STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING ______ B. WING ______	08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	**43 N WHITE HORSE PIKE HAMMONTON, NJ 08037**

(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 8/21/2019 CENSUS: 201 SAMPLE SIZE: 35	F 000		
F 550 SS=B	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		9/20/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/06/2019

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

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to treat all residents in a dignified manner. This deficient practice was identified and confirmed at a resident's group meeting for 5 of 7 residents (Residents #110, #197, #97, #12, #132) and was evidenced by the following: On 8/14/19 at 12:40 PM, the surveyor observed a Certified Nursing Assistant (CNA) in a resident's room using her cell phone as she was standing next to the resident's bed. When the CNA saw the surveyor, she put her cell phone into her pocket and then started to provide care to the resident. On 8/15/19 at 10:27 AM, the surveyor met with a group of seven alert and oriented residents. When asked about staff cell phone use, 5 of 7 residents stated they had observed CNAs on their cell phones while providing resident care. The residents also stated they had observed CNAs on all shifts using their cell phones while in resident rooms, in the hallways, and at the nurses station during work hours. When asked when the residents had last seen staff on their cell phones, 5 residents stated "today." Resident #97 said he/she observed a CNA behind the nurses station	F 550	1. All staff were immediately educated on the policy and procedure for cell phone use while providing resident care. No residents were negatively affected. 2. All residents had the potential to be affected by the deficient practice in element 1. 3. The ADON in serviced all nursing staff on the proper policy and procedure of cell phone usage. The Unit managers will conduct weekly audits to ensure compliance with cell phone usage. 4. DON/ADON will conduct random weekly audits x 1 month and monthly audits x 3 months to ensure compliance. All findings will be reported to monthly QAPI meeting and decided if further action is necessary.	

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F 550	Continued From page 2 on her cell phone that morning while call lights were on in the hallway. On 8/19/19 at 12:00 PM, the surveyor reviewed the facility's policy titled "Cell Phone, E-Mail, and Social Media Use." The policy did not address the use of cell phones during resident care. NJAC 8:39-4.1(a)12	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not	F 561		9/20/19

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F 561	Continued From page 3 interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a resident with a food item that he/she had specifically requested. This deficient practice was identified for 1 of 1 residents reviewed for choices (Resident #45) and was evidenced by the following: The surveyor reviewed Resident #45's [redacted] Quarterly Minimum Data Set, an assessment tool, which identified that the resident was [redacted]. The surveyor also reviewed the resident's physician's orders which included a 4/23/19 diet order of "regular diet pureed texture." When interviewed in the resident's room on 8/19/19 at 8:40 AM, Resident #45 stated that he/she did not receive oatmeal for breakfast "today or yesterday" as requested. A Certified Nursing Assistant (CNA) who was in the hallway overheard the conversation. The CNA stated that when she had called the kitchen that morning, she was told they did not have any oatmeal. On 8/19/19 at 9:20 AM, the surveyor interviewed the Dietary Supervisor (DS) about Resident #45's oatmeal. The DS stated that no hot cereal had been prepared that morning because the kitchen "ran out of lids" (lids for hot cereal bowls). NJAC 8:39-17.4(a)(1) .	F 561	1. Once the facility identified that resident #45 did not receive their oatmeal as requested, it was immediately given the resident. No residents were negatively affected. 2. All residents that requested oatmeal had the potential to be affected by the deficient practice in element number 1. All residents that had requested oatmeal for that day were offered oatmeal for breakfast. 3. The food service supervisor in-serviced all dietary staff on the proper policy and procedure for providing residents with food items that are specifically requested as well as using alternative supplies as needed. The food service supervisor will conduct weekly audits to ensure compliance with specific requested food items for residents and to ensure supplies are available. 4. Administrator/Food Service Director will conduct random weekly audits x 1 month, then monthly x 3 months to ensure compliance. All findings will be reported to the monthly QAPI meeting and decided if further action is necessary.	

