STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315423	A. BUILDING ______ B. WING ______	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	2300 HAMILTON AVE HAMILTON, NJ 08619

(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: 10/2/19 CENSUS: 188 SAMPLE SIZE: 35 + 2 Closed Records The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. 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. §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. §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. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		10/28/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/18/2019

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

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F 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to serve meals in a dignified manner. This deficient practice was observed in 2 of 4 dining rooms observed for dining and for 20 unsampled residents and 2 sampled residents (Resident #120 and #171) and was evidenced by the following: On 09/23/19 at 12:06 PM, the surveyor observed the dining experience in the [redacted] and [redacted] dining room, located on the [redacted]. The residents' were observed drinking milk out of milk cartons and juices were served in small plastic containers with straws inserted through the foil covering on the top of the container. Residents' were not offered glasses for milk, juices or other drinking fluids. On 9/23/19 at 12:20 PM, the surveyor observed the dining experience in the [redacted] dining room which was located on the [redacted] floor where the residents were being served from the steam table	F 550	1. The corrective action(s) accomplished for resident(s) found to be affected by the deficient practice. Resident #120 and 171 are provided tumblers for each of their meals. Residents in all 4 dining rooms and all room meals are provided two tumblers for each meal. 2. Residents identified having the potential to be affected and corrective action(s) taken: All other residents were given tumblers for each meal. Staff assists with pouring beverages into the tumblers. Plastic lids with straw holes will be kept in each dining area for any residents in need/want. Any residents that need further intervention will be screened by OT.	

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F 550	Continued From page 2 in which the plates were placed on paper place mats. The residents' were also observed drinking liquids in cups and glasses which was different than what the dining experience was in the [redacted] and [redacted] Units on the [redacted]. According to the Admission Record (AR) dated [redacted], Resident #120 was admitted to the facility with the medical diagnoses of unspecified [redacted] The Minimum Data Set, an assessment tool dated [redacted], indicated that Resident #120 had clear comprehension of information, had [redacted] impairment and required limited to extensive assistance with activities of daily living (ADL's). On 09/24/19 at 12:10 AM, the surveyor interviewed Resident #120 who was eating lunch in the main dining room, named the [redacted] dining room. The resident told the surveyor that the food is served on trays and that drinks were served in cartons or containers. "They don't give us glasses for the juice or milk. I think that that would be too much trouble for them. It's easier for them to just serve the food on the trays because its easier to clean up. I would like a glass for my juice and milk." The surveyor did not observe glasses being offered to the residents' in the [redacted] dining room at this time. According to the AR dated [redacted], Resident #171 was admitted to the facility and had the medical diagnoses of [redacted] and [redacted]. The MDS dated [redacted] indicated that the resident had clear comprehension of information, clear speech, [redacted] impairment of cognition, and required	F 550	3. Measures that will be put into place to ensure the deficient practice will not recur: Education provided to Dietary and Nursing staff regarding the tumbler process. 4. Corrective action(s) will be monitored to ensure the deficient practice does not recur. Weekly audits X4 weeks then monthly for 6 months will be conducted by Nursing Administration &/or Dietary Director on compliance for tumblers given with each meal and the beverages being poured into the tumblers and with lids if needed. Results of the audits will be reported at Quarterly QAA.	

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F 550	Continued From page 3 extensive assistance of ADL's. On 09/25/19 at 12:21 PM, the surveyor interviewed Resident #171 who stated he/she eats mostly in the [redacted] dining room. The resident told the surveyor that [redacted] enjoyed the food but that the food was always served on the food trays. He/she also indicated that liquids are always served in the containers that they come in, and that the residents were not offered glasses for the liquids. "They put a straw through the top of the little juice container, but I would like to drink out of the glass if they have them." On 09/25/19 at 12:23 PM, the surveyor made a third observation of the dining experience in the main dining rooms called the [redacted] and [redacted]r dining rooms. Residents were served food trays that were placed in front of the residents. Residents' were not offered glasses for milk or juices. Juices were served in small plastic containers and straws were inserted through the top of the container and residents' were drinking out of the milk cartons. On 09/25/19 at 12:25 PM, the surveyor interviewed Certified Nursing Assistant (CNA) who was serving meal trays in the [redacted] dining room. She stated that meals were always served on food trays and that the residents received fluids in the containers. "It's always done this way. We just put a straw in the top of the juice container and the residents' usually drink out of the milk container, unless they want a straw." On 09/25/19 at 12:29 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) and the LPN Unit Manager (LPN/UM) from the [redacted] Unit, who were both serving the the	F 550		

