STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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F 000	INITIAL COMMENTS STANDARD SURVEY: 10/08/19 CENSUS: 225 SAMPLE SIZE: 35 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		11/11/19

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

Electronically Signed | 10/31/2019

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F 656	Continued From page 1 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) 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 the develop a comprehensive person-centered care plan (CP) for a resident who received [redacted] medications. This deficient practice was identified for Resident #21, 1 of 39 residents reviewed for CP development and was evidenced by the following: On 09/30/19 at 11:20 AM, the surveyor observed Resident #21 resting in bed with the head of bed elevated. The resident was pleasant and cooperative and did not express signs/symptoms of distress or discomfort. According the Admission Record, Resident #21 was admitted to the facility on [redacted] with diagnoses that included [redacted]	F 656	1. The Care Plan for Resident #21 was reviewed and updated to reflect the resident's diagnosis of [redacted] disorder, medications administered and interventions being used. 2. All resident's who have a diagnosis of [redacted] disorder have the potential to be affected. An audit of care plans for residents who have a diagnosis of [redacted] disorder was completed. The audit confirmed that each resident who had a diagnosis of [redacted] disorder had a care plan that addressed the diagnosis, medications administered and interventions being used. 3. A review of the center's policy and procedure for care planning was completed. No changes to the policy was made. The center nursing staff were in-serviced on care planning processes, including ensuring residents who have a	

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F 656	Continued From page 2 Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected the resident was [redacted] impaired. The MDS further reflected that Resident #21 received an [redacted] medication on a routine basis during the assessment period. The surveyor reviewed the [redacted] Care Area Assessment summary (CAA) (a section of the MDS that identify potential resident problems, strengths, and preferences). The CAA revealed that Resident #21 had a potential for complications related to [redacted] medication use. Under the "Care Plan Considerations" section of the CAA summary, the facility documented that [redacted] drug use would be addressed in the resident's CP. The surveyor reviewed the Quarterly MDS, dated [redacted], which reflected that Resident #21 received an antipsychotic medication on a routine basis. The MDS also indicated the resident received an [redacted] and an [redacted] medication for three days during the assessment period. Review of the resident's September and October 2019 Physician Order Sheet (POS) revealed a physician's order, dated [redacted], for [redacted] medication) [redacted] (mg) at bedtime for support [redacted] The September and October 2019 POS revealed a second physician order, dated [redacted], for [redacted] medication) [redacted] mg daily for severe [redacted] The September and October 2019 Medication	F 656	diagnosis of [redacted] disorder are care planned appropriately and interventions are in place. The center unit managers are responsible for the care planning process. They will ensure care plans are properly developed, written and implemented according to the center's policy and procedure. 4. The Director of Nursing or designee will audit care plans for residents who have a diagnosis of [redacted] disorder monthly for the next three months. The audit will ensure each resident with a diagnosis of [redacted] disorder has a proper care plan addressing medications and interventions. The results of the audit will be reported to the center's monthly QAPI committee for review for the next three months. The QAPI committee will review the results and make recommendations to the processes if a need is determined.	

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F 656	Continued From page 3	F 656		

Administration Records (MARs) revealed the corresponding physician's order for [redacted] at bedtime with a scheduled administration time of 9:00 PM and [redacted] mg daily with a scheduled administration time of 9:00 AM. The MARs reflected that the medications were documented as administered daily.

On 10/01/19 at 10:21 AM, the surveyor reviewed Resident #21's CP. The CP did not contain documentation of a focus area or interventions for the use of the [redacted] medications.

On 10/03/19 at 10:06 AM, the surveyor interviewed the Registered Nurse/Acting Unit Manager (RN/AUM) responsible for providing care for Resident #21. The RN/AUM stated that the managers were responsible for updating the nursing section of the CP, which included medications such as [redacted] s and [redacted]. The RN/AUM further stated she also care plan the triggered areas of the resident's CAA. The RN/AUM reviewed Resident #21's CP in the presence of the surveyor and confirmed that the CP did not include documentation of a focus area or interventions for the resident's use of [redacted] medications. The RN/AUM stated the resident was currently on [redacted] and [redacted] for [redacted] and that Resident #21 should have been care planned for the use of [redacted] medications.

