STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315506	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-WASHINGTON TOWNSHIP	**378 FRIES MILL ROAD** **SEWELL, NJ 08080**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY 2/6/2020 CENSUS: 91 SAMPLE SIZE: 19	F 000		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		3/24/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/24/2020

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

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F 625	Continued From page 1 by: Based on interview and record review, it was determined that the facility failed to notify, in writing, the resident or the resident's representative of the facility's bed hold policy for a resident's transfer to the hospital. This deficient practice was identified for 1 of 1 residents (Resident #77) reviewed for hospitalization and was evidenced by the following: The surveyor reviewed Resident #77's [redacted] Minimum Data Set, an assessment tool, and observed that the facility had identified the resident as [redacted] intact. The surveyor reviewed Resident #77's medical record and observed that Resident #77 had been transferred from the facility 911 to [redacted] (Hospital) [redacted] On 2/5/2020 at 12:02 PM, the surveyor asked the Social Worker (SW) for a copy of Resident #77's bed hold policy that was provided to the resident or resident representative prior to discharge from the the facility. The SW stated, "The resident was on Medicare and we are not required to provide bed hold notices to Medicare residents on transfer because Medicare doesn't pay for bed holds." The surveyor again asked for a copy of Resident #77's bed hold policy notification and the surveyor received a copy of the "Bedhold Policy" from the Director of Nursing (DON). The surveyor requested a signed copy of the bed hold policy provided to Resident#77 prior to transfer. The DON stated, "That comes from the business office. I'll get them to give you a copy." On 2/5/2020 at 12:06 PM, the Business Office Manager (BOM) provided the surveyor with a copy of the facility's Admission Agreement which	F 625	PRACTICE: Based on interview and record review, it is alleged that the facility failed to notify, in writing, the resident or the resident's representaive of the facility's bed hold policy for a resident's transfer to the hospital. This alleged practice was identified for 1 of 1 residents (Resident #77) reviewed for hospitalization. 1. Residents affected by alleged practice: Resident #77 no longer in the facility. 2. Residents having the potential to be affected by deficient practice: Residents residing in the facility have the potential to be affected by deficient practice. 3. Measures to be implemented to ensure alleged practice does not occur: Admissions and/or designee will provide newly admitted residents with written copy of bed hold policy. The second notice will be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. 4. How will the facility monitor the effectiveness of corrective action: Admissions and/or designee will randomly	

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F 625	Continued From page 2 also included the Patient Information Handbook and Voluntary Arbitration Agreement. When interviewed at that time, the BOM stated ,"We don't provide a copy of the bed hold policy prior to transfer. The bed hold policy is in the admission agreement packet and is signed on admission. The signed admission agreement satisfies the requirement that the resident is aware of our bed hold policy. That is why the nurses aren't getting the resident to sign a bed hold policy prior to transfer because there is not a copy provided to sign." The BOM further stated, "The Resident did not sign the admission agreement on admission to the facility. I don't have an answer why it didn't get signed. Admissions didn't get the admission packet signed, I don't know why, so [Resident #77] never got the supplemental packet which contained the bed hold policy." The surveyor then asked the BOM when the admission agreement should be signed by the resident. The BOM stated, "The admission agreement should be signed within 48 hours of admission. As far as I know we don't provide bed hold policies upon transfer." On 2/5/2020 at approximately 1:20 PM, the surveyors met with the DON, Administrator and Assistant DON. At that time, the DON acknowledged that Resident #77 should have been provided a copy of the facility's bed hold policy prior to transfer from the facility. NJAC 8:39-4.1 (a) (31)(i-iv)	F 625	audit residents who transfer to ensure bed hold policy was given at time of transfer weekly x4 and monthly x2. The findings of these audits will be presented to Quality Assurance Committee monthly x3 to ensure effectiveness and accuracy.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 658		3/14/20

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F 658	Continued From page 3 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow their policy for 1 of 1 resident (Resident #75) reviewed for an [redacted]. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered 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 wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."	F 658	PRACTICE: Based on observation, interview, and record review it was alleged that the facility failed to follow their policy for 1 of 1 resident (Resident #75) reviewed for an [redacted] 1. Residents affected by alleged practice: Resident #75 no longer resides in the facility. 2. Residents having the potential to be affected by the alleged practice: Residents who have [redacted] can be affected. 3. Measures to be implemented to ensure alleged practice does not occur: Director of Nursing and/or designee will educate/reeducate Certified Nursing Assistant staff to ensure that [redacted] bags are used for residents at risk (residents with an [redacted]). [redacted] bag was immediately placed on Resident #75. 4. How will the facility monitor the effectiveness of corrective action: Director of Nursing and/or designee will randomly audit residents at risk (residents	

