| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315486 | A. BUILDING _____ B. WING _____ | 10/18/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER | 100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>Standard Survey of: 10/18/19<br><br>Census: 44<br><br>Sample: 16 | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the | F 550 | | 12/3/19 |

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

Electronically Signed | 11/14/2019

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| F 550 | Continued From page 1<br>resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure that staff interact with residents in a dignified and respectful manner for 2 of 14 residents reviewed, Resident #6, and an anonymous resident.<br><br>This deficient practice was evidenced by the following:<br><br>On 10/15/19 at 8:56 PM, the surveyor entered the room of a resident that chose to remain anonymous. The resident was sitting in bed; the head of the bed was in an upright position. The resident asked if the surveyor could hand over the large Styrofoam cup filled with water that was on the overbed table on the resident's right side. The resident tried to reach the water but was unable to grasp the cup. The surveyor asked the resident if they could reach it. The resident replied, "I don't want to spill it." The surveyor suggested the resident ring the call bell. The resident said, "No, Please, I already called twice from my phone. I don't want them to get mad or holler." The surveyor asked if the staff yelled at him/her. The resident then said that they didn't want to get anyone in trouble. The resident could | F 550 | 1. Resident #6 no longer resides at Stonebridge at Montgomery for reasons unrelated to the cited deficiency. The anonymous resident is not identified, so all residents on the same assignment were interviewed by the social worker. No resident gave an indication of any related issue cited.<br><br>2. All residents have potential to be affected, as such all residents will be assessed by the social worker and nursing through the MDS process to determine if any resident may present issues as cited.<br><br>3. All staff who have the potential to be in contact with residents will be in-serviced on customer service and resident sensitivity at orientation upon hire and annually as needed by social worker and/or designee.<br><br>4. All Staff training on customer service will be reviewed with each manager by the social worker and/or designee to ensure compliance. All staff will be in-serviced | |

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| F 550 | Continued From page 2<br>not give names, or times of day, but added that the staff got mad at them if the resident called too much. The surveyor asked for details, but the resident was unable to provide any. The resident said that they didn't blame them, they're always "very busy." The resident denied feeling afraid or intimidated. The resident said they didn't want to bother anyone. This resident, who wished to remain anonymous, did not want the surveyor to talk to anyone about what was said.<br><br>On 10/17/19 at 11:00 AM, the surveyor asked the Registered Nurse (RN) at the nurse's station desk for the unit assignment. The surveyor found the anonymous resident's name on the day shift assignment sheet. The surveyor asked the RN which residents in the list of residents besides the anonymous resident were alert and oriented and able to be interviewed. The RN stated only [Resident #6].<br><br>On 10/17/19 at 11:45 AM, the surveyor interviewed Resident #6. Upon entering the resident's room, Resident #6 stated that some of the aides were nasty. The resident spoke of a Certified Nursing Assistant (CNA), that was also assigned to the anonymous resident before the surveyor asked about the attitude of the staff. The resident explained that they recently reported an incident to the Social Worker (SW). The resident explained that a few days before, they were in the bathroom and that they rang their call bell. The resident got tired of waiting, so the resident stated that he/she, "Got myself," to the recliner in the resident's room. The resident reported that when the CNA came in she yelled at them and said, "What are you doing with your feet up with the call bell on in the bathroom, then she walked out with her hand on her hip." As the surveyor was | F 550 | within their prospective departments by their supervising manager. The DON and/or designee will do rounds twice weekly monitoring staff interactions on alternating shifts and educating immediately if interactions are not appropriate. Findings will be reported to the administrator and presented to the QAPI committee meeting for 2 quarters. Results of completed training will be reported to the administrator by the social worker and/or designee and presented for 2 quarters at the QA team meeting. | |

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| F 550 | Continued From page 3 | F 550 | | |

speaking with Resident #6, the Social Worker (SW) knocked on the door. The resident asked her to come back later. The resident stated, "I asked her to come because I wanted to report something that happened last night. I was sleeping, and the CNA put my dinner on the table and walked out. She didn't even wake me up. When I woke up, my dinner was cold. I called the Registered Nurse and asked him to heat my dinner. He reamed me out, yelling that I always eat late. I don't always eat late, I was asleep when she brought my tray in, and no one woke me up." The resident added that that was the first time the RN had treated them in that way. The surveyor then asked the resident if they were afraid or intimidated by the CNA or the RN, or if the resident felt abused. The resident replied, "I wouldn't describe it as abusive. The few are discourteous. They make judgments and comments that aren't nice. I'm not frightened. I don't like being angry, because I don't feel well when I'm angry." The resident explained that most of the staff were friendly, but that a couple of people were not always nice.

On 10/18/19 at 9:00 AM, the surveyor reviewed the personnel files for the CNA, and the RN identified above. There were no similar incidences documented in the personnel files of the CNA or the RN.

On the same day at 10:18 AM, the surveyor interviewed the SW and asked if she had an investigation of the CNA incident that had occurred a few days previously, as revealed by Resident #6. The SW stated that she wasn't aware of any incident involving that CNA other than a schedule request. The surveyor asked if she went back and spoke with Resident #6. The

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| F 550 | Continued From page 4 | F 550 | | |

SW confirmed that she had followed up with the resident and provided a statement and that the resident spoke of a different CNA. According to the statement, Resident #6 requested to have the CNA in the morning, and not in the evening, because he/she felt that the CNA was less efficient in the evening.

The surveyor also asked the SW if Resident #6 mentioned the incident about the RN. The SW stated, "I have a voicemail from last night about how he made a face at
[ Resident #6 ] when the resident was being transferred to the hospital for abdominal pain last night." The surveyor asked the SW if they could listen to the voicemail together. According to the message, Resident # 6 explained to the SW, while he/she was leaving to go to the hospital, the RN came up to the [resident], and that his eyes were "very dark." Resident #6 further explained to the SW about how [the resident] told [the surveyor] about the way the RN had treated them the night before. And also, that the resident felt bad about telling the surveyor about this. Resident #6 also said that the RN had never acted this way before and that he had always been courteous. Resident #6 further stated that they had mentioned the incident involving the CNA. Resident #6 was apologetic to the SW and felt remorse for telling the [surveyor]"state."

After listening to the voicemail, the SW told the surveyor that Resident #6 was very rational and very sensitive to the feelings of others, so she understood that the resident was probably worried. The SW added that the resident was alert and oriented and able to express themselves.

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| F 550 | Continued From page 5<br>At 11:15 AM, the surveyor interviewed the RN that had been reported as being discourteous. The RN stated, "[The Resident] said [the resident] wanted to change [the resident's] dinner order to scrambled eggs, mashed potatoes and butter. I went directly to the kitchen to order the food. When the food came, one of the aides took it to [the resident's] room. Later when we finished with dinner, [The resident] rang the call bell, I went there and [the resident] asked me to heat up [the resident's] food. I said [Resident # 6], you got a total of [redacted] and you are not eating yet? I took the food to the microwave right away and I heat it up. It was almost an hour after [the resident] received the [redacted]. I said [Resident # 6] you better eat now, there is a lot of [redacted] in your body right now, you're going to bottom out, and I left the room. I didn't ask [the resident] no questions." The surveyor asked the RN what was the resident's response to him and he stated, "[The resident] said they brought the food and [the resident] didn't know that. My thing was eat now, that's a lot of [redacted], so eat now." The surveyor asked the RN if it was possible that the resident was offended by the way he spoke to them and the RN stated, "No, [The resident] said [the resident] didn't know the tray was there, but at that point I wasn't even listening, I was concerned about the [redacted]."<br><br>At 11:47 AM, the surveyor interviewed the CNA on a speaker phone, in the presence of other surveyors, about the incident reported by Resident #6. The CNA had an angry tone in her voice and stated,"I don't have issues with the residents. I am there to help the resident and to give them what they need. I do not have issues with the residents." | F 550 | | |

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| F 550 | Continued From page 6 | F 550 | | |

At 2:00 PM, the surveyor met with the Administrative staff and expressed the concern identified by the aforementioned residents. The surveyor then asked for any training that had been done with the RN and the CNA on Abuse, Sensitivity, Customer Service, and Dignity.

On 10/18/19 at 5:00 PM, the Director of Nursing (DON) provided abuse training that the RN completed on [redacted], and abuse and resident rights training completed by the CNA on 7/12/19. The facility also provided a copy of a presentation that was given dated [redacted] and titled, Session 3, Resident Rights. Line one read:

"All residents are entitled to be treated with respect, courtesy, and consideration as an individual."

A second presentation dated [redacted] and titled, Customer Satisfaction, line two under Customer Service Basics read:

"Treat people with courtesy and respect. Remember that every contact with a resident, family member, or visitor-whether it's by email, phone, written correspondence, or face to face meeting leaves and impression. Use the resident's proper name unless you have been given permission to use their first name. Use phrases like "sorry to keep you waiting", "thank you", "it's been a pleasure helping you."

Number four read:

"Never argue with a resident. You know that residents aren't always right, but instead of focusing on what went wrong, concentrate on how to fix it, and don't take it personally."