On 10/08/19 at 12:57 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated the care planning process identified problems, implemented interventions, and reassessed whether the interventions were

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F 656	Continued From page 4 appropriate for the resident. The DON further stated areas triggered on the CAA were care planned and there would documentation in the medical record if the team decided to care plan a triggered area of the CAA. The DON was unable to provide documentation as to why the resident was not care planned for the use of [redacted] medications. The DON further stated Resident #21 should have been care planned for the use of [redacted] medications. Review of the facility's "Care Plans: Comprehensive" policy, revised 05/2019, reflected that individualized comprehensive care plans are developed to meet resident's medical, nursing, mental and psychological needs. The policy revealed the CP was based on a thorough assessment that included, but not limited to, the MDS. The policy further revealed that each resident's CP was designed to "incorporate risk factors associated with identified problems." and would be "revised as information about the resident and the resident's condition changes." NJAC 8:39-11.2(e)(i)	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to	F 658	1. The opened [redacted] injectable vial stored on the top shelf of	11/11/19

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F 658	Continued From page 5 ensure that expired [redacted] was not administered to a resident, in accordance with nursing standards of practice. This deficient practice was identified for Resident #195, 1 of 35 residents reviewed for medication and was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter. 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 or 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 a 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 with in 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 10/03/19 at 12:48 PM, in the presence of the Licensed Practical Nurse (LPN) #3, the surveyor inspected medication cart [redacted] located on the [redacted] unit. During the inspection, the surveyor observed an opened [redacted]	F 658	the medication cart was discarded. The pharmacy delivered a new [redacted] injectable vial to be administered to resident #135. 2. All residents who have physician orders for [redacted] injectable vial have the potential to be affected. All center medication administration carts were audited to ensure no other medications were expired. No other expired medications were identified. 3. A review of the center policy and procedure for [redacted] Administration was conducted. No changes to the policy and procedure were made. The center nursing staff was in-serviced on the administration of [redacted] including to check the expiration date and recording the date on the container when opening a multi-dose container. 4. The Director of Nursing or designee will audit all medication carts weekly x4 then monthly x 4 to ensure all expired medications are properly removed and discarded on a timely basis per policy. The results of the audits will be reported to the Center's Monthly QAPI Committee for the next 3 months. The QAPI Committee will review the results and follow up as determined.	

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injectable vial (a medication used [redacted]) stored on the top shelf of the medication cart. The surveyor observed that the opened vial of [redacted] was stored in a clear plastic bag with a pink label that had a handwritten opened date of [redacted]. The surveyor further observed that the [redacted] vial did not have an opened date or an expiration date on the vial. The [redacted] clear plastic bag also had a refill label still intact on the front of the plastic bag.

When interviewed at that time, LPN #3 stated the [redacted] vial of [redacted] was currently being used for Resident #195. The LPN #3 stated that the [redacted] vial should have been labeled with an opened date and an expiration date.

On 10/03/19 at 2:13 PM, the surveyor conducted an interview with the Registered Nurse/Unit Manager (RN/UM) #2 who confirmed the [redacted] was expired. The RN/UM #2 stated that the [redacted], when opened, is good for [redacted] days and should have been discarded by [redacted]. RN/UM #2 further stated that expired medications are to be returned to pharmacy.

At that time, the surveyor, in the presence of RN/UM #2, inspected the [redacted] locked medication room refrigerator and observed that Resident #195 did not have an additional [redacted] vial and there was no [redacted] in the back-up stock.

Review of the Admission Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed that Resident #195 was admitted to the facility on [redacted] with diagnoses that included but not limited to [redacted]

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F 658	Continued From page 7 [redacted]. The MDS revealed Resident #195 was cognitively intact and had received [redacted] seven out of seven days during the assessment period. The surveyor reviewed the Order Summary Report (OSR), with an order date of [redacted]9, for [redacted] inject [redacted] two times a day for [redacted]s. Review of the September and October 2019 Electronic Medication Administration Record (EMAR) reflected the corresponding [redacted] physician order for [redacted] inject [redacted] two times a day for [redacted] scheduled for 7:30 AM and 4:30 PM. The September 2019 EMAR reflected the nurses documented the [redacted] administrations as follows: 09/08/19 at 7:30 AM: [redacted] was administered for a [redacted] 09/08/19 at 4:30 PM: [redacted] was administered for a [redacted] 09/09/19 at 7:30 AM: [redacted] was administered for a [redacted] 09/09/19 at 4:30 PM: [redacted] was administered for a [redacted] 09/10/19 at 7:30 AM: [redacted] was administered for a [redacted] 09/10/19 at 4:30 PM: [redacted] was administered for a [redacted] 09/11/19 at 7:30 AM: [redacted] was administered for a [redacted] 09/11/19 at 4:30 PM: [redacted] was administered for a [redacted] 09/12/19 at 7:30 AM: [redacted] was administered for a [redacted]	F 658		