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F 658	Continued From page 4 On 2/2/2020 at 8:27 AM, 2/3/2020 at 8:32 AM, and 2/4/2020 at 8:07 AM the surveyor observed Resident #75 lying in bed with an [redacted] leading to a [redacted] that was hanging from the bed. The [redacted] was transparent with [redacted] visible inside. The surveyor reviewed the resident's [redacted] Comprehensive Minimum Data Set (MDS), an assessment tool, and observed that the facility had identified the resident as [redacted] intact. During further review of the MDS the surveyor observed that the resident had a diagnosis of [redacted] to [redacted]) with an [redacted]. When interviewed on [redacted] at 12:06 PM, the resident stated he/she had an [redacted] due to [redacted] issues. When asked if the staff cover the [redacted] bag, Resident #75 replied that they were unsure, because they cannot turn their body to see the [redacted] hanging from the bed. When interviewed on 2/4/2020 at 10:10 AM, the resident's Certified Nursing Assistant (CNA) stated that residents with a [redacted] are provided a [redacted] cover for the resident's dignity. When asked if Resident #75 had a [redacted] cover, the CNA stated she had to double check. When interviewed on 2/4/2020 at 10:15 AM, the resident's Registered Nurse (RN), stated that she checks Resident #75's [redacted] to make sure the [redacted] bag is hanging properly and that it has a [redacted] cover. The RN further	F 658	with an [redacted]) weekly x4 and monthly x2. The findings of these audits will be presented to the Quality Assurance Committee monthly x3 to ensure effectiveness and accuracy.	

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F 658	Continued From page 5 stated that privacy covers are important for the resident's dignity. When asked if Resident #75 had a privacy cover, the RN stated that she instructed the [redacted] aid earlier that morning to put a cover on the [redacted] bag. When interviewed on 2/4/2020 at 10:50 AM, the Assistant Director of Nursing stated that for residents with an [redacted], the facility provides a dignity cover for the resident's dignity. On 2/4/2020 at 1:30 PM, the surveyor observed Resident #75 lying in bed with a privacy cover over the [redacted] bag. The resident's spouse was in the room and stated he/she visits the resident daily and has never seen a [redacted] cover on the resident's [redacted] bag since the resident was admitted in the [redacted] of [redacted] The surveyor reviewed the facility's "[redacted] [redacted]" policy, revised 4/2019, and observed it included, [redacted] bags should be covered with a [redacted] bag to preserve the dignity of the patient." NJAC 8:39-27.1(a)	F 658		
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.	F 695		3/14/20

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F 695	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow their [redacted] Administration policy for 1 of 2 residents reviewed for [redacted] (Resident #254). This deficient practice was evidenced by the following: On 2/2/2020 at 9:45 AM, 2/3/2020 at 8:37 AM, and 2/3/2020 at 9:48 AM, the surveyor observed Resident #254 in bed receiving [redacted]. When interviewed on 2/3/2020 at 9:48 AM, Resident #254 said they used [redacted] for [redacted] and had been using it since they returned from the hospital. On 2/3/2020 at 10:23 AM, the surveyor reviewed the facility's [redacted] Administration Policy, last updated on 07/2017, that was provided by the Director of Nursing, and observed that it included, "Verify Physician's order" and "Record [redacted] administration on Treatment Administration Record (TAR)." On 2/3/2020 at 12:33 PM, the surveyor reviewed the "Order Summary Report" and the "Clinical Physician Orders" of Resident #254 and observed there was no physician's order for [redacted]. The surveyor reviewed the [redacted] Electronic Medication Administration Record (EMAR) and Electronic Treatment Administration Record (ETAR) and observed that neither contained a physician's order for the use of [redacted]. When interviewed on 2/3/2020 at 1:55 PM, the Registered Nurse (RN) confirmed that Resident	F 695	PRACTICE: Based on observation, interview, and record review, it was alleged that the facility failed to follow their [redacted] Administration policy for 1 of 2 residents reviewed for [redacted] (Resident #254). 1. Residents affected by alleged practice: Resident #254 currently resides at this facility. Order was immediately obtained for [redacted] for resident #254. 2. Residents having the potential to be affected by alleged practice: Residents who are utilizing [redacted] who have returned after being transferred to the hospital. 3. Measures to be implemented to ensure alleged practice does not occur: Director of Nursing and/or designee will educate/reeducate licensed nurse staff on [redacted] Administration policy. 4. How will the facility monitor the effectiveness of corrective action: Director of Nursing and/or designee will randomly audit residents at risk (residents who are utilizing [redacted] who have returned after being transferred to the hospital) to ensure [redacted] Administration policy is followed weekly x4 and monthly	

