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	315158	A. BUILDING ______ B. WING ______	11/01/2019

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F 000	INITIAL COMMENTS STANDARD SURVEY: 11/1/19 CENSUS: 71 SAMPLE SIZE: 26 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 550 SS=D	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	F 550		12/4/19

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

Electronically Signed — 12/02/2019

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 or resident of the United States. §483.10(b)(1) The facility must ensure that the 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 and interview, it was determined that the facility failed to serve meals to residents in a dignified manner. This deficient practice was identified for 1 of 3 unit dining rooms [redacted] Dining Room) observed during meal service on 10/29/19 and 10/30/19. The deficient practice was evidenced by the following: The surveyor observed the lunch meal in the facility's west unit dining/day room on 10/29/19. Fifteen residents were seated in four separate groupings of tables. The surveyor observed that a cart of trays and a small truck arrived in the hallway in front of the dining room at 12:01 PM. At 12:08 PM, the staff began distributing trays in the dining room. There were three Certified Nursing Assistants (CNAs) (CNA #2, #3, #4) and two nurses, Licensed Practical Nurse (LPN#1), and Licensed Practical Nurse/Charge Nurse (LPN/CN) assisting with the passing of trays.	F 550	1. F550 2. The residents in the [redacted] Day Room/Dining Room are now served at the same time as their tablemates. All resident eating in on unit day room/dining rooms are at risk for this practice. 3. Provide a list of residents to Dining Services who regularly eat in each on-unit dining areas. The Dining Services Department will organize all trays of those who choose to eat in the on-unit dining rooms on one truck per unit; those that dine at the same table are to be group together. Provide education to the Dining Service Department on the systematic change. Provide education to nursing personnel and department managers on the Table Service procedure. 4. CED/CNE/Designee will observe 1	

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F 550	Continued From page 2	F 550	breakfast, 1 lunch, and 1 dinner in each on-unit dining room per week for 3 months, and monthly thereafter for a total of 12 month time. Results will be presented during monthly QAPI meetings.	

The surveyor observed that Table #1 received the first tray at 12:08 PM. At 12:11 PM, a second resident was served their food; Table #1. A third resident seated at Table #1, who had not received a tray, called out three times, verbalizing they were upset that the other residents had their lunch and that they hadn't received their food. The resident attempted to lift the tablemate's dome lid that covered the tablemate's meal after the tray was left on Table #1 by staff. A staff person told the resident that their lunch was coming. The resident received their tray at 12:15 PM, and CNA #4 assisted the resident with feeding at 12:20 PM (12 minutes after the first tray was delivered to table #1). The surveyor observed all four tables in the dining room were served randomly, failing to ensure that residents seated at the same tables were served at the same time.

On 10/30/19, the surveyor observed the meal service in the [redacted] unit dining/day room. The cart of trays and small truck arrived on the unit at 11:54 AM. Seventeen residents were seated at four tables. There were two CNAs (CNA #2 and CNA #3), three nurses (LPN #1, LPN#2, LPN/CN), and the Director of Social Services assisting with meal service.

On 10/30/19, the surveyor observed the first tray delivery at 12:12 PM. The surveyor noted the residents were served randomly, not ensuring that residents who were seated together at the same table were served at the same time. One tray was delivered to Table #2 at 12:20 PM; the second resident's tray was brought to Table #2 at 12:25 PM; a third resident's tray was delivered to Table #2 at 12:30 PM. The resident served at

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12:30 PM, who was dependent on staff for feeding, called out, "I want someone to help me."

On 10/31/19 at 9:36 AM, the surveyor interviewed the LPN/CN, who stated that she was aware that residents seated at the same table should be served at the same time. She also said that sometimes the trays don't arrive at the same time. The surveyor replied that she had observed on two separate occasions (10/29 and 10/30), that all of the trays were delivered at the same time. The LPN/CN did not respond.

On 10/31/19 at 9:48 AM, the surveyor interviewed CNA #3, who stated that she should serve tables at the same time, but sometimes it's not possible because the trays come to the unit at different times. The surveyor replied that she had observed that all of the trays arrived on the unit at the same time. CNA #3 did not respond.

On 10/31/19 at 10:15 AM, the surveyor requested the Facility's Meal Service policy. The Director of Nursing stated she would provide it.

On 10/31/19 at 1:30 PM, the surveyor discussed the above observations and concerns with the Administrator and the Director of Nursing (DON). The Administrator stated that all residents seated at the same table should be served at the same time. She further said that she would be working with the Dietary Department to ensure trays would be placed on the meal carts grouped by table. The surveyor made a second request asking for the Facility's Dining/Meal Service policy. At that time, the DON stated that the facility did not have one.

