STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315253	A. BUILDING _____ B. WING _____	11/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER AT SOMERSET, INC	15 DELLWOOD LANE SOMERSET, NJ 08873

(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: DATE: 11/9/2020 CENSUS:101 SAMPLE:24 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §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 record review, it was determined that the facility failed to appropriately administer pain medication in accordance with a physician's order for [redacted] of 2 residents reviewed (Resident #91) for [redacted] in accordance to professional standards of practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered	F 658	Submissions of this plan does not constitute an admission or agreement by the provider of the truth of the information set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted because of the requirements under State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance. F658 □ Meet Professional Standards 1. Corrective action for the residents affected by the alleged deficient practice: Resident # 91 was immediately reassessed for [redacted]. The physician	12/15/20

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

Electronically Signed | 11/30/2020

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F 658	Continued From page 1 professional nurse is defined as diagnosing and treating human responses to actual and 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 wellbeing, and executing 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." On 10/30/2020 at 11:25 AM, the surveyor observed Resident #91 sitting in his/her room. The resident stated that he/she had just returned from [redacted] and [redacted] so he/she had declined to speak with the surveyor. The surveyor reviewed the medical record for Resident #91. A review of the Admission Record (an admission summary), reflected that the resident was admitted to the facility in [redacted] with [redacted]	F 658	was notified, and orders were received for additional medication available for severe pain. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Residents receiving pain medication for acute post-surgery pain were re-assessed to determine if their pain reduction needs were met. Residents reporting pain scale in excess of current medication regiment were reported to their physicians for additional pain medication as needed options. Staff was educated regarding accurate pain scale assessment and documentation. 3. Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: Staff will be reeducated regarding accuracy of pain assessment. Nurses transcribing pain medication orders will ensure physician has been made aware of residents pain needs to assure medication is available to meet needs. Orders will reflect accurate pain assessment for use of medication as needed. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not reoccur: The Unit Manager/designee will conduct weekly audits to assess monitoring and modification process which includes the interventions are implemented timely, correctly, and consistently. Audits will be	

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F 658	Continued From page 2 A review of the admission Minimum Data Set (MDS), an assessment tool to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for [redacted] A review of the resident's individualized care plan, dated [redacted], indicated that the resident was at [redacted] for [redacted] related to [redacted] Interventions included to administer as needed [redacted] per physician order and evaluate effectiveness. A review of the [redacted] Order Summary Report (OSR) reflected a physician's order (PO) dated [redacted] A review of the corresponding [redacted] electronic Medication Administration Record (eMAR) reflected the following: On [redacted] was administered for a [redacted]. On [redacted] which was [redacted] On [redacted] On [redacted] A review of the [redacted] had not reflected a nurse's note corresponding to these [redacted].	F 658	conducted on residents receiving pain medications for acute post-surgery pain weekly X 4 weeks, on all units and rotating shifts to ensure proper procedure is followed. Audits will then continue with monthly X 3 months and then quarterly X 2 and on an as needed basis. Audits will also be conducted to measure the evaluation of the effectiveness of interventions as appropriate. Audits will be conducted on residents receiving pain medications for acute pain post-surgery on all units to ensure protocol and policy is followed. Corrective measures will be taken for non-compliance and will be presented to QAPI monthly to identify patterns or trends, make recommendations for improvement.	

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F 658	Continued From page 3 On 11/5/2020 at 10:39 AM, the surveyor interviewed the resident who stated that he/she Executive Order 26, 4.b. The resident stated tha Executive Order 26, 4.b. for him/her, but the Executive Order 26, 4.b. At 10:40 AM, the surveyor interviewed the Registered Nurse (RN) who stated that the resident Executive Order 26, 4.b. The RN stated that she could not recall the resident ever Executive Order 26, 4.b. but the resident Executive Order 26, 4.b. on both a Executive Order 26, 4.b. and an Executive Order 26, 4.b. The RN stated that Executive Order 26, 4.b. was administered per PO. If the resident had Executive Order 26, 4.b. of the PO, the nurse called the physician. The RN stated that a resident who Executive Order 26, 4.b. At 11:35 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that residents on pain management had as needed pain medications based on a numerical pain scale. The pain scale was mild (1-3), moderate (4-6), and severe (7-10). The nurse administered the appropriate pain medication based on the corresponding PO and pain scale. If the pain level was greater than the prescribed medication, the nurse called the physician. On 11/6/2020 at 8:59 AM, the Director of Nursing (DON) stated that pain medication was sequenced based on a numerical pain scale of mild, moderate, and severe pain. An alert and	F 658		