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F 577 SS=B	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to post the New Jersey Department of Health State Survey results in a location that was frequented and/or, easily accessible to the residents. This deficient practice was identified and confirmed by 7 of 7 residents who attended a resident's group meeting (Residents #110, #197, #97, #12, #132, #80, #62), and was evidenced by the following:	F 577	1. Survey binders were immediately provided on the [redacted] and [redacted] floor in an area accessible to all residents. The survey binder will remain at the front desk of facility lobby as well, in a conspicuous location. No residents were negatively affected. 2. All residents had the potential to be affected by the deficient practice in element 1.	9/20/19

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F 577	Continued From page 5 On 8/13/19 at 8:15 AM, the surveyor observed a sign on the wall at the receptionist's desk in the main lobby that noted, "SURVEY BINDER LOCATED" with an arrow pointing down to the countertop. The surveyor observed the state inspection survey results binder lying flat on the counter with two items lying on top of it. One of the items was a floor plan of the facility in a picture frame and the other item was the facility's fire emergency plan notification, also in a picture frame. The lobby area of the facility was located between the main entrance doors and a set of double doors that lead to the nursing units and the rest of the facility. The double doors were locked at all times and could not be opened from either side without entering a 4 digit code into a code lock device on the wall by the door. The residents did not have free access to the lobby area and the surveyors did not observe residents frequenting the lobby area. On 8/15/19 at 10:27 AM, the surveyor met with a group of seven alert and oriented residents. When asked if the residents knew about the state inspection survey results, all seven residents said they were unaware of the state inspection survey results or where they were located in the facility. When asked if state inspection survey results were reviewed in the resident council meetings each month, all seven residents said it was not discussed at the monthly meetings. NJAC 8:39-9.4(b)	F 577	3. The Activity Director in serviced all alert and oriented residents on the State Inspection Survey Results and where the result binders were located in the facility. During the facilities monthly resident council meetings the location of the survey result binder will be reviewed with residents. 4. Administrator/Activities director will conduct random weekly audits x 1 month and monthly x 3 months to ensure survey result binders are in the appropriate location. All findings will be reported to monthly QAPI meeting and decided if further action is necessary.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		9/20/19

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

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F 584	Continued From page 7 Based on observation, interview and record review, it was determined that the facility failed to maintain a clean and sanitary environment for 2 of 2 Nourishment rooms. This deficient practice was evidenced by the following: On 8/20/19 at 8:54 AM, the surveyor observed the [redacted] floor Nourishment room located on the [redacted] hallway. When interviewed at that time, a Certified Nursing Assistant said the refrigerator in the nourishment room was used by residents for any left overs or foods brought in that might need to be refrigerated. The surveyor went into the nourishment room and observed three wooden shelves to the left of the door. The shelves and surrounding wall area had dried food spills. There were dried food spills on the wall next to the refrigerator and the wall across from the refrigerator where electrical panels were located. The rubber cove base molding around the room was visibly soiled. There was a build-up of dust in the ceiling vent. There were three drawers below the counter that contained foam cups, plastic cup lids, and small plastic cups. The insides of the drawers were visibly soiled with debris. There was a build-up of dirt in the corners and at the floor/wall junctures around the room. On 8/20/19 at 9:06 AM, the surveyor observed the Nourishment room on the first floor located in the [redacted] hallway. The walls around the room were scuffed and had dried spills. The rubber cove base molding around the room was soiled in appearance, loose in many areas and a section was missing. There was a build-up of dust in the ceiling vent above the refrigerator. There were three drawers below the counter that contained	F 584	1. The Nourishment rooms located on [redacted] and [redacted] were scrubbed, painted and thoroughly cleaned. The buildup of dust in the ceiling vent above the refrigerator was cleaned and painted. No residents were negatively affected. 2. All other nourishment rooms in the facility were thoroughly cleaned and painted to ensure cleanliness. 3. The Housekeeping Director/Maintenance director Re-inserviced all Housekeeping and Maintenance staff on proper policy and procedure of cleaning the nourishment rooms. The Housekeeping director will conduct weekly audits to ensure compliance with cleanliness with all nourishment rooms. 4. Administrator/Housekeeping Director will conduct random weekly audits x 1 month and monthly x 3 months to ensure compliance. All findings will be reported to monthly QAPI meeting and decided if further action is necessary.	

