STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. BUILDING ______ B. WING ______	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922

(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: 12/12/19 CENSUS: 210 SAMPLE SIZE: 36 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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 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	F 656		1/17/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 12/23/2019

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 656	Continued From page 1 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 interview and record review, it was determined that the facility failed to initiate a Care Plan with interventions and goals to address a skin abrasion for 1 of 38 residents reviewed for Care Plan (Resident #35). The deficient practice was identified by the following: On 12/03/19 at 9:59 AM, the surveyor observed Resident #35 in bed with the head of bed elevated with the tube feed running. Resident #35 had a) that was attached by a . The surveyor observed Review of the Admission Record revealed Resident #35 was admitted to the facility on with diagnoses that included	F 656	1.ID PREFIX TAG F656 SS-D 2. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE Resident #35 care plan was immediately updated to include to . Care plan further updated 12/10/19 to include was resolved. 3. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE An audit was completed on all residents with to monitor and ensure care plans updated promptly.	

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F 656	Continued From page 2 Review of the Annual Minimum Data Set (MDS), an assessment tool dated , revealed Resident #35 had Review of the Quarterly MDS, dated revealed Resident #35 had Review of the Progress Note, dated 11/17/19, revealed there was observed on the of the resident's The note included that the resident would be seen by care and that an order for was needed. Review of the Progress Note, dated 11/18/19, revealed a nurse evaluated the resident's and noted a area that appeared to be caused by from the resident's . Review of the Physician's Order, dated 11/18/19, reflected and order for , every evening shift for treatment. Review of the November 2019 Treatment Administration Record (TAR) revealed an order	F 656	4. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Registered Nurse Facility Educator in serviced licensed staff on care planning wounds and updating as appropriate. 5. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE Unit managers/designee to audit all care plans for completeness and updates, daily x 14 days, weekly x 4 weeks then monthly x12 months and report findings monthly to the Quality Assurance Performance Improvement Committee for review and action as appropriate. 6. COMPLETION DATE 1/17/2020	

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F 656	Continued From page 3 for [redacted], apply to [redacted] [redacted] every evening shift for [redacted] treatment with a start date of 11/18/19. The TAR included documentation that the nurses signed that the treatment was administered from 11/18/19-11/30/19. Review of the December 2019 TAR revealed an order for [redacted], [redacted] [redacted] every evening shift for [redacted] treatment with a start date of 11/18/19. The TAR included documentation that the nurses signed that the treatment was administered from 12/01/19 up to the review date of 12/10/19. Review of Resident #35's Care Plan, dated 08/21/19, revealed on 11/11/19 that the resident had an [redacted] related to a [redacted] to the [redacted] that was resolved on 11/18/19. The Care Plan did not include documentation of the [redacted] to the [redacted] [redacted] During an interview with the surveyor on 12/10/19 at 11:29 AM, the direct care Licensed Practical Nurse (LPN) #2 stated Resident #35 had a [redacted] [redacted] on the [redacted] that was currently healed and a [redacted] on the [redacted] that had been discovered about three weeks ago that was still being treated. LPN #2 stated that the process regarding [redacted] or concerns would be to document the [redacted], notify the physician, and notify the [redacted] care nurse to evaluate the resident. LPN #2 stated that any new orders would be put on the TAR and on the Care Plan. LPN #2 stated the unit managers are responsible for updating the Care Plan. During an interview with the surveyor on 12/10/19	F 656		

