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F 000	INITIAL COMMENTS Standard Survey: 2/10/20 Census: 97 Sample Size: 23 A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		2/24/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed

TITLE

(X6) DATE 02/19/2020

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 657	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to review and revise care plans over several quarters for 2 of 23 residents reviewed (Resident #56 and Resident #91). The deficient practice was evidenced by the following: 1. On 2/05/20 at 9:47 AM, the surveyor observed Resident #56 in bed, lying on an air mattress, padded 1/2 side rails with eyes closed. The surveyor reviewed Resident #56's medical records that revealed the following: According to the Face Sheet, Resident #56 was admitted to the facility with diagnoses that included [redacted] The Quarterly Minimum Data Set an assessment tool dated [redacted], indicated that the Resident #56 was [redacted] by the facility for the Brief Interview of Mental Status Interview (BIMS) and the facility had assessed the resident as [redacted]. The February 2020 Physician's Order Form (POF) indicated that Resident #56 had an order for a puree diet with thin liquids. The diet order had been changed on 6/28/19 from nectar thick liquids (NTL) to thin liquids. Thickened liquids are needed for people with feeding and/or swallowing problems. Thickening the fluids makes swallowing safer.	F 657	F657 1. Resident #56 and Resident #91 care plans were updated to reflect changes to the care plan from previous quarters. 2. All residents have the potential to be affected by the deficient practice of failing to review and revise comprehensive care plans. 3. The IDCP team, which will also include the Consulting Registered Dietician, will be in-serviced regarding updating resident comprehensive care plans episodically, significant changes and routinely. The Registered Dietician□s contract and role will be reviewed and revised, by the administrator, to include the compliance with facility policy related to comprehensive care plans and IDCP meetings. 4. The DON or designee will monitor 5 comprehensive care plans weekly for the next two quarters to ensure updates are documented indicating the care received from the previous quarter. All findings will be reviewed at the next quarterly QA meeting. 5. Date of completion February 24, 2020.	

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F 657	Continued From page 2 The Risk for [redacted] care plan was initiated on [redacted] and last updated on [redacted] that indicated the resident had a diet order of [redacted] with [redacted] There was a second care plan titled Risk for [redacted] that was initiated on [redacted] that indicated the resident had a diet order for [redacted] with [redacted] and the last update was on [redacted] with a new diet order for puree with [redacted] [redacted]. The Weight Loss/Gain care plan initiated on [redacted] indicated the resident was on a [redacted] with [redacted] and updated on [redacted] to reflect the diet change to [redacted] with [redacted] [redacted]. The last update on [redacted] indicated to continue the [redacted]. There was no documentation on the care plans that the Consultant Registered Dietitian (CRD) was involved in the development of the care plans. However, there was documentation in the Dietary Progress Notes (DPN) that the CRD documented the resident's progress quarterly. The CRD identified in the DPN dated [redacted] that Resident #56 was on a [redacted] with [redacted] [redacted] The IDCP (Interdisciplinary Care Plan) Resident Summary sheets indicated that the Interdisciplinary Care Plan Team (ICPT) met to discuss Resident #56's plan of care on [redacted] [redacted]. These meetings are done quarterly for all residents to discuss the residents plan of care, and to review and update the care plans, which would include adding or removing interventions that reflect the services provided to the resident.	F 657		

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The IDCP Resident Summary sheet dated [redacted] indicated that Resident #56 was on a [redacted]. This was not consistent with the physician's orders on the February 2020 Physician Order Form and the documentation made by the Consultant Registered Dietitian. The care plans mentioned above were not updated to reflect any documented changes with the resident or any change in the services provided.

On 2/6/20 at 9:47 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) assigned to Resident #56 who stated that the resident was on a [redacted]. At 9:59 AM, the surveyor interviewed the Licensed Practical Nurse assigned to Resident #56 who confirmed the resident was on a [redacted].

