediate reporting of suspected or confirmed outbreaks of [REDACTED] illness is required. Continued reading revealed: An outbreak may be occurring if: 1. Several residents who exhibit similar [REDACTED] symptoms are in the same room, the same wing of a facility, or attended a common activity. 2. Two or more residents develop [REDACTED] illness within 72 hours of each other. 3. There is an increase in employee absences, with many staff reporting similar [REDACTED]l symptoms. The guideline then addressed how to report. The surveyor then placed a call to the LHD and was informed that the Health Officer was not working on [REDACTED] The surveyor then spoke with the LHD Program Manager, who stated that she was unaware whether or not the facility had reported a potential [REDACTED] to the Health Officer. The surveyor again interviewed the DON regarding the notification of the [REDACTED] to	S1360	DOH and or State DOH and will be reviewed by both the Infection Control Committee. Tracking and trending of outcomes will be reviewed at the monthly QAPI meetings.	

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S1360	Continued From page 3 the LHD, and she stated that she had called the LHD after the surveyor inquired and that the Health Officer was "not at work today." The surveyor then asked the DON what she planned on doing in the meantime. The DON stated that she would contact the Health Officer on Monday when she returned to work. The DON was observed to have the same guidelines as identified above in her possession. The surveyor then reviewed the guidelines under How to Report with the DON, the facility shall: When the LHD cannot be reached, the facility shall make the report directly to the State Department of Health (DOH), which will then contact the LHD. The phone number of the State DOH contact was noted. The DON added that she would notify the State DOH. On 1/28/20 at 11:54 AM, the DON provided the surveyor with an email dated [redacted] at 6:02 PM from the LHD to the DON. The email requested a line list be filled out daily from when the outbreak began until it was over. The DON then provided the line listing of the [redacted] residents that had been identified initially and included an email with the name of an additional resident that reported symptoms on [redacted] On 1/31/20 at 10:22 AM, the surveyor interviewed the Local Health Officer, who confirmed that the [redacted] should have been reported to them before [redacted].	S1360		
S2110	8:39-31.1(a) Mandatory Physical Environment (a) No construction, renovation or addition shall be undertaken without first obtaining approval from the Department, Long-Term Care Licensing	S2110		4/22/20

New Jersey Department of Health

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S2110	Continued From page 4 and Certification Program and/or the Department of Community Affairs, Health Care Plan Review Unit This REQUIREMENT is not met as evidenced by: Based on observation and interview and renovation of facility documents, in the presence of the Maintenance Director and Facility Owner, it was determined that the facility failed to obtain approvals from the Department of Health, Certificate of Need and Licensing Program (CN&L), or the Department of Community Affairs (DCA) prior to conducting renovations and re-occupying the areas. This deficient practice was evidenced by the following: During a tour of the facility on 2/02/20, beginning at 10:10 AM, the surveyor observed that many areas of the facility [redacted] appeared to have been renovated since the previous survey. The removal of a [redacted] bathroom, new lighting, new ceiling tiles, new wall finish, and flooring. In an interview during a tour of the facility on 2/02/20 at 10:30 AM, the Director of	S2110	S2120 Complete Care at Green Knoll The deficient practice is that there was construction in the facility and paperwork was not available in the facility approving said construction. The facility has reached out to the project engineer to ensure that the proper submissions are made in a correct and timely fashion. Licensed nursing home administrator was educated on the need to have prior approval for all construction prior to work being initiated. Identification of other affected residents: All residents have the potential to be affected by this deficient practice of construction approvals not being available in the facility. Construction work was ceased and facility is waiting for approvals to be sent to initiate any further construction to be done	

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S2110	Continued From page 5 Maintenance stated that the construction company might have obtained a township permit for the new electrical wiring, plumbing removal and demolition of the bathroom, but had no information on CN&L or DCA approvals for the renovations. In an interview with the Maintenance Director at 10:45 AM, the surveyor requested a timeline of the renovations with a project narrative along with any approvals obtained from CN&L, DCA, and local authorities. In an interview with the Maintenance Director, Administrator, and Facility Owner at 11:45 AM, they all stated that they were under the impression that the project was just cosmetic and did not require any notifications. The owner notified the facility construction company to see if they obtained any permits and notification, but still, no information was obtained by the end of the day. There was no documented evidence provided from the facility that CN&L or DCA were notified to obtain approvals for the renovation project.	S2110	in the building. Systemic changes: Administrator will be provided with C,N & L notification paperwork for work done. Corrective actions and monitoring: All construction approvals will be reviewed by the Administrator and brought to the QAPI committee for approval and will be reviewed on a monthly basis.	