NJAC 8:39-4.1

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately assess and properly code a resident's status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for 1 of 26 residents (Resident #8) reviewed. This deficient practice was evidenced by: On 10/29/19 at 8:10 AM, two surveyors observed Resident #8 lying in bed with and limitations. There were no in use at that time. On that same day at 12:29 PM, the surveyor observed the resident seated in a wheelchair in the unit dining area with in use. The resident was able to hold a cup of juice in his/her . Resident #8's was , and the resident was unable to use the during the lunchtime meal. There was no observed in use at that time. On that same day and time, the surveyor observed the Certified Nursing Assistant #1 (CNA#1) assist Resident #8 with the lunch meal.	F 641	1. F641 2. Resident #8 was reassessed by the MDS Coordinator and the quarterly MDS was modified accordingly. Resident #8's Care Plan was reviewed by the Interdisciplinary team and updated as needed. 3. Residents with have the potential to be affected by the deficient practice. Nursing Administration completed a comprehensive review and audit of residents with contractures to ensure assessments and ADL coding are accurate, coded correctly on the MDS, and that the Care Plans are current and match the MDS. 4.The MDS Coordinator was re-educated on the facility Policy for conducting Nursing Assessments and on the process for accurately coding residents with contractures on the MDS. Education was completed by Regional MDS Coordinator. CNAs and Licensed Nurses were re-educated on accurate ADL coding on 11/4/19 and on 11/19/19. Education was completed by the ADON/DON. The DON or designee will review 2 MDS a	12/4/19

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F 641	Continued From page 5 The surveyor reviewed the resident's Face Sheet (an admission summary). The face sheet reflected that the resident was admitted to the facility on [redacted] with diagnoses which included, but were not limited to, [redacted] A review of the Comprehensive (C) MDS, Assessment Reference Date (ARD) of [redacted] indicated a brief interview for mental status (BIMs) score of [redacted]. The CMDS further revealed that the resident required total assist of one person with eating and that there was no functional limitation with regards to [redacted] and [redacted] Further review of the medical record revealed that the Quarterly (Q) MDS with an ARD of [redacted], indicated that Resident #8's [redacted] The MDS also reflected that Resident #8 required total assistance of one person with eating and had no functional limitations with regards to [redacted] and [redacted]. A review of the October 2019 Physician's Orders, revealed an order dated 8/23/19, for a [redacted] when out of bed to prevent [redacted] A review of the physician's Progress Notes dated 8/29/19, revealed that Resident #8 was a long-term care resident with [redacted].	F 641	week for 1 month (related to residents with [redacted]) and then 2 MDS a month for 3 months to ensure compliance. The MDS Coordinator will audit the ADL sheets for 2 Residents (related to [redacted]) each week for 1 month then 2 a month for 3 months to ensure accuracy. The results of the audits will be reviewed in the QAPI meeting each month for 3 months.	

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The surveyor reviewed the 8/8/19 Annual Care Plan Meeting Note, which indicated Resident #8 was assessed to have [redacted], required extensive assistance with all areas of activities of daily living (ADL), and was fed by staff and at times able to feed self.

A review of the resident's personalized care plan reflected that the resident had [redacted] and [redacted] with an intervention to apply a [redacted] when out of bed to prevent further [redacted]. Additionally, the resident was care planned for ADL's due to [redacted] that required total dependence with eating.

On 10/30/19 at 10:36 AM, CNA #1 informed the surveyor that the resident was [redacted] able to hold the cup on his/her [redacted], and required assistance with eating due to [redacted]. She stated that the resident wore [redacted] when out of bed due to [redacted].

On 10/30/19 at 12:56 PM, the surveyor interviewed the Licensed Practical Nurse #1 (LPN#1), who informed the surveyor that Resident #8 was [redacted] and required assistance with eating due to [redacted] She stated that the resident had [redacted] are in use when the resident is out of bed to prevent further [redacted]

On 10/31/19 at 11:05 AM, the surveyor interviewed the MDS Coordinator, who informed the surveyor that Resident #8 was [redacted]

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[redacted]. She stated, "I am not sure" if the resident had [redacted]. She then said, "if it's not affecting ADLs, c[redacted] don't have to be captured in the MDS."

At that same time, the surveyor asked why the [redacted] limitations were not coded on the [redacted] CMDS and the [redacted] QMDS. The MDS Coordinator informed the surveyor that she followed the Resident Assessment Instrument (RAI) Manual with regard to policy and coding the MDS.

On 10/31/19 at 1:17 PM, the survey team met with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON), Licensed Practical Nurse/Charge Nurse (LPN/CN), Registered Nurse/Unit Manager (RN/UM) and Regional Nurse and discussed the above observation and concerns.

On 11/1/19 at 12:06 PM, the DON, in the presence of the Administrator and Regional Director, informed the survey team that there were no changes with the resident's functional ability. She further stated the resident was still able to feed him/herself, and there was no limitation with his/her [redacted], and that's why the MDS was coded as no limitations.

On that same day and time, the Administrator, DON, and Regional Director could not speak to why the QMDS dated [redacted] and the CMDS dated [redacted], was coded as total assistance of one for eating and was care planned for [redacted] and [redacted].