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F 584	Continued From page 8 foam cups and plastic cups. The insides of the drawers were visibly soiled with debris. There was a build-up of dirt in the corners and at the floor/wall junctures throughout the room. When interviewed on 8/20/19 at 9:24 AM, the Housekeeping Director (HD) said housekeeping staff cleaned the nourishment rooms daily. When asked if he monitored the nourishment rooms, the HD said he checked the rooms 2 to 3 times each week. The surveyor asked if there was a policy for cleaning the nourishment rooms. On 8/20/19 at 10:20 AM, the HD provided the surveyor with "Policy: Utility rooms will be disinfected for cleanliness." The surveyor reviewed the policy which included "Procedure: In am, assigned Housekeeper will disinfect utility rooms" and "All areas are wiped, floors swept and mopped." NJAC 8:39-31.4 (a,f)	F 584		
F 755 SS=E	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		9/20/19

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F 755	Continued From page 9 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 and record review, it was determined that the facility failed to maintain narcotic medication countdown logs that were completed in their entirety and signed by the nurses. This was cited at a level E denoting a pattern as it was identified for 6 of 10 narcotic countdown logs on the medication carts. In addition, this was also a repeat deficiency as it was cited at the last standard survey of 8/24/18. This deficient practice was evidenced by the following: On 8/14/19 at 9:03 AM, the surveyor observed the "Nurse Narcotic Sign Out Log" on the ██ medication cart. The surveyor, in the presence of the Licensed Practical Nurse (LPN), observed that the 8/14/19 narcotic sheet was not signed out for the incoming 7-3 shift that morning. The LPN	F 755	1. All residents receiving narcotic medication have been reviewed to ensure proper administration occurred and were found to be in compliance. All licensed nursing staff have been re-educated on the proper policy and procedure for controlled substances to include counting controlled drugs at the end and beginning of each shift. No residents were negatively affected. 2. All residents had the potential to be affected. A facility wide audit has been conducted on all residents receiving narcotics and were all found to be in compliance. 3. The ADON Re-inserviced all licensed nursing staff on the proper policy and procedure on the documentation needed on the narcotic medication countdown	

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F 755	Continued From page 10 then signed it in front of the surveyor and then signed the outgoing slot for 3:00 PM. The surveyor asked the LPN if she usually signed the outgoing space on the log before she did the med count with the incoming nurse and she stated, "Yes, I usually do." Upon further review, the surveyor observed blanks where the nurses, Registered Nurses and Licensed Practical Nurses, had failed to sign the log upon performing the narcotic medication countdown throughout the month of August, 2019. (A countdown of the narcotic medications is done at the end of each nursing shift to ensure that the count is correct. The outgoing nurse and incoming nurse do the count down together and both sign the accuracy of the count.) The surveyor observed that on some days there was only one nurse's signature, not two as required according to the facility policy. The surveyor also observed blanks in the 5 other narcotic books on the [redacted] and [redacted] nursing units. The surveyor requested the policy for controlled substances from the Corporate RN. According to the policy "Controlled Substances", "Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services." When interviewed on 8/19/19 at 1:57 PM, the Director of Nursing stated the expectation is that the outgoing nurse and incoming nurse count the narcotics and sign the count sheet together at the change of shift.	F 755	sheets. The Unit managers and nursing supervisors will conduct daily random audits on every shift to ensure compliance with the narcotic medication countdown sheets. 4. DON/ADON will conduct random audits weekly x 1 month and monthly x 6 months to ensure compliance. All findings will be reported to the monthly QAPI meeting and decided if further action is necessary.	

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F 755	Continued From page 11 NJAC 8:39-29.7(c)	F 755		
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to offer bedtime snacks. This deficient practice was identified for 7 of 9 residents at a resident's group meeting (Residents #110, #197, #97, #12, #132), and for 2 additional, individually interviewed residents (Resident #34 and #141) and evidenced by the following: On 8/15/19 at 10:27 AM, the surveyor met with a group of seven alert and oriented residents. When asked about bedtime snacks, five	F 809	This Plan of Correction is not an admission of liability and we are filing it in compliance with state and federal requirements. 1. A facility wide audit was completed to ensure all residents were offered and given Bedtime snacks appropriately per policy and procedure. 2. A facility wide audit was completed to ensure all residents were offered and given Bedtime snacks appropriately per	9/20/19