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F 550	Continued From page 4 residents' trays in the [redacted] dining room. The LPN and the LPN/UM both told the surveyor that residents in the [redacted] dining rooms always eat off food trays and that fluids were not served in glasses. The LPN/UM added, "This is the way that it's always done. I'm not sure why the residents are not given glasses to drink their fluids." On 10/01/19 at 10:47 AM, the surveyor interviewed the Food Service Director (FSD) who stated that the residents that are eating their meals in the [redacted] dining room were served off the tray line and were not provided with cups or glasses because they don't have enough staff in that dining room to pour the liquids. "We do offer glasses to the residents' that eat in the dining room upstairs in the rehab dining room, but not downstairs. The residents that eat downstairs are given trays from the tray-line and are not provided with glasses. I'm not sure why the residents' upstairs are served food from the steam table and are offered glasses for their drinks and not the residents downstairs." On 10/01/19 at 11:04 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she was not sure why the residents' were served meals differently in the upstairs ([redacted] Dining room) then in the downstairs dining [redacted] dining room) rooms. The DON revealed that the resident's served meals in the [redacted] dining room, were served food from a steam table and were offered glasses for their liquids. The DON stated that she did not know that the residents' downstairs were not offered glasses for their liquids.	F 550		

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F 550	Continued From page 5 On 10/01/19 at 12:41 PM, the surveyor interviewed the Regional Food Service Director who stated that he came into the facility today and observed the dining experience in [redacted] and [redacted] dining rooms. He stated that the residents in the [redacted] Dining rooms were not given glasses for liquids. "We have identified that residents should be given glasses for the liquids and we have identified that this was a dignity issue." On 10/02/19 at 10:17 AM, the surveyor interviewed the Administrator who acknowledged that the residents on the [redacted] units were not being served liquids from cups. The Administrator did not have a response as to why the residents on the [redacted] Unit were not given cups or glasses for their liquids. The FSD provided the surveyor with a policy titled: "Dining Experience." The undated policy indicated that the the dining experience will be with the purpose of enhancing each individual patient's/resident's quality of life and being supportive of each individuals needs during dining and that individuals will be provided with services to maintain or improve eating skills. NJAC 8:39-4.1(a)12 NJAC 8:39-17.2(e)	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		10/28/19

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F 584	Continued From page 6 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was	F 584	1. The corrective action(s) accomplished	

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F 584	Continued From page 7 determined that the facility failed to provide a homelike environment during meal service in 2 of 4 dining rooms and was evidenced by the following: On 9/23/19, 9/24/19 and 9/25/19, during the lunch meal service on the first floor dining rooms named [redacted] dining rooms, the surveyors observed that the meals were served on meal trays and left on the trays in front of the residents. On 09/25/19 at 12:25 PM, the surveyor interviewed a Certified Nursing Assistant (CNA) who stated that meals were always served on food trays. "It's always done this way. On 09/25/19 at 12:29 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) and the LPN Unit Manager (LPN/UM) from the [redacted] Unit, who were both serving the the residents trays in the [redacted] dining room. The LPN and the LPN/UM both stated that residents in the [redacted] dining rooms always eat off food trays. The LPN/UM added, "This is the way that it's always done. I'm not sure why the residents are served food on food trays in the dining room." On 10/01/19 at 10:47 AM, the surveyor interviewed the Food Service Director (FSD) who stated that the residents that are eating their meals in the [redacted] dining rooms were served from the tray line and not steam tables. The FSD added that the residents that eat "downstairs," indicating the [redacted] and [redacted] dining rooms, are given trays to eat from and that the residents eat directly from the food tray that was provided.	F 584	for resident(s) found to be affected by the deficient practice. Residents in the [redacted] dining rooms are served lunch and dinner without a tray. Plates, drinks, utensils, etc. are removed from the tray and placed on a placemat. 2. Residents identified having the potential to be affected and corrective action(s) taken: Residents in both the [redacted] [redacted] dining rooms are served on placemats without trays. 3. Measures that will be put into to ensure the deficient practice will not recur: Nursing and Dietary staff educated on the tray-less process. 4. Corrective action(s) will be monitored to ensure the deficient practice does not recur: Weekly audits X4 weeks then monthly for 6 months will be completed by Nursing Administration or Dietary Director to ensure compliance with the tray-less process. Results will be presented at the Quarterly QAA.	