A review of the October 2019 Centers for Medicare & Medicaid Services (CMS) RAI

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F 641	Continued From page 8 Manual provided by the MDS Coordinator, indicated the Definition of Functional Limitation in Range of Motion was defined as "Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury." A review of the facility policy regarding Assessment with a revision date of 11/1/19 provided by the DON indicated, "The Center will conduct initially and periodically a comprehensive, standardized, reproducible assessment of each patient's functional capacity; The assessment must accurately reflect the patient's status at the time of assessment " and "The assessment process must include direct observation and communication with the patient, as well as communication with licensed and non-licensed direct care staff members on all shifts." NJAC 8:39-11.2(e)1; 27.1(a)	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a) ensure that the Medication Administration Record (MAR) was signed promptly. This deficient practice was observed during the medication (med) administration for 1 of 5	F 658	1. F658 2. The nurse responsible for delayed signing of the MAR for resident #30 received additional training and return demonstrated the correct procedure for	12/4/19

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residents (Resident #30), and; b) label an [redacted] with resident identifying information and the physician's order for the [redacted] of 1 (Resident #38) of 1 resident sampled.

This deficient practice was evidenced by the following:

Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual 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 registered nurse or licensed or otherwise legally authorized physician or dentist."

1. On 10/30/19 at 11:03 AM, the surveyors observed the Licensed Practical Nurse #1 (LPN#1) administer medications to Resident #30,

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medication administration and signing of the MAR. At the time that the nurse identified that she had not signed the MAR timely, the nurse sought guidance from her supervisor and subsequently followed the policy for Charting Errors and/or Omissions for the remainder of the missing signatures.

At the time it was identified that the label was missing from the [redacted], the feeding had completed. The bag was removed and discarded. The licensed nurse responsible for [redacted] for resident #38 received additional training and return demonstrated the correct procedure for labeling the [redacted] with resident identifying information and the physician's order for the [redacted].

3. Residents receiving medication and [redacted] are at risk for this practice.

4. Licensed nurses were re-educated and completed competency on the medication administration policy to include timely signing as well as re-education on the policy for Charting Errors and/or Omissions.
All licensed nurses were re-educated on the protocol for [redacted]. [redacted]

5. Unit Manager/Designee will audit for proper labeling of [redacted], MAR and TAR 3 times weekly for 3 months,

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F 658	Continued From page 10 which included [redacted] one tablet by mouth [redacted] On that same day and time, the surveyors observed LPN #1 sign the MAR for the [redacted] for the following dates 10/29/19 and 10/30/19. At that same time, the surveyor interviewed LPN#1, who stated that she forgot to sign the MAR for the [redacted] on 10/29/19. She further said that she was the nurse who worked on 10/27/19 and 10/28/19 and "missed" signing the MAR. LPN#1 informed the surveyor that she remembered administering the [redacted] for Resident #30 on 10/27/19, 10/28/19, and 10/29/19. She further stated that the MAR should have been signed immediately after administering the medications. On 10/31/19 at 1:17 PM, the survey team met with the Administrator, Director of Nursing (DON), Licensed Practical Nurse/Charge Nurse (LPN/CN), Registered Nurse/Unit Manager (RN/UM), Assistant Director of Nursing (ADON) and the Regional Nurse and discussed the above observations and concerns. On 11/1/19 at 12:06 PM, the DON informed the survey team that LPN#1 acknowledged that she missed signing the MAR for the [redacted] for three consecutive days. The DON stated that LPN#1 should have followed the facility protocol and procedure for medication omissions. A review of the facility's Policy titled Charting Errors and/or Omissions provided by the DON	F 658	and weekly thereafter for a total of 12 months. Results will be presented during monthly QAPI meetings.	

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with a review date of 3/10/17 indicated that "facilities will follow professional standards of practice when changes or clarifications to medical records are necessary."

A review of the facility's Policy titled Medication Administration provided by the DON with a revision date of 11/1/19 indicated that "[the] Licensed nurse per state regulations, will administer medications to patients; accepted standards of practice will be followed."
2. On 10/29/19 at 8:06 AM, the surveyor observed Resident
#38 in bed sleeping with the head of the bed elevated. An [redacted].

The surveyor reviewed Resident #38's face sheet (an admission record), which reflected that the resident was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses which included: [redacted]

The surveyor reviewed the Significant Change Minimum Data Set (MDS), an assessment tool dated [redacted], which indicated a Brief Interview for Mental Status (BIMS) score of [redacted]

Review of the resident's care plan dated 9/5/19 indicated that the resident had [redacted] in order to meet the resident's nutritional needs.

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F 658	Continued From page 12 A review of the Physician's order for enteral protocol revealed an order dated for 10/14/19 for On 10/30/19 at 9:40 AM, the surveyor interviewed the resident, who stated that "the nurses 2 PM every day." On 10/30/19 at 12:44 PM, the surveyor interviewed the Unit Manager (UM #1) who stated that it was the facility's policy to label UM, #1, further stated that nobody should have to guess what type of the resident was getting. On the same day at 1:45 PM, the survey team met with the Administrator, the Director of Nursing and the Assistant Director of Nursing and discussed the above observations and concerns. On 10/31/19, the surveyor interviewed Licensed Practical Nurse (LPN) #4. The LPN stated, "I was the nurse for resident #38 on Monday, 10/28/19. At 2 PM, I the resident's I tried to On 11/1/19 at 1:27 PM, the survey team met with	F 658		

