STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	05/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WANAQUE CENTER FOR NURSING & REHABILITATION, THE	1433 RINGWOOD AVE HASKELL, NJ 07420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY 5/15/17 CENSUS: 215 SAMPLE SIZE: 30	F 000		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 279		6/2/17

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

Electronically Signed | 05/25/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	05/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WANAQUE CENTER FOR NURSING & REHABILITATION, THE	1433 RINGWOOD AVE HASKELL, NJ 07420

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F 279	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to develop an individualized comprehensive care plan for Resident #25, who was 1 of 27 residents reviewed for care planning, as evidenced by the following: This deficient practice was identified for 1 of 30 residents, Resident #25, and was evidenced by	F 279	1. a. Resident #25 had no ill effect from the deficient practice. His care plan and care guide were updated to reflect communication techniques. b.The Teacher Aide was in-serviced to ensure that when a child is noted not being his/her usual self, not feeling well, in pain, discomfort, distress, or having	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	05/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WANAQUE CENTER FOR NURSING & REHABILITATION, THE	1433 RINGWOOD AVE HASKELL, NJ 07420

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F 279	Continued From page 2 the following: On 5/4/17 at 10:00 a.m. during the initial tour, the Licensed Practical Nurse (LPN #1) informed the surveyor that Resident #25 was nonverbal and had diagnoses which included Cerebral Palsy, Seizure Disorder and Temperature Instability. On 5/9/17 at 12 p.m. the surveyor observed the resident in his room in a "tilt in space" wheel chair with a seatbelt, arm and leg rests, padded lap tray, chest strap and a head rest. The enteral feeding (a nutritional feeding supplied through a tube in the stomach) was infusing via a pump at 50cc/hr. The LPN #1 told the surveyor that the resident was nonverbal, unable to communicate and staff must anticipate the resident's needs. The Interdisciplinary team (IDT) assessed the resident utilizing the Annual Minimum Data Set (MDS), an assessment tool dated 6/22/16. The IDT assessed Resident #25 as having no speech with severely impaired cognition. The resident's hearing and vision was also documented as being severely impaired. On 5/10/17 at 10:45 a.m. the surveyor observed Resident #25 sleeping in the day room on the second floor during a music class. At 10:55 am. the resident began to cough and continued coughing loudly and attempting to clear the airway of secretions. A teacher from the Division of Children and Family Services (DCFS) School asked a Teachers Aide (TA) to bring Resident #25 to his/her room. The TA brought the resident to the room without informing the nurse that the resident was coughing and having difficulty clearing	F 279	respiratory problems, a Licensed Clinical Staff member must be informed so they can immediately assess the child's condition and provide needed interventions. 2. All Cognitively impaired residents were reevaluated to identify effective communication techniques so staff will be able to recognize needs such as resident's behavior used to indicate pain, distress and respiratory problems, emergencies or any meaningful behaviors. These communication techniques will be added to the Resident's Care Plan and Care Guide. 3.All Teachers Aides were in-serviced to ensure that when they noticed that a child has any sign and symptoms of pain, discomfort, distress, not being their usual selves or not feeling well, the Teacher Aides must notify the licensed clinical staff immediately so they can assess the condition of the child and provide needed clinical interventions. 4. ADON/designee will perform a random weekly observation of the children while in the classrooms to ensure that Teacher Aides are recognizing the needs of each children and that clinical staff are being notified as needed. Outcome of the weekly audits will be reported monthly by the ADON/designee to the Risk Management Committee and Quarterly to the QA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	05/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WANAQUE CENTER FOR NURSING & REHABILITATION, THE	1433 RINGWOOD AVE HASKELL, NJ 07420

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F 279	Continued From page 3	F 279		

secretions.

The surveyor, who was following the resident and TA, asked the TA if she was going to inform the nurse about the resident's status. The TA said "yes" and went to the nurses' station where she told the Assistant Director of Nursing (ADON) that the resident was "crying and stuff."

At that time the surveyor located the resident's Nurse (LPN #2) who accompanied the surveyor to the resident's room to speak with the TA. The surveyor inquired as to why the resident's coughing episode was not reported to the ADON (who was at the nurses' station at the time). The TA stated,"Because s/he coughs and cries all the time, I guess I should have told the nurse."

LPN #2 told the surveyor that Resident #25 does not cough profusely all the time and the school staff was instructed to call her immediately if any of her "kids" were in trouble.

The surveyor then interviewed one of the teachers who was present during the coughing episode who stated that the resident "needed to be taken to the nurse."

The surveyor interviewed the ADON who told the surveyor, "they should have called for a nurse."

The surveyor interviewed LPN #1 who stated that the TA should have stopped at the nurses' station so the nurses could bring the resident into the treatment room to assess whether or not s/he needed to be suctioned.

