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 _____	C 09/01/2020

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 COMPLAINT #: NJ00137503, NJ00136530, NJ00138002, NJ00136435, NJ00136588, NJ00134868, NJ00134403, NJ00136784, NJ00136264, NJ00132954, NJ00137884, NJ00136744, NJ00136944, NJ00132839, NJ00136425, NJ00136103, NJ00136068, NJ00132394. CENSUS: 200 SAMPLE: 19 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART483,SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including 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	F 584		9/30/20

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

Electronically Signed 09/12/2020

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F 584	Continued From page 1 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: Complaint #NJ00138002 Based on observation, interview, and record review, it was determined that the facility failed to maintain a clean, safe and sanitary environment. This deficient practice was evidenced by the following: On 8/26/20 at 9:50 A.M. the surveyor observed the following while touring the facility: 1. Resident room doors that needed to be painted along with the lower plastic protective panel that was damaged in 46 of 120 resident	F 584	1. The resident room doors that needed to be painted along with the lower plastic protective panel that was damaged to include, [redacted] and [redacted] have been painted and repaired. The wall identified in the [redacted] dining room was painted. The wall covering on	

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F 584	Continued From page 2 room corridor doors observed in the following areas of the facility: Floor [redacted]: Floor [redacted] 2. The floor [redacted] dining room lower section of the wall was patched and in need of paint. 3. The floor [redacted] outside the soiled utility closet had the wall covering coming off the wall along with a 2' foot section of missing handrail. 4. The floor [redacted] ice machine room between [redacted] and [redacted] wings had a hole in the wall board in the lower rear section of the room along with an indication of water damage in that area. 5. The floor [redacted] corridor between resident room [redacted] and [redacted] had a hole in the wall board and an indication of water damage in that area. 6. The floor [redacted] ice machine room between [redacted] and [redacted] wings with water stained ceiling tiles along with water damage to the wall board in the lower rear section of the ice machine. 7. The floor [redacted] wing corridor by the nurse station had a 2 foot section of missing handrail. 8. The floor [redacted] wing MDS room was missing a	F 584	the [redacted] floor near the soiled utility closet was repaired and the missing handrail was replaced. The hole in the wall board in the [redacted] floor ice machine room was repaired and the water damage has been repaired. The hole in the wall board between resident rooms [redacted] and [redacted] as well as the water damage has been repaired. The stained ceiling tiles in the [redacted] floor ice machine room have been replaced and the water damage to the wall board was repaired. The hand rail on the [redacted] floor [redacted] corridor by nurses station was replaced. The ceiling tile in the MDS office was replaced. The PTA cover in room [redacted] was replaced, the water damage surrounding that area was repaired and the hole behind the door was also repaired. No residents were negatively affected. 2. All other resident room doors, walls, hand rails and ceiling tiles throughout the facility have been inspected and found to be in compliance. 3. The Inservice Director inserviced all staff on the proper policy and procedure on maintaining a safe, clean, comfortable and homelike environment to include preventative communication maintenance schedule. The Maintenance Director will conduct weekly audits to ensure compliance is met. . 4. The Administrator/Maintenance Director will conduct weekly audits of 10 residents rooms and shared ancillary rooms x 1 month and monthly x 3 months	

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F 584	Continued From page 3 2 foot x 4 foot ceiling tile. On 8/27/20 at 9:50 A.M. the surveyor observed in resident room [redacted] that the bed by the door was occupied. The cover of the PTAC (packaged terminal air conditioner) was on the floor exposing the internal parts of the unit. The walls surrounding that area had a heavy indication of water stains. The door to the same room had a hole in the wall behind the door handle. On 8/27/20 at 9:25 A.M. an interview was conducted with the facility Administrator to provide any documents and/or policies and procedures on building maintenance including painting schedules, but at that time no documents were provided. On 8/27/20 at 10:05 A.M. an interview was conducted with the facility Maintenance Director and he stated painting was done when manpower was available and when painting was needed. He was asked to provide a maintenance schedule, but at that time no documents were provided. NJAC 8:39-31.4(a)	F 584	to ensure compliance. All findings will be reported to monthly QAPI meetings and determined if further action is necessary.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint # NJ00136784, NJ00136425	F 658	1. The licensed nurses identified with the deficient practice were immediately	9/30/20