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	315158	A. BUILDING ______ B. WING ______	11/01/2019

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F 658	Continued From page 13 the Administrator, DON, and the Regional Administrator. The Administrator informed the surveyors that LPN #4 said that she [redacted] the morning of 10/29/19. The DON stated that when she made rounds on 10/29/19 at 8:45 AM, she saw the [redacted] A review of the facility policy for [redacted] dated 6/1/96 and revised on 11/1/19 indicated: [redacted]: Procedure #18.2 [redacted]: 18.2.1 indicated "[redacted]" 18.2.4 indicated "[redacted] NJAC 8:39-11.2 (b) NJAC 8:39- 25.2 (i)	F 658		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		12/4/19

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F 688	Continued From page 14 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate services to a resident with limited mobility for a total of one year. This deficient practice was identified for 1 of 2 residents (Resident #8) reviewed for a limited range of motion (ROM). This deficient practice was evidenced by: On 10/29/19 at 8:10 AM, two surveyors observed Resident #8 lying in bed with [redacted] [redacted] and [redacted] [redacted] limitations. There were no [redacted] in use at that time. On that same day at 12:29 PM, the surveyor observed the resident seated in a wheelchair in the [redacted] unit dining area with [redacted] in use. The resident was able to hold the cup of juice in the [redacted]. Resident #8's [redacted] was fisted, and the resident was unable to use the [redacted] during lunchtime. There was no [redacted] in use at that time. At that same time, the surveyor observed the	F 688	1. F688 2. Upon identification that Resident #8 did not have a screen on file for more than 1 year, Rehab initiated a screen. 3. All residents are at risk for this practice. 4. Re-education on the policy for Rehab Screens was provided to all licensed nurses and licensed therapists. Director of Rehab/Designee will audit current residents to ensure that each has a minimum of one screen completed in the past year. For those residents that do not have a completed screen on file, one will be completed. If appropriate, therapy services will rendered. 5. The MDS Coordinator/Designee will compare residents due for annual/significant change assessments with completed Rehab Screens on a monthly basis. Findings will be reported monthly during QAPI for the duration of the year.	

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F 688	Continued From page 15 Certified Nursing Assistant #1 (CNA#1) assist Resident #8 eat his/her lunch meal. A review of the resident's Face Sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted], with diagnoses which included [redacted] A review of the Comprehensive (C) MDS, an assessment tool, with an Assessment Reference Date (ARD) of [redacted], reflected a brief interview for mental status (BIMs) score of [redacted] A review of the October 2019 Physician's Orders revealed an order dated 8/23/19 for the use of [redacted] when out of bed to [redacted]. A review of the physician's Progress Notes dated 8/29/19 revealed that Resident #8 was a long-term care resident with [redacted]. The surveyor reviewed the 8/8/19 Annual Care Plan Meeting Note which indicated Resident #8 was assessed to have [redacted]; required extensive assistance with all areas of activities of daily living (ADL), and was fed by staff and at times able to feed self. Further review of the medical record revealed a Rehab Department Communication to Nursing, dated 10/5/18, which indicated the use of [redacted]	F 688		

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F 688	Continued From page 16	F 688		

to . There was no Rehab documentation that the resident was seen for routine screening with regard to

On 10/30/19 at 10:36 AM, CNA #1 informed the surveyor that the resident was able to hold the cup in the and required assistance with eating due to . She stated that the resident had

On 10/30/19 at 12:56 PM, the surveyor interviewed the Licensed Practical Nurse #1 (LPN#1), who informed the surveyor that Resident #8 was and required assistance with eating due to a . She stated that the resident had and in use when out of bed to prevent further .

On 10/31/19 at 10:41 AM, the surveyor interviewed the Occupational Therapist Rehab Director (OT/RD). The OT/RD stated that it was the facility's policy and procedure that nursing would refer residents to the Rehab Department (Dept) for Rehab screening or evaluations if nursing noted a functional decline. She further stated that the Rehab department does only Annual screens/evaluations of residents.

Later that same day at 12:03 PM, the OT/RD stated to the survey team that Rehab screens/evaluations of residents were completed annually and when referred by Nursing. She said that she was not sure if Resident #8 was

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F 688	Continued From page 17	F 688		

screened for [redacted] and would get back to the surveyor.

On 10/31/19 at 1:13 PM, the OT/RD provided a copy of the Interdisciplinary Therapy Screen (ITS) dated 6/28/18, which revealed impairment on the [redacted] for self-care. The resident refused therapy, and the resident stated they would possibly accept it at a later time. Additionally, the OT/DR provided an ITS document indicating OT last screened the resident on 10/4/18. The OT/DR acknowledged that there was no OT or PT Rehab Screen completed since 10/4/18. On that same date and time, the OT/RD informed the surveyor, "there was no Rehab Screen for this year." She stated she would continue to look for the facility's Rehab Screen Policy.

On 10/31/19 at 1:17 PM, the survey team met with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON), Licensed Practical Nurse/Charge Nurse (LPN/CN), Registered Nurse/Unit Manager (RN/UM) and Regional Nurse and discussed the above observations and concerns.