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F 658	Continued From page 4 oriented resident might have a pain level higher, but preferred the lower strength medication. The DON stated that the nurse documented in the ePN or the care plan of this. The DON stated that if the resident experienced pain greater than the level of medication prescribed, then the nurse contacted the physician. On 11/9/2020 at 9:46 AM, the DON in the presence of the Licensed Nursing Home Administrator and the survey team, confirmed that the nurse should administer pain medications per the PO. A review of the facility's Pain Management policy dated revised date 7/1/18 included that pain will be assessed using a pain scale prior to offering a resident an as needed or break through pain medication. Pain medication will be offered as prescribed by the physician, however if the resident requested milder pain medication not corresponding to the pain scale, the resident's request will be honored. NJAC 8:39-11.2(b)	F 658		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		12/15/20

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F 755	Continued From page 5 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 interview and review of facility documents, it was determined that the facility failed to ensure that all Drug Enforcement Administration (DEA) 222 forms were completed with sufficient detail to enable accurate accountability and reconciliation for controlled medications for 5 of 8 DEA 222 forms reviewed in 1 of 1 back up controlled medication storage area. This deficient practice was evidenced by the following: On 11/5/20 at 11:14 AM, the surveyor reviewed all DEA 222 forms provided by the Director of Nursing (DON) for the past twelve months which	F 755	Submissions of this plan does not constitute an admission or agreement by the provider of the truth of the information set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted because of the requirements under State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance. F755- Pharmacy Services 1. Corrective action for the residents affected by the alleged deficient practice: The Medical Director, Pharmacy, and Pharmacy Consultant were immediately	

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F 755	Continued From page 6 revealed the following: 1. Review of a DEA 222 form dated 12/03/19, revealed that the portion of the form designated for signature of Purchaser or Attorney or Agent failed to contain a signature of authorization. Review of the attached Packing Slip that was signed by a Registered Nurse (RN) and dated 12/4/19, revealed that the pharmacy issued the facility the following controlled medications as requested on the unsigned DEA 222 form: Two packages of Fentanyl 25 microgram (mcg) patches (an opioid medication used to treat pain), one package of Morphine Sulfate IR (Immediate Release) (an opioid medication used to treat pain) 15 milligram (mg) tablets (tab), three packages of Morphine oral solution (5 mg/0.25 milliliter (ml)), twenty packages of Oxycodone (an opioid used to treat pain) IR 5 mg tab, and eleven packages of Oxycodone/APAP (an opioid used to treat pain) 5/325 mg tab. 2. Review of a DEA 222 form dated 12/31/19, revealed that the area of the form designated to be filled in by the purchaser that detailed the number of packages received and the date received was blank. Review of the attached Packing Slip that was signed by a RN and dated 01/02/20, indicated that the facility was issued the following controlled medications as requested on the aforementioned DEA 222 form: One package of Fentanyl 12 (12.5) mcg patches, three packages of Fentanyl 25 mcg patches, two packages of Morphine oral solutions 5 mg/0.25 ml, four packages of Oxycodone ER (extended release) 10 mg tab, three packages of Oxycodone IR 5 mg tab and	F 755	notified of the incomplete DEA 222 forms. All forms for 2019 and 2020 to date were reviewed to ensure no additional missing information was noted. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: No residents were harmed due to this citation. Future House Stock Controlled Substance Medications supply can potentially be affected. 3. Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: The DEA 222 forms will be completed by the medical director and DON/Designee. The medications will be accounted for by 2 RN's to ensure accuracy of delivery based on the DEA 222 forms. Following delivery of the medications, the received packing slip will be immediately scanned/emailed to the DON/designee and a copy to be placed in the mailbox to ensure delivery matches on the DEA 222 forms. 4. Corrective actions will be monitored to ensure the alleged deficient practices will not reoccur: The Director of Nursing/designee will review and audit all DEA 222 forms for accuracy. Pharmacy Consultant will complete review of forms based on delivery schedule to ensure accuracy and completeness, assessing monthly. Results of the review will be reported to the QAPI and reviewed with Medical	