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F 658	Continued From page 4 Based on observation, interview and record review, it was determined that the facility failed to administer medications in a timely manner and failed to maintain medication records that were complete with staff signatures according to the facility's policy and professional standards of clinical practice related to timing of medication administration. This was identified for 1 of 3 residents reviewed for medication administration (Resident #9). The facility also failed to follow acceptable standards of clinical practice with following the facility policy on staff wearing Identification (ID) badges. This deficient practice was identified by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a	F 658	issued a medication error for the omission of medications during a scheduled medication pass. The licensed nurses were re-educated on the standards of practice on medication administration and the five rights of medication administration to ensure compliance with medication administration documentation. Review of the medical record indicates that no lasting negative effect was incurred by resident #9. Resident #9 no longer resides in the facility. 2. All residents had the potential to be affected. A facility wide audit was completed and negative findings were addressed with the licensed nursing staff. 3. All licensed nurses were re-educated by the Assistant Director of Nursing and Facility Educator on the standards of practice in regards to medication administration and the five rights of medication administration. The Unit Managers will conducts weekly audits x 1 month and monthly x 3 months to ensure that MARS/TARS contain appropriate documentation. 4. The Director of Nursing developed an audit tool. The Director of Nursing/Assistant Director of Nursing will conduct weekly audits of 10 random residents x 1 month and then monthly until compliance is met for 3 consecutive months on the documentation of medication administration. All findings will be brought to monthly QAPI meeting to determine if further action is necessary. 1. The Facility Educator and Staffing	

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F 658	Continued From page 5 registered nurse or licensed or otherwise legally authorized physician or dentist." RESIDENT #9 1. Resident # 9 was a resident in the facility from [redacted] until [redacted] and had diagnoses that included [redacted]. The surveyor reviewed the facility's "Medication Pass" policy which included "Medications may not be prepared in advance and must be administered within one hour of their prescribed time, unless otherwise specified (i.e., 8 am will be administered between 7am and 9 am) and the individual administering medication must initial the resident's MAR (Medication Administration Record) on the appropriate line after giving each medication and before administering the next ones." On 8/31/2020 at 10:00 AM the surveyor reviewed the April 2020 MAR for Resident #9. When medications were ordered by the physician, the order was placed on the MAR. When administered by the nurses, the nurse would sign their initials on the MAR indicating that they had given the medication. The surveyor observed the [redacted] mg ordered on [redacted] to be given in the morning for [redacted]. The surveyor observed blank areas, that is no nurse's initials which would indicate administration of the medication on 4/4/2020, 4/6/2020, 4/7/2020, 4/16/2020, and 4/18/2020 at 0800. The surveyor observed a physician order dated	F 658	Coordinator distributed ID badges to staff that did not have them on 8/27/20. No residents were negatively affected. 2. A facility wide audit was conducted to ensure all facility employees had an ID badge on their uniform. No further issues were identified. 3. The Facility Educator re-educated all facility staff on the policy and procedure for □Identification name badges□ to include that personnel are required to wear ID badges and have them clearly visible at all times. The Facility Educator and Staffing Coordinator will conduct weekly audits x 1 month and monthly x 3 months to ensure compliance with ID badges. 4. The Administrator will conduct random weekly audits of 10 staff members x 1 month and monthly until compliance is met. All findings will be brought to monthly QAPI meeting and determined if further action is needed.	

