STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	**66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205**

(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: CENSUS: 95 SAMPLE SIZE: 21+13+3 C/O # NJ 00118729 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 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 all Certified Nursing Assistants (CNA) received 12 hours of mandatory education training, annually as required. This deficient practice was identified for 4 of 5 CNA files reviewed and was evidenced by the following: On 9/19/19 at 10:40 AM the surveyor obtained and reviewed the performance evaluations and	F 730	1. Full review of all current employees CE hours completed on 9/24/19. Employee files were found to be in compliance and on track to complete the required CE hours by end of calendar year. 2. All residents had the potential to be affected. 3. RN/NE re-educated on regulations regarding mandatory CE of employees by	10/2/19

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

Electronically Signed | 09/29/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	**66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205**

(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 730	Continued From page 1 continuing education (CE) records of five randomly selected CNA staff members, from the Registered Nurse/Nursing Educator (RN/NE). Upon review of the records, the surveyor noted the following: CNA #1 had a date of hire of [redacted]. CNA #2 had a date of hire of [redacted] CNA #3 had a date of hire of [redacted]. CNA #4 had a date of hire of [redacted] CNA #5 had a date of hire of [redacted] The five files contained various tests, educational content sheets, and lengths of time devoted to course completion. The referenced information was not complete on all the forms. On 9/20/19 at 9:45 AM, the surveyor questioned the RN/NE related to continuing education credits for CNA staff, in the presence of the survey team, the Director of Nursing (DON), and Director of Clinical Services. The RN/NE confirmed that CE credits for CNA staff were counted in terms of a calendar year, from January 1 through December 31 of a given year. On 9/20/19 at approximately 10:00 AM, the surveyor asked the RN/NE to count the CE credits given to the five randomly selected CNA staff members for the calendar year of 2018, due to the incomplete information contained within the files. On 9/20/19 at approximately 11:00 AM, the RN/NE gave the surveyor a ledger that accounted for the CE credits, for each of the five randomly selected CNA staff members for 2018. The records revealed the following:	F 730	Administrator on 9/24/19. 4. Employee CE tracking tool created and to be monitored monthly by RN/NE x 3 monthly and then Quarterly. Results of audits to be shared monthly with the QAPI committee for further review and to formulate proper plan of action if needed. 5. Completion date: 10/2/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 730	Continued From page 2 CNA #1 had 3 hours and 50 minutes of CE credits. CNA #2 had over 12 hours of CE credits. CNA #3 had 4 hours and 30 minutes of CE credits. CNA #4 had 3 hours and 45 minutes of CE credits. CNA #5 had 10 hours and 57 minutes of CE credits. On 9/20/19 at 2:32 PM, the surveyor interviewed the RN/NE, in the presence of the DON, Licensed Nursing Home Administrator (LNHA), and the survey team. The RN/NE confirmed that the recorded CE credits were accurate for each of the five CNA staff members for 2018 The RN/NE also confirmed that there were less than 12 hours of CE credits, as required, for 4 of 5 CNA staff members reviewed for CE educational requirements.	F 730		
F 755 SS=D	NJAC 839-43.17(b) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		10/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 755	Continued From page 3 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to detect and remove expired medication in 1 of 1 automated pharmacy dispensing machines and in 1 of 1 intravenous supply kits, which were inspected as part of the medication and storage task of the survey. This deficient practice was evidenced by the following: On 9/17/19 at 11:30 AM, the surveyor inspected the automated pharmacy dispensing machine (a supply of medication kept in locked storage so that the medication may be started until further supplies are available from the pharmacy) located on the [redacted] Floor Nursing Unit, in the presence of the Registered Nurse/Unit Manager (RN/UM #1).	F 755	1. Audit done by Pharmacy provider representative on 9/17/19 on facility backup medication including the emergency IV box and the automated pharmacy dispensing machine. All medications that where within 90 days of listed expiration date where removed. 2. All residents had the potential to be affected. 3. All Licensed nursing staff were re-educated on the facility Policy & Procedure on how to discard of expired medications. Pharmacy provider representative will continue his monthly audits and share his findings with facility nursing administration. 4. RN Unit Managers / Designee will audit medication storage locations Monthly X3 months and then quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 755	Continued From page 4 The surveyor found the following expired medications: 14 tablets of [redacted] that expired on 8/31/19; four tablets of [redacted] that expired on 5/10/19; 10 tablets of [redacted] four tablets of which expired on 5/9/19, two tablets of which expired on 6/8/19, and four tablets of which expired on 6/18/19; two tablets of [redacted] that expired on 2/4/19; three tablets of [redacted] one tablet of which expired 6/13/19 and two tablets of which expired on 7/30/19; two tablets of [redacted] that expired on 3/27/19. The [redacted] Floor Nursing Unit also contained and intravenous (IV) supply kit, for the purpose of starting any required IV medication until such a supply would become available from the pharmacy. An IV medication is one that is administered directly into a blood vessel through a needle. The surveyor found two bags of [redacted] that expired 7/19, which indicated that the products expired at the end of the referenced month. During an interview on 9/17/19 at 11:45 AM, RN/UM #1 acknowledged that all the referenced medications were expired and that they should have been removed from the supply of stock. She also stated that she did not know why the expired	F 755	Results of audits to be shared monthly with the QAPI committee for further review and to formulate proper plan of action if needed. 5. Completion date: 10/2/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 755	Continued From page 5	F 755		

