STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	09/09/2019

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PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

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F 000	INITIAL COMMENTS STANDARD SURVEY 9/9/19 CENSUS: 112 SAMPLE SIZE: 24	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		10/9/19

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

Electronically Signed | 09/27/2019

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F 582	Continued From page 1 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide residents with documentation notifying the resident regarding the termination of Medicare coverage termination. This deficient practice was identified for 2 of 3 residents (Resident #37, and Resident #216) reviewed for payor status changes and was evidenced by the following: On 9/4/19 at 1:06 PM, the surveyor reviewed the records of insurance coverage for two residents, Resident #37 and Resident #216, both of whom had a change in status of insurance coverage and chose to remain in the facility. During record review the surveyor observed that "SNF ABN", CMS Form 10055 was not provided to either of	F 582	1. Resident # 216 is now [redacted]. Resident #37 will be issued an ABN notice. 2. Residents receiving therapy services have the potential of not receiving the proper notice of ABN prior to discharge. 3. Social Services Director will keep a binder with proof that the ABN was issued. 4. Social Services Director will perform a monthly audit X 3 to ensure the ABN's were issued to all resident discharged from therapy services. The audit will be reported monthly at the QA meeting. The QA committee will review the audit and make recommendations based on the findings.	

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F 582	Continued From page 2 the two residents as required. When interviewed on 9/4/19 at 1:56 PM, the Licensed Nursing Home Administrator said "they were not issued" to Resident #37 or Resident #216. No further information was provided.	F 582		
F 684 SS=D	NJAC 8:39-4.1(a)(7) 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 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 provide a resident with care in a timely manner. This deficient practice was identified for 1 of 24 residents reviewed, Resident #108, and was evidenced by the following: On 9/4/19 at 11:05 AM the surveyor reviewed the 8/17/19 Resident Assessment Instrument (RAI), an assessment tool. The RAI identified Resident #108 as [redacted] The RAI also identified Resident #108 as a fall risk. According to the medical record Resident#108	F 684	1. Once the issue was identified and DON aware resident #108 was put into bed and incontinence care rendered. DON called the staffing agency and reported the incident and requested the agency nurse involved not be sent to the facility in the future. 2. All residents have the potential to be affected by not following fall risk safety precautions and standard nursing care. 3. RN's, LPN's and CNA's will be in-serviced on proper fall precautions for those residents identified as fall risks. In addition they will be in-serviced that nursing staff is expected to render appropriate care as needed regardless of	10/9/19

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F 684	Continued From page 3 had diagnoses that included [redacted]. On 9/5/19 at 1:45 PM, the surveyor observed Resident #108 in their room seated in the wheelchair at the side of his/her bed. The resident was grabbing the comforter with both hands and attempting to pull him/herself out of the wheelchair to get into bed. The surveyor encouraged Resident #108 to wait until staff could come to assist him/her. The resident stated, "I would use my call bell but I don't know how." At 1:49 PM, the surveyor went to the nurses station and alerted a Registered Nurse that Resident #108 was attempting to get out of his/her wheelchair and needed staff assistance. The surveyor then returned to the resident's room and noted an odor that Resident #108 had possibly moved his/her bowels. At 1:51 PM, the Licensed Practical Nurse (LPN) responsible for Resident #108, entered the room and stated "Ok, how do they get him in bed?" The surveyor asked the nurse if she was familiar with the resident. The LPN stated, "Not really" and left the room. The surveyor remained with the resident. The resident had stated to the surveyor that he/she "wanted to take a nap, that's why I have accidents." On 9/5/19 at 2:01 PM, the surveyor returned to the nurses station from Resident #108's room; No staff had returned to the room after the LPN had left. The surveyor observed the LPN seated in the nursing station in conversation with an unidentified person. The surveyor then returned to Resident #108's room at 2:03 PM. The resident remained seated in his wheelchair, and then	F 684	title. 4. Unit managers and shift supervisors will make monthly rounds X 6 months on all shifts to ensure that high fall risk residents are properly attended to and incontinent residents are being cared for by any member of the nursing team. The findings will be reported by the DON at the monthly QA meeting. The QA committee will determine if further audits are necessary.	