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F 584	Continued From page 8	F 584		

On 10/01/19 at 11:04 AM, the surveyor interviewed the Director of Nursing who stated that she was not sure why the resident's were served meals differently in the upstairs [redacted] Dining room) than the downstairs dining [redacted] dining room) rooms. The DON revealed that the residents served meals in the [redacted] dining room [redacted]), were served food from a steam table and that residents that ate in the [redacted] units [redacted] off of food trays.
The DON told the surveyor that the reason residents were served food from food trays in the [redacted] dining rooms was to create a "barrier" for the residents who had a diagnoses [redacted], but confirmed that there were residents that did not have the diagnoses of [redacted] who were also being served their meals off of trays in the [redacted] dining room.

On 10/01/19 at 12:41 PM, the surveyor interviewed the Regional Food Service Director who stated that he came into the facility today and observed the dining experience in [redacted] and [redacted] dining rooms and admitted that the residents in the [redacted] Dining rooms were being served off of food trays that were placed in front of the residents. He described this type of dining experience as "institutional" dining.

On 10/02/19 at 10:17 AM, the surveyor interviewed the Administrator who acknowledged that the residents on the [redacted] units were being served meals from trays. The Administrator stated that there was only one steam table in the facility, but did not give a response as to why the residents on the [redacted]

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F 584	Continued From page 9 and [redacted] units were being served and eating their meals from food trays that were placed in front of the residents. The FSD provided the surveyor with a policy titled: "Dining Experience," undated and indicated that the dining experience will be with the purpose of enhancing each individual patient's/resident's quality of life and being supportive of each individuals needs during dining and that individuals will be provided with services to maintain or improve eating skills. N.J.A.C. 8:39-4.1(a)12 Refer F550	F 584		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews it was determined that the facility failed to a.)obtain complete physician orders needed to provide [redacted] and [redacted] care to Resident #69, 1 of 2 residents reviewed for [redacted] care. and b.) the facility also failed to follow the physician's order for continuous use of [redacted] for Resident # 389, 1 of 3 residents with orders for [redacted].	F 695	1. The corrective action(s) accomplished for resident(s) found to be affected by the deficient practice: For resident #69, the Physician was notified and clarification was ordered for the [redacted] and [redacted] For resident #389, the Physician was	10/28/19

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F 695	Continued From page 10 These deficient practices were evidenced by the following: On 09/24/19 at 01:44 PM, the surveyor observed Resident #69 in the sitting area in a wheelchair. The surveyor observed that the resident had a [redacted], an [redacted] At this observation there was no [redacted] being applied to the [redacted] and the [redacted] was open to the air. Review of the resident's profile in the electronic medical record showed the resident was initially admitted to the facility on [redacted] Review of Resident #69's Transfer/Discharge report showed the resident had medical diagnoses that included [redacted] eak), and abscess of abdominal wall (infection). The surveyor reviewed the residents quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] The Brief Interview of Mental Status was coded as [redacted], meaning that the resident was [redacted] impaired. The resident was assessed as requiring two-person physical assistance for transfer and a one-person physical assist for dressing, eating, and toilet use. The MDS also reflected the resident had a [redacted] and was [redacted] dependent.	F 695	notified and the [redacted] was discontinued. 2. Residents identified as having the potential to be affected and corrective action(s) taken: No other residents were affected by this practice. All [redacted] orders were reviewed for thoroughness. All patients receiving [redacted] were checked and reviewed for continuous usage. 3. Measures that will be put into place to ensure the deficient practice will not recur: Education provided to nursing staff for thoroughness of [redacted], and [redacted] orders. Education provided to nursing staff regarding continuous [redacted] orders. If a resident refuses the [redacted] or feel they may not require it, the physician will be notified for further orders. 4. Corrective action(s) will be monitored to ensure the deficient practice does not recur: Nursing Administration will complete weekly audits X4 weeks then monthly for 6 months for all [redacted] and continuous [redacted] orders and application. Results of the audits will be presented at the Quarterly QAA.	