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| F 550 | Continued From page 7<br><br>There were no sign in sheets provided for these presentations.<br><br>N.J.A.C. 8:39-4.1, 12 | F 550 | | |
| F 583 SS=D | Personal Privacy/Confidentiality of Records<br>CFR(s): 483.10(h)(1)-(3)(i)(ii)<br><br>§483.10(h) Privacy and Confidentiality.<br>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.<br><br>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.<br><br>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.<br>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman | F 583 | | 12/3/19 |

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| F 583 | Continued From page 8<br>to examine a resident's medical, social, and administrative records in accordance with State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to provide resident privacy during a [redacted] treatment for 1 of 2 wound treatments observed (Resident #3).<br><br>This deficient practice was evidenced by the following:<br><br>On 10/17/19, at approximately 10:39 AM, the surveyor observed the completion of [redacted] prior [redacted] treatments for Resident #3. In the middle of the [redacted] treatment to the [redacted] of Resident #3, the Licensed Practical Nurse (LPN) medicated the resident with [redacted] medication and then proceeded to finish the [redacted] treatment to the [redacted] without closing the resident's door to provide the resident with privacy. The resident's doorway opened to the unit's hallway.<br><br>After finishing the [redacted] treatment, the LPN proceeded to perform the [redacted] treatment to the [redacted] of Resident #3. During the treatment to the [redacted], the LPN went to the treatment cart to obtain a border gauze dressing. The LPN then returned to Resident #3 to finish the [redacted] treatment to the [redacted] without closing the resident's door to provide the resident with privacy.<br><br>On 10/18/19 at 9:46 AM, during surveyor interview, the LPN stated that it was the first time | F 583 | 1.The nurse was in-serviced by the DON 1:1 on privacy for residents.<br><br>2. All residents have the potential to be affected by privacy. All doors closed and opened to ensure they are operational.<br><br>3. All current direct care giving staff will be re- in-serviced on residents' right to privacy standards. Newly hired direct care giving staff will be educated on residents right to privacy standards at orientation, annually and as needed by DON or designee.<br><br>4. DON or designee will do rounds during peak care times, twice weekly, to monitor for resident privacy. Findings will be reported to the administrator and presented to the QAPI committee for 2 quarters to ensure 100% compliance is met. | |

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| F 583 | Continued From page 9<br>she was being watched and that she was nervous and forgot to close the door.<br><br>On the same day at 1:20 PM, the surveyor reviewed the facility policy titled, Elder Rights, with a revised date of 11/28/17, which read: under Procedure:<br><br>d. Privacy and Confidential Treatment,<br><br>1) To have physical privacy. You must be allowed, for example, to maintain privacy of your body during medical treatment...<br><br>N.J.A.C. 8:39-4.1(a)16 | F 583 | | |
| F 658 SS=E | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to follow professional standards of clinical practice with respect to a.) maintain full view of medication at all times; and b.) follow physician's orders. This deficient practice was observed for 4 of 14 residents reviewed for professional standards of practice (Resident's #3, #28, #32 and #241) and was evidenced by the following:<br><br>Reference: New Jersey Statues, Annotated Title 45, Chapter. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The | F 658 | 1. Residents #3,#28,#32 and #241 have all been assessed by RN and MD with no negative outcomes identified. Each residents' orders reviewed by MD to ensure accuracy and necessity.<br><br>2. All residents who receive medications or treatments from the nurses have the potential to be affected.<br><br>3. RN, LPN#2 and LPN#3 were given 1:1 in-service on proper medication and treatment pass techniques, focusing on | 12/3/19 |

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| F 658 | Continued From page 10<br>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."<br><br>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities with in the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."<br><br>1. On 10/17/19 at 9:33 AM, the surveyor observed the Registered Nurse (RN) prepare medication for Resident #241 for morning medication pass. The medication included; [redacted], used to treat a [redacted]), [redacted] (used to treat [redacted], [redacted] (used to [redacted] used in the body for [redacted]), a [redacted] (used to treat [redacted]), [redacted] (used to treat [redacted] functioning of the [redacted]), and [redacted] | F 658 | reviewing E-MAR for all details involved, such as [redacted] or area to be treated. All nurses will be re-educated on medication administration and treatment pass by DON and/or designee on orientation and annually as needed. All nurses will have med pass observation and treatment pass observation performed by consultant pharmacist, pharmacy, DON and/or designee annually and as needed.<br><br>4. Education, med pass observation and treatment pass observation will be monitored by the DON and/or designee. Results will be reported to the administrator monthly and presented at the Quarterly QAPI committee meeting for 4 quarters to ensure compliance. | |

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| **STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER** | **100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558** |

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At that time, the RN walked into Resident #241's room and placed their medications on the resident's overbed table, located away from the resident's bedside. The RN then walked into the resident's bathroom to wash her hands, leaving the medications unattended and not within the nurse's line of sight. The nurse then returned to the resident's bedside and administered their medications as ordered by the physician and completed the medication pass.

At 10:29 AM, the surveyor interviewed the RN and asked if it was appropriate for her to leave medications on the overbed table and go into the bathroom to wash her hands. The RN confirmed that she should not leave medications on the overbed table and out of her line of sight.

At 11:00 AM, the surveyor reviewed Resident #241's facesheet, which revealed, the resident was admitted to the facility on [redacted] with diagnoses which included; [redacted]

The surveyor then reviewed the current Physician's Order Sheet (POS) which read: [redacted] one tablet one time daily, [redacted] (mgs) [redacted] one time daily, [redacted] mg one tablet one time daily, [redacted] tablet one tablet one time daily, [redacted] mg tablet one tablet one time daily, [redacted] mg one tablet one time daily, [redacted]) one [redacted] three times a day, [redacted]

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one capsule one time daily, [redacted]) one capsule two times a day.

A review of the resident's most recent admission MDS (an assessment tool used to facilitate the management of care), reflected that the MDS assessment was still in progress, as the resident was admitted to the facility less than 14 days earlier.

On 10/17/19 at 9:58 AM, the surveyor observed the RN prepare medication for Resident #32's morning medication pass. The medications included: [redacted], [redacted] used to [redacted] (used to treat [redacted] (used to treat [redacted]), [redacted] (used to treat [redacted] (used to [redacted]) [redacted] (used to help decrease [redacted]) and [redacted] (used to treat [redacted]).

At that time, the RN walked into the resident's room. Resident #32 was sitting upright in bed, and the resident's private aide was sitting in a chair opposite the resident's foot of the bed. The RN placed the resident's medications on the resident's overbed table and walked into the resident's bathroom to wash her hands, leaving the medications unattended and not within the nurse's line of sight.

At 10:29 AM, the surveyor interviewed the RN and asked if it was appropriate for the nurse to leave medications on the overbed table and go into the bathroom to wash her hands. The RN stated she should not leave medications on the overbed table and out of her line of sight.

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At 11:30 AM, the surveyor reviewed the resident's facesheet, which revealed that Resident #32 was admitted to the facility on [redacted] with diagnoses which included; [redacted]

The surveyor then reviewed the current Physician's order sheet (POS) which read: [redacted] orally two times daily, [redacted] ( a medication used to treat [redacted] ) [redacted] mg tablet one tablet one time daily, [redacted] (a medication used to [redacted] mg tablet one tablet one time daily, [redacted] a medication used to treat [redacted] as [redacted] ) [redacted] mg one tablet one time daily, [redacted] (a medication used to [redacted] mg tablet one tablet two times daily, [redacted] (a medication used to relieve [redacted] ) [redacted] actuation [redacted] two [redacted] into both [redacted] one time daily, [redacted] (a medication used to [redacted] mg tablet one tablet one time daily.

The surveyor then reviewed Resident #32's BIMS on the most recent MDS, dated [redacted] which recorded that the resident scored a [redacted] of a possible [redacted] which established the resident was [redacted] intact.

2. On 10/17/19 at 12:10 PM, the surveyor interviewed the Consultant Pharmacist (CP) and asked if she did any medication pass training with the nurses. The CP confirmed that she did. The surveyor asked the CP what the nurses were told about leaving the medication at the bedside for the resident to take later. The CP stated, "Absolutely, we tell the nurse to stay at the

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bedside to watch the resident take the medicine. If the nurse leaves it there to get gloves even, we count that as an error. If we leave an open cup in the room, we don't know what happens to it or where it goes. You can't sign off that it's been administered if you didn't observe it." The surveyor asked if there was a process for residents who wanted to self administer medication, and the CP stated, "I don't think there are any residents here who do that. I don't know if that's possible. I would have to check." The surveyor asked the CP what she would suggest if the nurse went to give the resident the medication, and the resident said to leave it. They would take it later. The CP further stated, "I would tell the nurse to stay with and ask the resident to take it or to call the doctor." The surveyor asked if, as a last resort, should the nurse leave the medication with the resident. The CP stated, "No."

At 12:25 PM, the surveyor interviewed the Director of Nursing (DON) and asked if it was appropriate for a nurse to leave pills with a resident to take later. The DON stated, "Only one resident is care planned for that, and I believe it's [Resident #6] because it will take an hour for the resident to take the medicine. [The resident] wants to drink this and take a bite of that. It's very time-consuming."

On the same day at 2:00 PM, the survey team met with the Administrator, the DON, the Regional Registered Nurse (RN) Consultant, the Executive Vice President of Health Services, and the Executive Director. The survey team shared the concern of the nurse leaving the resident's medication in the resident's room and not remaining with the resident until the medication

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was observed as taken.

On 10/18/19 at 12:55 PM, the DON stated the nurses must have sight of medications at all times and that all the nurses would be in-serviced and re-educated.

At 1:00 PM, the surveyor reviewed the facility's policy and procedure titled; Administering medication with an effective date of 4/1/01 and a revised date of 2/6/18. The policy did not address the issue of leaving medication at the bedside unattended.

3. On 10/17/19 at 8:52 AM, the surveyor observed LPN #2 prepare medications for Resident #28 for medication pass observation. One of the medications LPN #2 prepared for the resident was two [redacted] (used to ease [redacted] to be applied to the resident's [redacted] and a [redacted] to be applied to the resident's [redacted]. LPN #2 then proceeded into the resident's room to administer the resident's morning medications.