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F 684	Continued From page 4	F 684		

stated, "I can't wait anymore." The surveyor observed the resident still trying to get in bed as before.

On 9/5/19 at 2:06 PM, the surveyor approached the nurses station again and requested the LPN's name. The LPN was seated in the nurses station and was completing a phone call. After the LPN hung up the phone, the LPN stated, "I can't find anybody." The surveyor then asked the LPN if Resident #108 was a fall risk. The LPN stated, "I'm sure [redacted] is" then became visibly irritated and got up out of her chair. The surveyor asked the LPN if she would normally leave a resident who was a fall risk alone because she did not know how to transfer the resident. The LPN stated, "No, but I can't find [redacted] aide anywhere." The LPN then went to Resident #108's room and proceeded to wheel the resident from the room and out to the nurses station. At 2:11 PM, the surveyor observed the resident sitting in the wheelchair in the hallway near the nurses station where the LPN had left him/her. The surveyor did not observe the LPN assess if the resident required incontinence care. The surveyor observed the LPN seated at the desk in the nurses station.

On 9/5/19 at 2:24 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The surveyors told the LNHA and DON about the encounter with Resident #108 and the LPN. The DON agreed that Resident #108 was a "fall risk" and that the LPN should have attended to the resident "if he/she had been suspected of having a bowel movement." The surveyors asked if the resident had been attended to. The DON replied, that she would check. The DON, accompanied by a nurse

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F 684	Continued From page 5 surveyor, went to check the resident. The nurse surveyor observed the LPN wheel Resident #108 to his/her room and then leave the room. A Certified Nursing Assistant (CNA) and the DON then assisted the resident onto the bed. The CNA then left the room. Upon assisting the resident onto the bed, it was determined that Resident #108 had been incontinent of bowel. During an interview at that time, the surveyor asked the DON if nurses can render care. The DON stated, "They can and they are expected to." After the resident had been provided with care, the surveyor spoke with the resident about the previous events. The resident said he/she was happy to be in bed and was not even aware that he/she had been incontinent of his/her bowels. NJAC 8:39-27.2	F 684		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		10/9/19

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F 732	Continued From page 6 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the 24-hour staffing information was posted and displayed in a place that was readily accessible to residents, family members, the public, and caregivers. This deficient practice was evidenced by the following: On 3/19, 9/4/19 and 9/5/19, the surveyors toured both nursing units and were unable to find the 24-hour staffing information posted in a prominent place that was accessible to residents and visitors. On 9/6/19 at 11:15 AM, the surveyor observed that the staffing information was posted in the lobby above the employee time clock. The	F 732	1. The nurse staffing is now being posted in the lobby and on each nursing unit. 2. All residents that are unable to access the code to the lobby have the potential to be affected by this practice. 3. The staffing coordinator and all nursing supervisors will be in-serviced on the locations that the staffing is to be posted each shift. 4. The LNHA will perform a weekly audit for 1 month to ensure staffing is posted in the appropriate areas. The results of this audit will be reported at the monthly QA meeting. The QA committee will make recommendations based on the findings.	

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F 732	Continued From page 7 lobby was connected to the nursing units but was behind closed doors that required a code in order to unlock the doors. When interviewed by the surveyor on 9/6/19 at 11:19 AM, the Director of Nursing stated that not all residents would be able to access the staffing information.	F 732		
F 757 SS=D	NJAC 8:39-41.2 Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide documented evidence that an increase in	F 757	1. Resident #9 was re-evaluated by the [redacted] on 9[redacted] and the [redacted] dose was reduced to [redacted]. The	10/9/19