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F 658	Continued From page 6 [redacted] for the [redacted] mg, give [redacted] tablet by mouth at bedtime for major [redacted] disorder. The surveyor observed no nurse's initials which would indicate administration of the medication on 4/11/2020 and 4/16/2020 at 2100. The surveyor observed the same for the [redacted] mg at bedtime with an order date of [redacted] The surveyor observed a physician order dated [redacted] for the blood pressure medication [redacted] mg, give 3 tablets by mouth every 8 hours for [redacted]. The surveyor observed no nurse's initials which would indicate the medication had been administered on 4/4/2020, 4/5/2020, 4/6/2020, 4/16/2020, 4/18/2020 at 1400 and 4/9/2020, 4/11/2020, and 4/16/2020 at 2200. The surveyor observed a physician order dated [redacted] for the [redacted] medication [redacted] mg, give 1 by mouth 2 twice a day for [redacted] which was ordered [redacted]. The surveyor observed no nurse's initials which would indicated the medication had been administered on 4/4/2020, 4/6/2020, 4/7/2020, 4/16/2020, 4/18/2020 at 0900 and at 1700 on 4/11/2020. The surveyor observed a physician order dated [redacted] for [redacted] mg, give 1 tablet by mouth at bedtime for [redacted]. The surveyor observed no nurse's initials which would indicate the medication had been administered on 4/11/2020 and 4/16/2020 at 2100. The surveyor observed a [redacted] physician's order for [redacted] due to Resident #9's diagnosis of [redacted] to be done two times a day	F 658		

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and notify the physician for a [redacted] than [redacted] The surveyor observed no nurse's initials which would indicate that the [redacted] had been performed on 4/4/2020, 4/6/2020, 4/7/2020, 4/16/2020, 4/18/2020 at 0730 and 4/9/2020 and 4/11/2020 at 1630.

The surveyor observed a physician order dated [redacted] for the [redacted] medication [redacted] give [redacted] mg by mouth one time a day for [redacted] The surveyor observed no nurse's initials which would indicate the medication had been administered on 4/4/2020, 4/6/2020, 4/7/2020, 4/16/2020, and 4/18/2020 at 0900.

The surveyor observed a physician's order dated [redacted] for [redacted] at bedtime for [redacted]. The surveyor observed no nurse's initials which would indicate the medication had been administered on 4/9/2020, 4/11/2020, and 4/16/2020 at 2100.

The surveyor observed a physician order dated [redacted] mg to treat [redacted] give 1 tablet by mouth one time a day. The surveyor observed no nurse's initials which would indicate the medication had been administered on 4/4/2020, 4/6/2020, 4/7/2020, 4/16/2020, and 4/18/2020 at 0900.

The surveyor observed a physician's order dated [redacted] tablet [redacted] mg, give 1 tablet by mouth one time a day for the diagnosis of [redacted] The surveyor observed no nurse's initials which would indicate the medication had been administered on 4/4/2020, 4/6/2020, 4/7/2020, 4/16/2020, 4/18/2020 at 0900.

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The surveyor observed a physician's order dated [redacted] for the [redacted] mg, give 1 tablet by mouth one time a day. The surveyor observed no nurse's initials which would indicate the medication had been administered administration on 4/4/2020, 4/6/2020, 4/7/2020, 4/16/2020, and 4/18/2020 at 0900.

The surveyor observed a physician's order dated [redacted] for the [redacted], [redacted] Instill [redacted] at bedtime for [redacted]. The surveyor observed no nurse's initials which would indicate the medication had been administered on 4/11/2020 and 4/16/2020 at 2100.

The surveyor observed a physician order dated [redacted] for the [redacted] mg, give 1 tablet by mouth at bedtime for [redacted]. The surveyor observed no nurse's initials which would indicate the medication had been administered on 4/11/2020 and 4/16/2020 at 2100.