medication was present in the back-up supply and that the consultant pharmacist was responsible for checking the expiration dates for the medication in the automated dispensing machine and the IV supply kit.

During an interview on 9/17/19 at 12:02 PM, the Director of Nursing (DON) stated that the consultant pharmacist staff was responsible for checking the expiration dates of medications stored in the automated pharmacy dispensing machine and in the IV supply kit. She further stated that it was also a part of nursing practice to check the expiration dates when accessing the supply of medications in back-up storage.

The surveyor also interviewed the Pharmacy Accounts Manager of the provider pharmacy on 9/17/19, in the presence of the survey team. He stated that nursing staff was required to manually enter expiration dates into the automated dispensing machine for proper monitoring of expiration dates to occur but could not say with certainty whether this practice was being performed.

A review of the facility's policy titled, "Medication Dispensing: Back-Up Medications: Electric Medication Storage (EMS)" with a revision date of 8/2015 revealed the staff of the provider pharmacy was responsible for checking the back-up medication monthly to ensure that medications were not expiring. It was also their responsibility to remove any medication due to expire and destroy it with a designated representative of the facility.

NJAC 8:39-29.4(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6	F 880		
F 880 SS=D	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, 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;	F 880		10/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	**66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7 (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to a.) adhere to the accepted standards of infection control practices for the proper storage of respiratory equipment for 3 of 5 residents reviewed for respiratory care (Resident #13, #14, and #34). This deficient practice was evidenced by the following:	F 880	1. Resident #13,14, &34 had their [redacted] assessment performed by an RN and there were no negative findings. Audits done by Nursing Supervisor on 9/17/19 and again on 9/19/19 on all [redacted] and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 1. During the initial tour of the [redacted] floor high hallway on 9/17/19 at 10:06 AM , the surveyor observed a [redacted] for Resident #34 that was stored directly on the top of the [redacted] on the bed side table. The [redacted] were uncovered and dated 8/27. According to the "Admission Record" Resident #34 was admitted to the facility on [redacted] with diagnosis including but not limited to: [redacted] A review of the most recent Minimum Data Set (MDS), an assessment tool dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted]. A review of the Medication Review Report (MRR) revealed a physician's order with a start date of 11/08/2018, for [redacted]. The MMR also showed a physician's order for [redacted], Change Weekly every Thursday for Infection Control Prevention. A review of the August 2019 Treatment Administration Record (TAR) revealed a physician order for [redacted] Change Weekly every Thursday for Infection Control Prevention. The	F 880	[redacted]. Nursing documentation was reviewed and congruent with findings. 2. All residents that are on respiratory therapy have the potential to be affected. 3. Policy and Procedure for proper medical equipment tubing and humidification changes were reviewed by Admin, DON and MD on 9/18/19, no revisions were necessary. All Licensed nursing staff re-educated on Policy and Procedure for tubing as well as properly documenting on tasks once completed. 4. RN Unit Managers or Designee will audit all tubing/humidification weekly as well as the TARs for compliance X 4 weeks and then Monthly. Results of audits to be shared monthly with the QAPI committee for further review and to formulate proper plan of action if needed. Completion date: 10/2/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9	F 880		

TAR revealed a signature indicating the [redacted] was changed on 8/29/19. The September 2019 TAR further revealed signatures indicating that the [redacted] was changed on 9/5 and 9/12.