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F 809	Continued From page 12 residents stated bedtime snacks were not passed out at night. When questioned further, Resident #132 and Resident #197 stated a snack cart was brought down at approximately 7:00 PM each night and then placed at the nurses station by dietary staff. All five residents stated, "you have to go to the nurses station to get snacks" and that they only received a snack after requesting one from staff. On 8/15/19 at 1:34 PM and 1:56 PM respectively, Resident #141 said no one ever came to the room to ask if he/she wanted a snack. Resident #141 said, "the snacks are at the desk, you go out there and get one." Resident #34, who is bedridden, said "no one ever comes to the room and asks me if I want a snack." Resident #34 further stated that his/her spouse will go to the desk and get a snack for them. On 8/19/19 at 11:04 AM, the surveyor interviewed the Dietary Supervisor regarding snacks delivered to the units. The Dietary Supervisor stated snack carts were delivered to the nurses station at 7 PM, and that nursing staff "are supposed to pass them out." When the surveyor asked the Dietary Supervisor if there were any complaints from the residents about night time snacks he stated, "Yes, once in a while there are complaints about not getting snacks. They are usually by someone expecting us to bring it (the snack) to them." On 8/19/19 at 12:00 PM, the surveyor received the facility's policy "Snacks (Between Meal and Bedtime), Serving" which included "1) Place the snack on the overbed table or serving area. Arrange the supplies so they can be reached by the resident."	F 809	policy and procedure. All residents have the potential to be affected. 3. The ADON in-serviced all nursing staff on the proper policy and procedure of snacks at bedtime. The Unit Managers/Nursing Supervisors will conduct random weekly audits to ensure compliance with bedtime snacks. 4. DON/ADON will conduct random weekly audits x 1 month and monthly audits x 3 months to ensure compliance with bedtime snacks. All findings will be reported to monthly QAPI meeting and decided if further action is necessary.	

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F 809	Continued From page 13 NJAC 8:39-17.4(b)	F 809		
F 812 SS=F	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 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 sanitation in a safe and consistent manner in order to prevent food borne illness. This deficient practice was evidenced by the following: On 8/13/19 from 8:34 to 9:37 AM, the surveyor, accompanied by the Dietary Supervisor (DS), observed the following in the kitchen:	F 812	1. The Dietary aide immediately donned a beard guard. The temperature in milk refrigerator #2 was immediately recorded and found to be in compliance. The temperature for milk box #3 was completed and found to be incompliance. The 8 Italian ice cups were immediately discarded. The mini pizzas and the 4 cupcakes were immediately discarded. The orange and 2 yogurts were immediately discarded. The walk-in refrigerator was immediately swept of all	9/20/19

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1. Upon entrance to the kitchen, the surveyor observed a Dietary Aide (DA) with a lengthy beard in the food production area. The DA was not wearing a beard guard and had exposed facial hair.

2. The surveyor and DS reviewed the Milk Refrigerator #2 "Refrigerator Freezer Temperature Log", dated August 2019. Review of the temperature log revealed that no temperatures had been recorded since 8/9/13 for the AM temperature observation. There were no temperatures recorded for the 8/9/19 PM, and no AM or PM temperatures were recorded on the following dates: 8/10, 8/11, 8/12 and 8/13/19 for the AM. The DS stated, "oops, we're a little behind on that." The DS further explained, "the temperatures are to be completed in the AM and PM by the morning and evening cook."

3. Observation of the milk box #3 "Refrigerator Freezer Temperature Log", dated August 2019, revealed that the recording of the milk box temperature had not been completed for the following dates: 8/2/19 PM, 8/3, 8/4, 8/5, 8/6 AM, 8/7, 8/8, 8/9, 8/10, 8/11, 8/12 and 8/13/19 AM. The DS stated, "That should have been completed and up to date."

4. There were 8 Italian ice cups on the floor in the walk-in freezer. When interviewed at that time, the DS stated, "my staff is stretched pretty thin, those are going in the trash." On a middle shelf, three trays of mini pizzas were covered with plastic wrap and had no dates. The DS stated, "We prepped them this morning for today. They should have been dated. I will in-service my staff on it." On an upper shelf, an opened plastic

F 812

debris. The manual wash titration log was completed immediately and all dietary employees were re-educated on recording temperatures on the manual wash titration log. The two stacks of plates were immediately cleaned and sanitized again and placed appropriately on the cart. The brown dried substance on the front of milk fridge #1 was cleaned immediately. All products stored on the shelf that were less than six inches from the floor were immediately removed. The metal shelving in the dry storage room was repaired. The Low Dish Machine was immediately repaired and all temperatures for sanitizing were found to be within acceptable standards. All previously washed dishes were re washed. The metal pans that were stacked on top of each other were immediately re-washed, dried and stacked appropriately. Manual wash and sanitizer PPM temperatures were completed and found to be in compliance. The Dietary Supervisor was immediately educated and disciplined for the deficient practice. No residents were negatively affected.