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F 755	Continued From page 7 six packages of Oxycodone/APAP 5/325 mg tab. The number of packages received, and date received were not documented by the purchaser as required in the area allotted on the corresponding DEA 222 Form as required. 3. Review of a DEA 222 form dated 01/10/20, revealed that the area of the form designated to be filled in by the purchaser that detailed the number of packages received and the date received was blank. Review of the attached Packing Slip that was signed by an RN and dated 01/13/20, indicated that the facility was issued the following controlled medications as requested on the aforementioned DEA 222 form: Twenty packages of Oxycodone IR 5 mg tabs, two packages of Fentanyl 12 mcg patch and two packages of Morphine Oral Solution 5 mg/0.25 ml. The number of packages received, and date received were not documented by the purchaser as required in the area allotted on the corresponding DEA 222 form as required. 4. Review of a DEA 222 form dated 01/27/20, revealed that the area of the form designated to be filled in by the purchaser that detailed the number of packages received and the date received was blank. Review of the attached Packing Slip that was signed by an RN and dated 01/27/20, indicated that the facility was issued the following controlled medications as requested on the aforementioned DEA 222 form: Six packages of Morphine Solution 5 mg/0.25 ml and six packages of Oxycodone IR 5 mg tab.	F 755	Director monthly.	

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F 755	Continued From page 8 The number of packages received, and date received were not documented by the purchaser in the area allotted on the corresponding DEA 222 form as required. 5. Review of a DEA 222 form dated 02/20/20, revealed that the area of the form designated to be filled in by the purchaser that detailed the number of packages received and the date received was blank. Review of the attached Packing Slip that was signed by an RN and dated 02/21/20, indicated that the facility was issued the following controlled medications as requested on the aforementioned DEA 222 form: Two packages of Fentanyl 12 (12.5) mcg/hr. patch, four packages of Fentanyl 25 mcg patch, 20 packages of Hydrocodone/Acetaminophen 5/300 mg tab (an opioid medication used to treat pain), nine packages of Hydromorphone 2 mg tab (an opioid medication used to treat pain), two packages of Morphine solution 5 mg/0.25 ml syr., twenty packages of Oxycodone IR 5 mg tab, and six packages of Oxycodone/APAP 5/325 mg tab. The number of packages received, and date received were not documented by the purchaser in the area allotted on the corresponding DEA 222 form as required. The surveyor reviewed the Instructions that were printed on the back of all the DEA 22 forms which revealed the following: A person properly authorized by a power of attorney, on file at the registered location as set forth in 21 CFR 1305.5, may sign on behalf of the	F 755		

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F 755	Continued From page 9	F 755		

purchasing registrant. In such cases the officer or agent will indicate the capacity in which he signs, as "Secretary," "Agent," Attorney in-fact," etc.

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

On 11/05/20 at 12:01 PM, the surveyor interviewed the DON who stated that the former DON was responsible for the completion of the DEA 222 forms prior to September 2020. She stated that when controlled medications were needed for the back up narcotic storage the DON was required to complete the DEA 222 form, obtain a signature from the Medical Director and fax the form to the Narcotic Department at the pharmacy. The DON stated that the Medical Director should have signed the DEA 222 form before the form was sent to the pharmacy.

The DON stated the facility received confirmation of receipt of the DEA 222 form from the pharmacy. The pharmacy notified the facility of any irregularities noted on the form if applicable prior to processing. The pharmacy then sent for the DEA 222 form via courier and the order was filled within 24 to 48 hours. She further stated that when the delivery arrived the DON would compare the order received against the Packing Slip and confirm the quantity sent matched the amount requested on the DEA 222 form.

The DON stated that the DON was the only responsible party at the facility who ensured that the DEA 222 forms were completed accurately. The DON was responsible to document the number of packages received and the date received on the DEA222 form.

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On 11/06/20 at 8:52 AM, the DON stated that the pharmacy admitted to the oversight regarding the DEA 222 form dated 12/03/20, which failed to contain the Medical Director's Signature. She stated that she spoke to the Director of Quality Assurance at the pharmacy who acknowledged the oversight and stated that the DEA 222 form was sent to the Drug Enforcement Agency (DEA) and the pharmacy was not questioned regarding the missing signature. She further stated that the pharmacy admitted the oversight on their part and the former DON was no longer employed by the facility.