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F 656	Continued From page 4 at 11:32 AM, the Registered Nurse Unit Manager (RN/UM #2), on Resident #35's unit, stated the facility had a daily morning meeting to discuss newly identified resident concerns which would then be added to the resident's Care Plan. RN/UM #2 stated a previous supervisor did the Care Plan but now the unit managers do it. RN/UM #2 stated examples of concerns that would be on a Care Plan are behaviors, new admissions and [redacted]. RN/UM #2 stated that she would review the Care Plan for accuracy at least weekly on Fridays. RN/UM #2 reviewed Resident #35's Care Plan, in the presence of the surveyor, and acknowledged the [redacted]n to the [redacted] along with the interventions and goals had not been added to the Care Plan but should have been. The RN/UM #2 stated that the purpose of the CP was to inform and guide staff in the management of any problems or issues with the residents. During an interview with the surveyor on 12/10/19 at 12:15 PM, the Assistant Director of Nursing (ADON) stated the Care Plans were to address concerns such as falls, [redacted] and fragile skin. During an interview with the surveyor on 12/10/19 at 12:20 PM, the Director of Nursing (DON) stated the facility had an Interdisciplinary Care Team (IDCT) to review each resident to make sure Care Plans are up to date and that the IDCT meets each morning, weekly and quarterly. The DON stated things such as falls, behaviors, non compliance, [redacted], and pain would be included on the Care Plan. The DON stated that if the staff reported a [redacted], the supervisor gathered the information, and an intervention would be put into place immediately by the primary nurse or supervisor. The DON added	F 656		

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F 656	Continued From page 5 that at the next morning meeting, the IDCT would look at the issue as a team and draw a conclusion. The DON stated the purpose of the Care Plan was to provide the plan of care for the resident's needs. The DON stated the identified problem, intervention and follow up would be on the Care Plan. Review of the facility's undated "Care Plan-Comprehensive" policy revealed the Care Plan should include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. The Care Plan was designed to reflect treatment goals, timetables and objectives in measurable outcomes. When possible, intervention address the underlying source of the problem area. The Process: Identifying problem areas and their causes, developing interventions that are targeted and meaningful to the resident. Revisions: Assessments of residents are ongoing and Care Plans are revised as information about the resident and the resident's condition change. The IDCT is responsible for the review and updating of Care Plans when there has been a change in the resident's condition. NJAC 8:39-11.2 (e 2)(i)	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		1/17/20

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F 684	Continued From page 6 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to obtain a physician order for a therapy recommended positioning device and to utilize the device in accordance to the therapy recommendation for 1 of 1 residents reviewed for positioning devices (Resident #141). This deficient practice was evidenced by the following: According to the Admission Record, Resident #141 was admitted to the facility on [redacted] with diagnoses which included [redacted] Review of a Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that the resident had [redacted] Review of the resident's Care Plan, dated 06/24/19, revealed that the resident was dependent on staff for ADLs and included an intervention, dated 07/10/19, for a [redacted] to the [redacted] Review of the Occupational therapy discharge summary, dated 07/04/19, included discharge recommendations for a [redacted]	F 684	1. ID PREFIX TAG F684 SS-D 2. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE Resident # 141 was immediately assessed by therapy and no harm was noted to resident. Resident no longer using [redacted]. 3. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE An audit was completed on all residents with [redacted] to monitor and ensure orders in place and care plans updated promptly. 4. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR DOR/designee to bring all new therapy recommendations to clinical meeting daily where unit managers /designee will assure all orders are in place and care	

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F 684

Continued From page 7

Review of a "Rehab Department Endorsement" form, dated 07/04/19 and signed by the Rehab Assistant and Registered Nurse (RN) #1, revealed instructions to obtain a telephone order from the physician and document in the physician's order sheet for the following: positioning device, at all times, remove during am [morning] and pm [evening] care and skin checks. Additionally, the form revealed that the resident required the for positioning due to a

On 12/04/19 at 9:49 AM, the surveyor entered Resident #141's room and observed a sign on the wall that read,)!" The resident was in bed sleeping and there was no observed on the resident's

On 12/05/19 at 9:46 AM, the surveyor observed the resident in his/her room in bed with eyes closed. There was no observed on the resident's . The surveyor observed the was on the resident's gerichair (recliner chair).

On 12/10/19 at 10:28 AM, the surveyor observed the resident in bed. There was no observed on the resident's . The surveyor noted that the was lying on the resident's gerichair.

During an interview with the surveyor on 12/10/19 at 10:28 AM, Licensed Practical Nurse (LPN) #1 stated that the resident required the for

F 684

plans updated. Registered Nurse Facility Educator in serviced licensed staff on receiving therapy recommendations, ensuring MD made aware and orders placed as appropriate and care plans updated.

5. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE

DON/designee to audit all new therapy recommendations daily x14 days, weekly x4 weeks then monthly x12 reporting all findings monthly to the Quality Assurance Performance Improvement Committee for review and action as appropriate.

6. COMPLETION DATE
1/17/2020

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F 684	Continued From page 8 positioning and was to be put on when the resident was out of bed and that the recommendation was in the resident's medical record. During an interview with the surveyor on 12/10/19 at 10:49 AM, the Rehab Director stated that the resident was discharged with recommendations for the resident to wear a [redacted] at all times in order to keep the resident's [redacted] positioned in place to prevent further [redacted]. The Rehab Director stated that when there were therapy recommendations, the therapist in-services the nursing staff on the recommendations, and the nurse signs the form. During an interview with the surveyor on 12/10/19 at 12:22 PM, the RN Unit Manager (UM) stated that when therapy has a recommendation, they give an in-service to the staff, and the rehab endorsement form is signed. The nurse then obtains a physician order and the order goes on the Treatment Administration Record (TAR) for the nurses to sign off on. The UM stated that she thought Resident #141 required a [redacted] because there was space in between the resident's [redacted] and the [redacted] helped with positioning to prevent further spacing. The UM stated that the [redacted] was to be on during the day when out of bed. The UM reviewed the resident's medical record with the surveyor and was unable to locate a physician's order for the [redacted] recommendation and that the recommendation was not on the TAR. During an interview with the surveyors on 12/10/19 at 1:22 PM, the Medical Director, accompanied by the Director of Nursing (DON), stated that she never made a recommendation or ordered a [redacted] for the resident. The DON stated	F 684		

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F 684	Continued From page 9 that when a recommendation was made from therapy, the staff obtains an order and the order goes on the TAR. During a follow up interview with the surveyor on 12/11/19 at 9:27 PM, the UM stated that there should have been an order for the [redacted] and if the physician did not agree with the recommendations, that there should be documentation. During an interview with the surveyors on 12/11/19 at 1:07 PM, the DON confirmed that there was no order for the [redacted] and stated that the nurse should have called the physician to obtain the order. Review of an undated facility policy titled, "Rehabilitation Devices Endorsement Policy," included that an endorsement form would be completed by rehab, the nursing staff would be trained on the endorsement/recommendation, a physician order should be obtained prior to the implementation of rehab's endorsement and recommendation of use of rehab device, and any rehab devices would be included in the care plan. NJAC 8:39- 27.1(a); 37.1(a)(b)	F 684		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;	F 803		1/17/20

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F 803

Continued From page 10

§483.60(c)(2) Be prepared in advance;

§483.60(c)(3) Be followed;

§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;

§483.60(c)(5) Be updated periodically;

§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure adequate starch was provided to resident's in accordance with the facility's four-week cycle menus, facility policy and national nutritional standards for 12 of 26 residents prescribed a mechanically altered pureed diet.

This deficient practice was evidenced by the following:

On 12/04/19, the surveyor observed the following:

At 11:43 AM, in the [redacted]-floor main dining room, the surveyor observed the lunch meal and noted "PUREE 1 slice Garlic Bread" indicated on the meal ticket for six residents who did not

F 803

1.ID PREFIX TAG
F803 SS-E

2. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE

Immediately FSD generated a report on all residents on puree diet and all puree resident trays were checked for puree bread.