2. During the initial tour of the [redacted] high hallway on 9/17/19 10:10 AM , the surveyor observed a [redacted] for Resident #14 that was stored directly on the top of the [redacted] on the bed side table. The [redacted] were uncovered and dated 8/20.

According to the "Admission Record", Resident #14 was admitted to the facility on [redacted] with diagnoses including but not limited to: [redacted].

A review of the most recent MDS dated [redacted] revealed a BIMS score [redacted]

A review of the Order Summary Report (OSR) revealed a physician's order for [redacted] and [redacted]. The OSR for August and September 2019 did not include a physician order to change the [redacted] weekly.

During an interview on 9/17/19 at 11:57 AM, Resident #14 said that the [redacted] just sits on the table and is never covered or in a bag. Resident #14 also said they change the [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	**66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 whenever needed. The surveyor interviewed a Licensed Practical Nurse (LPN #1) on 9/18/19 at 11:18 AM. LPN#1 said that staff change all respiratory [redacted] on a weekly basis. This is done by night shift. LPN #1 went on to say he was not sure if the change is signed out and that a physician's order is not necessary to change the [redacted]. LPN #1 further said the facility practice is to change the [redacted] weekly. On 9/18/19 at 11:20 and 11:22 AM respectively, LPN #1 checked the physician's orders in the presence of the surveyor for Residents #34 and #14, and said he did not see an order to change the [redacted]. During an interview on 9/18/19 at 11:32 AM the Registered Nurse/Unit Manager (RN/UM #2) stated that we change [redacted] weekly on the night shift. RN/UM #2 went on to say the [redacted] are to have the residents name and date on the bag that the [redacted] is stored in and staff are supposed to put the tape on the [redacted] with the date of change. RN/UM #2 told the surveyor that was the facility protocol so a physician order is necessary to change the [redacted]. The order to change [redacted] is on the Medication Administration Record (MAR)/TAR and the nurse signs when the [redacted] is changed. RN/UM #2 further said a [redacted] is not to be lying on the table but should be stored in a plastic bag. On 9/18/19 at 11:36 AM, the surveyor reviewed the aforementioned findings with the Director of Nursing (DON) and RN/UM #2 both of whom confirmed the findings and said the [redacted] should have been changed weekly and the [redacted] should have been stored in a bag.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	**66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11	F 880		

3. On 9/18/19 and 9/19/19, the surveyor made multiple observations of Resident #13's [redacted] laid over the pillow on the resident's bed. The [redacted] was not dated nor covered.

On 9/18/19 at 9:39 AM, the surveyor observed the [redacted] that was connected to the [redacted] was empty and not dated as to when it had last been changed.

According to the "Admission Record", Resident #13 was admitted to the facility on [redacted] with diagnoses including but not limited to: [redacted]

A review of the most recent MDS dated [redacted] revealed a (BIMS) score [redacted].

A review of the MRR revealed a physician's order with a start date of 4/24/2018, to change [redacted] every night shift every Tuesday for infection control. Date each item with current date. The MRR also showed a physician's order with a start date of 6/13/2019 for [redacted]. Check distilled water every shift and change if needed every shift related to [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 A review of the September 2019 TAR revealed a physician's order to change [redacted], [redacted] every night shift every Tuesday for infection control. The TAR did not include documentation to indicate that the [redacted] was changed on 9/17. The TAR also showed a physician's order for [redacted]. Check distilled water every shift and change if needed every shift related to [redacted]. The TAR did not include documentation to indicate that the [redacted] was checked/changed on 9/17 (night shift) and 9/2 (day and night shift). During an interview on 9/19/19 at 2:02 PM, RN/UM #1 verbalized that the [redacted] is dated every time the bottle is opened and should be dated weekly. The RN/UM #1 confirmed that the [redacted] was not labeled with a date and that she will date it. On 9/20/19 at 2:37 PM, DON reviewed Resident #13's September 2019 TAR in the presence of surveyor and confirmed that the aforementioned lack of signatures indicated "it wasn't done". A review of a facility policy titled [redacted] with a revision date of 3/1/2017, revealed under the policy section [redacted] (when used) are changed no less than weekly." The policy showed under the Procedure section 3. "A bag is to be kept at each resident's bedside where [redacted]r is being used. Bag is for storage of [redacted] when not in use." NJAC 8:39-27.1 (a)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	**66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205**

(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