On 11/1/19 at 9:54 AM, the OT/RD informed the surveyor, "I was wrong" when she stated the resident was screened annually. She said that according to facility policy, Rehab screens would be completed in coordination with the Quarterly, Annual, or Significant Change in Status MDS Assessments or when referred by Nursing. She further stated that "It was best practice to see the resident annually."

On that same date and time, the surveyor asked the OT/RD why there was no Rehab Screen

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F 688	Continued From page 18 completed in [redacted] when the [redacted] Comprehensive MDS was completed. The OT/RD stated, "I missed it." The OT/RD acknowledged that the Rehab Screen was not done for a year. On 11/1/19 at 12:06 PM, the DON informed the survey team that there were no changes with the resident's functional ability. The Administrator, DON, and Regional Director acknowledged that the Rehab Screen was not completed for one year and not until it was brought to their attention by the surveyor. The surveyor reviewed the facility policy regarding Therapy Screenings with a revision date of 7/29/19, which was provided by the DON. The policy indicated "Screens may be conducted: upon admission or re-admission, upon change in condition, upon request of the interprofessional team, upon request of the individual, caregivers and other care providers, upon identified population health need or targeted risk management e.g. seating, fall, risk, memory clinic, osteoporosis; upon a regularly scheduled frequency to support optimal function, health, and wellness." Additionally, it indicated staff should "Utilize screening to identify risks and determine potential need for rehab or other services and to promote health and wellness." NJAC 8:39-27.1(a), 27.2(m)	F 688		
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	F 730		12/4/19

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F 730	Continued From page 19 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 the interview and review of facility documentation, it was determined that the facility failed to ensure that Certified Nursing aide's (CNAs) received 12 hours of in-service training. This deficient practice was identified for 1 of 3 CNA employee files reviewed for 12 hours of education, (CNA #1) as evidenced by the following: On 10/30/19, at approximately 10:00 AM, the surveyor requested a list of the facility's CNA's which was provided to the surveyor by the facility's Administrator. The surveyor reviewed the list and randomly selected 5 CNAs for review of performance evaluations and in-service training. On 10/31/19 at 1:00 PM, the ADON provided the surveyor files of in-services which were completed by the calendar year even though the surveyor specified the in-services were to be provided using the CNAs anniversary date of hire (2018 or 2019). On 11/1/19 at 9:00 AM, the surveyor again requested the 12 hours of in-service training by the anniversary date of hire and the CNA performance evaluations. On 11/1/19, at approximately 10:30 AM, the Administrator provided the surveyor with the CNA education files. The surveyor reviewed the sheets documenting the in-services received by each	F 730	1. F730 2. CNA #1 completed the remainder of the mandatory 12 hours of in-service education. 3. All nursing personnel are at risk for this practice. 4. The Center will audit nursing personnel education files and ensure that all have the 12 mandatory hours of education. The Center will roll out an in-service program to include all mandatory in-services and standardized time allotments for the education to be delivered. 5. The Director of Nursing (DON)/ADON will audit monthly to ensure that all nursing personnel have completed the mandatory 12 hours of education by their anniversary date. Findings will be reported monthly during QAPI for the duration of one year.	

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F 730	Continued From page 20 CNA. CNA #1 had a hire date of [redacted]. According to the 2018-2019 in-service record, CNA #1 had not completed the 12 hours of mandatory in-service education. The surveyor interviewed the Administrator on 11/1/19 at 11:30 AM, who could not provide any further information regarding the lack of CNA required in-services. NJAC 8:39-43.17 (b)	F 730		
F 880 SS=F	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;	F 880		12/4/19

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F 880	Continued From page 21 §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; (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.	F 880		

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F 880	Continued From page 22 §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, and record review, it was determined that the facility failed to: a) follow appropriate infection control practices during the medication (med) administration observation for 1 of 4 nurses; b) ensure proper infection control practices were followed during a [redacted] treatment observation for 2 of 2 residents (Resident #37 and #66); c) properly store a [redacted] for 1 of 1 resident (Resident #52) reviewed for [redacted] treatment; and, d) follow acceptable infection control procedures in 1 of 3 dining rooms observed during meal services. This deficient practice was evidenced by the following: 1. On 10/30/19 at 9:33 AM, the Licensed Practical Nurse#4 (LPN#4) informed the surveyor during med administration that she was the nurse in [redacted] unit, and had a [redacted] side med cart. On that same date and time, the surveyor observed LPN#4's med cart sharps container contents (used syringes) were extending above the white line that indicated "Full" and "Do Not Fill above this line." LPN#4 stated that it was the nurse's responsibility to check the sharps container and to replace it with a new one when it was full. She further noted the sharps container should have been replaced as it's contents were over the full line. On 10/31/29 at 1:17 PM, the survey team met with the Administrator, Director of Nursing (DON),	F 880	1. F880 2. Sharp container was removed from the Medication cart on date identified. [redacted] for resident #52 was replaced and stored appropriately. Treatment for residents #37 and #66 were Completed again same day using correct infection control practices. Trash was removed from resident #37's room by CNA on 10/31/19 and the sink was repaired by Maintenance on 10/31/19. CNA and LPN that provided hand hygiene to the residents identified in the 2567 were re-educated on 10/31/19 regarding own hand hygiene practices during resident care. Education was provided by the ADON. 3. Center residents have the potential to be affected, in regards to [redacted] treatments, [redacted] usage, Sharp containers, and hand hygiene in dining areas. Both Nurses identified were re-educated on 10/31/19 regarding aseptic [redacted] treatments along with New Competency per the ADON. Nurse Management ensured each center sharp container was appropriate, [redacted] were stored appropriately, no other issues with sinks and overflowing	