The surveyor then reviewed Resident #25's Plan of Care which did not include a Care Plan on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	05/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WANAQUE CENTER FOR NURSING & REHABILITATION, THE	1433 RINGWOOD AVE HASKELL, NJ 07420

(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 279	Continued From page 4 communication techniques to inform staff on behaviors used to indicate the resident's pain or distress and interventions to be used for distress, respiratory problems, emergencies or any meaningful behaviors. The surveyor interviewed the Director of Education/ RN who told the surveyor that she recently in-serviced the school staff about when to call for nurses. On 5/10/17 at 12:20 p.m. the surveyor interviewed the Director of Nursing and the Regional Clinical Manager who were not able to provide a Comprehensive Care plan for Communication and told the surveyor "there should have been one."	F 279		
F 441 SS=E	NJAC 8:31-11.2(d) INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (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 (facility assessment	F 441		6/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	05/15/2017

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WANAQUE CENTER FOR NURSING & REHABILITATION, THE	**1433 RINGWOOD AVE HASKELL, NJ 07420**

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F 441	Continued From page 5 implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	05/15/2017

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F 441	Continued From page 6 under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure infection control practices were followed. This deficient practice was identified for 2 of 27 residents reviewed for infection prevention, Resident #1 and #5 and for 11 of 11 medication carts inspected on pediatric floors 1 and 2 and was evidenced by the following: 1. On 5/5/17 at 8:50 a.m. the surveyor observed the 1st floor medication nurse (Nurse #1) prepare medication for administration to a pediatric resident. The surveyor noted loose unwrapped syringes without needles stored in a green cup on top of the medication cart. The surveyor also observed the same type of syringes stored inside the medication cart. The surveyor observed that Nurse#1 removed a syringe from the green cup on top of the medication cart, used the syringe to measure a liquid medication and transferred the medication to a medication cup for administration. Nurse#1 placed the syringe back in the green cup on top of the medication cart. Nurse#1 put the medication cup onto a small medication tray for transport to the resident's room. The surveyor observed Nurse#1 remove another syringe from the top drawer of the medication cart. She	F 441	1. a.There were no residents affected by the deficient practice. b. All oral syringes used to measure liquid medications were discarded and replaced with new oral syringes. These new oral syringes were placed inside an individual zip lock bag and taped to each individual medication. The oral syringe will only be used to measure for each individual liquid medication and will be discarded after medication is completed or discontinued. c. All medication trays were discarded and replaced with disposable trays to be thrown out after each use. d. All the scoops found inside powder canister formulas were discarded and replaced with new ones. All new scoops will be placed individually on a zip lock bag. e. All loose unwrapped blue Adaptacaps were discarded. New Adaptacaps will be used for each medication and will be	

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	315229	A. BUILDING _____ B. WING _____	05/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 7	F 441		

measured another liquid medication, transferred the medication to a medication cup for administration, and placed the cup on the same small tray as the other medication. Nurse#1 put the syringe just used into the green cup on top of the medication cart.

Nurse#1 took the small tray with the medications into the resident's room and placed it on an over-bed table. The table was not disinfected with a germicide wipe. After the medication was given to the resident the tray was removed from the table and it was placed on top of the medication cart to use for another resident. The tray was not cleaned of surface contaminants from the over-bed table in the room.

When Nurse#1 completed administering the resident's medication, the surveyor asked her to explain the difference between the syringes stored in the green container on top of the medication cart and the syringes stored in the top drawer of the medication cart. Nurse#1 explained that the syringes in the top drawer of the medication cart are used to accurately measure liquid medication for administration and the syringes in the green container on top of the medication cart had already been used for medication measurement and needed to be washed, dried, and then placed back into the top drawer of the medication for reuse. The surveyor noted that the syringes were used for multiple residents and not identified for use for a single resident.

On 5/5/17 at 9:25 a.m. the surveyor observed the 2nd floor medication nurse, Nurse#2, use a syringe from the top drawer of the medication cart

discarded after medication use is completed.

f. Oxygen tubing was discarded immediately and replaced with a new tubing which was placed appropriately in a plastic bag.

g. The licensed nurse that performed the deficient practice was in-serviced on the proper way to dispose and store items like the germicidal wipes and sanitizer after treatment pass.

2. All units were inspected to make sure that all deficient practice were corrected.

3. Policy on Proper Use and Storage of Oral Syringes, Medication trays, Adaptacaps and Formula scoops was revised.

All licensed staff were in-serviced on the revised Policy on Proper Use and Storage of Oral Syringes, medication trays, Adaptacaps and formula scoops.

All nursing staff were in-serviced regarding all deficient findings and measures put in place for correction.