The surveyor observed a Physician's order dated [redacted] for the [redacted], give [redacted] grams by mouth one time a day for [redacted] in 4-6 oz of water. The surveyor observed no nurse's initials which indicate the medication had been administered on 4/4/2020, 4/6/2020, 4/7/2020, 4/16/2020, and 4/18/2020 at 0900.

The surveyor observed a physician order dated [redacted] Tablet [redacted] mg, give [redacted] tablets by mouth three times a day for [redacted] [redacted] mg =2 tabs. The surveyor observed no nurse's initials which would indicate the

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medication had been administered on 4/4/2020, 4/6/2020, 4/7/2020, 4/16/2020, 4//18/2020 at 1400 and on 4/9/2020, 4/11/2020, and 4/16/2020 at 2100.

The surveyor observed a physician's order dated [redacted] for the the [redacted], give 1 capsule by mouth one time a day for [redacted]. The surveyor observed no nurse's initials which would indicate the medication had been administered on 4/4/2020, 4/6/2020, 4/7/2020, 4/16/2020 and 4/18/2020 at 0900

The surveyor also reviewed the section of the MAR that identified the "Scheduled Time" and the "Administered Time" of the administration. Allowing for the one hour leeway pre and post administration time the surveyor observed multiple administration times of the [redacted] that were inconsistent with the facility's "Medication Pass" policy as follows:
4/1/2020 scheduled 21:00 administered 01:00 (3 hours)
4/2/2020 scheduled 21:00 administered 22:51(51 minutes)
4/7/2020 scheduled 21:00 administered 23:47 (1 hour 47 minutes)
4/8/2020 scheduled 21:00 administered 22:28 (28 minutes)
4/10/2020 scheduled 21:00 administered 22:54 (54 minutes)
4/14/2020 scheduled 21:00 administered 22:56 (56 minutes)
4/15/2020 scheduled 21:00 administered 22:57 (57 minutes)
4/17/2020 scheduled 21:00 administered 23:27 (1 hour 27 minutes)

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F 658	Continued From page 10 4/19/2020 scheduled 21:00 administered 23:32 (1 hour 32 minutes) 4/21/2020 scheduled 21:00 administered 23:51(1 hour 51 minutes) 4/27/2020 scheduled 21:00 administered 22:19 (19 minutes) 4/30/2020 scheduled 21:00 administered 22:58(58 minutes) When interviewed on 8/26/2020 at 10:40 AM, the Registered Nurse Supervisor stated that if a MAR was blank, the nurse did not sign the MAR or did not give the medication. When interviewed on 9/1/2020 at 8:50 AM regarding the late documentation on the Location of Administration Report, the Director of Nursing stated "of course not" when asked if the facility policy was followed. When interviewed on 9/1/2020 at 9:10 AM the Licensed Practical Nurse stated that if the MAR is signed late the nurses are not following the facility policy. There was no documented evidence in the medical record that the resident experienced a negative reaction/harm from the late administration of the medications. 2. During a tour of the facility on 8/25/2020 at 9:45 AM the surveyor was on the [redacted] floor nursing unit and observed a Dietary Aide (DA) with no visible ID badge. When interviewed at that time, the DA said she had just started 2 weeks ago and said "they never gave me one." On 8/25/2020 at 9:45 AM the surveyor observed 2 housekeeping employees with no visible ID badges. The surveyor observed the lanyards from the ID badges hanging out of the employees' pockets.	F 658		