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F 803	Continued From page 11 receive pureed bread. At 12:30 PM, in the [redacted]-floor main dining room, the surveyor observed "PUREE 1 slice Garlic Bread" indicated on the meal ticket for three residents who did not receive pureed bread. At 12:33 PM, in the [redacted]-floor [redacted] day room, the surveyor observed "PUREE 1 slice Garlic Bread" indicated on the meal ticket for three residents who did not receive pureed bread. During an interview with the surveyor on 12/11/19 at 11:35 AM, the Food Service Director (FSD) stated that residents had not been receiving pureed bread. She stated that resident's on prescribed pureed diets had received a double portion of starch in the past (not pureed bread); however, approximately five to six weeks ago, the menus were updated with the addition of pureed bread instead. The FSD further stated that the Registered Dietitian(s) involved with updating the menus were no longer employed and her and her staff were not provided with the recipe or education on the process. During an interview with the surveyor on 12/12/19 at 12:00 PM, a Registered Dietitian (RD), who provided support to the food service department prior to and during the survey, stated that she would have expected that menu items on a resident's tray to adhere to standards and meet the resident's nutritional needs. The RD further stated that she could not speak to why the pureed bread was not provided to the residents on a prescribed puree diet; however, any resident on a mechanically altered diet, should have received the same menu items as a regular consistency diet. She added that to her knowledge someone	F 803	3. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE An audit was completed on all residents with orders for puree diet to ensure puree bread was in place. 4. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR FSD/designee to generate a report on all residents receiving a puree diet. Dietician /designee will then audit trays for accuracy. Registered Nurse Facility Educator in-serviced dietary staff on ensuring all puree diet residents receive puree bread. 5. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE FSD/designee to generate a report daily on residents receiving puree diet. Dietician/designee will monitor all trays of puree residents all meals daily x 14 days, weekly x4 and monthly x12, and will report findings monthly to Quality Assurance Performance Improvement Committee for	

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F 803	Continued From page 12 in food service management oversaw the tray line (a process that involves plating residents' meals) to ensure the menu was followed. Review of the facility's four-week cycle menus (four weeks of menus that repeat) reflected that pureed bread or the like (including but not limited to the following: muffins, pancakes, waffles, English muffins, biscuits, blintzes, croissants, French toast, pizza, and bread or buns for sandwich meals) should have been served: For Cycle 1, 17 times out of 21 meals for the week. For Cycle 2, 19 times out of 21 meals for the week. For Cycle 3, 18 times out of 21 meals for the week. For Cycle 4, 19 times out of 21 meals for the week. Review of a list of residents and their diets reflected that 26 residents were on a prescribed pureed diet. Review of the facility provided "Puree Consistency Policy," undated, reflected that menus should be planned to be nutritionally adequate in all nutrients according to the Dietary References Intakes established by the Food and Nutrition Board: Institute of Medicine and the USDA Dietary Guidelines for Americans 2015-2020. It also reflected the example that bread, pancakes and plain muffins should be pureed or slurried. Review of the sample menu for a puree consistency, further reflected that	F 803	review and action as appropriate. 6. COMPLETION DATE 1/17/2020	

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F 803	Continued From page 13 pureed or slurried bread should be offered for each meal. Review of the facility provided "Menu Planning Policy," undated, reflected that nutritional needs of individuals should be provided in accordance with established national standards to provide a nourishing and well-balanced diet. NJAC 8:39-17.4(a)(3)	F 803		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		1/17/20

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F 880	Continued From page 14 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. §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.	F 880		

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F 880	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure the consistent provision of hand hygiene to residents prior to meal service in 5 of 7 dining areas. The deficient practice was evidenced by the following: On 12/03/19, surveyor #1 observed the following during the lunch meal served in the [redacted]-floor [redacted] day room: At 12:36 PM, there were seven residents present who were not offered hand hygiene before their lunch meal was served. At 12:40 PM, the surveyor observed another resident brought to the day room who was not offered hand hygiene before the lunch meal was served. On 12/04/19, surveyor #1 observed the following during the lunch meal service: At 11:36 AM, the surveyor observed that there were 32 residents present in the [redacted]-floor main dining room who were not offered hand hygiene before their lunch meal was served. At 12:15 PM, the surveyor observed the lunch meal in the [redacted]-floor main dining room. There were 17 residents present who were not offered hand hygiene before their lunch meal was served. At 12:30 PM, the surveyor observed two more residents brought into the [redacted]-floor main dining	F 880	1.ID PREFIX TAG F880 2. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE Residents were immediately provided with hand hygiene cloths. 3. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE An audit was completed by each unit manager on each floor in each dining room assessing hand hygiene of residents prior to eating, including availability of hand wipes. 4. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Each dining room has hand wipes in easy pull containers bolted to the wall at the entrances to the dining room. Both residents and staff were in serviced on utilizing hand wipes prior to meals and placing soiled wipes in the garbage directly located beneath the wipes.	