4. ADON/designee will perform random monthly audit of their units to ensure that staff are observing appropriate infection control techniques with regards to use of oral medication syringes, medication trays, formula scoops, Adaptacaps, oxygen tubing, and disposal/storage of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	05/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WANAQUE CENTER FOR NURSING & REHABILITATION, THE	1433 RINGWOOD AVE HASKELL, NJ 07420

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F 441	Continued From page 8	F 441		

to accurately measure liquid medication. The nurse transferred the medication to a medication cup and placed the syringe into the green cup on top of the medication cart. The medication cup was placed on a small medication tray for transporting. The nurse placed the tray on the resident's over-bed table without disinfecting the table. After administration of the medication, the surveyor observed Nurse #2 rinse the tray with water and place the wet tray back on the medication cart for use with the next resident. The surveyor asked the nurse what was done with the syringes in the green cup that were used to measure the liquid medications. Nurse #2 responded that the syringes were washed, dried and reused.

On 5/5/17 at 10:55 a.m. the surveyor continued to inspect the 2nd floor pediatric unit of the facility. The surveyor noted three medication carts each with green cups on top of the cart for used syringes and washed syringes stored in the top drawer of the medication carts. The surveyor also observed in the top drawer several different sizes of loose unwrapped blue Adaptacaps, used to replace the caps on liquid medications to facilitate withdrawal of the liquid medication.

On 5/5/17 from 11:30 a.m. to 11:50 a.m. the surveyor inspected the 1st floor pediatric unit and observed eight medication carts (med carts). The surveyor checked each med cart as follows on the 1st floor:

-Med cart marked #2 which had a dry and wet small medication tray on top of the cart along with a green cup for used syringes. The surveyor observed many syringes together with loose

germicidal wipes and hand sanitizers after treatment pass. Outcome of the monthly audits will be reported by the ADONs quarterly to the QA Committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	05/15/2017

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WANAQUE CENTER FOR NURSING & REHABILITATION, THE	**1433 RINGWOOD AVE HASKELL, NJ 07420**

(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 441	Continued From page 9	F 441		

unwrapped blue Adaptacaps stored in the top drawer of the medication cart.

The surveyor also observed a scoop stored in an Amino Acid Powder (ElecCare Powder) canister in the bottom drawer of the medication cart, potentially exposing the powder to contamination when repeatedly used by the nurse to scoop to add the powder to a liquid for administration.

-Med cart marked #1 and observed a green cup used to store used syringes on top of the cart, and washed syringes in the top drawer together with loose unwrapped blue Adaptacaps. The surveyor asked the Nurse#3 (assigned to med cart #1) what was done with the used syringes in the green cup and she responded that the syringes are washed, dried and reused.

-Med cart marked #8 had two small medication trays, one clearly soiled with a white powdery residue on top of the medication cart. The surveyor also observed a green cup for used syringes on top of the cart. The surveyor then found many wet syringes together with loose unwrapped blue Adaptacaps, some of which were visually soiled with a white powdery residue, stored in the top drawer of the medication cart.

The surveyor also observed scoops left in powdered products stored in the bottom drawer of the medication cart. The drawer contained canisters of ElecCare Powder, Similac Powder and Cholestyramine. The surveyor asked the medication Nurse#4 (assigned to med cart #8) what was done with the syringes in the green cup. The nurse responded that the syringes are washed, dried and reused. The nurse admitted that the syringes in the drawer were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WANAQUE CENTER FOR NURSING & REHABILITATION, THE	1433 RINGWOOD AVE HASKELL, NJ 07420

(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 441	Continued From page 10	F 441		

thoroughly dried but stated they should be dried before use.

-Med cart marked #5 had four small wet medication trays on a washcloth on top of the medication cart. The surveyor also observed loose unwrapped blue Adaptacaps stored in the top drawer of the medication cart.

-Med cart marked #6 had two small medication trays with water droplets stored on top of the medication cart and loose unwrapped blue Adaptacaps stored in the top drawer of the medication cart.

-Med cart marked #7 had a green cup with soapy water for used syringes on top of the cart and one medication tray as well as loose unwrapped blue Adaptacaps stored in the top drawer of the medication cart. The surveyor asked medication Nurse #5 (assigned to med cart #7) what they did with the syringes in the green cup and she responded that the syringes were washed, dried and reused.

-Med cart marked #3 had a small tray with an ear thermometer on top of the medication cart. The surveyor also observed loose unwrapped blue Adaptacaps stored in the top drawer of the medication cart.

-Med cart marked #4 had two medication trays on top of the cart, one having wet droplets on it and the other one dry. A green cup filled with used syringes was stored on top of the medication cart and loose unwrapped blue Adaptacaps were observed in the top drawer of the cart. The surveyor asked the medication Nurse#6 (assigned to med cart #4) what they did with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	05/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WANAQUE CENTER FOR NURSING & REHABILITATION, THE	1433 RINGWOOD AVE HASKELL, NJ 07420

(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 441	Continued From page 11	F 441		

syringes in the green cup and she responded that the syringes are washed, dried and reused.