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F 757	Continued From page 8 a resident's [redacted] medication was warranted. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #9) and was evidenced by the following: On 9/4/19 at 11:47 AM, the surveyor reviewed the [redacted] Resident Assessment Instrument (RAI), an assessment tool which identified that Resident #9 had [redacted]. The RAI noted that the last attempted Gradual Dose Reduction (GDR) had been performed on 5/7/2019. The RAI also noted that Resident #9 had diagnoses that included [redacted] and that Resident #9 was also receiving [redacted]. The surveyor observed in the medical record that the resident had been receiving the [redacted] medication [redacted] every 6 hours since 12/11/18. Upon review of the March 2019 Medication Administration Records (MAR), the surveyor observed that on 3/13/19 the [redacted] every 6 hours was decreased to [redacted]. Then on 3/27/19 Resident #9's [redacted] order was decreased from [redacted] tablet by mouth TID to [redacted]. The surveyor did not observe any documentation in the medical record of increased behaviors or negative affects related to the medication decrease. The surveyor reviewed a 5/7/2019 [redacted] progress note, written by the [redacted] Advanced Practice Nurse (APN), that included, "Staff rpts (sic) no significant behaviors at this	F 757	nursing staff has been instructed to document behaviors on resident #9. 2. All residents receiving [redacted] medications have the potential to be affected. 3. The DON spoke with the [redacted] APN requesting that the DON be notified of any increases in [redacted] meds. The ADON spoke with the [redacted] nurse and [redacted] medical director advising them that the ADON or unit manager must be involved in any recommendations for [redacted] med changes. A new behavior monitoring form will be instituted for all residents on [redacted] medications to be completed daily by nurses on each shift. 4. The DON will complete a monthly audit for residents on [redacted] to ensure no dose increases have been initiated without proper documentation. The audit will be reported at the monthly QA meeting. Based on the findings the QA committee will make recommendations as needed.	

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F 757	Continued From page 9	F 757		

time." The APN then recommended "GDR - [redacted] po BID" and documented that she had discussed the risk vs benefits of the [redacted] GDR with the resident's daughter who agreed with the GDR. The surveyor was unable to find any follow-up and/or order change regarding the APN's recommendation.

During further review of the medical record the the surveyor observed a 5/16/19 Physician's order for the resident to receive, [redacted] tablet by mouth four times a day for [redacted] Give half tab to equal [redacted]" This was an increase in the medication going from [redacted] TID to [redacted] four times a day.

The surveyor reviewed the progress notes in the electronic medical record for the period 3/13/19 up to and including 9/5/19. The surveyor was unable to find any progress notes or behavior notes for Resident #9, except for a 5/16/19 note from the [redacted] nurse that included "per staff, pt with [redacted], more so later in the day." When interviewed on 9/9/19 at 9:37 AM, the Director of Nursing stated "There was no documentation of behaviors for (resident's name)."

The surveyor reviewed the facility policy titled [redacted] Medication Use, Including [redacted], Policy NO: CA-12 and last Date Revised: 05/2019. Under the Procedure section the policy stated the following:

1. "Residents will only receive [redacted] medications when necessary to treat specific conditions for which they are indicated and

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F 757	Continued From page 10 effective." 2. "The Attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. An informed consent will be reviewed with the resident representative and resident (if appropriate)." 3. "The Attending Physician in conjunction with the [redacted] will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of [redacted] medications." NJAC 8:39-27.1(a)	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		10/9/19

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F 761	Continued From page 11 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: 1. properly store refrigerated controlled medications (a regulated drug) in a permanently affixed compartment; and 2. label medications with the resident name and date opened. This deficient practice was identified for 1 of 2 Medication Storage rooms and 1 of 4 Medication Carts reviewed for medication storage and was evidenced by the following: 1. On 9/3/19 at 10:42 AM, the surveyor, accompanied by the Assistant Director of Nursing (ADON), went into the [redacted] locked Medication Storage room. The surveyor observed a locked refrigerator which was then unlocked by the ADON. Inside of the refrigerator, the surveyor observed a locked narcotic box sitting on the bottom shelf, a silver colored key lock in the open position hanging off of another shelf and a black cable rolled up and attached at one end to the back wall. At that time, the surveyor picked up the narcotic box and was able to completely remove it from the refrigerator. When opened, the surveyor observed that the narcotic box contained a resident's [redacted], a controlled medication. The ADON stated, "the box should not be left like that...it should be attached to the cable."	F 761	1. The narcotic box located in the [redacted] med room refrigerator has been permanently affixed in the refrigerator. The [redacted] medication cart #2 were all labeled and dated. 2. All medication carts and both med room refrigerators have the been inspected for proper labeling and storage of medications. 3. Nurses will be in-serviced on the proper procedure for labeling/dating of [redacted] and proper placement and fixation of narcotic box in the refrigerator. 4. Nursing supervisors will audit the medication carts and the medication room refrigerator weekly X 3 months then monthly X 6 months to ensure proper dating of [redacted] and ensure narcotic box is fixated in the med room refrigerator. The audit findings will be reported at the monthly QA meeting. Based on the findings the QA committee will determine if further auditing is necessary.	