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F 658	Continued From page 11 On 8/25/2020 at 9:50 AM the surveyor a [redacted] floor Unit Manager (UM) with no visible ID badge. When interviewed at that time, the UM said "it's in the car." At the same time the surveyor observed a Certified Nursing Assistant (CNA) come from a resident's room. There was no visible ID badge and when interviewed, the CNA said "mine is in the car." On 8/25/2020 at 10 AM the surveyor observed a second CNA with no visible ID badge. When interviewed at that time, the CNA said he had one and then pulled it out of his shirt. On 8/26/2020 the surveyor went to both nursing units and randomly selected 4 residents to interview about employees wearing ID badges. Their responses were as follows: 1. At 8:40 AM a resident on the [redacted] said "some don't wear them. So you can't call them by name and sometimes you forget their names even with the ones you know." When asked how he would communicate, the resident said "you just start talking to them." 2. At 8:50 AM a resident on the [redacted] rolled his/her eyes when the surveyor asked about staff wearing ID badges. The resident said the staff "often" did not wear ID badges. The resident said "you can't call them by name so I will just call out 'nurse' or 'mam.'" The resident said "normally I would say 'Good Morning (staff member's name)' but with no ID I just say 'Good Morning Mam.'" 3. At 10:30 AM a resident on the [redacted] floor said "some wear them, some don't." 4. At 10:45 AM a resident on the [redacted] floor said "not always, you know some of their names but not everyone."	F 658		

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F 658	Continued From page 12 The surveyor reviewed the facility's policy "Identification Name Badges" and observed the policy included "All personnel are required to wear identification nametags or badges during their work shift" and "An identification name tag or badge must be clearly visible." NJAC 8:39-27.1(a)	F 658		
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.; §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	F 803		9/30/20

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F 803	Continued From page 13 by: Complaint # NJ00137884, NJ00132954 Based on observation, interview, and record review, it was determined that the facility failed to follow and produce resident meals according to their weekly cycle menu and individual resident meal plan tickets. This deficient practice occurred for 2 of 2 meals observed by the surveyor and was evidenced by the following: 1. On 8/26/2020 at 8:45 AM the surveyor observed the breakfast meal of a first floor randomly selected resident. The resident's meal plan ticket, dated Wednesday Breakfast 8/26/2020, noted that the resident was to receive 6 oz of supercereal (a fortified hot cereal to provide additional calories), 2 biscuits, 2 servings of egg and cheese, 8 oz fruit juice, 8 oz whole milk and 1 cup coffle with 1 creamer. The resident's meal ticket also noted that the resident received a regular, mechanical soft diet and double portions. The surveyor did not observe any hot cereal on the resident's meal tray and when interviewed at that time, the resident stated that he/she did not receive any hot cereal. In addition, the resident stated "I did not receive a biscuit, what is a biscuit?" On 8/26/2020 at 8:52 AM the surveyor entered the main kitchen and interviewed the Evening Cook/Supervisor (EC/S). When interviewed the EC/S stated "What is supercereal? The EC/S then proceeded to get 2 individual boxes of [redacted] and stated that it was what they used as supercereal. The surveyor asked the EC/S if he knew what supercereal consisted of and the EC/S responded "I assume supercereal was oatmeal, grits or [redacted] with	F 803	1. The Food Service Director and Evening Cook/Supervisor were immediately educated by the Regional Dietician on following the weekly cycle menu and individual resident meal plan tickets. The Evening Cook/Supervisor was re-educated on what super cereal is and what it consists of. No residents were negatively affected. 2. An audit was completed on all residents with orders for super cereal. All residents were found to not have any significant weight loss. All residents with super cereal ordered had the potential to be affected by the deficient practice. 3. All dietary staff have been re-educated on following the weekly cycle menu and individual resident meal plan tickets by the Facility Educator. The Food Service Director/Dietician will conduct weekly audits x 1 month and monthly x 6 months to ensure the weekly cycle menu and individual resident meal plan tickets are accurate and being followed appropriately. 4. The Administrator/Dietician will conduct weekly audits x 1 month and monthly until compliance is met. All findings will be reported to monthly QAPI meeting and decided if further action is necessary.	

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cream and butter." On further interview concerning whether the kitchen had supercereal available for the breakfast meal on 8/26/2020 the EC/S replied, "We made oatmeal today, we did not make any supercereal." The EC/S further stated "Our last director did not order biscuits, he got let go of his duties before he got to do the order, we made 200 pieces of toast instead." In addition the EC/S told the surveyor "Yes, I am supposed to serve the residents what is listed on their meal ticket but our last food service director didn't stress for us to follow the tickets."