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F 880	Continued From page 16 room who were not offered hand hygiene before their lunch meal was served. On 12/04/19, surveyor #2 observed the following during the lunch meal in the [redacted] dining area: At 11:31 AM, the surveyor observed six residents in the unit dining area who were provided with hand hygiene wipes. At 11:38 AM, the surveyor observed four more residents enter the dining area who were not offered hand hygiene before their lunch meal was served. At 11:45 AM, the surveyor observed two more residents enter the dining area who were not offered hand hygiene before their lunch meal was served. At 11:50 AM, the surveyor observed that a resident left and another entered the dining area by wheelchair that he/she self propelled by touching the wheels. The resident was not offered hand hygiene before the lunch meal was served. At 11:57 AM, the surveyor observed a resident enter the dining area who was not offered hand hygiene before the lunch meal was served. At 11:58 AM, the surveyor observed a resident enter the dining area who was not offered hand hygiene before the lunch meal was served. On 12/05/19, surveyor #1 observed the following during the breakfast meal service: At 8:31 AM, in the [redacted]-floor [redacted] day room, there	F 880	5. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE ADONS/designees to audit all dining rooms for compliance of hand hygiene daily x 14 days, weekly x 4 and monthly x12 and report findings to the monthly Quality Assurance Performance Improvement Committee for review and action as appropriate. 6. COMPLETION DATE 1/17/2020	

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F 880	Continued From page 17	F 880		

were seven residents present who were not offered hand hygiene before their breakfast was served.

At 8:38 AM, in the [redacted]-floor [redacted] day room, there were five residents present who were not offered hand hygiene before their breakfast was served.

At 9:01, the surveyor observed a resident brought into the [redacted]-floor [redacted] day room who was not offered hand hygiene before the breakfast was served.

During an interview with surveyor #1 on 12/11/19 at 11:35 AM, the Food Service Director stated that the staff should provide residents with hand hygiene before dining service for infection control purposes. She further stated that hand hygiene was important since the residents touch many things, and many received finger foods and sandwiches at meals.

During an interview with surveyor #1 on 12/11/19 at 11:49 AM, a Certified Nursing Assistant stated that hand hygiene should be provided to the residents prior to meals because the residents touch a lot of things and good hand hygiene prevents the spread of germs which would keep the residents and the facility safe.

During an interview with surveyor #1 on 12/11/19 at 11:52 AM, Licensed Practical Nurse (LPN) #3 stated that hand hygiene should be provided to residents prior to mealtime. She further stated that the purpose of performing hand hygiene was to sanitize the residents hands and prevent the spread of germs.

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F 880	Continued From page 18	F 880		

During an interview with surveyor #1 on 12/11/19 at 11:55 AM, LPN #4/Unit Manager stated that hand wipes were used for the residents before meals to disinfect their hands. She further stated that was part of the infection control process.

During an interview with surveyor #1 on 12/11/19 at 12:23 PM, the Infection Control Nurse/LPN stated that hand hygiene should be provided to residents prior to meal service. She further stated that the purpose of doing so was to disinfect the residents' hands.

During an interview with surveyor #1 on 12/11/19 at 1:50 PM, the Director of Nursing stated that hand hygiene should be provided to residents prior to meals to ensure their hands were clean. She further stated that it was part of the infection control process and if hand hygiene was not provided a concern would be that a resident could get sick.

During an interview with surveyor #1 on 12/12/19 at 12:00 PM, an assisting Registered Dietitian stated that residents should receive hand hygiene prior to meals to prevent the spread of germs, bacteria and infection.

Review of the facility provided "The Dining Experience," undated, included that individuals would be provided with proper hand hygiene prior to each meal or snack.

NJAC 8:39-19.4(a 1)(m)