2. On 2/04/20 at 11:26 AM, the surveyor observed Resident #91 lying in bed with eyes open. The resident's padded side rails were in the up position. The resident was [redacted] and the surveyor was informed by the nurse that the resident communicated by waving their arms and bangs on the side rails.

The surveyor reviewed Resident #91's medical records that revealed the following:

According to the Face Sheet, Resident #91 had diagnoses that included [redacted].

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The Quarterly MDS dated [redacted], indicated that the resident was [redacted] for the BIMS and the facility had assessed the resident as [redacted]

The February 2020 Physician Order Form indicated that Resident #91 had a order for [redacted] through the [redacted] and to provide [redacted]

On 2/6/20 at 11:02 AM, the surveyor interviewed the CNA assigned to Resident #91 who stated that the resident doesn't always eat the pleasure foods well, but will eat what the family brings from home. At 11:05 AM, the surveyor interviewed the LPN assigned to the resident who stated that the resident often refuses [redacted]

The "At Risk for Altered Nutrition Care Plan" related to [redacted] initiated on 12/18/18 had no updates since 12/18/18.

The Aspiration Precaution care plan was initiated on 3/10/17 and the last update was dated 12/27/18.

There was no documentation on the care plans that the CRD was involved in the development of the care plans. However, there was documentation in the Dietary Progress Notes (DPN) by CRD regarding the resident's progress and slow downward trend with weight related to the resident's frequent refusal of the [redacted].

The Nurse's Notes revealed that Resident #56 frequently refused the [redacted] and has had occasions where the resident [redacted]

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[redacted] and would require hospitalization to have the [redacted].

The IDCP Resident Summary sheets available for review indicated that the ICPT met to discuss Resident #91's plan of care on 9/26/19 and 1/2/20. However, the care plans mentioned above were not updated to reflect any documented changes with the resident or any change in the services provided.

On 2/6/20 at 11:00 AM, the surveyor interviewed the Consultant Registered Dietitian (CRD) who stated she comes to the facility once or twice a week, she does not develop nutrition care plans and that she would give her recommendations to nursing and the nurses write the care plans. The RD further stated she does not attend the ICPT meetings. The surveyor asked if she reviewed care plans for appropriate interventions and she replied no.

On 2/6/20 at 11:30 AM, the surveyor interviewed the MDS Coordinator who was responsible to arrange the ICPT meetings for every resident. She stated that she doesn't bring the care plans to the ICPT meetings to be reviewed or updated. She stated she had a lot to keep track of and document.

On 2/06/20 at 2:17 PM, the surveyor discussed with the Administrator, Director of Nursing (DON) and the Corporate Registered Nurse the above care plan concerns and that this was a repeat deficiency from the previous survey,

A review of the Consultant Dietitian Contract dated October 21, 2019 under #1 and #3 indicated that the CRD reviews the resident's

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F 657	Continued From page 6 medical history and CRD would meet with the DON, MDS Coordinator or Nursing Supervisor prior to leaving the facility and provide a summary of residents evaluated and recommended interventions. There was no mention in the contract for the Consultant Dietitian to attend the ICPT meetings. A review of the facility's policy Resident Care Plan Policy and Procedure dated 12/2019 indicated under "Updating Care Plans" the following: "1. Care plans are modified between care plan conference when appropriate to meet the resident's current needs, problems, and goals and 2. The care plan will be updated and/or revised for the following reasons: a. Significant change in the resident's condition. b. A change in planned interventions. c. Goals are obtained and new goals established to meet current resident needs and/or goals. d. New diagnosis, new medication, etc" NJAC 8:39-4.1,3	F 657		
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 maintain professional standards of clinical practice by not transcribing and initiating a physician's order (PO) for [redacted] treatment	F 658	F658 1. Resident #5 has completed the [redacted]	2/24/20

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in a timely manner for 1 of 23 residents (Resident #5) reviewed.