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F 695	Continued From page 7 #254 was receiving [redacted]. The RN stated there should be a physician's order for [redacted] and [redacted] should be documented on the EMAR or ETAR. The RN acknowledged that there was no physician's order and no documentation on the EMAR or ETAR for the [redacted] When interviewed on 2/5/2020 at 8:34 AM, the Assistant Director of Nursing stated there should be an order for [redacted] 8:39-27.1(a)	F 695	x2. The findings of these audits will be presented to the Quality Assurance Committee monthly x3 to ensure effectiveness and accuracy.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. 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). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that Certified Nursing Assistants (CNA) completed 12 hours of mandatory education/in-service training which also included training on abuse prohibition. This deficient practice was identified for 1 of 5 CNA (CNA #1) files reviewed for in-service training and was evidenced by the following: The surveyor reviewed the files of 5 randomly selected CNAs for compliance with 12 hours of annual in-service education/training. It was also required that the yearly education/training was to include education/training in dementia and abuse	F 730	PRACTICE: Based on interview and record review, it was alleged that the facility failed to ensure that Certified Nursing Assistants (CNA) completed 12 hours of mandatory education/in-service training which also included training on abuse prohibition. This alleged practice was identified for 1 of 5 CNAs (CNA #1) files reviewed for in-service training. 1. Staff affected by alleged practice:	3/14/20

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F 730	Continued From page 8 prohibition. During the review, the surveyor observed that one CNA (CNA #1) had less than 3 hours and no training on abuse prohibition. When interviewed on 2/4/20 at 12:30 PM, the Human Resources Director (HRD) said the previous Assistant Director of Nursing (ADON) had been in charge of education/training. The HRD said the ADON left in October 2019, and there hadn't been anyone in that position (education/training) after she left. At 12:49 PM, the HRD said she could not justify why there weren't more education/training hours for CNA #1, and further said, CNA #1 only worked part-time. When interviewed on 2/5/20 at 08:29 AM, the surveyor asked the current ADON who had taken over with staff education/training when the previous ADON left. The ADON said, "I did" and then said, "I took over on (previous ADON's name) last day, which was [redacted]. When asked if she provided more staff education/training after 11/28/19, the ADON said, "I did quite a bit." The ADON said, "pretty soon after I started, I made a matrix excel spreadsheet for education/training. When asked why CNA #1 had not received the required 12 hours, the ADON could not provide an answer and said, "I wasn't looking at the total number for the year." On 2/5/20, the surveyor requested a print-out of the hours CNA #1 had worked in 2019, which was provided by the Director of Nursing (DON) at 8:40 AM. When reviewed, the surveyor observed that CNA #1 had worked "889:38" hours between "1/01/2019-12/31/19." This amount of worked hours was ample time for the CNA to receive the required amount of mandatory	F 730	CNA #1 2. Residents having the potential to be affected by alleged practice: Residents residing in the facility have potential to be affected by alleged practice. 3. Measures to be implemented to ensure alleged practice does not occur: Administrator and/or designee will educate/reeducate Human Resources Director on 12 hour mandatory education/in-service training. 4. How will the facility monitor the effectiveness of corrective action: Human Resources Director and/or designee will randomly audit staff at risk (CNAs currently on staff) to ensure 12 hours of annual in-service education/training is completed weekly x4 and monthly 2. The findings of these audits will be presented to the Quality Assurance Committee monthly x3 to ensure effectiveness and accuracy.	