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F 695	Continued From page 11 On 09/26/19 at 10:08 AM, the surveyor reviewed the initial and still current physician orders dated [redacted]. The orders revealed that the resident had a size [redacted]. There was an order for [redacted] to the [redacted] to run at the rate of [redacted] every shift when the [redacted] was not in use. There was not a [redacted] on the resident's [redacted] when the resident was initially observed by the surveyor on [redacted], and the resident had no [redacted] in place. The order did not include for how long or when the [redacted] was to be [redacted] The order also did not include for how long or when the resident should be wearing the [redacted] On 09/26/19 at 10:10 AM, the surveyor reviewed respiratory therapy progress notes and found that on [redacted], and [redacted] the notes all included that the therapist administered [redacted] care and described [redacted]. None of the notes were timed, only dated and the notes did not state whether the resident's [redacted] was [redacted] or was [redacted] being used. On 09/26/19 at 10:20 AM, the surveyor reviewed another note written by the respiratory therapist. This note documented that on [redacted] Resident #69 was using the [redacted] and the [redacted] The note was not timed. The surveyor asked the Assistant Director of Nursing (ADON) to speak with the Respiratory Therapist, but the ADON stated the Respiratory Therapist was unavailable for	F 695		

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F 695	Continued From page 12 interview. On 09/26/19 at 10:37 AM, the surveyor observed Resident #69 in a wheelchair with his/her eyes open. The resident was in the hallway in a wheelchair being escorted by staff to the activities room. Resident #69 did not have any [redacted] [redacted] to the [redacted] and the [redacted] was not [redacted] On 09/26/19 at 10:40 AM, The surveyor interviewed the resident's Licensed Practical Nurse (LPN#1) regarding [redacted] to the [redacted] and [redacted] of the [redacted]. The nurse stated the [redacted] gets [redacted] during the day when the resident was out of bed and when the residents goes in their room the [redacted] is removed, and the [redacted] gets applied using [redacted] The surveyor asked the LPN why the [redacted] was not capped for the resident to go to activities and the LPN stated she would bring the resident back to the room. On 09/26/19 at 10:46 AM, the surveyor asked the LPN to show the surveyor the physician's order for [redacted] of the [redacted] and how staff would know when to [redacted] the [redacted] and when to [redacted] and apply [redacted]. The LPN could not explain the process and stated there was only an order for the [redacted] [redacted] [redacted] via [redacted]. The order did not include when to apply the [redacted] On 09/26/19 at 11:00 AM, the surveyor reviewed the resident Treatment Administration Record which included [redacted] care each shift and [redacted] every shift when [redacted] not in use.	F 695		

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F 695	Continued From page 13	F 695		

The staff were initialing these treatments as done for day shift, evening shift, and night shift but staff did not document if the resident was wearing [redacted] or if the [redacted] was [redacted].

On 10/01/19 at 11:15 AM, the surveyor reviewed Resident #69 current care plan. The care plan included [redacted] care and an intervention to apply [redacted] as ordered. [redacted] of the [redacted] was not included in the resident's care plan.

On Tuesday, 10/01/19 at 11:44 AM, the surveyor asked the ADON if the Respiratory Therapist was available for an interview. The ADON stated the respiratory therapist is only available on Thursdays.

On 10/01/19 at 12:15 PM the surveyor reviewed the policy titled Respiratory Therapy Policy and Procedure [redacted] with a [redacted] [redacted] The policy was dated 05/2009. The policy did not include [redacted]. The surveyor asked the ADON if there was a specific policy for the [redacted]. The facility was unable to provide a specific policy.

b. During the initial tour on 09/24/19 at 10:51 AM, Resident #389 was observed sitting in a wheelchair. The resident appeared comfortable with non-labored breathing. The surveyor observed an [redacted] [redacted] located near the window in the off position. Resident #389 told the surveyor he/she didn't use the [redacted] last night.

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F 695	Continued From page 14	F 695		

On 09/25/19 at 10:38 AM, the surveyor returned to Resident #389's room and observed the resident was not wearing [redacted] the concentrator was in the same location, and still turned off. The resident denied breathing difficulty and told the surveyor he/she hasn't had the [redacted] on in, "awhile." The resident confirmed not having the [redacted] on the night before. Later that day at 02:05 PM, the surveyor observed the resident in the room with visiting family members. The resident was not wearing [redacted]. The [redacted] was turned off. A family member told the surveyor Resident #389 only used [redacted] for the first 2 days after admission and has not used [redacted] since.