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 well being, 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."

On 2/5/20 at 9:21 AM, the surveyor observed Resident #5 walking down the hallway using a cane.

The surveyor reviewed Resident #5's medical record that revealed the following:

F 658

2. All residents have the potential to be affected by the deficient practice of failing to transcribe and initiate a physician�s order in a timely manner.
3. The DON will in-service all nurses on Transcribing Medication Orders onto the Medication Administration Record Policy and Procedure, 24 Hour Chart Check Policy and Procedure and 24 Hour Reporting Communication.
4. The DON or designee will monitor 5 random physician order forms on each unit weekly for the next quarter to ensure that all physician orders received have been appropriately transcribed to the Medication Administration Record and administered to the resident as ordered. All findings will be reviewed at the next quarterly QA meeting.
5. Date of completion February 24, 2020

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According to the Face Sheet, Resident #5 was admitted to the facility with diagnoses that included [redacted].

The Quarterly Minimum Data Set, an assessment tool dated [redacted] revealed the resident scored a [redacted] on the Brief Interview for Mental Status which indicated that Resident #5 was [redacted].

On the Physician's Order form dated 1/24/20, revealed a new order that was written by the Nurse Practitioner (NP) for the [redacted] by mouth to be administered twice daily for [redacted]

The Nurse Practitioner documented on the Progress Note dated 1/24/20 under Assessment the following note: [redacted] and under Plan: [redacted].

The January 2020 Medication Administration Record (MAR) revealed that Resident #5 received the first dose of [redacted] on [redacted] at 5:00 PM.

The surveyor requested a list of back up medications from the RN Supervisor #1. The RN Supervisor #1 provided the facility's back up medication binder titled Utilization Declining Inventory. There was a form that indicated [redacted] was available in the back up box. Under the section titled Quantity and Medication, it had indicated that on the evening of 1/24/20 and the morning of 1/25/20 there were [redacted]

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capsules available in the back up box if needed.

On 2/7/20 at 10:50 AM, the surveyor interviewed the RN Supervisor #1 on duty. After reviewing the physician order for [redacted] written on 1/24/20 and the January 2020 MAR, RN Supervisor #1 stated that the [redacted] should have been given to the resident on 1/24/20 during the evening shift and on 1/25/20 at 8:00 AM. The RN Supervisor #1 further stated "We have this medication in the back up box."

On 2/7/20 at 11:00 AM, the surveyor interviewed Resident #5 concerning the time of the Nurse Practitioner's visit. Resident #5 stated it was evening when the NP told the resident they had an [redacted] and needed to be treated with [redacted]. The resident informed the surveyor that the resident received the first dose of [redacted] at 5:00 PM the next day.

On 2/7/20 11:10 AM, the surveyor interviewed the NP, who stated she wrote the [redacted] order for Resident #5 between 8:00 PM and 8:30 PM on 1/24/20 and she informed one of the nurses about the order, but could not recall which nurse she had spoken to. The NP further stated that whenever she writes orders she flags the chart and informs the nurse on duty.

There was no documentation in the Nurses Notes on 1/24/20 that the NP had visited and ordered an antibiotic.

On 2/7/20 at 11:15 AM, the surveyor interviewed the 11-7 Registered Nurse (RN #1) assigned to Resident #5 on the 1/24/20 night shift. RN #1 stated that when she was completing her 24-hour chart checks (review of all resident's charts to

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ensure all new PO's received in the last 24 hours were carried out and transcribed) she saw that Resident #5 had had a new order dated 1/24/20 for the [redacted]

RN #1 then stated she reviewed Resident 5's January 2020 MAR and noted that the [redacted] order had not been transcribed. RN #1 stated she wrote the new order for [redacted] onto the MAR and scheduled the medication for 8:00 AM and 5:00 PM.

RN #1 furthur stated that during morning report on 1/25/20 she told the day nurse about the new order for the [redacted] and also wrote it on the 24 hr report.