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F 730	Continued From page 9 education/in-service training. Additionally, the surveyor observed that there was no documented evidence on CNA #1's "Transcript Report" that the CNA had received education/training on abuse prohibition. On 2/5/20, the surveyor requested a copy of the facility's policy on CNA education/training, which was provided to the surveyor by the Director of Nursing (DON) at 12:05 PM. There was no title nor any date on the policy that was provided. Upon review, the surveyor observed that the policy included "Nursing assistants are required to have sufficient training to ensure their continuing competence, but must training be no less than 12 hours" [sic]. It also included "1. Annual Mandatory Training. These trainings are auto-assigned and include courses due each quarter." The surveyor also observed that the policy referenced the year "2017" in several paragraphs. The surveyor mentioned to the DON that the policy was not titled nor dated and asked the DON if there was any other policy that provided more detail on CNA education/training. During a follow-up interview with the DON on 2/6/2020 at 8:09 AM, the DON stated there was "no set policy on 12 hours of in-services." NJAC 8:39-43.17	F 730		
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	F 761		3/14/20

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F 761	Continued From page 10 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to remove expired medications from the medication cart. This deficient practice was identified for 1 of 3 medication carts observed (Cart #1, [redacted] and was evidenced by the following: On 2/2/2020 at 9:15 AM, the surveyor, accompanied by the Licensed Practical Nurse (LPN), observed the medication cart (#1 [redacted] [redacted] on the nursing unit. During review of the medications in the cart, the surveyor noted two expired, over the counter, medication bottles in the house stock section of the medication cart. The expired medications were [redacted] with an expiration date of "9/19" and [redacted] [redacted] mg with an expiration date of "9/19."	F 761	PRACTICE: Based on observation, interview, and record review, it was alleged that the facility failed to remove expired medications from the medication cart. This alleged practice was identified for 1 of 3 medication carts observed (cart 1, [redacted] 1. Medication carts affected by deficient practice: Cart #1, [redacted] Medication was immediately destroyed and disposed of. 2. Residents who have the potential to be	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-WASHINGTON TOWNSHIP	**378 FRIES MILL ROAD** **SEWELL, NJ 08080**

(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 761	Continued From page 11 When interviewed on 2/3/2020 at 8:51 AM, the LPN further stated that he did not know the medication bottles were expired and said the medication cart was supposed to be checked daily for expired medications. The LPN said that particular medication cart was used to administer medications to residents in specific rooms, which the LPN identified. The number of residents receiving their medications from that medication cart was approximately one-third of the residents in that nursing unit. On 2/5/2020 at 9:28 AM, the surveyor reviewed the "Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles" policy for the facility, updated 8/2018, which noted "#3. The Nursing Center should ensure that drugs and biologicals, 1) have an expiration date on the label or medication container, 2) have not been retained longer than recommended by manufacturer or supplier guidelines"; "#15. The Nursing Center should destroy or return all discontinued, outdated/expired or deteriorated drugs or biologicals in accordance with Pharmacy return/destruction guidelines"; and "#16. Nursing Center personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis." NJAC 8:39 29.4(g)	F 761	affected by alleged deficient practice: Residents have the potential to be affected by the alleged deficient practice. 3. Measures to be implemented to ensure alleged practice does not occur: Director of Nursing and/or designee will educate/reeducate licensed nursing staff to remove expired medications from medication carts. 4. How will the facility monitor the effectiveness of corrective action: Director of Nursing and/or designee will randomly audit medication carts at risk to ensure expired medications are removed from medication carts weekly x4 and monthly x2. The findings of these audits will be presented to Quality Assurance Committee monthly x3 to ensure effectiveness and accuracy.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		3/14/20

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F 812	Continued From page 12 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous food and maintain kitchen sanitation safely and consistently to prevent foodborne illness. This deficient practice was evidenced by the following: On 2/2/2020 from 8:11 AM to 8:52 AM the surveyor, accompanied by the Food Service Director (FSD), observed the following in the kitchen: 1. In the dry storage area on a multi-tiered rack, a can of Mandarin oranges had a significant dent on the upper seam of the can. When interviewed, the FSD stated, "Yes sir, that should be over there in the designated dented can area." The FSD put the can in the designated dented can area.	F 812	PRACTICE: Based on observation, interview, and record review, it was alleged that the facility failed to handle potential hazardous food and maintain kitchen sanitation safely and consistently to prevent foodborne illness. 1. Items affected by alleged practice: Cans, plastic knives/forks, Styrofoam plates, and bags of pasta in the dry storage area. 2. Residents who have the potential to be affected by alleged practice: Residents who reside in the facility. 3. Measures to be implemented to ensure alleged practice does not occur:	

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F 812	Continued From page 13	F 812		

2. On a middle shelf, a box contained plastic knives. The box was opened, and the blades were exposed. During the interview, the FSD stated, "They should be closed to prevent contamination." On the same shelf, a box of plastic forks was also opened and exposed. The FSD closed the box and stated, "they should have been closed also."