The DON stated that the number of packages received, and the dates received that were missing on the DEA 222 forms could be validated by the packing slips as proof of receipt. She stated that she documented the number of packages received and date received when the supervisor and another nurse put the controlled medications into the back up narcotic storage unit and the quantity was verified.

The DON stated that the Consultant Pharmacist (CP) stopped coming into the facility in March 2020 due to the COVID-19 lock down and provided the surveyor with contact information.

On 11/06/20 at 10:22 AM, the surveyor phoned the CP via speaker phone in the presence of the survey team with permission. The CP stated that she was at the facility in March 2020 right before the COVID-19 lock down. She further stated that she reviewed the DEA 222 forms when the facility was in the window for a State Survey and not on a routine basis. The CP was unable to recall when she last reviewed the DEA 222 forms. She

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F 755	Continued From page 11	F 755		

further stated that she had not identified any issues with DEA 22 form completion at the facility.

The CP stated that a physician signature was required to be documented on the DEA 222 form when it was sent to the pharmacy and should be sent back to the facility with an explanation if not completed correctly. The CP stated that the DEA 222 form needed to be signed and reviewed by the physician to ensure that he/she approved the medications that were ordered. The physician signature provided authorization for the order and receipt of controlled medications.

The CP stated that the DON should document the date and quantity of controlled substances at the time the order was received. The purpose of the form was to order back up narcotics and the facility must keep the forms on file for accountability of narcotics. The CP stated that there was no issue with drug diversion at the facility.

The surveyor reviewed the facility policy, "Controlled Substances" (revised January 1, 2018), which included the following:

House Stock Controlled Substance Medications are medications which have not been ordered specifically for a resident (elder) but are kept on hand in limited quantities to administer in the event the medication is required before delivery of the controlled substance from the pharmacy.
All house stock controlled substance medication is ordered by a form submitted to the pharmacy.
Schedule II house stocks must be ordered using the specific DEA 222 Form.
The Medical Director must sign and date at the bottom.

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F 755	Continued From page 12 N.J.A.C- 8:39-29.7 (C)	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. 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;	F 880		12/15/20

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	315253	A. BUILDING _____ B. WING _____	11/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER AT SOMERSET, INC	15 DELLWOOD LANE SOMERSET, NJ 08873

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F 880	Continued From page 13 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation it was determined that the facility failed to clean medical equipment between resident use, according to facility policy to prevent the spread of infection. This deficient practice was identified on 1 of 4 nursing units (Birch) and was evidenced by the following:	F 880	Submissions of this plan does not constitute an admission or agreement by the provider of the truth of the information set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted because of the requirements under State and Federal Law. Please	

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F 880	Continued From page 14 On 10/30/20 at 10:36 AM, the surveyor observed Certified Nursing Aide (CNA #1) walk down the hallway on the [redacted] unit pushing a [redacted] lift, an assuasive device that allows people to be transferred between bed and chair. CNA #1 entered resident room #[redacted] to assist the resident in [redacted] out of the [redacted] to the [redacted] On 10/30/20 at 10:49 AM, the surveyor observed CNA #1 exit resident room #[redacted] with the [redacted] lift and placed the [redacted] in the hallway against the wall between resident rooms #[redacted] and [redacted] CNA #1 was wearing the gloves they wore inside the room, then they walked back into resident room [redacted] and exited with two small bags of soiled linen. CNA #1 then walked down the hall to dispose of the two linen bags. CNA #1 then removed her gloves and performed hand hygiene with an alcohol-based hand rub, but never returned to clean the [redacted] lift. On 10/30/20 at 10:50 AM, the surveyor interviewed CNA #2 regarding the cleaning process for [redacted] lifts. CNA #2 told the surveyor that [redacted] lifts were brought to the shower area after use and they were cleaned and stored in the shower area. On 10/30/2020 at 10:55 AM, the surveyor observed CNA #1 take the same [redacted] lift used in resident room #[redacted] from the hallway and entered resident room #[redacted] to assist a resident out of bed. On 10/30/20 at 11:34 AM, the surveyor observed CNA #1 exit resident room #[redacted] with the [redacted] lift and placed the [redacted] against the wall in the hallway between resident rooms #[redacted] and #[redacted]	F 880	accept this Plan of Correction as our credible allegation of compliance. F880- Infection Prevention and Control 1. Corrective action for the residents affected by the alleged deficient practice: The staff member was immediately educated regarding the appropriate sanitization of resident equipment. The [redacted] Lift was immediately cleaned and disinfected. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: All residents requiring mechanical lift support have the potential to be affected. All mechanical lifts were disinfected before and after resident use. All staff was reeducated regarding the importance of ensuring equipment is disinfected prior to any resident use. 3. Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: Signage was placed on all lifts to remind staff regarding the importance of disinfecting equipment prior to resident use. Wipes have been attached to all lifts to ensure supplies are available for cleaning and disinfecting prior to resident use and after all resident use. Manager/designee will check disinfection wipe supply each shift to ensure supplies are available for staff use. 4. Corrective actions will be monitored to	