The 1/24/20 24 hour report titled Daily Report form under the section titled 3:00 PM to 11:00 PM Shift revealed that the Licensed Practical Nurse (LPN #1) had not documented next to Resident #5's name that the resident had been seen by the NP who had ordered [redacted] Further review of the form under the section titled 11:00 PM to 7:00 AM it was documented under Resident #5's name by the RN #1 "[redacted] coming tonight."

On 2/7/20 at 11:40 AM, the surveyor interviewed via telephone LPN #1 assigned to Resident #5 on 1/24/20 evening shift. LPN #1 stated he did not remember receiving an order for [redacted] for the resident on 1/24/20.

On 2/7/20 11:50 AM, surveyor interviewed via telephone the evening RN Supervisor #2, who worked on 1/24/19 evening shift . The RN Supervisor #2 stated he did not remember receiving a PO for [redacted] for Resident #5 on 1/24/20.

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F 658	Continued From page 11 On 2/7/20 12:00 PM, the surveyor attempted to interview via telephone LPN #2 assigned to Resident #5 on 1/25/20 day shift concerning why she did not administer the 1/25/19 8:00 AM dose of [redacted]. LPN #2 could not be reached. A review of the facility's policy titled Back Up Box indicated under Procedure #2: Back up medications shall only be used under circumstances where due to the condition of the resident it would be beneficial to initiate prompt administration of a medication (prior to the pharmacy delivery). A review of the facility's policy titled Transcribing Medication Orders Onto The Medication Administration Record did not include any information on transcribing and initiating PO's in a timely matter. On 2/7/20 at 1:15 PM, the surveyor met with the Administrator, Director of Nursing (DON) and Corporate RN about the above concerns. The DON stated that LPN #2 no longer worked at the facility. No further information was provided. NJAC 8:39-11.2(b).	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		2/24/20

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F 684	Continued From page 12 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a) apply floor mats in accordance with the physician's order and b) collaborate with [redacted] for the development and implementation of the plan of care and to ensure that the residents needs are met according to the facility's policy. This deficient practice was identified for 1 of 1 resident (Resident #30) reviewed for [redacted] services and was evidenced by the following: On 2/4/20 at 11:25 AM and 2/5/20 at 9:32 AM, the surveyor observed Resident #30 lying in bed with eyes closed. There were two floor mats folded up and leaning up against the resident's nightstand. The surveyor reviewed Resident #30's medical record which revealed the following: According to the Face Sheet, Resident #30 was admitted to the facility with diagnoses that included: [redacted] The February 2020 Physician's Order Form indicated that Resident #30 had a physician's order dated 2/2/19 for floor mats to both sides of bed while in bed every shift. The Certified Nursing Assistants (CNA) refer to the Resident Care Card for the resident's plan of care daily. The Resident Care Card dated 2/11/19 listed interventions that included floor mats to both sides of bed while in bed every shift.	F 684	F684 1. A physicians order was obtained to discontinue Resident #30 bilateral fall mats on February 5, 2020 and communicated to the [redacted] company and the resident□s family member. The [redacted] company provided a completed care plan. 2. All residents have the potential to be affected by the deficient practice of failing to not apply fall mats in accordance with physician orders and collaborate with [redacted] for the development and implementation of the plan of care to ensure that the resident□s needs are met according to the facility□s policy. 3. The DON will in-service all nursing staff and the hospice company regarding verbal shift reporting before and after the [redacted] staff has rendered care. The DON will in-service the [redacted] management that all residents receiving [redacted] services must have a comprehensive care plan in the resident□s chart within 48 hours of implemented services. A collaborative administration meeting has been scheduled to ensure precise communication occurs immediately upon initiated [redacted] services and throughout the course of [redacted] care in order to provide holistic continuity resident care. 4. The DON or designee will monitor the charts and comprehensive care plans of	