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F 761	Continued From page 12 The surveyor reviewed the facility's "Medication Storage" policy and procedure dated November 2010 and observed the following: "Policy: Medications will be stored safely and securely in accordance with all state and federal guidelines and as per manufacturer recommendations" and 4. "controlled drug substances will be kept under double lock." The policy did not address permanently affixing the narcotic boxes as is required. 2. On 9/3/19 at 10:50 AM, the surveyor, in the presence of LPN #1, reviewed Medication Cart #2 on the [redacted] nursing unit and observed the following: a. There was an opened [redacted] in a pharmacy storage bag. When interviewed at that time, LPN #1 said she had used the [redacted] that morning. The surveyor observed there was no date when the [redacted] had been opened on the pharmacy storage bag or on the [redacted] itself. b. There was an opened [redacted] in a pharmacy storage bag with no resident label on the [redacted] and no date when opened on the [redacted] itself or the pharmacy storage bag. During this observation, LPN#1 stated she had used both of the [redacted] without seeing the resident label on the [redacted] or date when opened on both [redacted]. She stated that she goes by the pharmacy bag to identify if the drug belongs to the resident and dates the bag when she opens the [redacted]. The LPN further stated, "the resident label and date opened should have been on the pens and I should not have used them." On 9/5/19 at 9:43 AM, the surveyor interviewed another nurse who was working on the [redacted] nursing unit. LPN #2 stated, "[redacted] are	F 761		

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F 761	Continued From page 13 good for seven days after they are opened." She further stated, "I date the [redacted] when I open it." (manufacturer specifications: [redacted] expires 28 days after opened). When interviewed on 9/5/19 at 10:49 AM, the DON stated, "an [redacted] is good for 28 days after it has been opened and the date it was opened should be written on the pen itself or the pharmacy storage bag." The DON further stated, "all medications when received should have a pharmacy resident label....and if it is not labeled, then I would expect the nurse to label the medication." The surveyor requested a policy which was provided by the Assistant Director of Nursing on 9/5/19. The policy did not address [redacted] medications. NJAC:8:39-29.7(c) 29.2(b)(d)	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		10/9/19

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F 812	Continued From page 14 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous food and maintain kitchen sanitation in a safe and consistent manner in order to prevent food borne illness. This deficient practice was evidenced by the following: On 9/3/19 from 8:48 to 9:56 AM, the surveyor, accompanied by the Food Service Director (FSD), observed the following in the kitchen: 1. On a middle shelf in the Dry Storage (Food) area, 2 bags of opened pasta had no dates. The FSD stated, "they're trash." 2. On a middle shelf of the multilevel drying rack, 4 stacks of cleaned and sanitized plates used to serve resident meals, were not inverted and were exposed. The FSD instructed a staff member to ensure that cleaned and sanitized plates were inverted. 3. On a shelf in the the salad area, a cleaned and sanitized meat slicer was uncovered and exposed. The FSD instructed a Dietary Aide (DA) to cover the meat slicer. 4. On an upper shelf in the Salad Refrigerator a 1/3 pan contained cranberry sauce. There were	F 812	1. The following items were addressed and corrected as follows: 2 bags of opened pasta were immediately discarded. 4 stacks of plates were cleaned, sanitized and inverted. The Slicer in the salad prep area was cleaned, sanitized and covered. The cranberry sauce apple pie without dates were discarded. The gallon of mayonnaise without open date was discarded. The shelf above the 8 burner stove with the yellow powder was cleaned and sanitized. 2 opened chocolate cakes in the produce cooler/freezer with plastic wrap and no dates were discarded. The Floor Drain below the salad prep sink with debris and tomato slice was cleaned, sanitized and replaced. The two open boxes of plastic wrap with the lids torn off were discarded and replaced with new ones. The staff member with her hair hanging down was immediately counseled and instructed to cover her hair. The female staff member was immediately counseled and instructed to wash her hands and put on a new pair of gloves. The double plate warmer in the corner of the room with dry food spills/debris on top of the warmer around the plates was cleaned and sanitized. All dishes were cleaned and sanitized and put back in the warmer. The	