On 09/26/19 at 10:33 AM, the surveyor observed Resident #389 in bed with his/her eyes closed. The residents breathing was non-labored and the resident was not wearing [redacted]. The [redacted] was turned off.

A review of the Admission Record reflected Resident #389 was admitted to the facility on [redacted] with a medical diagnosis which included; [redacted].

A review of the Medication Administration Record (MAR) revealed nurses were documenting that [redacted] therapy was being administered each shift since the resident was admitted to the facility through the surveyors observation period.

A review of the Physician Order sheet revealed an order for [redacted] to be administered

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F 695	Continued From page 15 on a continuous basis [redacted] for the diagnosis [redacted] A review of the Resident #389's care plan initiated on [redacted] noted the resident had the potential for [redacted] complications due to the diagnosis [redacted] On 09/26/19 at 11:16 AM, the Certified Nursing Assistant told the surveyor Resident #389 does not use [redacted] On 09/26/19 at 01:26 PM, the surveyor interviewed the per diem Licensed Practical Nurse (LPN) working with Resident #389 for the day. The LPN told the surveyor Resident #389 wasn't initially wearing [redacted] when she started her shift. The per diem LPN said she checked the resident's [redacted] and notified the physician who changed the order, so the resident only received [redacted] when it was needed. The per diem LPN indicated she only marked on the MAR that [redacted] was provided because she placed it on the resident as ordered until she got the new order from the physician. On 09/30/19 at 11:45 AM, the Unit Manager (UM) told the surveyor if [redacted] was ordered as [redacted] but the resident wasn't receiving [redacted], the nurse should take the resident's vital signs, put [redacted] on the resident, call the physician, and get further orders. This should also be documented in progress notes. If someone was not using [redacted] for a reason, it should be initialed with a circle on the MAR indicating the [redacted] was held and should be documented on the back of the MAR prior to a follow up call from the physician and documentation in the progress notes.	F 695		

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F 695	Continued From page 16 On 10/01/19 at 10:51 AM, the Director of Nursing (DON) confirmed [redacted] therapy should remain in use for a resident as ordered until a new order is obtained from the physician. The DON also confirmed if a nurse wasn't providing [redacted], the nurse should circle their initials on the MAR, write a follow up note and call the physician requesting a new doctors order. The surveyor reviewed the undated and unsigned, "[redacted] and [redacted] Products," policy provided by the facility. The policy provided no information regarding continuous [redacted] therapy. The procedure portion revealed, "Proper documentation on TAR (treatment administration record), POS to ensure a current physician order." NJAC 8:39 11.2(b), 25.2 (c) (4), 27.1(a)	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		10/28/19

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F 761	Continued From page 17 personnel to have access to the keys. §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 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that the facility failed to ensure that expired medications and supplies were removed from the medication storage and supply room where other current in use items were stored. This deficient practice was identified for 2 of 4 medication storage rooms and was evidenced by the following: 1. On 09/24/19 at 11:05 AM, the surveyor inspected the medication storage and labeling of medications and medical supplies on the [redacted] Unit and noted the following: - Three (3) expired [redacted] in a drawer dated 3/31/18. - One [redacted] syringe which expired on 08/2019. The Licensed Practical Nurse Unit Manager (LPN/UM) from the [redacted] Unit was interviewed at this time and stated that she was the person responsible for checking the medication storage	F 761	1. The corrective action(s) accomplished for resident(s) found to be affected by the deficient practice. All expired supplies were discarded. 2. Residents identified having the potential to be affected and corrective action(s) taken: No residents were affected by this deficient practice. All supply rooms were checked for any expired/expiring supplies. 3. Measures that will be put into place to ensure the deficient practice will not recur: Nursing staff and Central Supply Coordinator were educated on process of discarding any expired or expiring supplies/medications. 4. Corrective action(s) will be monitored to ensure the deficient practice does not	