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F 684	Continued From page 13 Resident #30's care plan titled "[the resident] is at risk for falls R/T (related to) [redacted] [redacted]" initiated on 1/23/19 had interventions that included "2/2/19 floor mat to both sides of bed." The Initial Physician Orders and Certification form completed by hospice listed a start of care date of 1/29/20. The form, under Equipment, did not include any orders for floor mats. There were two [redacted] Aide Care Plan's dated 1/29/20 and 1/30/20 that did not include floor mats. The Nurse's Notes from 1/29/20 through 2/5/19 had no documentation that the facility had discussed the residents plan of care, to include floor mats, with the [redacted] provider. On 2/5/20 at 9:35 AM, the surveyor interviewed the CNA assigned to the resident. The surveyor asked the CNA about the folded up floor mats that were leaning against Resident #30's night stand. The CNA stated that the floor mats should be on the floor on both sides of the bed at all times when the resident was in bed. The CNA stated that when she came in at 7:00 AM she checked Resident #30 and the floor mats were in place as ordered and that the hospice aide came in at 8:00 AM and must have not replaced them before she left. The CNA further stated that she speaks with the [redacted] aide regularly. However, had never discussed that the resident's need for floor mats when the resident was in bed. On 2/5/20 at 9:40 AM, the surveyor interviewed	F 684	residents receiving hospice services weekly for the next quarter receiving hospice care. All findings will be reviewed at the next quarterly QA meeting. 5. Date of completion February 24, 2020	

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F 684 Continued From page 14 F 684

the Licensed Practical Nurse (LPN) assigned to the resident who stated that the resident required floor mats. When asked about the folded up floor mats that were leaning against Resident #30's night stand the LPN stated that the hospice aide must have removed the mats when she was doing care and must not have put them back.

The LPN also reported that she had noticed on 2/4/20 that the [redacted] aide did not put the floor mats down before she left. She stated she did not call [redacted] provider or talk to the [redacted] aide about the floor mats the next time she was in the facility.

On 2/5/20 at 9:48 AM, the surveyor interviewed the Registered Nurse Supervisor (RN) who stated that all staff should reference the Resident Care Card and plan of care before providing care to the resident. The RN was unsure if the [redacted] aide had access to the plan of care or the Resident Care Care, but stated staff should be giving the hospice aide verbal report daily.

The RN could not recall giving the hospice aide verbal report related to the floor mats and was unsure why the floor mats were not listed on the [redacted] Aide Care Plan. The RN further stated that she had not discussed the plan of care with the [redacted] provider and was not aware of any plan of care from the hospice provider.

On 2/5/19 at 10:02 AM, the surveyor interviewed the Minimum Data Set (MDS) Coordinator responsible for scheduling and arranging care conference meetings. The MDS Coordinator stated no meeting was held to discuss the residents plan of care with the [redacted] provider. She stated that the [redacted] care plan was

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F 684	Continued From page 15 separate from the facility care plan and the facility has not reached out to the [redacted] to formulate a collaborative plan of care for this resident and had not discussed floor mats with the [redacted] provider. On 2/7/20 at 12:15 PM, the Director of Nursing (DON) looked through the chart in the presence of the surveyor and confirmed that there was no plan of care from [redacted] in the chart and was unsure why it was not there. The DON stated that she knows that [redacted] should have one and it should be in the resident's chart. On 2/7/20 DON provided an Interdisciplinary Care Plan (ICP) that had been faxed to the facility from the [redacted] provider. The ICP printed on 2/7/20, titled "Risk for falls/injury" did not include floor mats as an intervention. On 2/10/20 at 10:55 AM, the surveyor interviewed the [redacted] Team Leader (TL) assigned to the resident who stated that the [redacted] care plan is developed within 48 hours of admission to [redacted] and should have been sent to the facility. The TL was unsure why it was not sent to the facility. The TL also stated that when a resident is admitted to [redacted], they make immediate recommendations. However, they do not collaborate with the facility to create the plan of care. On 2/10/20 at 11:01 AM, the surveyor interviewed the hospice RN Case Manager (RNCM) assigned to the resident. The RNCM stated that she did not know that the resident required floor mats and had not been made aware of this prior to 2/5/20. The RNCM also stated that the [redacted] aide only references the [redacted] Aide Care Plan when they	F 684		