3. On a middle shelf, a plastic bag contained Styrofoam plates. The plastic bag was opened and exposed. The FSD stated, "they should be closed."

4. On a middle shelf, an opened bag of pasta noodles had no dates. The FSD threw the pasta in the trash. At that time, the FSD stated, "they should be labeled for opened date and use by date."

5. On an upper shelf of a multi-tiered shelf in the walk-in refrigerator, a package of deli-sliced turkey in plastic wrap was dated "1/24/20." At that time, the FSD stated, "that's good for seven days. It should have been used by or thrown away on the 31st. I'm throwing it in the trash. I'm gonna double-check the policy; I'm not sure if it's seven days or not."

6. On a lower shelf in the walk-in freezer, two bags of frozen Brussel sprouts were removed from their original box. The bags had no dates. There were no signs of spoilage. On interview, the FSD stated, "They should have been dated when they were removed from their original box."

7. On a middle shelf in the walk-in freezer, a box of frozen sliced carrots was opened and exposed.

Food Service Director and/or designee will educate/reeducate kitchen staff on safe handling of potentially hazardous food and kitchen sanitation.

4. How will the facility monitor the effectiveness of corrective action:

Food Service Director and/or designee will randomly audit items at risk (cans, plastic knives/forks, Styrofoam plates, and bags of pasta in the dry storage area) to ensure safe handling of potentially hazardous foods and kitchen sanitation is met weekly x4 and monthly x2. The findings of these audits will be presented to the Quality Assurance Committee monthly x3 for effectiveness and accuracy.

1. Items affected by alleged practice:

Deli-sliced turkey in the walk-in refrigerator, Brussel sprouts in the walk-in freezer, sliced carrots in the walk-in freezer and cheese pizzas in the walk-in freezer.

2. Residents who have the potential to be affected by alleged practice:

Residents who reside in the facility have the potential to be affected by alleged practice.

3. Measures to be implemented to ensure alleged practice does not occur:

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F 812	Continued From page 14 On interview, the FSD stated, "they were just opened yesterday, they should close the box after opening to prevent exposure." 8. On a lower shelf in the walk-in freezer, an opened box contained frozen Cheese Pizzas. A bag contained two frozen pizzas and was opened, exposing the pizzas. On interview, the FSD stated, "they should be sealed after opening." The FSD threw the frozen pizzas in the trash. The surveyor reviewed the facility policy titled "Labeling Food And Date Marking," date: September 2014. Under the section Labeling Guidelines For Dietary at number 2, the policy noted the following: "Foods from processing plants are marked at the time the original container is opened and if the food is held for more than 24 hours, the date or day by which the food is to be consumed or discarded. The day the original is opened is counted as day 1, and the day or date marked for consumption or discarding may not exceed a manufacturer's 'use-by' date. If not specified, seven days is used." The policy further noted at 6 and 11 the following: 6. "Refrigerators and storage areas are routinely checked for temperatures, labeling, and dating of food items with food being discarded when beyond the 'use-by' date." 11. "Store potentially hazardous (TCS) foods under refrigeration at or below 41F for a maximum of 7 days, unless there is a different manufacturer's "use-by" date specified."	F 812	Food Service Director and/or designee will educate/reeducate kitchen staff on facility policy titled "Labeling Food and Date Marking". 4. How will the facility monitor the effectiveness of corrective action: Food Service Director and/or designee will randomly audit items at risk (open food items in the walk-in freezer and walk-in refrigerator) to ensure facility policy titled "Labeling Food and date Marking is met weekly x4 and Monthly x2. The findings of these audits will be presented to the Quality Assurance Committee monthly x3 for effectiveness and accuracy.	

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F 812	Continued From page 15	F 812		

Continued From page 15

The surveyor reviewed the "HCR ManorCare Food Services Policies & Procedures Section III Production & Controls," revised June 2013. The policy/procedure noted that following:

14. "Seal and label open frozen foods. Frozen foods held at or below 0 degrees Fahrenheit are biologically safe indefinitely but may deteriorate in quality over time. Freezer storage times vary based on generally accepted guidelines to ensure the preservation of the quality. Consider FIFO (first in first out) for rotating foods in frozen storage."

In addition, the policy/procedure at number 15 noted the following:

15. "Discard food that has exceeded the expiration date or when the use-by date is unclear."

NJAC 8:39-17.2 (g)