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F 812	Continued From page 15 no dates. The FSD removed it to the trash. On a lower shelf, an apple pie was covered with plastic wrap. The pie had no dates. The FSD stated, "that's trash." On an upper shelf, a gallon container of mayonnaise had a received date of 7/22/19. The mayonnaise had no open or use by date. The FSD threw it in the trash. 5. In the Cooks area, a shelf located above the 8 burner stove was covered with an unidentified yellow powder. The FSD stated, "I'll ask the cook what she is cooking. That looks like chicken base powder." When interviewed, the cook stated that she had not used any chicken base powder to cook with and it was from a previous cook. The FSD instructed the cook to get it cleaned up. 6. In the Produce Cooler/Freezer, on a multi-tiered cart, 2 opened chocolate cakes covered with plastic wrap had no dates. The FSD threw them in the trash. 7. In the Salad Bar/ Prep Sink area, the surveyor observed the drain below the sink. The drain basket contained unidentified debris and tomato slices. The FSD had a DA remove the drain basket and empty the basket. The FSD stated, "that drain should be cleaned on a daily basis." The DA returned the drain basket cleaned. 8. On a shelf in the cooks prep area, 2 opened boxes of plastic wrap had no lids and the plastic wrap was exposed. The FSD stated, I'll throw them away and get two new boxes out." 9. On 9/3/19 at 12:39 PM, the surveyor observed a dining room staff member enter the kitchen through a door where food was being served from the steam table. The staff member had hair that	F 812	dried food splashes behind the utensil-hanging-rack were removed and the wall was cleaned and sanitized. The dried food splashes around the slider windows were removed, cleaned and sanitized. All walls in the kitchenette where there were food splashes were cleaned and sanitized.The first white cabinet under the window was cleaned and sanitized. All items inside the 6 cabinet shelves were discarded and shelves were cleaned and sanitized. The cups and lids that were uncovered and unwrapped were discarded. The large refrigerator chest was emptied, cleaned and sanitized including the shelving brackets inside the fridge. All items were discarded and restocked. All items on the lower shelf were removed. Both shelves were cleaned and sanitized. The second white cabinet below the second window filled with supplies and debris was emptied. All items were discarded, cleaned and sanitized, and restocked.The ledge behind the coffee and juice machine was cleaned and sanitized. The coffee/juice station stand, including the shelves were cleaned and sanitized. All items except the juice boxes were removed. The floor that was sticky throughout was deep cleaned All items in the reach-in refrigerator/freezer were discarded. The reach-in refrigerator/freezer was cleaned, sanitized and restocked onto the shelves. The well covers for the 5 well steam table were cleaned and sanitized. All items behind the steam table on the ledge above were removed. The ledge was cleaned and	

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F 812	Continued From page 16 extended to the lower back. The staff member was not wearing a hairnet and her hair was exposed. 10. On 9/3/19 at 12:43 PM, the surveyor observed a female staff member in the dining room remove a pair of disposable gloves from a box on the counter adjacent to the doorway. The staff member carried the gloves around the dining room in her hands for several minutes, then proceeded to don the single use gloves without performing handwashing. On 9/3/19 at 9:17 AM, the surveyor observed a Satellite Kitchen in the [redacted] unit dining room. The surveyor entered and observed the following: 1. There was a double-well plate warmer with white plates in the corner of the room to the right of the doorway. There was dried food spills/debris on the top of warmer around the exposed plates. 2. There was a two tone wall behind the plate warmer, the lower half of the wall, directly behind the plate warmer, was orange and the upper half, above the plate warmer, was white. There was a rack attached to the wall on the white section. The rack held large food scoops and tongs. There were dried food splashes on the wall behind the rack. 3. There was a slider window on the wall between the Satellite Kitchen and the dining room. There were dried food splashes on the wall around the window, the window frame and the panes of the window. There were dried food splashes all along this wall that lead to another window and to the corner of the room. 4. There were dried food splashes on every wall in the room. 5. There was a white cabinet under each of the 2	F 812	sanitized. The ceiling vent was removed and cleaned. The dried food debris/splashes on the inside of the room door was removed, cleaned and sanitized. The build-up of dirt/debris at the floor/wall junctures and in the corners of the room were cleaned. The cabinets and drawers beneath the countertop outside of the kitchenette were emptied and cleaned. All non snack/nourishment items were removed from the drawers. 2. All residents of Healthcare Facility could be affected by these deficient practices. 3. The Dietary staff were in-serviced on Food Safety and Handling procedures for Labeling and Dating. The Dietary staff were in-serviced on storing of clean and sanitary dishes. The cooks and Food Prep staff were in-serviced on Cleaning, Sanitizing and Storage of the Slicer. The Dietary staff were in-serviced on cleaning of the 8 Burner Stove top shelf. The Dietary staff were in-serviced on the cleaning of the floor drains under the sink. The Dietary staff were in-serviced on the proper wearing of Hairnets. The Dietary staff were in-serviced on the use of Disposable Gloves and proper Hand Washing procedures. The [redacted] Dietary staff were in-serviced on maintaining the cleanliness and sanitation in the Nelson Five (5) Kitchenette. 4.The Food Service Director and Dietary Manager will conduct weekly Food Safety and Sanitation rounds in the Main Kitchen	