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F 761	Continued From page 18 room for expired medications or supplies. She also stated, "I guess I just missed it." 2. On 9/24/19 at 11: 40 AM, the surveyor inspected the Central Supply Medication and Equipment Storage room on the [redacted] in the presence of the Certified Nursing Assistant/Central Supply (CNA/Central supplier) staff member and noted the following: - Four (4) [redacted] care sterile dressing [redacted] with an expiration date of 11/2013 were observed on the shelf of the storage closet. - One (1) [redacted] with an expiration date of 7/2019 was located on the shelf of the storage closet. On 9/24/19 at 11:45 AM, the surveyor interviewed the CNA/Central supplier who stated that she was responsible for checking that there were no expired items in the [redacted] supply medication storage closet and that she should have thrown the expired dressing [redacted] and expired tube of [redacted] ointment away. According to the facility policy titled, "Medication Use: Medication Storage" numbered 3.7 and dated 02/2009, indicated that expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy. NJAC 8:39- 29.4 (a)(h)	F 761	recur: Nursing Administration &/or Central Supply Coordinator will conduct weekly audits X4 weeks then monthly for 6 months of all supply rooms to ensure no expired/expiring supplies/medications are stored. Results of the audits will be presented at the Quarterly QAA.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		10/28/19

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F 880	Continued From page 19	F 880		

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(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:

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F 880	Continued From page 20 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) adhere to the accepted standards of infection control practices for housekeeping services in isolation rooms and b.) provide education to visitors regarding the use of personal protective equipment (PPE) to prevent the spread of infection while visiting with residents on isolation precautions. This practice was observed for Residents #154 and #388, 2 of 3 residents reviewed for infection control/ isolation	F 880	1. The corrective action(s) accomplished for resident(s) found to be affected by this deficient practice. a. Said housekeeper was educated and a return demonstration provided of cleaning of an isolation room and infection control practices. b. Re-education was provided and documented in resident's #154 and 388	

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F 880	Continued From page 21 precautions. This deficient practice was evidenced by the following: a.) On 09/24/19 at 10:00 AM, the surveyor observed a housekeeping staff member exit an isolation room (identified as [redacted] in the [redacted] [redacted] hall of the [redacted] unit wearing PPE. The room was identified as isolation by a cart next to the room's entryway and a stop sign posted on the door frame which warned anyone entering the room to see the nurse prior to entering. The surveyor observed the housekeeper remove her isolation gown and gloves in the hallway, deposit them into a trash bag on the cart and roll the cart down the hall. The housekeeper did not wash her hands during this observation. On 09/25/19 at 11:15 AM, the housekeeper was observed cleaning isolation [redacted] in the [redacted] [redacted] hall of the [redacted] unit. The housekeeper wearing PPE entered and exited the isolation room opening the side cabinet of the cart, touching a broom handle and ripping plastic bags from a roll with gloved hands before replacing the roll back on the cart, touching the cart on its sides and disposing of articles in a plastic bag on the side of the cart. The housekeeper came out of the room to the doorway wearing PPE multiple times during the observation. At 11:26 AM, the housekeeper exited the room and placed a wet floor sign in the doorway before removing PPE in the hallway and wheeling the cart down the high side hall. The housekeeper returned to the low hall, put on new gloves and began cleaning the doorway of an unoccupied room. The surveyor did not observe the housekeeper wash hands their or use sanitizer. When the surveyor attempted to interview the housekeeper, she	F 880	medical record for education of visitors isolation precautions. 2. Residents identified having the potential to be affected and corrective action(s) taken: No other residents were identified as being affected by this practice. a. All isolation rooms were observed for proper isolation procedures being utilized by staff. b. All isolation rooms were checked for non-compliant visitors. Nursing staff was educated on the need to educate visitors on proper isolation precautions and to document and notify Social Services for any non-compliance. 3. Measures that will be put into place to ensure the deficient practice will not recur: a. The housekeeping department was educated and return demonstration provided for proper cleaning and precautions for isolation rooms. b. Education provided to Nursing and Social Service Department of need to document any education and non-compliance with visitors not following proper isolation precautions. 4. Corrective action(s) will be monitored to ensure the deficient practice does not recur:	