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09/12/19 at 4:30 PM: [redacted] was administered for a [redacted]
09/13/19 at 7:30 AM: [redacted] was administered for a [redacted];
09/13/19 at 4:30 PM: [redacted] was administered for a [redacted]
09/14/19 at 7:30 AM: [redacted] was administered for a [redacted]
09/14/19 at 4:30 PM: [redacted] was administered for a [redacted]
09/15/19 at 7:30 AM: [redacted] was administered for a [redacted];
09/15/19 at 4:30 PM: [redacted] was administered for a [redacted];
09/16/19 at 7:30 AM: [redacted] was administered for a [redacted]
09/16/19 at 4:30 PM: [redacted] was administered for a [redacted]
09/17/19 at 7:30 AM: [redacted] was administered for a [redacted];
09/17/19 at 4:30 PM: [redacted] was administered for a [redacted]
09/18/19 at 7:30 AM: [redacted] was administered for a [redacted];
09/18/19 at 4:30 PM: [redacted] was administered for a [redacted]
09/19/19 at 4:30 PM: [redacted] was administered for a [redacted];
09/20/19 at 4:30 PM: [redacted] was administered for a [redacted]
09/21/19 at 7:30 AM: [redacted] was administered for a [redacted]
09/21/19 at 4:30 PM: [redacted] was administered for a [redacted];
09/22/19 at 7:30 AM: [redacted] administered for a [redacted]
09/22/19 at 4:30 PM: [redacted] was administered for a [redacted]
09/23/19 at 7:30 AM: [redacted] was administered for

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a [redacted];
09/23/19 at 4:30 PM: [redacted] was administered for a [redacted];
09/24/19 at 7:30 AM: [redacted] was administered for a [redacted]
09/24/19 at 4:30 PM: [redacted] was administered for a [redacted]
09/25/19 at 7:30 AM: [redacted] was administered for a [redacted]
09/25/19 at 4:30 PM: [redacted] was administered for a [redacted];
09/26/19 at 4:30 PM: [redacted] was administered for a [redacted];
09/27/19 at 4:30 PM: [redacted] was administered for a [redacted]
09/28/19 at 4:30 PM: [redacted] was administered for a [redacted]
09/29/19 at 7:30 AM: [redacted] was administered for a [redacted]
09/29/19 at 4:30 PM: [redacted] was administered for a [redacted]
09/30/19 at 7:30 AM: [redacted] was administered for a B[redacted]
09/30/19 at 4:30 PM: [redacted] was administered for a [redacted]

Review of the October 2019 EMAR reflected the nurses documented the administration of the [redacted] as follows:

10/01/19 at 7:30 AM: [redacted] was administered for a [redacted]
10/01/19 at 4:40 PM: [redacted] was administered for a [redacted]
10/02/19 at 7:30 AM: [redacted] was administered for a [redacted]
10/02/19 at 4:30 PM: [redacted] was administered for a [redacted].

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F 658	Continued From page 10 On 10/04/19 at 9:44 AM, the surveyor interviewed the Pharmacy Consultant (PC) who confirmed that [redacted] vials expire [redacted] days after opened. The CP stated that if [redacted] was administered after the expiration date, the [redacted] loses its potency. The surveyor reviewed the "Medications with Shortened Expiration Dates" document, dated 07/14, provided by the CP. The document revealed a list of medications that require nurses to date upon opening, as they have shortened expiration dates once opened. This form included injectable diabetic medications and listed that [redacted] vials expire [redacted] days after opening/removed from refrigerator as a standard of practice. On 10/08/19 at 11:42 AM, the Director of Nursing (DON) was interviewed in the presence of the survey team. The DON confirmed that the [redacted] vial, dated [redacted], expired [redacted] after opening. The DON also stated that if the nurse was using a new [redacted] vial, the nurse was to date the vial with "an opened date." The DON also confirmed that the nurse should check the expiration date prior to administering the medication. Review of the [redacted] Administration" procedure, revised 09/14, indicated to check the expiration date and, if opening a new vial, the nurse was to record the expiration date and time on the vial (follow manufacturers recommendations for expiration after opening). The facility's policy titled "Medication Administration," revised 02/19, reflected that when opening a multi-dose container, the date	F 658		