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F 812	Continued From page 17 windows. The first one upon entering the room, had dried food spills on the front. There were 6 shelves inside of the cabinet, all 6 had loose debris. The shelves include boxes of disposable gloves, towels, a box of tea bags, a container with uncovered plastic ware, a 5lb container of peanut butter, an ice cream scoop, several stacked plastic cups and a container of plastic lids. The cups and lids were not in any type of wrapping or covering. 6. There was a large chest style refrigeration unit along the wall between the 2 window units. The refrigeration unit contained trays of individually prepared juices, a tray of individual yogurt cups, and boxes of individual creamers. The inside base of the unit had loose debris. The brackets holding the trays contained a substance that wiped off on the surveyor's finger. There were 2 shelves above the unit. The top shelf was empty. The lower shelf contained a box of gloves, a box of 100 "Probe Wipe"packets, a plastic blue bowl that had a key and 3 thumb tacks, a yellow marker, a black 3 ring binder titled '[redacted] Temp Sheets & Cleaning Sheets Do Them Every Day?!" and a short stack of food trays. The shelf was visually soiled with dust and loose debris. 7. The other white cabinet below the second window contained 6 shelves. The bases of the 6 shelves contained loose debris. The shelves contained 7 unopened packages of napkins, multiple 8 oz cans of soda, a box of individual packets of "Thick & Easy " food and beverage thickening powder. 8. There was a ledge part of the wall behind the coffee machine and juice dispensing machine that was heavily soiled with unknown substances that wiped off on the surveyor's finger. 9. The surface of the coffee and juice machines stand had dried food/liquid spills. The 2 shelves	F 812	x1 month then monthly x3 months and report findings to the monthly QAPI committee. The Food Service Director and Dietary Manager will conduct weekly audits x1 month then monthly x3 months on proper wearing of Hairnets, usage of Disposable Gloves and proper Hand Washing procedures and report findings to the monthly QAPI committee. The Food Service Director and Dietary Manager will conduct weekly Food Safety and Sanitation audits in the Nelson Five (5) Kitchenette x1 month then monthly x3 months and report findings to the monthly QAPI committee. The Food Service Director and Dietary Manager will conduct weekly Food Safety and Sanitation audits in the [redacted] Pantry x1 month then monthly x3 months and report findings to the monthly QAPI committee. Based on the findings of all the above shared at the monthly QAPI Committee, the QA committee will make recommendations if further audits are necessary.	