At 9:05 AM, the surveyor observed LPN #2 remove a [redacted] patch from the resident's [redacted], and then shaking her head, applied a new [redacted] to the [redacted] Then LPN #2 continued to the resident's [redacted]

At 9:07 AM, the surveyor observed LPN #2 remove a [redacted] from the resident's [redacted] r, this time sighing and shaking her head. She then proceeded to apply a new [redacted]

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On 10/17/19 at 2:00 PM, the survey team met with the Administrator, the DON, the Regional Registered Nurse (RN) Consultant, the Executive Vice President of Health Services, and the Executive Director. The survey team shared the concern of the nurse not removing the resident's medication patches per physician's order.

On the same day at 2:29 PM, the surveyor interviewed LPN #2 and asked her if she had expected the resident to have [redacted] patches in place when she attempted to place new patches that morning during morning medication pass. LPN #2 stated the resident had a physician's order to have the [redacted] patches applied to each [redacted] in the morning and a physician order to remove the patches in the evening. LPN #2 stated that the patches should have been removed the evening before and that physician's orders were not followed.

At 2:45 PM, the surveyor reviewed Resident #28's facesheet, which revealed that the resident was admitted to the facility on [redacted] with diagnoses which included; [redacted]

The surveyor then reviewed the current Physician's Order Sheet (POS) which read: [redacted] patch apply 1 patch to [redacted] once daily, ON at 9:00 AM, OFF at 5:00 PM, [redacted] patch apply 1 patch to [redacted] once daily, ON at 9:00 AM, OFF at 5:00 PM.

The surveyor then reviewed the BIMS on the most recent MDS, dated [redacted], which recorded that Resident #28 scored a [redacted] out of a possible

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| F 658 | Continued From page 17<br>[redacted], which established the resident was [redacted] intact.<br><br>On 10/18/19 at 12:55 PM, the DON stated that the nurse who did not remove the [redacted] patches per physician's orders, was an omission of treatment and that the nurse had been re-educated.<br><br>4. On 10/17/19 at 9:58 AM, the surveyor observed the RN prepare medication for Resident #32's morning medication pass. The medications included [redacted].<br><br>At that time, the RN walked into the resident's room where the resident was sitting upright in bed, and the resident's private aide was sitting in a chair opposite the resident's foot of the bed. After the RN washed her hands, she attempted to administer the resident medications, which included placing [redacted] into the resident's [redacted]. Located above the resident, attached to the wall, was a laminated sign indicating, [redacted]."<br><br>At 10:10 AM, the surveyor intervened before the RN could give the resident the [redacted] to aid in administering the [redacted]. The RN, accompanied by the surveyor, stepped outside with the medications and [redacted]. The surveyor then pointed out the sign above the bed, as well as an additional sign located on the side of the resident's wardrobe, indicating [redacted] The surveyor asked why the resident could not use [redacted], and the RN stated that they could [redacted]. The RN then removed the [redacted] from the [redacted] and proceeded to administer the medications to the resident without difficulty. | F 658 | | |

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| F 658 | Continued From page 18<br><br>At 10:29 AM, the surveyor interviewed the RN and asked if it was appropriate to use a [redacted] to administer the medications to Resident #32. The RN stated it was not appropriate and that she should have checked the Medication Administration Record (MAR), where it would indicate the resident's diet and any instructions for administering the resident's medications.<br><br>At 11:30 AM, the surveyor reviewed the resident's face sheet, which revealed that they were admitted to the facility on [redacted] with diagnoses which included; [redacted]<br><br>The surveyor reviewed the current Physician's order sheet (POS), which read: [redacted] orally two times daily, [redacted] mg tablet one tablet one time daily, [redacted] mg tablet one tablet one time daily, [redacted] mg one tablet one time daily, [redacted] mg tablet one tablet two times daily, [redacted], suspension two [redacted] into both [redacted] one time daily, [redacted] mg tablet one tablet one time daily. Diet orders: Thin liquids, Diet Consistency [redacted], Regular Diet.<br><br>A review of the Physician's written orders dated [redacted] revealed a change of diet order to [redacted] with [redacted] soup/thin liquid (no [redacted]).<br><br>At 2:00 PM, the survey team met with the Administrator, the DON, the Regional Registered Nurse Consultant, the Executive Vice President | F 658 | | |

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of Health Services, and the Executive Director. The survey team shared the concern of the RN attempting to use a [redacted] to administer medications to a resident with a diet order that stated, [redacted]."

On 10/18/19 at 11:04 AM, the surveyor interviewed the Speech-Language Pathologist (SLP) who stated that she had been working with the resident for quite some time for [redacted] and [redacted]. The SLP stated the resident was most recently evaluated on [redacted], for not responding to cues to eat as they had in the past, as well as taking an extended amount of time to chew their food. The SLP stated the resident's liquid consumption was a thin consistency. The SLP explained the reason the resident had a [redacted]" order was that the resident tended to take too big of a sip of thin liquids when using the [redacted] and would cough. The SLP stated the [redacted] was thicker than thin liquids and would take longer to swallow. The SLP said she believed the resident could tolerate the thicker consistency [redacted] via [redacted] if the resident took small sips, and someone was there to cue them to drink slowly. The SLP stated she had considered trying to reintroduce the straw back, but her main goal was nutrition. The SLP stated the resident was doing well with the current diet and expected he/she would be discharged from speech therapy soon.

At 12:00 PM, the surveyor reviewed the most recent SLP treatment note dated [redacted], which revealed, as of now, current PO (by mouth) diet [redacted] with a big portion of [redacted] soup with thin liquid [redacted]) is judged to be least restrictive at this time.

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At 1:04 PM, the DON stated the nurse should have reviewed the resident's eMAR before preparing the resident's medications and confirmed that the RN did not follow the Physician's diet order.

At 1:15 PM, the surveyor reviewed the facility's policy titled; Administering Medication under Number 3 it read:

Medications must be administered in a timely manner and in accordance with the attending Physician's written/verbal orders.

5. On 10/17/19, beginning at 9:55 AM, the surveyor observed the [redacted] treatment to the [redacted] of Resident #3. LPN #3 put a barrier sheet on the already wiped bedside table and placed the supplies for the treatment on the barrier sheet. LPN #3 then performed handwashing for 20 seconds with the soap bubbles rising out of the sink and touching her hands. After putting on a pair of gloves, LPN #3 removed the non-adherent dressing on the resident's [redacted] LPN #3 sprayed a 4 X 4 gauze dressing with [redacted] and wiped the wound on the [redacted]. LPN #3 then grabbed the entire stack of 4 X 4 gauze dressings and moved them closer to her on the bedside table. LPN #3 sprayed another 4 X 4 gauze dressing with [redacted] and wiped the [redacted] on the [redacted]. The spray bottle of [redacted] then fell to the floor, and LPN #3 left the bottle on the floor. LPN #3 then placed [redacted] (used [redacted] onto her gloved finger and applied the ointment to the resident's [redacted]. LPN #3 did not change her gloves or use an appropriate

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transfer method to apply the medication. After removing her gloves, LPN #3 performed handwashing for 13 seconds in the non-draining sink with rising soap bubbles. After putting on a pair of gloves, LPN #3 placed a non-adherent dressing on the [redacted]. After removing her gloves, LPN #3 performed handwashing for 12 seconds in the non-draining sink with rising soap bubbles. LPN #3 then went to the computer to check the order for the next [redacted] and put on a pair of gloves.

LPN #3 removed the dressing from the resident's right heel and put [redacted] used to [redacted]) on a 4 X 4 gauze dressing and wiped the heel with the moistened 4 X 4 gauze dressing. LPN #3 then took a dry 4 X 4 gauze dressing and wiped the resident's [redacted]. After removing her gloves, LPN #3 performed handwashing for 14 seconds in the non-draining sink with rising soap bubbles. While LPN #3 had performed the handwashing, Resident #3 had placed [redacted] on the bedsheet. After putting on gloves, LPN #3 applied [redacted] ointment with a tongue depressor to the resident's [redacted] LPN #3 then applied a dry 4 X 4 gauze dressing, thick absorbent pad dressing, and wrapped the [redacted] with an absorbent gauze roll dressing.

LPN #3 then performed the wound treatment to the [redacted] of Resident #3. LPN #3 then performed handwashing for 13 seconds in the non-draining sink with rising soap bubbles. After putting on a pair of gloves, LPN #3 started to perform the treatment to the [redacted] of Resident #3. During the removal of the dressing to the [redacted] the surveyor had to intervene, and LPN #3 stopped the treatment to give Resident #3 [redacted]

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medication. After asking the resident if she could continue, LPN #3 performed handwashing for 10 seconds in the non-draining sink with rising soap bubbles. After putting on a pair of gloves, LPN #3 placed [redacted] ointment on her gloved finger and placed it on the resident's [redacted] LPN #3 then changed her gloves without performing hand hygiene. LPN #3 then placed a small piece of [redacted] and a bordered gauze dressing on the left shin. After removing her gloves, LPN #3 performed handwashing for less than 20 seconds in the non-draining sink with rising soap bubbles. LPN #3 then performed the treatment to the [redacted] of the [redacted] of Resident #3.

On 10/17/19 at the surveyor reviewed the medical record of Resident #3, which revealed the following physician orders:

1. Cleanse [redacted] with [redacted] apply santyl followed by [redacted] and cover with dry dressing daily.
2. Cleanse [redacted] with [redacted]. [redacted] to [redacted]. Apply [redacted] followed by gauze lightly moistened with [redacted] BID (twice daily) and PRN (as needed). Cover with bordered gauze dressing.
3. Cleanse [redacted] with [redacted] (a non-adherent sterile dressing) and cover with [redacted] (a non-adherent dressing) daily.