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F 658	Continued From page 11 shall be recorded on the container. The policy also reflected that the expiration date on the medication label must be checked prior to administering. Review of the facility's "Medication-Storage" policy, revised 01/19, revealed that expired, discontinued and/or contaminated medications will be removed from medication storage areas and disposed of in accordance with facility policy. NJAC 8:39-11.2(b), 27.1(a)	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow a physician's order for a floor mat while a resident was in bed. This deficient practice was identified for Resident #196, 1 of 7 residents reviewed for accidents, and was evidenced by the following: During a tour of the facility on 09/26/19 at 9:58 AM, the surveyor observed Resident #196 lying diagonally in bed. The back of the resident's knees were positioned on the edge of the bed	F 689	1. Floor mats were located and placed on the floor adjacent to the bed of resident #196. 2. All residents who have physician orders for floor mats to be placed on the floor adjacent to the patient's bed have the potential to be affected. An audit of all center residents who have physician orders to place floor mats on the floor adjacent to a resident's bed for safety was conducted. The audit verified that all other residents who had physician orders for floor mats to be used for resident	11/11/19

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F 689	Continued From page 12 and both legs were floating off of the bed. The surveyor observed the head of the bed was elevated to a sitting position and the resident was struggling to reposition him/herself in bed. The resident reached out to the surveyor and was unable to verbally communicate. The surveyor observed the resident was not wearing socks and that there was no floor mat on either side of the bed. At that time, an activity staff entered the room and observed the resident's position in bed. The activity staff then exited the room to inform the nurse who was at the medication cart. According to the Admission Record, Resident #196 was admitted to the facility on [redacted] and had medical diagnoses that included [redacted] Review of a Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected the resident had [redacted], was [redacted] impaired, and required extensive assist of two persons for bed mobility and transfers. The resident was also identified as having an impairment to [redacted]. The surveyor reviewed Resident #196's "Quarterly Evaluation," with the effective date of [redacted], which identified the resident as moderately at risk for falls. Review of Resident #196's Care Plan (CP), initiated on [redacted], revealed a "Focus" of "resident is at risk for falls r/t [related to]	F 689	safety had the floor mats in place. 3. The nursing staff was in-serviced on the usage of floor mats as a safety intervention for residents who are identified at risk for falls. The Center C.N.A.s are responsible to ensure that floor mats are used and in placed for residents who are identified at risk for falls and care planned for usage of floor mats as a safety intervention. The Center Unit Managers and Nursing Supervisors will make daily rounds to ensure compliance. 4. The Director of Nursing or Designee will audit all residents who have physician orders for usage of safety floor mats when in bed to ensure compliance weekly x4 then monthly x 4. The results of these audits will be reported to the center Monthly QAPI Committee meetings for the next three months. The center QAPI Committee will review the results and follow up as determined.	

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F 689	Continued From page 13	F 689		

gait/balance problems." The CP reflected an intervention, initiated on [redacted], for "floor mats x2."

The surveyor reviewed Resident #196's September and October 2019 "Order Summary Reports" (OSR) which included a physician's order, initiated on [redacted], for "floor mats next to bed WIB [while in bed] Q [every] shift for safety."

Review of Resident #196's September and October 2019 Treatment Administration Records (TARs) reflected the [redacted] physician order for floor mats next to bed while in bed every shift was not documented on the September and October 2019 TARs.

On 10/01/19 at 8:56 AM, 10/02/19 at 9:29 AM, and 10/03/19 at 9:55 AM, the surveyor observed Resident #196 lying in bed with the head of bed elevated. The surveyor did not observe floor mats on either side of the resident's bed while the resident was in bed.

On 10/03/19 at 10:27 AM, the surveyor interviewed the Certified Nurse Assistant (CNA) #1, responsible for caring for Resident #196. CNA #1 stated that the resident required total assistance with care. CNA #1 further stated that she could not recall if the resident had any falls but sometimes the resident would throw his/her legs over the side of the bed. She further stated the resident had a floor mat but did not know what happened to it.