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F 880	Continued From page 15 without cleaning the lift. At this time, the surveyor interviewed CNA #1 and asked the process for cleaning [Executive Orde] lifts between residents. CNA #1 told the surveyor, "I use wipes and I just cleaned it in the room". The surveyor entered resident room #[Executive] with CNA #1 and asked to see wipes that were used to clean the [Executive Orde] lift. The CNA #1 went through Resident #75's nightstand drawer looking for wipes and closed it without locating any wipes. CNA #1 then picked up a package of aloe hand cleansing wipes that were on top of a dresser in the room and said, "I used these". The surveyor asked if they killed bacteria and if they were the wipes used to clean equipment and CNA #1 repeated, "this is what I used, I used these". On 10/30/20 at 12:10 PM, the surveyor interviewed the unit Licensed Practical Nurse (LPN) regarding the process for cleaning [Executive Orde] lifts between resident use. The LPN told the surveyor that [Executive Orde] lifts were cleaned prior to going into a resident room. When the staff were finished using them, they could either clean it at the resident's room doorway or in the hallway. The LPN told the surveyor the "Purple wipes (bleach wipes)" that were stored in the blood pressure cuff machine were the wipes that were used to clean the [Executive Orde] lifts. The surveyor asked if aloe hand wipes were used and the LPN said "No". On 10/30/20 at 12:19 PM, the surveyor interviewed the Unit Manager/Registered Nurse (UM/RN) regarding the cleaning of the [Executive Orde] lifts. The UM/RN said that [Executive Orde] lifts were cleaned before and after each resident use. The UM/RN told the surveyor they needed to be cleaned	F 880	ensure the alleged deficient practices will not reoccur: Unit manager/ designee will conduct audits of supplies and complete weekly observations to monitor staff compliance. Audits will be conducted three times a week for four weeks, two times a week for four weeks, weekly for four weeks, monthly for 3 months to ensure compliance is maintained. Results of audits will be reported to QAPI monthly to review and identify any patterns or needs for additional education and training.	

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F 880	Continued From page 16	F 880		

before going in the room and then cleaned again either by the resident's doorway or in the hallway.

The surveyor reviewed the medical record for Resident #75.

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 9/29/20, reflected a Brief Interview for Mental Status (BIMS) could not be completed for the resident due to severe cognitive impairment.

A further review of the MDS in Section G. Functional Status, reflected that the resident was a two plus person physical assist for bed mobility and transfers.

The surveyor reviewed the medical record for Resident #95.

A review of the most recent quarterly MDS dated 10/20/20, reflected that the resident had a [redacted]

A further review of the [redacted] was a two-person physical assist for bed mobility and transfers.

On 11/15/20 at 10:45 AM, the surveyor interviewed the Director of Nursing (DON) regarding the cleaning of reusable resident equipment. The DON told the surveyor that any reusable equipment that goes from resident to resident would be cleaned both before use and after use. The DON told the surveyor that "bleach" wipes were provided to the staff and

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F 880	Continued From page 17 readily available. A review of the facility's Cleaning and Disinfection of Resident-care items and Equipment policy dated revised date of November 2019. The policy included under section #1, d. that reusable items are cleaned and disinfected or sterilized between residents (e.g. stethoscopes, blood pressure cuffs, pulse oximeter, glucometer, point of care devices and other durable medical equipment). The policy also included under number 3, that durable medical equipment must be cleaned and disinfected before reuse by another resident. NJAC 8:39-19.4	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315253 Y1	A. Building B. Wing Y2	12/8/2020 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER AT SOMERSET, INC	15 DELLWOOD LANE SOMERSET, NJ 08873

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 12/04/2020	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 12/04/2020	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 12/08/2020
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/9/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			