On 10/18/19 at 9:46 AM, during the surveyor interview, LPN #3 stated that she kept going back to the computer to make sure she was doing the correct treatment, but that there were so many wounds and that she was nervous since she was being observed.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 658 | Continued From page 23<br>On the same day at 12:16 PM, during the surveyor interview, the DON confirmed that LPN #3 should have performed the correct physician's ordered treatment to the corresponding [redacted] for which it was ordered. The surveyor requested a facility policy for following physician's orders. The facility did not provide a policy at the time of the survey exit.<br><br>N.J.A.C. 8:39 - 29.2 (d) | F 658 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to a.) determine a causative factor for a resident who experienced a fall for 1 of 3 residents reviewed for falls, Resident # 7; and b.) failed to ensure that the pull cord in the bathroom of a resident was accessible at all times for 1 of 14 residents reviewed for hazards, Resident # 3.<br><br>This deficient practice was evidenced by the following:<br><br>1. On 10/15/19 at 8:46 AM, the surveyor observed the resident in the resident's room. The resident was in a low bed with half side rails up. | F 689 | 1. Residents #3 and #7 were assessed for fall risk and interventions to prevent falls and promote safety, were reviewed and adjusted as needed. Fall report for resident #7 was completed. Call bell cord for resident for resident #3 was corrected.<br><br>2. All residents have the potential for safety risk and all residents are assessed for fall risk on admission, quarterly and as needed based on changes in condition.<br><br>3. Incidents and accidents are reported per policy and reviewed by the ICD team on day of or next business day post | 12/3/19 |

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| F 689 | Continued From page 24<br>The resident reported that they had a fall not too long ago and cut their [redacted]. The resident didn't remember the details of the fall.<br><br>On 10/17/19 at 10:31 AM, the surveyor spoke with the spouse of Resident #7. The [redacted] repeated the same event of the resident falling not too long ago when trying to get out of bed.<br><br>On the same day at 10:45 AM, the surveyor reviewed the resident's record, which revealed a facesheet which indicated that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted]. The Residents most recent Brief Interview of Mental Status Assessment, dated [redacted], indicated that the resident scored a [redacted] of a possible [redacted] which identified that the resident had [redacted] cognitive impairment.<br><br>The surveyor then reviewed the two fall care plans for Resident #7. One with an effective date of [redacted] and one with a change date of [redacted] that read the same and as follows:<br><br>I am at risk for falls related to my needing assistance with transfer and my decline in my balance.<br><br>After the [redacted] fall, the new intervention listed on the care plan that was dated [redacted] read: Maintain frequent rounding and anticipate resident's needs.<br><br>The surveyor then reviewed a third care plan which read: | F 689 | occurrence. Rooms will be monitored by all staff that are in direct care of residents to ensure all call bell pull strings are in working order. Room call bell pull strings will be audited weekly by nurse supervisor and/or designee to ensure they are operational. ICD team will meet daily to discuss incident interventions and ensure compliance. The DON and /or designee shall round twice weekly and check resident rooms for proper placement of call bell cords and ensure fall prevention interventions in place. Findings will be immediately corrected and staff educated on corrections.<br><br>4. All incident and accident reports will be completed per policy. Results will be reported to the administrator monthly and presented at QAPI committee meeting for 4 quarters. Findings from bi-weekly rounds will be reported to the administrator and presented at the QAPI committee meeting for 2 Quarters. | |

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| F 689 | Continued From page 25<br><br>I am at risk for falls related to my needing assistance with transfer and my decline in my balance. There was a new intervention dated [redacted] which read: Maintain frequent rounding and anticipate resident's needs. That was the same intervention that was initiated a month after the [redacted] fall.<br><br>On 10/17/19 at 12:00 PM, the surveyor reviewed the fall investigation for Resident #7. The investigation indicated that the resident fell on [redacted] at 8:35 PM. There were no injuries identified. The nurses note on the investigation read: Writer called to resident's room [the resident] was on the floor. Upon arriving, the resident was lying supine on the floor. Vitals assessed when asked about [redacted], [the resident] stated that [the resident] feels [redacted] on the [redacted], but nowhere else hurts.<br><br>Further review of the investigation revealed that the fall was unwitnessed. Facility nursing staff were unsure if the resident hit their head, so 911 was called, and the resident taken to hospital for an evaluation. Under Conclusion, it read: N/A.<br><br>The surveyor then reviewed a second fall investigation for Resident #7. The investigation indicated that the resident fell on [redacted] at 5:45 AM. The resident sustained a [redacted] on the resident's [redacted]. The nurses's note on the investigation read:<br><br>Assigned CNA reported to this writer at 5:45 AM, that resident was on a floor, noted lying supine on a floor by [the resident's] bedside, surrounding assess, bed in lower position, half bilateral side rails up, call light within reach but not in use, no | F 689 | | |

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| F 689 | Continued From page 26 | F 689 | | |

wet floor, no clutter. When asked how [the resident] ended up on the floor, stated, "I was trying to get something." Told to remain on floor, body assessment done noted a skin tear on left hand, 3rd finger, stated, "I hit my head on a floor", no swelling or hematoma noted at this time, move all extremities on commands, pupil equal and reactive to light, verbalized no pain when asked, remained in the same position, MD made aware, order to transfer resident by 911 to [the hospital] for further evaluation. [Residents [redacted] made aware. 911 dispatched took resident [to hospital] at 6:15 AM. Under Conclusion, it read: N/A.

On 10/18/19 at 5:00 PM, the surveyor interviewed the Director of Nursing (DON) about the conclusion related to the [redacted] fall. The DON stated that she was still working on it, that other falls with injuries took precedence over this resident's investigation.

On the same day at 6:00 PM, the surveyor reviewed the facility's Policy and procedure titled, Incident Reporting, under Policy it read:

It is the policy of the community that all incidents are properly reported, recorded and analyzed for causative factors and trends. Corrective and/or preventative measures shall be implemented as indicated:

1. Reduce risk to residents, visitors, and employees.
2. Assure incidents are recorded and reported to the proper agencies and internal departments.
3. Analyze all incidents for risk potential implementing corrective and/or preventative actions as required.
2. On 10/17/19 at 9:55 AM, the surveyor

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| F 689 | Continued From page 27<br>observed a [redacted] treatment for Resident #3. During the handwashing observation of the Licensed Practical Nurse (LPN), the surveyor noted the bathroom call bell, which was draped over the towel bar.<br><br>On 10/18/19 at 9:25 AM, the surveyor entered Resident #3's bathroom and observed the call bell cord was again draped over the towel bar.<br><br>At 9:30 AM, the surveyor showed the LPN the call bell, and the LPN stated that housekeeping probably put it there when they were changing the toilet paper roll and that they forgot to put it down.<br><br>At 9:45 AM, the surveyor reviewed the most recent quarterly Minimum Data Set, an assessment tool, dated [redacted], which revealed the resident required two people to extensively assist him/her when toileting.<br><br>At 12:36 PM, during the surveyor interview, the DON confirmed that the call bell cord should not be draped over anything and that it should be hanging straight down. The surveyor then requested a facility policy for the bathroom call bells. The facility did not provide a policy at the time of the survey exit.<br><br>N.J.A.C. 8:39-27.1 (a) | F 689 | | |
| F 697 SS=D | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, | F 697 | | 12/3/19 |

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| F 697 | Continued From page 28<br>and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to identify and provide[redacted] management for a resident that exhibited signs of [redacted], during a [redacted] treatment, consistent with professional standards of practice, for 1 of 2 residents observed during[redacted] treatments (Resident #3).<br><br>This deficient practice was evidenced by the following:<br><br>On 10/17/19, at approximately 10:30 AM, the surveyor observed the completion of three wound treatments to the[redacted], and [redacted] of Resident #3's [redacted] The resident had not complained of [redacted] during the previous treatments. While the Licensed Practical Nurse (LPN) performed hand washing, Resident #3 stated that their [redacted]. The LPN said that she was sorry and that when she was done, she would give Resident #3 [redacted] medicine. The LPN then started to remove the dressing from Resident #3's left shin. The resident was observed to make a face suggesting [redacted] The LPN was trying to remove the dressing, but the dressing was stuck to the resident's[redacted]. Resident #3 stated that the nurse should stop and that the resident was done [with the treatment]. After a failed attempt to remove the dressing, the LPN poured the [redacted] onto the dressing to help ease the removal of the dressing from the resident skin. The LPN went to try and remove the dressing when the surveyor intervened and asked the LPN if there was anything else she could do for the resident at this | F 697 | 1. Resident #3 has been assessed by RN and MD with no negative outcomes identified. Medication for pain has been evaluated and adjusted to ensure optimal pain control during treatment pass.<br><br>2. All residents who receive treatments from nursing staff have the potential to be affected.<br><br>3. All nurses will be re- educated on pain assessment with treatment pass by the DON and /or designee. Newly hired staff will be educated on orientation, annually and as needed. All nurses will have med pass and treatment observation performed by the consultant pharmacist, DON and/or designee annually and as needed.<br><br>4. Education results and pain assessment observation with treatment pass observation will be monitored by the DON and/or designee and reported to the administrator quarterly at the QAPI committee meeting for 4 quarters. | |

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| F 697 | Continued From page 29 | F 697 | | |

time. The LPN asked the resident to rate the [redacted] at that time, in which, Resident #3 said it was a ten on a [redacted] scale of [redacted], with each [redacted] being increasingly more [redacted]

On the same day, at approximately 10:39 AM, the surveyor observed the LPN medicate Resident #3 with an [redacted] tablet (a medication used to treat [redacted]). The LPN then asked Resident #3 if she could finish the treatment to the [redacted], and Resident #3 agreed. The LPN then finished the treatment to Resident #3's [redacted]. Resident #3 appeared to be asleep when the LPN placed the dressing on the resident's [redacted]

At approximately 10:51 AM, the LPN asked Resident #3 about the [redacted] in which the resident did not respond. The surveyor then observed the LPN start the treatment to the [redacted], which was on Resident #3's [redacted].