On 10/03/19 at 10:32 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) responsible for caring for Resident #196. LPN #1 stated the resident required extensive

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F 689	Continued From page 14	F 689		

assist with care and was not able to get out of bed by himself/herself. LPN #1 further stated Resident #196 had no falls but sometimes would throw his/her legs over the side of the bed and the resident did not have floor mats to either side of bed when in bed.

On 10/04/19 at 9:12 AM, the surveyor observed Resident #196 lying in bed with the head of bed elevated. The surveyor did not observe floor mats on either side of the resident's bed.

On 10/04/19 at 9:58 AM, the surveyor interviewed the covering LPN/Unit Manager (LPN/UM) #1 for Resident #196's unit, in the presence of the Assistant Director of Nursing/Infection Preventionist (ADON/IP). LPN/UM #1 reviewed Resident #196's physician's orders and stated that a floor mat should be next to the resident's bed when the resident was in bed. She further stated the floor mats were stored folded up along the side of the bed or the dresser in the resident's room when not in use. LPN/UM #1 stated the resident was at risk for falls and that the CNAs documented placement of the floor mats on the CNA report. LPN/UM #1 reviewed Resident #196's [redacted] TAR and confirmed that the [redacted] physician order had not been transcribed onto the [redacted] and [redacted] TARs. LPN/UM #1 further stated the [redacted] physician order should have been documented on either the MAR or TAR.

On 10/04/19 at 10:13 AM, the surveyor and ADON/IP walked to Resident #196's room. The surveyor observed the ADON/IP look around the resident's room and at that time, the ADON/IP stated she did not see any floor mats located in Resident #196's room.

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F 689	Continued From page 15 On 10/20/19 at 10:20 AM, the surveyor reviewed Resident #196's "POC Response History" form (CNA report), dated [redacted], provided by the ADON/IP. The CNA report reflected documentation of "yes" for floor mats x2 on [redacted] 1:36 AM, 1:52 PM, and 3:21 PM; [redacted] 1:29 AM, 2:15 PM, and 8:48 PM; [redacted] at 2:09 AM, 1:53 PM, and 6:13 PM; [redacted] at 1:11 AM and 7:00 PM; 10/04/19 at 12:01 AM and 7:17 AM. On 10/08/19 at 11:43 AM, the surveyor interviewed the Director of Nursing (DON). The DON confirmed Resident #196 was care planned for floor mats. The DON stated the resident's room was recently cleaned and the floor mats were removed but not returned to the resident's room. The DON was unable to show the surveyor when the resident's floor mats were removed and stated the missing floor mats should have been reported to the Unit Manager. NJAC 8:39-27.1(a)	F 689		
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	F 761		11/11/19

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F 761	Continued From page 16 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 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 ensure that expired medications were removed from active inventory and that medications were appropriately dated when opened. This deficient practice was identified for 1 of 5 medication carts inspected and was evidenced by the following: On 10/03/19 at 12:48 PM, in the presence of the Licensed Practical Nurse (LPN) #3, the surveyor inspected the medication cart located on [redacted] The surveyor observed one opened [redacted] injectable [redacted] medication used to [redacted]) stored in the top drawer of the medication cart. The [redacted] was stored in a clear plastic bag labeled with a pink sticker that had a handwritten opened date of [redacted] and the [redacted] vial was undated. When interviewed, LPN #3 confirmed the medication had expired.	F 761	1. The opened [redacted] injectable vial stored on the top shelf of the medication cart was discarded. The pharmacy delivered a new [redacted] injectable vial. 2. All residents who have physician orders for [redacted] injectable vial have the potential to be affected. All center medication administration carts were audited to ensure no other medications were expired. No other expired medications were identified. 3. A review of the center policy and procedure for Insulin Administration was conducted. No changes to the policy and procedure were made. The center nursing staff were in-serviced on the administration of [redacted]. The in-service included checking the expiration date and recording the date on the container when first opening.	