2. All residents had the potential to be affected by the deficient practice identified in element #1. All areas mentioned have been addressed.

3. Dietary supervisor and the entire dietary staff were re-inserviced on the proper policy and procedure to ensure the facility maintained handling of potentially hazardous food and maintained kitchen sanitation in a safe and consistent manner to prevent food borne illness.

4. Administrator/Dietician will conduct

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F 812	Continued From page 15 container contained 4 cupcakes. The plastic container was not sealed and exposed to the air and had no dates. The DS stated, "Activities staff puts stuff in here." The DS threw the container of cupcakes in the trash. 5. There was an orange and two yogurts on the floor in the walk-in refrigerator. When asked how often the walk-in refrigerator is cleaned, the DS stated, "The guy who comes in on the 12-8 shift is responsible for cleaning and rotating the stock. We have had staffing issues lately." 6. The surveyor observed the "Manual Wash Titration Log", dated August 2019 that was hanging on the wall in front of the wash sink. The log was completed for the dates 8/1/19 up to and including 8/3/19 for the breakfast meal. The log was incomplete for the dates 8/3/19 at lunch up to and including 8/13/19 for the breakfast meal. The DS stated, "Ahh no. That should be filled out before they initiate dishwashing." Review of the "Manual Wash Titration Log" indicated the following: "A designated food service employee will record the temperatures, as outlined below, and their initials." 7. The surveyor observed a wheeled cart utilized to store cleaned and sanitized plates used to serve resident meals. There were two stacks of cleaned and sanitized plates on the cart that were not inverted and were exposed to air. 8. There was an unidentified brown, dried substance on the front of the #1 milk fridge. The DS stated, "I see what you mean. We need to get that cleaned up." 9. In the dry storage room, the surveyor observed	F 812	multiple weekly audits x 1 month and monthly x 6 months to ensure dietary compliance. All findings will be reported to monthly QAPI meeting and decided if further actions is necessary.	

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a metal lower shelf that was collapsed/bent in the middle of the shelf. The products stored on the shelf were less than six inches off the floor. Multiple dry storage shelves were observed to be bent and prevented food products from being stored at least 6 inches from the surface of the floor.

On 8/15/19 from 9:48 to 10:35 AM, the surveyor was accompanied by the Food Service Director (FSD) from a sister facility. The surveyor and FSD observed the following in the kitchen:

10. The surveyor observed the "Low Dish Machine Temperature Log", dated August 2019, while the dish washing machine was actively in operation. The log revealed the following: "Minimum Wash 120 Fahrenheit (F) and Rinse 120; Sanitizer: 50-" The log revealed the following on 8/15/19 for the AM dish period, "Wash cycle 125, Final Rinse 125 and Sanitizer PPM (Part Per Million) 100." On 8/15/19 9:54 AM, the surveyor and the FSD observed the following temperatures while the low temp dish machine was in service, wash of 112F and rinse of 115F. The FSD stated, "I checked the sanitizer at 7 AM this morning. I also checked the wash temperature at 125F and the rinse temperature at 125F. The sanitizer was 50 PPM. We are shutting the machine down. The dishwashers should be monitoring the temperatures throughout the dishwashing process. They should stop the machine if they notice a problem and we will go to paper. We are going to work on it right now. All washed dishes will be recleaned once the machine is up to temperature." At 10:14 AM, the FSD notified the surveyor that the dish machine had been fixed and was running at an acceptable temperature. The FSD stated, "they were working on the boiler

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and had turned the temperature down." The surveyor observed a wash temperature of 135F and a final rinse temperature of 130F. The FSD was then asked by the surveyor to perform a test of the sanitizer level (Generex chlorine sanitizer) once the proper temperatures for the wash and rinse were confirmed. The FSD made two attempts at testing the sanitizer level utilizing manufacturer specified test strips and instructions. The FSD obtained both results at less than 10 PPM and the acceptable standard is established at 50 PPM. The dish machine was shut down at 10:17 AM. After adjusting the chlorine sanitizer, the FSD attempted to re-check the sanitizer level. The FSD accidentally dropped all test strips onto the washed plate. The test strips that were dropped onto the test plate for sanitizing indicated a sanitizer level of 50-100 PPM. Dishwashing was restarted and all previously washed dishes were rewashed.