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F 880	Continued From page 22 informed the surveyor she did not speak English. b1) On 09/24/19 at 09:44 AM, the surveyor entered Resident #154's isolation room. The room was identified as an isolation room by an isolation equipment cart in the hall next to the resident's doorway outside doorway and a "Stop-see nurse for instructions"- sign on doorway at the entrance. Resident #154 told the surveyor he/she was not sure why he/she was on isolation. Resident #154 stated, "Sometimes people enter with isolation gowns and sometimes they don't." Resident #154's grandson was seated in the room by the window without PPE. The surveyor noted the grandson was holding the resident's television remote which he handed back to Resident #154 prior to exiting the room. He did not wash his hands prior to exiting. A review of the Admission Record reflected Resident #154 was admitted to the facility on [redacted] with a medical diagnosis which included; [redacted] According to the admission Minimum Data Set (MDS), an assessment tool, dated [redacted], the brief interview mental status (BIMS) assessment reflected that the resident had a score of [redacted] which indicated a fully intact cognition. In addition, the MDS reflected that Resident #154 required limited to extensive care with activities of daily living and had an active diagnosis of a [redacted] A review of the Physician Order sheet revealed	F 880	a. Infection Control Nurse will conduct audits on isolation room cleaning by housekeeping weekly X4 weeks then monthly for 6 months. Results will be presented at the Quarterly QAA meeting. b. Audits will be completed by the Infection Control Nurse weekly X4 weeks then monthly for 6 months to identify any visitor non compliance and nursing documentation for education and compliance. Results will be presented at the Quarterly QAA meeting.	

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F 880		F 880		

Continued From page 23
the resident was on isolation precautions for a [redacted] infection and was receiving [redacted] therapy [redacted] while at [redacted]

A review of the Resident #154's care plan initiated on 8/28/19 revealed the resident was on isolation precautions related to a diagnosis of [redacted] in a [redacted]. The interventions included educating and assisting the resident with proper infection prevention and control techniques including handwashing and limiting visitors, explaining the need for isolation precautions and reeducating the resident and visitors and maintaining isolation precautions per physician orders.

At the surveyor's request, the facility was unable to provide proof of education regarding isolation precautions or the rationale for and instructions relating to the use of PPE were provided to the resident or visitors.

b2.) On 09/24/19 at 10:26 AM, the surveyor observed Resident #388 in isolation room in bed watching television. The room was identified as an isolation room by an isolation equipment cart in the hall next to the resident's doorway outside doorway and a "Stop- see nurse for instructions"- sign on doorway at the entrance. There was a visitor in room sitting in a chair. The visitor was not wearing PPE. The surveyor interviewed the visitor who said said Resident #388 came to the facility on isolation precautions for a [redacted] infection.

On 09/25/19 at 10:22 AM, the surveyor observed Resident #388's visitor in the residents isolation room with the resident. The visitor was sitting in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315423	A. BUILDING ______ B. WING ______	10/02/2019

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F 880	Continued From page 24	F 880		

chair by the window with eyes closed and snoring softly. The visitor was not wearing PPE.

On 09/25/19 at 11:41 AM, the surveyor observed two additional visitors enter Resident #388's room without first putting on PPE. The surveyor observed multiple staff including guest services, housekeeping and a certified nurse's assistant (CNA) look into the room of the resident as they passed. None of the staff stopped and educated the visitors concerning the use of PPE for a resident on isolation precautions.

A review of the Admission Record reflected Resident #388 was admitted to the facility on [redacted] with a medical diagnosis which included; [redacted]

According to the admission Minimum Data Set (MDS), an assessment tool, dated [redacted], the BIMS assessment reflected that the resident had a score of [redacted] which indicated cognitive impairment. In addition, the MDS reflected that Resident #388 required limited to extensive care with activities of daily living, was frequently incontinent [redacted] and had an active diagnosis of a [redacted].

A review of the Physician Order sheet revealed Resident #388 was on isolation precautions for [redacted].

A review of the Resident #388's care plan initiated on [redacted] revealed the resident was on isolation precautions related to a diagnosis of [redacted]. The interventions included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 25	F 880		

educating and assisting the resident with proper infection prevention and control techniques including handwashing and limiting visitors, explaining the need for isolation precautions and reeducating the resident and visitors and maintaining isolation precautions per physician orders and facility protocol.

At the surveyor's request, the facility was unable to provide proof of education regarding the use of isolation precautions or PPE were provided to visitors.

On 09/25/19 at 11:54 AM the surveyor interviewed a Certified Nursing Assistant (CNA). The CNA told the surveyor PPE should be removed and hands should be washed before exiting an isolation room. The CNA said everyone should wear PPE before entering an isolation room. The CNA revealed if a visitor was observed in a resident's isolation room without PPE, staff should notify the floor nurse or charge nurse. The CNA revealed she has informed the nurse about visitors not wearing PPE in Resident #154 and Resident #388's rooms in the past. The CNA stated when visitors entered Resident #388's room and she passed and looked in, "I wasn't really paying attention. I should have said something."