On 9/1/2020 at 12:10 PM the surveyor interviewed the Registered Dietitian Eligible (RDE). On interview the RDE told the surveyor "I give supercereal to residents for weight loss or weight maintenance, it provides additional calories. My expectation is that the residents that I ordered it (supercereal) for will receive it at their breakfast meal daily." The RDE further stated that she had conducted mealtime audits and identified several issues with tray accuracy, portion sizes, supplements/fortified meals, and snacks. The RDE presented the surveyor with a copy of an inservice, dated July 23, 2020 which identified supercereal as "Oatmeal made with extra milk, cream and butter." The RDE also provided the surveyor a current list of residents who received supercereal. On 9/1/2020 there were currently 25 residents who were ordered supercereal.

2. On 8/26/2020 the surveyor reviewed the lunch meal for Wednesday, week 3 of the "Hammonton Center Week-At-A-Glance Centers Spring/Summer 2020 Week 3" menu. The lunch meal consisted of vegetable lasagna as the main entree, beef pot pie as the alternate entree,

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Caesar salad, vanilla pudding, fruit juice, and coffee.

On 8/26/2020 at 12:08 PM the surveyor entered the main kitchen during the lunch meal service, already in progress. The surveyor, accompanied by the Evening Cook/Supervisor (EC/S), asked the EC/S to identify the foods that were being served to the residents at the lunch meal from the hot holding area of the trayline. The following foods were served for lunch: ravioli with marinara sauce, California blend vegetable, mashed potato, chopped chicken, beef gravy, puree knockwurst, and a mix of puree carrots and the EC/S could not remember the additional vegetable that was in the puree carrot blend. The surveyor then asked the EC/S why vegetable lasagna or beef pot pie was not being served and the EC/S stated, "We ran out of the beef pot pie, we didn't have enough. Somebody comes in here at night and takes stuff. We don't have Caesar salad or vegetable lasagna. We have stuffed shells and California blend vegetables to replace the Caesar salad."

When interviewed on 8/26/2020 at 12:18 PM, the Food Service Director (FSD) stated "We had no vegetable lasagna. I've been here two and a half days, we have no food. We substituted stuffed shells. We had beef pot pie but only 2 cases, which is 48 total, I had to use it all because we did not have vegetable lasagna. We do not have Caesar salad, we did substitute California blend vegetable for the Caesar salad. I explained to administration that we can't operate on one food drop (delivery) a week. I'm not even sure how to place the food order, the system is new to me and I have to learn it."

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F 803	Continued From page 16 On 9/1/2020 at 11:51 AM the Regional Director of Clinical Services (RDCS) provided the surveyor with a copy of the "Hammonton Center Quality Assurance Performance Improvement (QAPI)." The RDCS stated that only 4 of 25 residents that were to receive supercereal had a weight decline between July and August and the weight declines were not significant. The QAPI also noted that the "cook had lost the recipe for supercereal." The surveyor asked the RDCS whether kitchen staff were required to follow resident meal plan tickets and the RDCS stated "Yes." The surveyor reviewed the facility policy titled "Menus", revised October 2017. The Policy Statement section revealed the following: "Menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy." NJAC 8:39-17.4 (a)1	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources 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.	F 812		9/30/20