At approximately 10:56 AM, after finishing the treatment to the [redacted], the LPN asked Resident #3 if they were in [redacted]. Resident #3 stated that there was [redacted], but no [redacted]

On the same day at approximately 11:08 AM, after cleaning up the supplies from the [redacted] treatment, the LPN again asked Resident #3 if they were in [redacted] Resident #3 stated that the LPN did a fantastic job.

Later that same day at 1:43 PM, during the surveyor interview, the LPN stated that today was the first time that the resident had complained of [redacted] The LPN further stated that she never had to stop the treatment or medicate the resident for [redacted] in the past.

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| F 697 | Continued From page 30<br><br>On 10/18/19 at 12:16 PM, during the surveyor interview, the Director of Nursing (DON) confirmed that the LPN should have stopped the treatment, covered the [redacted] with a dressing, and medicated the resident for [redacted]. The DON further confirmed that the LPN should have waited 30 minutes before continuing the treatment.<br><br>At 2:00 PM, the surveyor reviewed the facility policy titled, [redacted] Management, with a revised date of 5/18/12, which read:<br>Under Philosophy:<br><br>Experiencing [redacted] is not a natural effect of growing old. The resident's perception of and or sensitivity to pain does not decrease with age. The elderly have developed coping mechanisms to deal with [redacted] Therefore, even if a resident appears to be occupied, asleep, or otherwise distracted, this does not mean he/she is not experiencing [redacted]. The nurse must use his/her assessment skills to evaluate the non-verbal cues of each resident, such as restlessness, grimacing, etc. The nurse must accept and respect the resident's reports of [redacted] and its severity, as the guide to [redacted] management. The resident is the authority on his/her [redacted]<br><br>At 2:10 PM, the surveyor reviewed the facility policy titled, [redacted] Skin Care, with a revised date of 5/4/18, which read:<br>Under General Policy:<br><br>Pain assessment is conducted during the initial assessment and is an ongoing process (i.e. prior to [redacted] care) to ensure [redacted] management strategies are effective. | F 697 | | |

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| F 697 | Continued From page 31<br><br>NJAC 8:39-27.1(a) | F 697 | | |
| F 730 SS=D | N.J.A.C. 8:39-27.1(a)<br>Nurse Aide Peform Review-12 hr/yr In-Service<br>CFR(s): 483.35(d)(7)<br><br>§483.35(d)(7) Regular in-service education.<br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure that Certified Nursing Aides (CNA) received 12 hours of mandatory in-service training that included dementia and abuse training for 1 of 5 CNA files reviewed (CNA #1).<br><br>This deficient practice was evidenced by the following:<br><br>On 10/18/19 at 11:30 AM, the surveyor reviewed the in-service education hours for five randomly selected CNA files, which were provided by the | F 730 | 1. CNA#1 will receive 12 hours of mandatory in-service training and an annual performance review.<br><br>2. All residents have the potential to be affected by the same deficient practice. An audit of all CNA in-service training and performance reviews will occur in conjunction with a tracking system to ensure compliance. Any requirements for in-service training and annual performance reviews will be performed when needed.<br><br>3. The DON and/or designee will provide | 12/3/19 |

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| F 730 | Continued From page 32<br>facility. The Staff In-service Logs showed the following:<br><br>CNA #1 had a hire date of [redacted] According to the Staff In-service Log, CNA #1 had completed 6.25 hours of in-service education training in the year after her date of hire.<br><br>On 10/18/19 at 11:40 AM, during the surveyor interview, the Administrator confirmed that the 1 of 5 CNA's reviewed did not have the required 12 hours in the annual period reviewed based on their hire date.<br><br>N.J.A.C. 8:39-43.17 (b) | F 730 | annual opportunities for in-service education and performance reviews.<br><br>4. The DON and/or designee will audit all CNA in-service training and annual performance reviews quarterly for 4 quarters. Findings will be reported to the administrator quarterly and presented to the QAPI committee meeting for 4 quarters. | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and | F 761 | | 12/3/19 |

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| F 761 | Continued From page 33<br>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and review of facility documentation, it was determined that the facility failed to a.) properly store refrigerated controlled medications (a federally regulated drug), and b.) remove expired medication from active inventory for 1 of 3 medication carts inspected, and was evidenced by the following:<br><br>1. On 10/15/19 at 6:37 PM, the surveyor, in the presence of the Licensed Practical Nurse (LPN) #1 inspected the [redacted] cart and found an opened bottle of [redacted] (a federally regulated medication used to [redacted]) that had been removed from the refrigerator and was improperly stored in the locked medication cart.<br><br>On the same day at 6:44 PM, LPN #1 stated to the surveyor that she had not administered any [redacted] that day and that the medication must have been left in the medication cart since the administration of the morning dose. LPN #1 then stated the medication should have been stored in the medication room in the locked refrigerator and later confirmed that the [redacted] was not cold to the touch. LPN #1 also confirmed that the last dose of [redacted] was given on that morning at 7:30 AM. LPN #1 stated that the process was to remove the [redacted] from the refrigerator right before it was to be administered, and when the administration was completed, the [redacted] was to be returned and locked in the refrigerator. LPN #1 | F 761 | 1. The medications which were improperly stored were discarded so no residents would be affected.<br><br>2. All residents who receive medications from nursing staff may be affected.<br><br>3. All nurses who distribute medications will be in-serviced on proper medication storage, proper controlled substance storage and proper use of the medication storage system that is in place.<br><br>4. All nurses will be educated on proper medication storage, proper controlled substance storage and proper use of the medication storage system in place during orientation, annually and as needed by the DON an/or designee. All nurses will be observed at med pass on orientation, annually and as needed by the pharmacy consultant, pharmacist, DON and/or designee. Results of completed education and med pass will be monitored by the DON and reported to the administrator monthly at the QAPI committee meeting for 2 quarters. All medication carts will be checked by DON and/or designee monthly for expired medications or medications improperly stored, with any findings corrected immediately. Staff educated immediately. | |

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| F 761 | Continued From page 34<br>further stated that at the change of shift, the controlled medications were counted for accuracy, and she, nor the outgoing nurse, had not noticed that the [redacted] had been left in the medication cart.<br><br>At 7:21 PM, the Registered Nurse/Evening Supervisor (RN/ES) stated that the lorazepam should not have been stored in the mediation cart, but that it should have been stored in the refrigerator. The RN/ES further stated that the change of shift process was the outgoing nurse and incoming nurse together counted the narcotics on the medication cart, once the count was verified the nurse handed off the medication cart key to the incoming nurse. The RN/ES stated that the nurses should have noticed that the bottle was not in the refrigerator and tried to locate it.<br><br>On 10/18/19 at 10:29 AM, the surveyor interviewed LPN #2, who was the outgoing nurse assigned to the [redacted] cart on the 10/15/19 day shift. LPN #2 stated that 10/15/19 was a very busy day and that she had taken the [redacted] out of the refrigerator around 2:00 in the afternoon, in anticipation of the controlled medication count at shift change. LPN #2 stated that she had a lot going on and had forgotten to return the [redacted] to the refrigerator.<br><br>The surveyor then reviewed the manufacturer recommendations for [redacted] Concentrate, which revealed that it should be stored in the refrigerator between 36 and 46 degrees Fahrenheit and that an opened bottle should be discarded after 90 days.<br><br>2. On 10/15/19 at 8:12 PM, the surveyor, in the | F 761 | Results reported to the administrator and presented at the QAPI committee meeting for 2 quarters. | |

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| F 761 | Continued From page 35 | F 761 | | |

presence of LPN #3, inspected the middle cart. In a medication drawer, the surveyor located an opened foil wrapper on which was written 9/25/19 and contained three single-use vials of [redacted] two medications used to treat [redacted] drops. Manufacturer recommendations on the container read: After pouch opened, throw away any unused single-use containers 15 days after the first opening.

At that time, LPN #3 stated that the date on the pouch indicated the date the pouch was opened and that the [redacted] were expired and should have been removed from the cart.

On 10/18/19 at 1:00 PM, the survey team met with the Director of Nursing (DON) and the Administrator. The DON confirmed that the [redacted] should have been secured in the refrigerator in the medication storage room and not in the locked medication cart. The DON further stated that LPN #1 and LPN #2 required re-education. At that same time, the DON confirmed that expired medications should have been removed from active inventory on the medication cart.

At 1:10 PM, the surveyor reviewed the facility policy titled, Controlled Substances, revised 2/6/18, which read under #6:

Controlled substances must be stored in the medication room or medication cart in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medications for elders.