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F 880	Continued From page 23 Assistant Director of Nursing (ADON), Licensed Practical Nurse/Charge Nurse (LPN/CN), Registered Nurse/Unit Manager (RN/UM), and Regional Nurse and were made aware of the concerns. On 11/1/19 at 9:57 AM, LPN#4 informed the surveyors that the DON had her "shake" the sharps container on 10/30/19 to make sure that it was not full. LPN#4 stated that she still replaced it with a new sharps container for the [redacted] unit [redacted] side med cart. She further noted that there was no log or documentation with regards to checking the sharps container routinely. On 11/1/19 at 12:06 PM, the survey team met with the Administrator, DON, and Regional Director. The DON stated that it was the nurse's responsibility every shift to check the sharps container and to replace it when it was full. 2. On 10/29/19 at 8:07 AM, the surveyors observed Resident #37 lying in a specialized bed with eyes closed. On 10/30/19 at 10:36 AM, the Certified Nursing Assistant#1 informed the surveyor that Resident #37 was [redacted] and required total assistance with activities of daily living (ADLs). She further stated that the resident was on a specialized bed, turning and repositioning to promote [redacted] healing. On 10/31/19 8:53 AM, both LPN#1 and LPN/CN informed the surveyor that the resident was on [redacted]. LPN#1 stated that the [redacted] was the same; the treatment was done daily and that there were no signs of infection.	F 880	trash on 10/31/19. CNA and LPN that provided hand hygiene to the residents identified in the 2567 were re-educated on 10/31/19 regarding own hand hygiene practices during resident care. Education was completed by ADON. 4. Re-education was completed with Nursed regarding Aseptic Treatment P&P along with Competency review. Education and competency was completed by the ADON/DON. Re-education was completed with the Nurses regarding Sharps container management and [redacted] storage. Education was completed by the ADON/DON. Re-education was completed with Nursing staff regarding hand hygiene practices and infection control practices with specifics to Resident contact requires hand hygiene, over flowing trash containers, clogged sink, and positioning of residents during Treatments. Education completed by the ADON/DON. 5. Nurses identified in the 2567 will be monitored by the ADON/DON during a Treatment for competency each week for 4 weeks then monthly for 3 months. ADON/DON will conduct weekly competency of a Nurse during [redacted] care each week for 4 weeks then monthly for 3 months. Infection control rounds will be conducted 3 times a week for 1 month then weekly for 3 months by the ADON/DON. Competency reviews and Infection control round findings will be reviewed in the	

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F 880	Continued From page 24 On that same date and time, LPN/CN stated that there was preventative treatment before the development of [redacted] that were in placed and was care planned. A review of the resident's Face sheet (an admission summary), reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included [redacted] A review of the Significant Change Minimum Data Set (MDS), an assessment tool dated [redacted], indicated a Brief Interview for Mental Status (BIMS) score of [redacted] A review of the October 2019 Physician's Order dated 10/28/19, revealed an order to pack the [redacted] with [redacted] Additionally, there was an order dated 8/26/19, for [redacted] three times a day, and order dated 10/31/19, for [redacted] apply [redacted] twice a day. On 10/31/19 at 11:19 AM, the surveyors observed LPN#1 perform a [redacted] treatment on Resident #37. She was assisted by Certified Nursing Assistant#2 (CNA#2). At that time, LPN#1, after reading the treatment orders, prepared the [redacted] All original packaging of the three medications in individual plastic bags was brought into the resident's room and put onto	F 880	QAPI meeting each month and acted on as needed.	

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the clean field along with cotton applicators, gauze, and loose gloves. LPN#4 instructed CNA#2 to leave the unit to obtain a bottle normal saline solution (NSS).

Upon entering the resident's room, the surveyors observed the trash can under the sink area was overflowing with used paper towels and other trash. LPN#1 performed hand washing and discarded the used paper towel in the overflowing trash can. The paper towel fell onto the wet floor. LPN#1 did not empty the trash can. Additionally, the surveyor observed that the sink was clogged while LPN#1 performed handwashing. She did not stop to call for assistance with the clogged sink.

LPN#1 donned gloves and placed the treatment medications and supplies onto the prepared table covered with a barrier cloth liner. LPN #1 moved the table inside the resident's room. LPN#1 informed the surveyors that the table was considered a clean field area and that she had sanitized the table before placing the liner. LPN #1 placed an opened box of gloves and loose gloves on the table. They were touching the privacy curtain.