11. There were cleaned and sanitized metal pans stacked on top of each other in an inverted position on a middle shelf on the pot drying rack. The pans were wet with a clear liquid substance that was water-like. The FSD stated, "that's wet nesting. They should be completely dry before stacking. They will need to be rewashed."

12. The surveyor again reviewed the "Manual Wash Titration Log", dated August 2019 that had previously been reviewed on the initial kitchen tour on 8/13/19 and deemed to be incomplete. The log revealed that no wash temperature, sanitizer PPM had been completed since breakfast on 8/3/19 up to and including breakfast on 8/17/19. Although the DS had identified this concern on 8/13/19, the deficient practice was still occurring.

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The surveyor reviewed the Centers Health Care facility policy titled "Staff Appearance and Hygiene", date originated 4/2014. Under the Procedures section, the policy revealed at 2. "Hair will be clean and worn pulled up if longer than shoulder length. Regardless of length, hairnet, hat and beard guard is required in all production and service areas."

The surveyor reviewed the facility policy titled "Cleaning Dishes - Manual Dishwashing", Source: 2013 Food Code, (4-501.114 and 501.119). U.S. Department of Health and Human Services. U.S. Food and Drug Administration. The policy revealed the following at Sink 3: Sanitize: (4). "Allow dishes to air dry. Invert dishes in a single layer to air dry. Check all dishes to be sure they are clean and dry prior to storing."

The surveyor reviewed the Centers Health Care policy titled "Dishwashing and Manual Ware washing", date originated: 4/2014. The policy stated at d. "Sanitizer concentration is checked each time the sink is filled."

The surveyor reviewed the facility "Cleaning Schedule" for the kitchen. The schedule revealed the following: Monday-Refrigerators "Clean out all refrigerators. Throw out all expired food. Clean inside and outside of refrigerator with soap and hot water."

The surveyor reviewed the Greenex Emergency Low Temp Sanitizer Procedures, provided by the facility. The procedure revealed the following: "Temperatures should be checked every meal period" and "If necessary available chlorine in Final Rinse should be checked every meal

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F 812	Continued From page 19 period" NJAC 8:39-17.2(g)	F 812		
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	F 880		9/20/19

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F 880	Continued From page 20 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. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to ensure that staff washed their hands according to the facility's policy. This deficient practice was identified for 1 of 2 nurses observed during the medication pass and was evidenced by the following:	F 880	1. The identified nurse was immediately re-educated by the ADON on the hand washing policy and procedure and completed a handwashing competency successfully. No residents were negatively affected.	

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F 880	Continued From page 21 After administering medications to the second of 2 residents, the Licensed Practical Nurse (LPN) went in to the residents' bathroom to wash her hands. The LPN turned on the water, put soap on her hands, and then immediately put her hands under the running water. The LPN rubbed her hands together under the running water for the entire handwashing time which was just under 10 seconds (9.97 seconds as identified by the surveyor's stopwatch). The surveyor reviewed the facility's "Handwashing/Hand Hygiene" policy which included under "Washing Hands"..."wet your hands with clean running water and apply soap. Vigorously lather hands with the soap and rub them together, creating friction to all surfaces, including the palms, backs, fingers, between your fingers, and under your nails, for a minimum of 20 seconds (Hum the "Happy Birthday", song twice) and then rinse hands thoroughly, under a moderate stream of running water, at a comfortable temperature. NJAC 8:39-19.4(a)1	F 880	2. All licensed nurses were re-educated on the hand washing policy and procedure and the hand washing competency was completed successfully by all nurses. All residents have the potential to be affected. 3. The ADON Re-inserviced all nursing staff on the proper policy and procedure for hand washing. Hand washing competencies were completed for all nursing staff and found to be in compliance. The Unit Managers will conduct random weekly audits on hand washing to ensure compliance. 4. ADON/Facility Educator will conduct random weekly audits x 1 month and monthly x 3 months to ensure compliance with handwashing. All findings will be brought to monthly QAPI meeting and decided if further action is necessary.	