On 5/5/17 at 11:50 a.m. the surveyor asked the Director of Nursing (DON) for the policy and procedure for reusing medication syringes. The DON presented the surveyor with a copy of "Nursing Medication Syringe-Proper Cleaning and Storage" policy and procedure (P&P) that the surveyor had previously observed during inspection in the 1st floor medication room. The P&P documented "1. After use, wash syringe well with soap and water, removing all residual medicine. 2. Rinse well-shake excess water off and dry. 3. Replace in plastic bag and put in resident's medication drawer."

On 5/5/17 at 2:00 p.m. the surveyor discussed with the Director of Nursing and Administrator the areas observed in infection control practices. The DON agreed that the procedure for utilizing, storing and reuse of syringes was not properly followed. The DON also agreed that the medication trays had to be sanitized/dry between every resident and that scoopers should not be stored in powder canisters rather separately so as not to introduce bacteria.

2. On 5/4/17 at 10 a.m., during the initial tour of the 3rd floor, the surveyor along with the Clinical Manager (CM) walked into Resident #5's room and observed a large standing Oxygen (O2) tank at the head of the resident's bed with O2 tubing wrapped around the top of the tank. The nasal cannula where O2 enters the resident's nose was left exposed. On the resident's over-bed table there was additional nasal cannula O2 tubing left exposed. The CM told the surveyor that Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	05/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 12 #5 was at the Dialysis Center. The CM discarded the O2 tubing and said they should have been placed in a plastic bag. 3. On 5/5/17 at 9:45 a.m., the surveyor observed a wound treatment performed by the nurse for Resident #1. The surveyor observed the nurse wiped the over-bed table with a germicide wipe and covered the table with a barrier pad. The surveyor observed the nurse remove the germicide container and a bottle of hand sanitizer from the treatment cart and placed them on the resident's over-bed table in preparation for the wound treatment. At the end of the treatment, the nurse discarded the remaining supplies from the over-bed table. She wiped the outside of the germicide container and the bottle of hand sanitizer with a germicide wipe and placed the two items back onto the resident's over-bed table. The nurse continued to perform routine tasks with the germicide container and hand sanitizer on the table. The nurse proceeded to remove the trash from the room and then returned to the over-bed table, picked up the germicide container and hand sanitizer and began to place them on the treatment cart. Upon surveyor inquiry the nurse did not place the uncleansed items on the cart. N.J.A.C. 8:39-19.4(a)	F 441		
F 514 SS=B	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5)	F 514		6/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	05/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 13 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure accurate clinical information was readily accessible for Resident #24, who was 1 of 27 residents reviewed for medical record	F 514	1. Care Card for Resident#24 was corrected. 2. All Resident Care Cards were reviewed to ensure that it has accurate clinical	

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F 514	Continued From page 14 documention and was evidenced by the following: On 5/4/17 at 10:00 a.m. during the initial tour of the facility, the Registered Nurse (RN) informed the surveyor that Resident #24 was legally blind and not interviewable. Resident #24 was a young adult admitted to the facility on 7/5/2010 with multiple medical diagnoses to include Cerebral Palsy, Intellectual Disabilities, and Obstructive Hydrocephalus and was fed via Gastrostomy Tube. On 5/12/17 at 8:30 a.m. the surveyor reviewed Resident #24's Medical Record and noted that Resident #24 was admitted to the facility on 7/5/10. The surveyor reviewed the Annual Minimum Data Set dated 12/27/16 and the corresponding Care Area Assessments triggered that identified Resident #24's vision status as severely impaired, blindness with peripheral vision or other vision problem that impedes ability to eat, walk, or interact with others. On 5/12/17 at 8:30 a.m. the surveyor reviewed Resident #24's eye examine from Resident Eye Care Associates dated 9/26/16 that confirmed and identified the resident as "legally blind by light reaction." On 5/12/17 at 8:30 a.m. the surveyor reviewed Resident #24's Resident Care Card which identified the resident's vision status as "Normal." The resident did not have the ability to eat, walk or interact in a meaningful way with other due to his medical condition. On 5/15/17 at 9:30 a.m. the surveyor interviewed Resident #24's Certified Nursing Assistant (CNA)	F 514	information which reflects the correct physical and medical condition of the residents. 3. All staff were in-serviced to ensure that the Resident Care Card has accurate clinical information which reflects the correct physical and medical condition of the residents. 4. DON/designee will perform random monthly audit of the Resident Care Cards to ensure that it has accurate clinical information of the residents. Outcome of the monthly audit will be reported quarterly by the DON to the QA Committee.	

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F 514	Continued From page 15 who stated Resident #24 just stared in the CNA's direction when she spoke to the resident and provided care. NJAC 8:39-11.2(b)	F 514		