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F 812	Continued From page 18	F 812		

below were visibly soiled with loose debris and were sticky to the touch. The top shelf contained large boxes of juices for the juice dispenser. The bottom shelf had 3 cases of 8 oz soda cans, a roll of plastic bags in a blue container and 2 sleeves of plastic cups.
10. The floor was sticky throughout the room.
11. There was a reach-in refrigerator/freezer with the top half being the refrigerator and the lower half being the freezer. In the refrigerator section there was a bin of individual mayonnaise packets, a gray bin of individual butter cups, and 6 cups of yogurt sitting directly on the bottom/base of the unit which was sticky to the touch and had loose debris.
In the freezer section there was a tray of individual ice cream cups and another box of unknown contents that the surveyor could not reach in the back. The items were sitting on the bottom/base of the freezer which had loose debris.
12. There was a steam table with 5 wells that contained water. The steam table did not have food in any of the wells but was on and the water in the wells was beginning to warm up. The well covers had dried food substances on them.
13. There was a ledge part of the wall behind and just above the steam table, same as behind the coffee machine. Sitting on the ledge was a plastic pitcher, a plastic lid for the pitcher, and a box of disposable gloves. The ledge had loose debris, dust and a greasy substance that came on the surveyor's hand.
14. There was a heavy accumulation of dust/dirt in the ceiling vent above the steam table.
15. The inside of the room door had dried food stains/splashes.
16. There was a build-up of dirt/debris at the floor/wall junctures and in the corners of the

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F 812	Continued From page 19	F 812		

room.

In the dining room just outside of the door to the Satellite Kitchen there was a wall of drawers/cabinets beneath a counter top. There were 5 drawers that did not open. The other three drawers contained loose packets of sugar, loose tea bags, and packets of saltine crackers and graham crackers, both with two crackers per packet. The bases of the drawers below all of those items contained loose debris. The fronts of the drawers had dried food/juice spills and were sticky to the touch. The lower cabinets were being used for storage and did not contain any food items. The inside bases of each cabinet were dirty in appearance and contained loose debris. The fronts of the cabinets had dried food/juice stains and were sticky to the touch.

On 9/3/19 at 10:09 AM, the surveyor observed a housekeeping employee in the [redacted] dining room. When interviewed at that time, the housekeeping employee said housekeeping was responsible for cleaning the dining room and dietary staff was responsible for the cleaning the Satellite Kitchen. When asked about cleaning the front of the cabinets and drawers, the housekeeping employee said, "they're supposed to be cleaned three times a week" and said she was getting ready to mop the floor.

On 9/5/19 from 1:16 to 1:30 PM, the surveyor observed the [redacted] nourishment/snack room. The surveyor opened an upper drawer below the microwave counter. The drawer contained a nebulizer kit, a bottle of shampoo/bodywash and red and yellow plastic biohazard bags, as well as individual portion control packets of salt and pepper. When interviewed at that time, a

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F 812	Continued From page 20	F 812		

Registered Nurse stated, "this room is only used for snacks and nourishments, that stuff should not be in there. I'm gonna get somebody else in here because I'm in the middle of something." At 1:30 PM, the surveyor interviewed the Assistant Director of Nursing (ADON). The ADON stated, "this room is only used for resident nourishments. It didn't used to be but it is now. We changed it a couple of months ago but housekeeping keeps putting this stuff in here. It does not belong in here, it's like the 800th time I've done this." The ADON removed the biohazard bags, nebulizer kit and bodywash/shampoo from the drawer and threw the items in the trash.

The surveyor reviewed the undated Satellite Kitchen Policy. The procedures included "1. The Satellite Kitchen area shall be kept clean." "2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair." "8. Kitchen surfaces not in contact with food shall be cleaned to prevent accumulation of grime."

The surveyor reviewed the undated "Glove Use Policy". The policy included under the Procedure section: "Food Service Worker must wash hands and dry hands thoroughly between changing gloves."

The surveyor reviewed the facility policy titled "General Kitchen Cleaning", Policy #S06, revised 8/01/18. The policy included the following under the Procedure section: "1. Cleaning and sanitation tasks for the kitchen will be recorded." "2. Tasks will be assigned to be the responsibility of specific positions." The policy also noted "3. Frequency of cleaning for each task will be defined."

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F 812	Continued From page 21 The surveyor reviewed the undated facility policy titled "Dating and Labeling Policy." The policy included the following under the Procedure section: "2. Label all products in storage with date the package was opened or expiration date with no more than 72 hours after opening, whichever is appropriate." The surveyor reviewed the undated facility policy titled "Uniform Policy." The policy included the following under the Procedure section: "5. Hair nets are worn and completely cover hair from front to back." NJAC 8:39-17.2(g)	F 812		