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F 684	Continued From page 16 come into the facility to provide care for the resident. The RNCM reported that she had not reviewed the facility care plans nor discussed the plan of care with facility staff. A review of the facility's policy titled [redacted] Policy and Procedures under policy Interpretation and Implementation #10 revealed the following: "10. In general, it is the responsibility of the facility to meet the residents' personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. These include: ... d. Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day." NJAC 8:39-27.1 (a)	F 684		
F 755 SS=C	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		2/24/20

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F 755	Continued From page 17 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documents it was determined that the facility failed to: a) maintain a system to account for controlled medications' receipt, b) maintain complete records of all required DEA 222 form (Drug Enforcement Administration) and c) ensure that all DEA 222 forms were completed with sufficient detail to enable accurate accountability and reconciliation for controlled medications for 1 of 3 DEA 222 forms provided. This deficient practice was evidenced by the following: On 2/10/20 at 9:15 AM, the surveyor reviewed all DEA 222 forms and back up log books provided by the Director of Nursing (DON) for the last 6 months. The surveyor reviewed the documents provided by the DON and noted the following: 1. A DEA 222 form, dated 8/27/19, contained an	F 755	F755 1. The DEA 222 form dated 8/27/19 containing the 10 tablets [redacted] and 10 tablets of [redacted] was investigated and confirmed by the pharmacy the date received, number of packages delivered and the receiving nurse. The photocopied DEA 222 form dated 10/23/19 containing 1 bottle of [redacted] was investigated and confirmed by the pharmacy the date received, number of packages delivered and the receiving nurse. The original DEA 222 form dated 10/23/19 was recovered in a secured location. The DEA 222 form dated 9/30/19 containing 10 tablets of [redacted]	

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F 755 Continued From page 18

order for 10 tablets of [redacted] [redacted] and 10 tablets of [redacted]. The DEA 222 form was missing the received date, number of packages received and the receiver's signature.

2. A photocopied DEA 222 form, dated 10/23/19, contained an order for 1 bottle of [redacted] [redacted]. The DEA 222 form was missing the date received, number of packages received and the receiver's signature. The facility was unable to provide the original DEA 222 form on request.

3. On 2/10/20 at 9:30 AM, the surveyor reviewed the facility's controlled substance back-up log book, in the presence of the DON, which contained a House Stock - Controlled Countdown Sheet (HSCCS) which revealed that the facility received 10 tablets of [redacted] and 10 tablets of [redacted] on 9/30/19. The DON was unable to offer an explanation for the missing DEA 222 form and was unable to provide the surveyor with the DEA 222 form dated 9/30/19, that contained an order for 10 tablets of [redacted] and 10 tablets of [redacted] [redacted]

On 2/10/20 at 10:20 AM, the surveyor interviewed the DON who stated that she was responsible for maintain all DEA 222 forms and ensuring that the forms are complete and accurate. The DON also stated that the DEA 222 forms were not filled out properly and that she had been unsure how to fill them out properly.

The facility policy titled "Controlled Substances Policy and Procedure" did not address DEA 222

F 755

and 10 tablets of [redacted] was found.

2. All residents have the potential to be affected by the deficient practice of failing to maintain a system to account for controlled medications receipt, maintain complete records of all required DEA 222 for and ensure that all DEA 222 forms were completed with sufficient detail to enable accurate accountability and reconciliation for controlled medications for 1 of 3 DEA 222 forms provided.