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F 812	Continued From page 17 (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: Complaint # NJ00137884, NJ00132954 Based on observation, interview, and record review, it was determined that the facility failed to monitor and record hot and cold food temperatures prior to resident meal service. This deficient practice was evidenced by the following: On 8/26/2020 at 12:08 PM the surveyor, accompanied by the Evening Chef/Supervisor (EC/S), observed the following food items on the trayline during the lunch meal service: Ravioli with marinara sauce, California blend vegetables, mashed potato, chopped chicken, beef gravy, puree knockwurst and puree carrots and (EC/S could not remember the other vegetable in the mix). The EC/S also had beef pot pies, which were in the oven at the time of service. On 8/26/2020 at 12:12 PM the surveyor asked to see the mealtime temperature log book. The surveyor observed a blank "Food Temperature Log" and no temperatures for the breakfast or lunch meal for 8/26/2020. When interviewed, the EC/S stated "I only have 2 hours between meal service to get ready (breakfast and lunch), I'll do the temperatures after lunch." The surveyor questioned the EC/S where he had recorded the	F 812	1. The Evening Chef/Supervisor was immediately re-educated on the policy and procedure for recording food temperatures in the food temperature log. The Food Service Director was immediately re-inserviced by the Regional Dietician on the appropriate policy and procedure for recording food temperatures in the food temperature log. No residents were negatively affected. 2. The food temperatures were immediately conducted for all hot/cold foods on the meal service. All temperatures were found to be in compliance with state regulations. All residents had the potential to be affected. 3. The Food Service Director and entire dietary staff were re-inserviced on the policy and procedure for recording food temperatures on hot and cold foods prior to meal service using the food temperature log sheets. The Food Service Director will conduct weekly audits x 1 month and monthly x 6 months to ensure all food temperatures are logged accurately and timely in the food temperature log.	

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F 812	Continued From page 18 breakfast and lunch meal temperatures and the EC/S stated "They're right here (the EC/S pointed to his temple)." When interviewed whether the EC/S recorded food temperatures for the breakfast and lunch meal prior to service on 8/26/2020 the EC/S stated "No." When interviewed on 8/26/2020 at 12:18 PM the Food Service Director (FSD) stated "We are supposed to temp our foods before food service starts, that is our policy. I showed him how to do it yesterday (EC/S), I just showed him." The surveyor requested a copy of the inservice the FSD had conducted with the EC/S regarding taking food temperatures prior to meal service. The FSD stated "I didn't do a formal inservice with him, just a verbal instruction." On 8/31/2020 at 1:42 PM the surveyor asked the FSD for a copy of the "Centers Healthcare Food Temperature Log" sheets for the month of August 2020. The surveyor reviewed the Food Temperature Log sheets and observed that the 8/26/2020 sheet had temperatures recorded for the breakfast and lunch meal. When interviewed at 2:05 PM, the FSD stated "These temperatures I recorded from the EC/S, the ones he said he had inside his head. These temperatures are based on what he told me he had remembered in his head from breakfast and lunch. Should I have not done that?" When further interviewed, the FSD stated "Our policy is to record food temperatures before the meal service, that is correct. Last week there were no temperatures recorded for breakfast and lunch for the 26th (August 26), I just filled this out afterwards from what he (EC/S) remembered from the breakfast and lunch that day."	F 812	4. The Administrator/Dietician will conduct weekly audits x 1 month and monthly on food temperature logs until compliance is met. All findings will be brought to monthly QAPI meeting and decided if further action is necessary.	

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The surveyor reviewed the 8/26/2020 Food Temperature Log provided to the surveyor from the FSD on 8/31/20 at 1:42 PM. The log identified temperatures for stuffed shells, beef pot pie, mashed potato, super mashed potato, and cal blend. The log had no temperatures recorded for the beef gravy, chopped chicken, puree knockwurst or puree carrots that were also served at the lunch meal. No cold food temperatures were recorded for this meal.

The surveyor reviewed the facility policy titled "Centers Health Care Recording Food Temperatures Policy. The policy included the following under the "Procedure" section:

1. "Food temperatures must be recorded on hot food and cold foods prior to service using the food temperature log."

2. Meal temperatures will be recorded at the beginning of meal service to ensure proper temperatures are achieved and repeated midway through point of service if meal service exceeds 2 hours."

NJAC 8:39-17.2(g)