LPN#1 removed her gloves without performing handwashing and took a pair of scissors from the treatment cart, placing them directly onto the table's clean field. LPN#1 performed handwashing at the clogged sink. The sink was not properly draining, and the sudsy water began to accumulate in the sink. LPN #1 discarded wet paper towels into the full trash can. They fell to the floor.

At that time, CNA#2 re-entered the room. CNA #2

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placed the bottle of NSS directly on top of the clean field of the table with the rest of the treatment medications and supplies. CNA#2 performed handwashing at the clogged sink and disposed of the used paper towels in the full trash can. They fell onto the floor. CNA#2 donned a pair of gloves obtained from the top of the table where the privacy curtain had contaminated the clean field. Wearing the contaminated gloves, CNA#2 repositioned the resident in bed, touching the resident's back. LPN#1 then asked CNA #2 to assist her in removing the contaminated clean field on the treatment table with a new uncontaminated clean field paper liner. CNA #2 handled the supplies that had been placed on the first clean field, transferring them to the new clean field. She did this with the gloves that had been contaminated by touching the privacy curtain and the resident's back.

At that time, the surveyor stopped LPN#1 when the nurse approached the resident to clean the [redacted] while wearing contaminated gloves from contact with the privacy curtain. The surveyor asked LPN #1 to step away from the resident. The surveyor asked LPN #1 if she was aware of why the treatment was stopped. The nurse did not answer at first, and then she stated that she was "nervous," which was why she did not realize she contaminated the clean field area of the table.

On 10/31/19 at 1:17 PM, the survey team met with the Administrator, DON, ADON, LPN/CN, RN/UM, and Regional Nurse and discussed the above observations and concerns.

On 11/1/19 at 8:14 AM, CNA#2 stated to the surveyor, "I realize that I shouldn't put the NSS on

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F 880	Continued From page 27 top of treatment table" and acknowledged that it shouldn't be placed on top of the clean field/table. 3. On 10/29/19 at 8:20 AM, the surveyors observed that Resident #52 was lying in bed. The [redacted] On that same date and time, the resident informed the surveyors that the [redacted] was being used twice a day, and it was the nurse's responsibility to administer and remove the [redacted] A review of the resident's Face Sheet (an admission summary), reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included, but were not limited to, [redacted]. A review of the Quarterly Minimum Data Set (QMDS), an assessment tool dated [redacted], indicated a Brief Interview for Mental Status (BIMS) score of [redacted] A review of the October 2019 Physician's Order dated 10/22/19, revealed an order for [redacted] twice a day for two weeks and [redacted] every 6 hours as needed (PRN) for [redacted]. Further review of the October 2019 Medication Administration Record (MAR) revealed that the	F 880		

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[redacted] routine order was signed as administered from 10/22/19 through 10/29/19. The PRN [redacted] was signed as administered from 10/1/19 through 10/29/19 except 10/7/19, 10/10/19 and, 10/16/19.

On 10/31/19 at 1:17 PM, the survey team met with the Administrator, DON, ADON, LPN/CN, RN/UM, and the Regional Nurse and were made aware of the concerns and observation.

On 11/1/19 at 11:01 AM, LPN#1 informed the surveyor that the resident received a [redacted] [redacted]. LPN#1 stated that it was her responsibility as a nurse to check placement, storage, and tolerance of the resident to [redacted] therapy. She further stated, "I don't know what had happened," referring to why the [redacted] was not properly stored in a plastic bag on 10/29/19.

A review of the Centers for Disease Control and Prevention's (CDC), Hand Hygiene Guideline for Healthcare Providers, last updated 3/24/17, revealed that hand hygiene must be performed after glove removal.

A review of the facility policy for Needle Handling and Sharps Injury Prevention, revised 10/15/19, provided by the DON indicated that "During use, containers for contaminated sharps will be: maintained upright throughout use and replaced routinely when 3/4 full."

A review of the facility policy for Wound Dressings, revised 11/1/19, provided by the DON, indicated that "[redacted] dressings are performed using aseptic technique. To decrease the risk of [redacted] contamination and cross-contamination

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during dressing change."

The surveyor reviewed the Facility's Hand Hygiene Policy which revealed that hand hygiene should be performed before and after any direct contact with residents.

A review of the undated facility [redacted] Equipment Labeling policy which was provided by the DON indicated that "Licensed nurse replaces disposable set-up [redacted] [redacted] weekly and as needed. Dates and stores in a treatment bag when not in use."
4. On 10/30/19 at 9:39 AM, the surveyor interviewed the Licensed Practical Nurse/Charge Nurse #1 (LPN/CN #1). LPN/CN #1 informed the surveyor that Resident #66 was on [redacted] and had a [redacted] [redacted].

On 10/31/19 at 10:30 AM, the surveyor observed LPN #2 assisted by LPN #1, perform a [redacted] [redacted] treatment on Resident #66. The resident was positioned on the right side on a low air loss mattress bed. The resident's head was supported with a pillow, and the head of the bed was elevated at 35 degrees. LPN #1 repositioned the resident to a left side-lying position with the head of the bed raised at 35 degrees, and a pillow placed under the resident's head. The resident's [redacted] was not visible to LPN #2.