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| F 761 | Continued From page 36<br>N.J.A.C. 8:39-29.4 (h) | F 761 | | |
| F 806 SS=D | Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;<br><br>§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of the medical record and of other facility documentation, it was determined that the facility failed to clarify if a resident had an intolerance and/or, an allergy to [redacted] and, failed to communicate the intolerance/allergy to the Dietary department for 1 of 14 residents reviewed (Resident #21).<br><br>This deficient practice was evidenced by the following:<br><br>On 10/15/19 at 7:55 PM, the surveyor observed Resident #21 sitting up in bed watching television. During the surveyor interview, Resident #21 stated that they had a [redacted] and that they were not sure if the facility knew because they received [redacted] for a lot of their meals. Resident #21 confirmed that they chose their meals.<br><br>On 10/17/19 at 8:27 AM, the surveyor observed | F 806 | 1. Allergy reviewed for resident #21 by the dietician. [redacted] allergy was documented in the resident's chart and the dining staff was notified via diet communication slip. An order was written for [redacted] restricted diet and entered into the EMAR. Resident's care plan was updated to include [redacted] restriction.<br><br>2. All residents have the potential to be affected by the deficient practice. The RD will audit all current residents' charts to check for food allergies and to ensure dining is notified to provide appropriate diet.<br><br>3. DON and/or designee will in-service nursing staff on the importance of communicating food allergies and intolerances on the diet communication form for all new admissions and entering proper diet restrictions into the EMAR. | 12/3/19 |

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| F 806 | Continued From page 37<br>Resident #21 sitting up in bed eating breakfast. The surveyor found Resident #21's meal ticket located on the resident's breakfast tray, which did not reveal any indication that the resident had an intolerance to [redacted] The breakfast tray contained a danish, bacon, and fresh fruit. The tray also included hot tea. During the surveyor interview, Resident #21 stated that they did not tell anyone about the intolerance to [redacted] but that they thought it should be listed on their medical record from when he/she was in the hospital.<br><br>On the same day at 12:03 PM, the surveyor observed Resident #21's lunch tray, which included shrimp creole soup, fruit salad, and tomato salad. The meal ticket had no [redacted] handwritten on it by the resident.<br><br>On the same day at 1:10 PM, the surveyor reviewed the Face sheet of Resident #21, which revealed [redacted] under allergy. The surveyor then reviewed the computer system, which contained the medical record of Resident #21, which revealed [redacted] listed as an allergy.<br><br>The surveyor then reviewed Resident #21's most recent Minimum Date Set (MDS), an assessment tool, dated [redacted]9 that revealed the resident's brief Interview of Mental status was scored a [redacted] out of [redacted] which indicated the resident [redacted] cognitively impaired.<br><br>On the same day at 2:23 PM, during the surveyor interview, the facility's Registered Dietician (RD) stated that no residents were currently on a [redacted] diet.<br><br>On 10/18/19 at 9:58 AM, during the surveyor | F 806 | The RD, DON and/or designee will also review allergies listed on new admission charts to check for food allergies and ensure dining was notified. New admissions will be reviewed by IDC team to ensure accuracy of information to all pertinent departments. Any discrepancies will result in RD meeting with resident or family if resident unable to clarify.<br><br>4. All resident diets will be reviewed and monitored by RD and DON and/or designee to ensure communication is accurate between the kitchen and nursing staff monthly. Results will be reviewed with the Dining Service Director monthly and presented at the QAPI comite meeting quarterly for 2 quarters. | |

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| F 806 | Continued From page 38<br>interview, the Registered Nurse (RN) confirmed that the two Diet Order and Communication forms, dated [redacted] and [redacted] that were given to the dietary department did not contain information about Resident #21's [redacted] intolerance. The RN further confirmed that the dietary department was not notified of Resident #21's [redacted].<br><br>At 10:17 AM, during the surveyor interview, the Food Service Director (FSD) stated that the Nursing staff fill out the Diet Order and Communication forms and send it to the Dietary department when a resident has a [redacted] intolerance. The FSD further stated that there were no residents currently on a [redacted] diet and confirmed that the Dietary department was not notified of Resident #21's [redacted].<br><br>On the same day at 12:15 PM, during the surveyor interview, the Director of Nursing (DON) confirmed that the staff should have clarified if Resident #21 had an allergy or intolerance to [redacted] The DON further confirmed that any allergy or intolerance should have been communicated to the dietary department.<br><br>The surveyor requested a facility policy for food allergy or food intolerance. The facility did not provide a policy at the time of the survey exit.<br><br>N.J.A.C. 8:39-17.4(a) | F 806 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must - | F 812 | | 12/3/19 |

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| F 812 | Continued From page 39<br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner in order to prevent food borne illness.<br><br>This deficient practice was evidenced by the following:<br><br>1. On 10/16/19 at 12:01 PM, in the presence of another surveyor, the surveyor observed Food Service Worker (FSW) #1 enter the second-floor pantry/kitchen and put on a pair of gloves. FSW #1 then proceeded to take the temperatures of the food. FSW #1 had not conducted hand hygiene before putting on a pair of gloves. FSW #1 wiped the thermometer with a sanitizing wipe before taking the temperature of the first food tray but did not clean the thermometer in between taking the temperatures of the five other food trays. | F 812 | 1. The HC pantry FSW#1 and FSW#3 were in-serviced on maintaining kitchen sanitation in a safe and consistent manner as in proper hand washing techniques, safe food handling and proper handling of dirty and clean dishes. FSW#1 and FSW#3 were then supervised by management oversight to ensure proper glove and hand washing techniques were used during meal service. Dishes were sent to the main kitchen for cleaning and sanitizing to allow for oversight in the pantry of proper techniques.<br><br>2. All residents have the potential to be affected by these deficient practices.<br><br>3.The HC pantry will be supervised by management oversight to ensure proper glove and hand washing techniques are used during meal service. Dishes will be | |

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| F 812 | Continued From page 40<br><br>FSW #1 then plated soup into soup cups and then scooped dressings into small black plastic containers. FSW #1 did not change her gloves. FSW #1 was then observed opening the refrigerator and opening the door of the food transport cart and then would proceed to plate more soup into soup cups without changing her gloves.<br><br>On the same date at approximately 12:20 PM, FSW #1 was observed to put on an oven mitt over her gloved hands and removed a stack of plates from the warmer. FSW #1 then placed the plates on the counter and removed the oven mitt from her gloved hands and proceeded to plate entrees. FSW #1 did not change her gloves.<br><br>At approximately 12:30 PM, FSW #1 was observed to scoop the pureed meat on to a plate and then scooped a white-colored pureed substance on top of the pureed meat. The white pureed substance started to fall off the pureed meat, and FSW #1 was observed to push the white pureed substance [that was falling off ] back on top of the pureed meat with her gloved finger. FSW #1 was later observed to use her left gloved hand to hold food that she was cutting with a serrated knife that was in her right hand.<br><br>At approximately 12:42 PM, the surveyor observed FSW #1 removed her gloves and did not perform hand hygiene. FSW #1 walked to the cabinet located just outside of the pantry/kitchen, removed a stack of paper plates from the cabinet, and placed them on the counter in the pantry/kitchen. FSW #1 then put on a new pair of gloves without performing hand hygiene. | F 812 | cleaned and sanitized in the main kitchen and not in the pantry to allow for oversight of proper techniques. Competency tests will be completed for all dining staff by the supervising dietary manager and/or designee by observing dining employees for proper practices during their shift.<br><br>4 Audits on staff hand hygiene, glove use, safe food handling and proper handling of clean and dirty dishes will be conducted my dietary manager and monitored by the Dining Service Director and/or designee. The results will be reported to the administrator monthly and presented for 6 months at the monthly QAPI committee team meeting to ensure compliance. | |

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At approximately 12:50 PM, the surveyor observed FSW #1 take the trays of the remaining food from the steam table and placed them back in the food transport cart. FSW #1 then put the metal lids on the steam table. FSW #1 did not change her gloves or perform hand hygiene.

At approximately 12:55 PM, the surveyor observed FSW #1 move the garbage can with her gloved hand and then moved a black cart and proceeded to place the dirty dishes into the sink. FSW #1 then removed her gloves and took the food transport cart onto the elevator. FSW #1 did not perform hand hygiene.

At approximately 1:08 PM, the surveyor observed FSW #1 come out of the elevator and put on two pairs of gloves. FSW #1 then loaded dirty dishes that she had rinsed in the sink onto a tray. FSW #1 then loaded the tray into the dishwasher, closed the door, and pushed the start button. FSW #1, after the dishwasher, was finished and without changing her gloves, removed the clean tray from the dishwasher. The surveyor observed that two white scalloped dishes had dishwasher fluid inside them. FSW #1 then dumped the fluid out of the two cups into the sink and stacked them on the counter. The surveyor observed FSW #1 stack the rest of the dishes and cups on the counter, which were still wet evidenced by occasional dripping of liquid from the items.

The surveyor then observed FSW #1 place another tray of dirty items into the dishwasher. FSW #1 then loaded dirty dishes from the sink into another tray. After the dishwasher was finished, FSW #1 again removed the clean tray from the dishwasher without changing her soiled gloves and placed another tray of dirty dishes into

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the dishwasher. The surveyor then observed FSW #1 remove the outer pair of gloves she had on. FSW #1 then put away more cleaned, wet dishes and cups onto trays on the counter.

At approximately 1:20 PM, the surveyor observed FSW #1 put a pair of gloves on over the gloves that she already had on. FSW #1 then placed the dirty silverware that she rinsed in the sink into a tray and put the tray in the dishwasher. FSW #1 then loaded another tray with dirty dishes and cups that she rinsed in the sink. When the dishwasher was finished, FSW #1 then removed the clean tray from the dishwasher without changing her dirty gloves.

On 10/17/19 at 8:19 AM, the surveyor observed FSW #1 walk into the pantry/kitchen on the second floor and put on a pair of gloves without performing hand hygiene.

On the same day at 9:38 AM, the surveyor observed FSW #1 taking dirty dishes from the black cart and placed them in the sink. FSW #1 was then observed, opening the finished dishwasher and removed a clean tray of dishes without changing her dirty gloves. FSW #1 then placed a tray of dirty dishes into the dishwasher. FSW #1 then rinsed dishes from the sink and loaded another tray of dirty dishes. After the dishwasher was finished, FSW #1 again removed a clean tray from the dishwasher, without changing gloves, and put a tray of dirty dishes into the dishwasher. FSW #1 then removed her gloves and put on a new pair of gloves without performing hand hygiene.

2. On 10/16/19 at 12:34 PM, the surveyor observed FSW #2 perform handwashing for 10

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seconds.

3. On 10/16/19 at 12:39 PM, the surveyor observed FSW #3 put on a pair of gloves without performing hand hygiene to collect the used dishes from the tables. FSW #3 placed the dishes on the black cart and then removed her gloves. FSW #3 then put on a new pair of gloves without performing hand hygiene.