3. The DON will in-service all nursing administration staff regarding the policy and procedure related to receiving and accurate recorded accountability of controlled substances.

4. The DON or designee will monitor weekly throughout the next quarter all DEA 222 forms to ensure that the DEA 222 form and Pharmacy Invoice is accurate, complete and reconciled. All findings will be reviewed at the next quarterly QA meeting.

5. Date of completion February 24, 2020

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F 755	Continued From page 19 forms or outline a system to account for controlled medications receipt to enable accurate accountability and reconciliation for controlled drugs. NJAC 8:39-29.7 (c)	F 755		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness; b.) failed to sanitize and air dry pans in manner to prevent cross contamination of microbial growth. This deficient practice was evidenced by the	F 812	F-812 1. The 5 pans in question were removed immediately, re-washed and air dried properly. The rest of the dishes and utensils in the kitchen were checked to assure they were air dried before use. The dented cans in the storage area were	2/24/20

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F 812 Continued From page 20
following:

On 2/4/20 at 9:32 AM, in the presence of the Food Service Director (FSD) the surveyor observed the following:

1. On top of the steam table there was a stack of 5 pans, in circulation for use, that were observed to have water in between them. The FSD stated that pans were clean and ready for use and that the staff should have ensured the pans were completely dry before stacking.

2. In the dry storage area, the surveyor observed dented cans which were in rotation for use as follows:
- a 100 fluid ounce can of whole potatoes with a one inch dent to the body of the can and a one inch to the upper lip.
- two six pound (lb) 10 ounce (oz) cans of diced peaches with a one inch dents to the upper lip and a one inch dent to the lower lip.
- two six lb 10 oz cans of diced peaches with quarter inch dents to the upper rim.
- a six lb eight oz can of apple sauce with a one and a half inch dent to the top.
- three six lb four oz cans of cut sweet potatoes in light syrup with one inch dents to the body.
- a three lb 14 oz can of mushrooms with a quarter inch dent to the upper rim.

FSD stated the cans were in circulation for use. The FSD also stated that the cans should have been removed and put in the dented can section by the staff member who received the delivery.

On 2/4/20 at 1:21 PM, the surveyor discussed with the Administrator and Director of Nursing of the above findings.

F 812

immediately removed and placed in the designated area to be returned to the vendor. The rest of the cans in the storage area room were examined for dents and any cans that were found were removed immediately to the dented can area. All policy for "dented cans" was reviewed and dated. The policy for "nesting water" was reviewed and dated.

2. All residents have the potential to be affected by this deficient practice when pans are not air dried properly and when dented cans are not removed and stored in the dented can area and returned to the vendor. The nesting water can potentially grow bacteria and the dented cans can potentially effect the contents in the can and result in foodborne illnesses.

3. All kitchen staff were in-serviced in the policy and procedure for "nesting water" to assure that all pans are air dired properly before use. Additionally, all kitchen staff was in-serviced to fully examine every can when taken out of the box and inspected for dents. Any cans found with dents are to be stored in the designated dented can area. All kitchen staff were inserviced as to the potential for foodborne illnesses should these policies and procedures not be followed.

4. The Administrator and Food Service Director will be inspecting the kitchen and storage area on a daily basis ongoing to assure that these deficiencies of "nesting water" and "dented cans" do not reoccur. All findings will be reviewed at the Quality

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F 812	Continued From page 21 The surveyor reviewed an undated facility policy titled, "Dented cans." The policy revealed that all cans must be removed from the box and inspected before they are stored on the shelves, if any of the cans are dented they are to be isolated in the designated dented can area to be returned to the vendor. The surveyor reviewed an undated facility policy titled, "Nesting water." The policy revealed that "all dishes, pots and pans have to be free of the nesting of water." The policy also revealed that after pots, pans and dishes are washed they are to be stored on a rack to air dry. NJAC 8:39-17.2(g)	F 812	Assurance meeting quarterly x 3 quarters	