LPN #2 loosened the resident's brief and stated the brief was, "wet with the [redacted]." LPN #2 folded the edge of the wet brief and then removed the resident's old gauze dressing, which was [redacted].

LPN #2 did not place a barrier between the

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and the soiled diaper. The resident's came in contact with the resident's soiled diaper while LPN #2 disposed of the soiled gauze. LPN #2 returned to the resident to continue and stated, "Ooh, the is touching the diaper." LPN#2 took a 4x4 gauze outer paper wrapper and placed it as a barrier between the resident's exposed d and the soiled diaper.

LPN #2 cleaned the with normal saline-soaked gauze using circular motions from inside (soiled area) out and then back from outside (clean area) to inside (soiled area) of the . LPN #2 was unable to entirely visualize the due to the poor positioning of the resident. As a result, LPN #2 did not clean the entire bed since she could not completely visualize the

LPN #2 applied in circular motions from inside out and then from outside to inside. LPN #2 then applied and covered the with gauze. She then removed the 4x4 wrapper paper, which had been used as a barrier between the and the soiled diaper.

While LPN #2 applied to the edges of the , the gauze and medication previously applied to the fell off. The uncovered came into contact with the soiled diaper and bed linen. LPN #2 stated, "I have to clean the wound again because it is contaminated; the is touching the wet diaper and the bed." LPN #2 looked at LPN #1 and stated, "Umm, the is contaminated; it is touching the diaper; it's not

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F 880	Continued From page 31 right." On the same day at 11:00 AM, the surveyor asked the LPN #2 to stop the treatment because of the infection control concerns as she had repeatedly contaminated the wound. The surveyor reviewed the medical record for Resident #66. According to the face sheet (an admission record), the resident was admitted on [redacted] with diagnoses which included: [redacted] A review of the Quarterly Minimum Data Set (MDS), an assessment tool with an Assessment Reference Date of [redacted], reflected that the resident had a [redacted]. The surveyor was unable to interview Resident #66 due to his/her [redacted] A review of the October 2019 Physician's Order Sheet (POS) and Treatment Administration Record (TAR), reflected an order dated 10/30/19 to cleanse the [redacted] edges before covering the [redacted] with [redacted]. A review of Resident #66's individualized care plan dated 3/5/19 and revised 10/05/19, reflected that the resident had a [redacted] and was at risk for further breakdown. On 10/30/19 at 10:47 AM, the surveyor	F 880		

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interviewed the Certified Nursing Assistant (CNA#4), who informed the surveyor that the resident was [redacted] and required total assistance with activities of daily living (ADLs). The CNA stated the resident was on a turning and positioning schedule, had a cushion for the wheelchair and was assisted out of bed at least daily to promote [redacted] healing.

On 11/1/19 at 1:35 PM, the survey team met with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Regional Administrator and discussed the above observations and concerns. The ADON stated that she had just done a [redacted] competency with LPN #2 "yesterday," and another was done, "about three months ago."

On that same day at that same time, the surveyor requested a Copy of the Treatment Policy and the Clinical [redacted] Competence for LPN #2.

The surveyor reviewed the competency validation for LPN #2, which confirmed that clinical competency validation for aseptic technique/[redacted] dressing was completed on 10/30/19.

A review of the facility policy for "[redacted] dressings: aseptic" dated 6/1/96 and revised on 11/01/19 reflected:

Procedure # 9 indicated, "Position the area to be treated."

Procedure #13 indicated, "If a break in aseptic technique occurs, stop the procedure."

Procedure # 16.2 indicated "discard dressing and

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gloves according to infection control policy."

The facility provided no further information.

5. On 10/29/19 at 12:01 PM, the surveyor observed lunch meal services on the [redacted] unit dining room/day room. The surveyor observed the Licensed Practical Nurse/Unit Manager (LPN/UM#1) who assisted five residents with hand hygiene, Residents #24, #63, #66, #31, and #7. The surveyor observed LPN/UM #1 cleanse the five residents' hands without first washing her hands and donning gloves. The LPN/UM#1 did not wash her hands between residents and did not discard the soiled wipes but instead held the accumulated dirty wipes in her hands.

On that same day, at that same time, the surveyor observed the Certified Nursing Assistant (CNA # 3) assist two residents with hand hygiene, Resident #72, and #69. CNA #3 did not wash her hands after providing direct contact with each resident's skin. CNA #3 proceeded down the hall to pass trays to residents in their rooms while holding on to the soiled wipes.

On 10/31/19 at 9:36 AM, the surveyor interviewed LPN/UM #1, who stated she should have discarded each wipe and washed her hands after she assisted each resident with hand hygiene. LPN/UM #1 further said that there was no sink in the [redacted] unit dining room/day room, which made it very inconvenient to clean her hands.

The surveyor reviewed the Facility's Hand Hygiene Policy which reflected that hand hygiene should be performed before and after any direct contact with residents.

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F 880	Continued From page 34 On 10/31/19 at 1:30 PM, the surveyor discussed the above observations and concerns with the Administrator and Director of Nursing. The facility provided no further information. NJAC 8:39-19.4 (a) (1)	F 880		