4. On 10/16/19 at 12:01 PM, the surveyor observed FSW #4 in the pantry/kitchen with a pair of gloves. During the entire lunch observation, the surveyor did not see FSW #4 change her gloves or perform hand hygiene. At approximately 1:26 PM, the surveyor observed FSW #4 remove her gloves and perform appropriate handwashing.

On 10/18/19 at 12:11 PM, during surveyor interview, the Administrator (ADM) confirmed that the FSW's gloves should have been changed more often, and that hand hygiene should be performed after removing gloves. The ADM also confirmed that gloves should be changed and hand hygiene performed before removing clean dishes from the dishwasher. Lastly, the ADM confirmed that handwashing should be performed for 20 seconds outside the flow of water.

On 10/21/19 at 10:50 AM, the surveyor reviewed the facility policy titled, Cleaning Dishes/Dish Machine, with an updated date of 5/20/18 which read:
under Procedure:

2. The person loading dirty dishes will not handle the clean dishes unless they wash their hands thoroughly and put on clean gloves before moving from dirty to clean dishes.

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| F 812 | Continued From page 44<br><br>10. Inspect for cleanliness and dryness, and put dishes away if clean (be sure clean hands or gloves used).<br><br>11. Dishes should not be nested unless they are completely dry.<br><br>On the same day at 11:00 AM, the surveyor reviewed the facility policy titled, General Good Preparation and Handling, with an updated date of 5/23/18 which read:<br>under Procedure:<br><br>3.h. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas or other suitable implements to avoid manual contact of prepared foods.<br><br>At 11:10 AM, the surveyor reviewed the facility policy titled, handwashing, with an updated date of 1/8/19 which read:<br>under Procedure:<br><br>Clean hands and exposed portions of arms immediately before engaging in food preparation.<br><br>1. When to wash hands:<br><br>a. When entering the kitchen at the start of a shift.<br>f. After handling soiled equipment or utensils.<br>g. During food preparation, as often as necessary to remove soil or contamination and to prevent cross-contamination when changing tasks.<br>i. Before donning gloves for working with food.<br>j. After engaging in other activities that contaminate the hands. | F 812 | | |

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| F 812 | Continued From page 45<br>2. How to wash hands:<br><br>b. Wet hands and forearms with warm water and apply an adequate amount of soap.<br>c. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds.<br><br>N.J.A.C. 8:39-17.2 (g) | F 812 | | |
| F 867 SS=F | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(g)(2)(ii)<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure that the Quality Assurance and Performance Improvement (QAPI) Committee develop and implement appropriate plans of action to correct identified quality deficiencies found in the kitchen in accordance with the facility's Plan of Correction (POC) from the last certification period.<br><br>This deficient practice was evidenced by the following:<br><br>On 10/16/19 at 12:01 PM, the surveyor observed the [redacted] pantry/kitchen and noted repeated deficiencies identified from the last survey. Refer to F812 | F 867 | 1. No residents were affected as evidenced by the absence of any break out a food borne related illness. QAPI plan was reviewed with Director of Dining Services to QAPI competencies for infection control as it relates to proper hand washing technique, proper glove usage, proper handling of dishes and safe food handling to ensure 100% compliance.<br><br>2. All residents have the potential to be affected by food related maladies.<br><br>3. The Dining director and/or designee will develop and implement QAPI project format to reflect the following deficient practices identified in F812. The Director | 12/3/19 |

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| F 867 | Continued From page 46<br>A review of the facility's POC submitted and electronically signed on 10/04/18 from the last survey included the following systematic changes:<br><br>* In-service activity and dietary staff on the Hand Washing Policy and Procedure. Give a competency test to all staff and have them demonstrate proper handwashing to pass the test.<br><br>* Implement a (Continuous Quality Improvement) CQI checklist that monitors all areas of the kitchen sanitation and dining standards to maintain standards of practice. Audits will be done daily, weekly, and monthly and will be reported to the Director of Food Services/Designee and reported at the monthly (Quality Assurance) QA meetings.<br><br>* If CQI Plan of Correction (POC) is needed for an audit, it will be initiated immediately by the Food Service Director/Designee and include any other Interdisciplinary Team (IDT) members. The Administrator will review the POC and report at the monthly QA Meetings.<br><br>On 10/18/19 at noon, in response to dietary concerns observed during the survey, the surveyor was provided with documents that included:<br>1) Hand Washing Policy and Procedure updated 1/08/19, 2) Employee handwashing in-service record for two employees on 2/20/19, 3) Training/In-Service Attendance Sheet on Working Together, Regulatory Compliance, Handwashing, Taking Temperatures, and Food Handling for 10 employees on 5/07/19 and 5/11/19, 4) Training/In-Service Attendance Sheet on Personal Hygiene for nine employees on 7/17/19 | F 867 | of Dining Services and/or designee will collect data that will support these QAPI projects to ensure 100% compliance. Results will be reported to the administrator monthly and presented to the QAPI committee team quarterly for 4 quarters.<br><br>4. The corrective action will be monitored by the QAPI committee in conjunction with the administrator to audit and review data. This will include the corrections implemented to achieve 100% compliance for QAPI improvement plans. | |

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| F 867 | Continued From page 47 | F 867 | | |

and 7/18/19, 5) Employee handwashing in-service record for one employee on 7/19/19, and 6) Employee handwashing in-service record for three employees on 10/17/19.

On the same day at 3:15 PM, the surveyor interviewed the Administrator. The Administrator confirmed she oversaw the Quality Assurance (QA) Committee, and she stated that the QAPI process worked by her asking all of the managers of every department in the facility to identify a problem and develop a plan to correct it and then it was reviewed at the monthly QA meetings.

The surveyor then asked the Administrator about the QAPI plan with the Dining Services Department Quality Improvement (QI) Projects of: 1) Daily and Weekly audits of the kitchen and pantries and 2) Compliance with State Requirements for Food as to how it was determined that the Threshold Desired was set at 95 % and what that meant. The Administrator stated they did not want to set it at 100% because they wanted the department to have something to work toward. The surveyor asked about the follow-up for when the Performance Achieved was less than the Threshold of 95%, such as in March 2019 when it was 93 %, and the Administrator stated she was not sure how it was calculated or how it was addressed.

The surveyor then asked the Administrator how follow-up action was measured and evaluated for the January 2019 QAPI report, which noted: 1) Maintain a proactive approach in order to comply with all standards and regulations, 2) Expanded Dining CQI audit has been implemented and tracked monthly and 3) Inservices scheduled on 1/16/19, 1/18/19, and 1/27/19 with entire staff,

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competency tests will be given every quarter, and the next test scheduled for February, for handwashing and taking temperatures. The surveyor asked the Administrator how the Committee measured number one, and she stated she was not sure. For number two, the Administrator showed the surveyor an audit form, but was unable to explain what the numbers meant, what action had been taken for measurements that were less than determined thresholds, why data was incomplete in some of the areas being tracked, and why data was not reported for the months of August and September 2019. The surveyor asked the Administrator what the follow-up was for in-service and competency tests not completed and she stated she did not know but confirmed that competency tests for all handwashing had not been completed quarterly for all Dining employees.

The Administrator stated that she thought the Director of Dietary Services might have a better understanding of the data and asked if he could speak to the surveyors' specific questions.

On 10/18/19, at 3:45 PM, the surveyor interviewed the Administrator, the Director of Dietary Services, and the Corporate Dietician. When questioned about Thresholds (defined as the magnitude or intensity that must be exceeded for a certain result to occur) set by the facility and data measurement, the Corporate dietician stated that if something needs to be set at 100% like Infection Control, it is set at 100%. She said many things go into the data to establish the Threshold and how it was measured. The surveyor asked the Administrator if she understood what was measured and if she knew what went into the calculation, and she stated, "No."

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| F 867 | Continued From page 49<br><br>At that time, the surveyor asked when Infection Control was 81% in January, 90% in February, and 91% in June, if there was any follow-up, the Corporate Dietician stated sometimes in-services are given to the staff as needed. The surveyor reviewed with the Administrator, the Director of Dietary Services, and the Corporate Dietician the documents provided for in-services that had been completed. No additional documents were presented to the surveyor. The surveyor asked if it was important for the Administrator, as head of the QA, to understand the data in order to oversee the Committee and QAPI plan, to monitor system issues, to take corrective action as needed and to resolve areas of concern and the Administrator stated, "Yes." The Administrator also added that it looked like the facility QAPI plan required specific interventions and that they needed to document an evaluation of the progress and updates to the problem as part of the monthly report.<br><br>N.J.A.C. 8:39-33.1; 33.2 | F 867 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention | F 880 | | 12/3/19 |

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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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| F 880 | Continued From page 51<br>by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of facility documents, it was determined that the facility failed to a.) conduct an annual review of the Infection Prevention and Control Policy (IPCP); and, b.) perform proper handwashing to reduce the risk of the spread of infection.<br><br>This deficient practice was evidenced by the following:<br><br>1. On 10/18/19 at 10:30 AM, the surveyor reviewed the facility's IPCP titled, Health Services-Infection Control, which contained sixty-one policies and procedures (P&P). Fifty-Four of the sixty-one P&P's had effective dates of 3/1/17. The following seven remaining P&P's had more recent revision dates:<br><br>Antibiotic Stewardship-Orders for Antibiotics revised 11/22/17<br>Antibiotic Stewardship 11/21/17<br>Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes 11/28/17 | F 880 | 1. No residents were affected as evidenced by the absence of any break out of any type of infection. There were no residents with any type of active infection during the survey. The sink was repaired before survey ended. The nurse was given 1:1 in-service on proper treatment pass technique. The resident was seen by the physician and has no active infection.<br><br>2. All residents have the potential to be affected.<br><br>3. The infection control policy and procedure manual will be reviewed and approved by the infection control committee annually. Each nurse was given a 1:1 in-service on hand washing and a copy of the policy on hand washing. All direct care staff will be educated on handwashing and observed for proper technique by the DON and/or designee on orientation, bi-annually, and as needed. | |