On 09/25/19 at 12:11 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated isolation rooms are considered contaminated. The LPN stated gowns should always be worn when entering an isolation room and gloves should be worn if someone, "Was going to touch the resident." LPN also stated everyone, including housekeeping and visitors, should remove PPE and wash hands prior to

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F 880	Continued From page 26	F 880		

exiting the isolation room and if visitors refused to comply with isolation precautions, they should be educated and documentation that education was provided should be in the progress notes.

The LPN also stated if a visitor did not comply with isolation precautions, they are, "Bringing the infection out to everyone out of the room." The LPN described Resident's resistant infection as, "A little tricky because [redacted] and can be anywhere."

On 09/25/19 at 12:35 PM, the LPN entered Resident #388's room and offered PPE to the visitor. The visitor put the PPE on.

On 09/25/19 at 12:49 PM, the [redacted] Unit Manager (UM) 2nd floor told the surveyor everyone who enters an isolation room should first wash or sanitize hands before putting on PPE prior to entering the room. The UM stated PPE should be worn in an isolation room, "The minute you step over the threshold of the room." The UM further revealed PPE should be removed and disposed of in a trash can in the isolation room near the doorway or in the bathroom and hands should be thoroughly washed with soap and water for 30 seconds prior to leaving the isolation room. The UM also stated when visitors received education for isolation precautions, it should be documented in the progress notes. The UM stated, "If a resident's family or friends refuse to comply with the education, they can bring the infection home to the family and spread the organism to employees and staff. The risk to spread infection is very high." The UM said Administration should be informed if visitors continued to not comply and this will be documented in the progress notes. The UM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 27	F 880		

denied any staff meetings of visitor noncompliance.

On 09/30/19 at 09:42 AM, the surveyor interviewed the housekeeper with a translator present. The housekeeper said she should remove PPE and wash her hands before returning to the cart and she would do this moving forward. The housekeeper confirmed receiving education when she was hired the previous year in a language she understood.

On 09/30/19 at 10:09 AM, the Director of Housekeeping told the surveyor housekeeping should put on PPE and grab necessary items and cleaning products prior to entering an isolation room. After cleaning an isolation room, the housekeeper should remove a glove, and gown with rags and place in appropriate bags, before removing the other glove, tie the bags they are in and wash their hands for 30 seconds, before putting the bags into soiled utility room.

On 09/30/19 at 10:28 AM, the Assistant Director of Nursing and Infection Prevention Nurse (ADON) told the surveyor since housekeeping was contracted the facility didn't do housekeeping's training. The ADON indicated she would, "Spot educate," if she saw an issue but the education was not usually documented. The ADON said the facility process was to wash hands, position the housekeeping cart in front of room doorway and apply PPE outside the room. The ADON added once room cleaning was complete, the housekeepers bag their gown and trash, drop their items into a separate bag on the cart while wearing PPE. At that point, PPE should be removed inside the doorway at the trash in the doorway before washing hands and

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F 880	Continued From page 28	F 880		

exiting the room.

The ADON said visitors should be educated by the nurse each time they enter the room prior to their entering and as often as possible. Noncompliant visitors should be instructed to wash their hands and not to hang around the facility. The ADON stated if someone made her aware of visitor noncompliance to my attention, she would attempt to educate the visitor and document the education in the progress notes. The ADON stated, "I would hope the nurses would document any education provided to the resident and their family."

On 10/01/19 at 10:55 AM, The Director of Nursing (DON) told the surveyor housekeeping entering an isolation room should put on PPE, clean according to the facility 7 step procedure, remove the equipment in the room and wash hands prior to exiting the room. The DON added housekeeping should not be in the hallway in isolation gear after being in the isolation room for any reason. The DON also said if staff members observed visitors in an isolation room, she would expect them to notify the nurse to educate the family member.

The surveyor reviewed the undated "Isolation Precautions" policy which was signed by the Administrator. The policy classified [redacted] [redacted]. The policy also indicated when someone entered a room with someone on contact precautions, they should wear appropriate PPE, including a gown and gloves, on entering the isolation room. The contact precautions also revealed PPE should be removed and hand hygiene should be performed prior to leaving the residents room. The

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F 880	Continued From page 29 procedure indicated linen should be bagged before leaving the resident's room. NJAC 8:39-19.4 (a)	F 880		