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| F 880 | Continued From page 52<br>Antibiotic Stewardship-Staff and Clinician Training and Roles 11/28/17<br>Infection Prevention and Control Committee 11/28/17<br>Infection Preventionist 11/28/17<br>Policy Review and Updating 11/28/17<br><br>The front page of the manual had a sheet which read: In-Service Sign-off Sheet-By signing below, you acknowledge that you have read and understand the policy below. The policy was listed as Infection Control. Presented by the Director of Nursing (DON) and dated 4/30/19. There were signatures on the page of the Administrator, DON, Medical Director, Infection Preventionist, and five members of the Infection Control Committee.<br><br>On 10/18/19 at 5:00 PM, the surveyor met with the Administrative team and expressed the concern of the facility's IPCP not being reviewed or approved since 2017. The DON stated that the signature page that read: In-Service Sign-off Sheet on the front of the manual dated 4/30/19 was evidence that the IPCP was reviewed and approved this year. The surveyor explained that it had been 21 months between the most recent review date listed and the date on the sign off sheet.<br><br>The surveyor then reviewed the facility's policy and procedure titled, Policy Review and Updating, under Purpose read:<br><br>The facility's infection control policies and procedures shall be reviewed and revised or updated as needed.<br><br>Number two under procedure read: | F 880 | 4. The infection prevention committee will meet and approve the infection control manual. The manual will be presented at the quarterly QA committee meeting. All direct care staff will be educated on proper hand washing technique and observed by the DON and/or designee. Findings will be reported to the administrator and results will be monitored and tracked by the Infection Preventionist and reported to the DON and /or designee. The results will be presented at the monthly QAPI meeting for 2 quarters. the DON and/or designee shall round twice weekly, monitoring for proper handwashing, proper treatment pass techniques and proper infection control practices for 2 quarters. Findings reported to the administrator and presented to the QAPI committee meeting for 2 quarters. | |

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| F 880 | Continued From page 53<br><br>Infection control policies, procedures, practices, etc., shall be reviewed, revised, and updated whenever necessary to reflect:<br>a. New or modified tasks and procedures that affect our infection control program and practices;<br>b. New or revised policies;<br>c. Changes in regulatory guidelines and recommendations.<br><br>2. On 10/17/19 at 9:04 AM, the surveyor observed Licensed Practical Nurse (LPN #1) prepare medications for Resident #28. LPN #1 washed her hands, outside the flow of water for greater than 20 seconds, used paper towels to dry her hands, and then used those same paper towels to turn off the water faucet tap.<br><br>On the same day at 9:37 AM, the surveyor observed LPN #1 prepare medication for Resident #14. LPN #1 washed her hands outside the flow of water for greater than 20 seconds, used paper towels to dry her hands, and then used those same paper towels to turn off the water faucet tap.<br><br>At 2:29 PM, the surveyor interviewed LPN #1, who stated that she had worked at the facility for [redacted] and was taught to use the same towel she dried her hands with to close the faucet tap. LPN #1 further stated that she had been in-serviced at least twice for the appropriate hand washing technique.<br><br>At 2:38 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM), who stated that during in-services, she encouraged the staff to wash their hands for more than 20 seconds to wash in between residents, and | F 880 | | |

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encouraged staff to use hand sanitizer. The RN/UM further stated that in-services were performed monthly to remind the staff of proper handwashing. The RN/UM confirmed that LPN #1 should have used a clean paper towel to close the faucet because the faucet was considered contaminated.

At 4:53 PM, the survey team met with the Director of Nursing (DON) and the Administrator for the facility. The DON stated the proper procedure for performing hand hygiene was to use a separate paper towel for drying hands and closing the water faucet tap. At that same time, the facility Administrator confirmed the DON's statement.

Surveyor: [redacted]

Surveyor: [redacted]

3. On 10/17/19 at 9:55 AM, the surveyor observed the following during the [redacted] treatment to the [redacted] of Resident #3:

LPN #2 performed handwashing for 18 seconds in Resident #3's bathroom sink. The surveyor observed that the sink was not draining well, and the bubbles from the soap were accumulating in the sink, and the soap bubbles were rising above the sink basin and toward the faucet. LPN #2 was unable to perform proper rinsing of her hands without her hands being contaminated from the dirty soap bubbles in the sink.

LPN #2 then put a barrier sheet on the already wiped bedside table and placed the supplies for the treatment on the barrier sheet.

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| F 880 | Continued From page 55<br>LPN #2 then performed handwashing for 20 seconds with the soap bubbles rising out of the sink and touching her hands.<br><br>After putting on a pair of gloves, LPN #2 removed the non-adherent dressing on the resident's [redacted] LPN #2 sprayed a 4 X 4 gauze dressing with [redacted] and wiped the [redacted] on the [redacted] LPN #2 then grabbed the entire stack of 4 X 4 gauze dressings and moved them closer to her on the bedside table.<br><br>LPN #2 sprayed another 4 X 4 gauze dressing with [redacted] and wiped the [redacted] on the [redacted]. The spray bottle of [redacted] then fell to the floor, and LPN #2 left the bottle on the floor.<br><br>LPN #2 then placed [redacted] (used to [redacted]) onto her gloved finger and applied the ointment to the resident's [redacted] LPN #2 did not change her gloves or use an appropriate transfer method to apply the medication.<br><br>After removing her gloves, LPN #2 performed handwashing for 13 seconds in the non-draining sink with rising soap bubbles.<br><br>After putting on a pair of gloves, LPN #2 placed a non-adherent dressing on the [redacted]<br><br>After removing her gloves, LPN #2 performed handwashing for 12 seconds in the non-draining sink with rising soap bubbles.<br><br>LPN #2 then went to the computer to check the order for the next [redacted] and put on a pair of gloves. | F 880 | | |

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LPN #2 removed the dressing from the resident's [redacted] and put [redacted] (an [redacted] used to [redacted]) on a 4 X 4 gauze dressing and wiped the [redacted] with the moistened 4 X 4 gauze dressing.

LPN #2 then took a dry 4 X 4 gauze dressing and wiped the resident's [redacted]. After removing her gloves, LPN #2 performed handwashing for 14 seconds in the non-draining sink with rising soap bubbles.

While LPN #2 had performed the handwashing, Resident #3 had placed [redacted] on the bedsheet.

After putting on gloves, LPN #2 applied [redacted] ointment with a tongue depressor to the resident's [redacted].

LPN #2 then applied a dry 4 X 4 gauze dressing, thick absorbent pad dressing, and wrapped the [redacted] with an absorbent gauze roll dressing.

LPN #2 then performed the wound treatment to the [redacted] of Resident #3.

LPN #2 performed handwashing for 15 seconds in the non-draining sink with rising soap bubbles and put on a pair of gloves.

LPN #2 then picked up the spray bottle of [redacted] from the floor and sprayed the [redacted] on the [redacted] without wiping the spray bottle with a disinfectant.

LPN #2 then changed her gloves without performing hand hygiene and completed the

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| | 315486 | A. BUILDING _____ B. WING _____ | 10/18/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER | 100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558 |

| (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 880 | Continued From page 57<br>[redacted] treatment to the [redacted]<br><br>LPN #2 then performed handwashing for 13 seconds in the non-draining sink with rising soap bubbles.<br><br>After putting on a pair of gloves, LPN #2 started to perform the treatment to the [redacted] of Resident #3.<br><br>During the removal of the dressing to the [redacted] LPN #2 gave Resident #3 pain medication.<br><br>After asking the resident if she could continue, LPN #2 performed handwashing for 10 seconds in the non-draining sink with rising soap bubbles.<br><br>After putting on a pair of gloves, LPN #2 placed [redacted] ointment on her gloved finger and placed it on the resident's [redacted]<br><br>LPN #2 then changed her gloves without performing hand hygiene. LPN #2 then placed a small piece of [redacted] (used to [redacted]) and a bordered gauze dressing on the [redacted].<br><br>After removing her gloves, LPN #2 performed handwashing for less than 20 seconds in the non-draining sink with rising soap bubbles.<br><br>LPN #2 then performed the treatment to the [redacted] of Resident #3.<br><br>On 10/18/19 at 12:16 PM, during the surveyor interview, the DON confirmed that LPN #2 should not have washed her hands in a clogged sink and that she should have performed handwashing for 20 seconds outside the flow of | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315486 | A. BUILDING _____ B. WING _____ | 10/18/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **STONEBRIDGE AT MONTGOMERY HEALTH CARE CENTER** | **100 HOLLINSHEAD SPRING ROAD SKILLMAN, NJ 08558** |

| (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 880 | Continued From page 58<br>water. The DON also confirmed that LPN #2 should have changed her gloves after cleaning a wound before placing medication on the [redacted] and that placing medication should not be done with a gloved finger.<br><br>On 10/22/19 at 8:30 AM, the surveyor reviewed the facility policy titled, [redacted] Care, with a revised date of 5/4/18, which did not contain information on how to perform the [redacted] treatment correctly.<br><br>On 10/22/19 at 8:45 AM, the surveyor reviewed the facility policy titled, Handwashing/Hand Hygiene, with a revised date of 7/18/18, which read:<br>Under Procedure:<br>7. Use an alcohol-based hand rub...or alternatively, soap and water for the following situations:<br><br>f. Before donning gloves;<br>g. Before handling clean or soiled dressings, gauze pads, etc.;<br>Under Washing Hands:<br>2. ...Wet your hands and wrists.<br>3. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) away from the stream of water.<br>4. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink.<br><br>N.J.A.C. 8:39- 19.4 (a) | F 880 | | |