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F 761	Continued From page 17 The surveyor also observed an opened and undated [redacted] medication used to treat [redacted]) stored in the top drawer of the medication cart. When interviewed, LPN #3 confirmed the vial of [redacted] was opened and undated. On 10/03/19 at 2:13 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) #3 who confirmed the [redacted] vial was expired and that the [redacted] vial was undated. RN/UM #3 further stated that [redacted] was to be labeled with an open date on both the clear plastic bag and on the vial. She further stated that [redacted] had an expiration date of [redacted] days after the opened date. On 10/04/19 at 9:44 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that [redacted] should be dated when opened and that [redacted] starts to lose its potency after [redacted] days. The surveyor reviewed the "Medications with Shortened Expiration Dates" document, dated 07/14, provided by the CP. The document revealed a list of medications that require nurses to date upon opening as they have shortened expiration dates once opened. This form included injectable [redacted] medications and revealed that insulin vials expire [redacted] days after opening/removed from refrigerator as a standard of practice. On 10/08/19 at 11:42 AM, the Director of Nursing (DON) was interviewed in the presence of the survey team. The DON stated that expired medications are not to be stored in the medication cart and are to be sent back to the pharmacy. The DON stated that the [redacted] when	F 761	4. The Director of Nursing or Designee will audit all medication administration carts weekly x4 then monthly x 4 to ensure all expired medications are properly removed and discarded on a timely basis per policy. The results of the audits will be reported to the Center's Monthly QAPI Committee for the next 3 months. The QAPI Committee will review the results and follow up as determined.	

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F 761	Continued From page 18 opened should have a "when opened date" on the vial and confirmed that the [redacted] had an opened date of [redacted] and expired [redacted] days after it was opened on [redacted] The surveyor reviewed the facility's "Medication-Storage" policy, revised 01/19. The policy revealed that expired, discontinued and/or contaminated medications would be removed from medication storage areas and disposed of in accordance with facility policy. Review of the "[redacted] Administration" policy, revised 09/14, indicated that when opening a new vial, the nurse was to record the expiration date and time on the vial (follow manufacturers recommendations for expiration after opening). Review of the facility's "Medication Administration" policy, revised 02/19, reflected that when opening a multi-dose container, the date shall be recorded on the container. NJAC 8:39-29.4(g)	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 804		11/11/19

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F 804	Continued From page 19 Based on observation, interview, and record review, it was determined that the facility failed to provide meals that had an appetizing temperature. This deficient practice was identified for 2 of 4 residents (Resident #3 and #91) reviewed for in-room meal service and was evidenced by the following: On 09/30/19 at 9:00 AM, the surveyor interviewed Resident #3 in the resident's room and during the breakfast meal. The resident was alert and oriented and stated he/she disliked the food and it was not hot. On 10/03/19 at 12:52 PM, the surveyor interviewed Resident #91 in the resident's room and during the lunch meal. The resident was alert and oriented and stated the food was not always hot. On 10/03/19 at 11:51 AM, during the lunch meal tray preparation, the surveyor selected a test meal which included the main entree, chili and puree beef, puree carrots and mashed potatoes. The test meal left the kitchen at 11:53 AM accompanied by the surveyor and FSD and arrived on unit 1A at 11:54 AM. The last meal tray was observed as distributed at 11:58 AM. At that time, the surveyor utilized a calibrated thermometer and checked the food temperatures and concurrently the Food Service Director (FSD) checked the food temperatures. The FSD stated the hot items should be 135 degrees Fahrenheit (F) when the food reached the resident. The food temperatures were as follows:	F 804	1. At approximately 12:15pm on 10-3-2019 the Food Service Director used a calibrated thermometer to check the food temperatures of each food item being service from the kitchen steam table. The temperatures were recorded within range 160-180°F. These temperatures were recorded in the Food temperature log for that meal. A subsequent meal temperature test tray was completed at the point of service. The temperature of each hot food item at the point of service was at least 136’ F. 2. Each hot meal delivered to a resident has the potential to be served at a temperature below 135’ F. The Food Service Director or designee will conduct a daily audit x 3days to ensure all hot foods served from the kitchen steam table is at or above 140°F and the temperature is recorded prior to meal service. 1 daily test tray audits will be conducted x 1week by the food service director or designee to ensure hot foods are served at 135’ or greater and cold foods at or below 41°F. 3. Policy of recording food temperatures was reviewed; no changes were made. The Food Service Director has in-serviced the Dietary staff on ensuring Food temperatures are taken/recorded prior to meal service to ensure all hot food has achieved and maintain a temperature above 140°F. 4. The food service director or designee will conduct weekly tray line temperature audits x4weeks then monthly	

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F 804	Continued From page 20 Chili: surveyor: 131.6 degrees F; FSD: 123 degrees F; Puree Beef: surveyor: 132.6 degrees F; FSD: 133.9 degrees F; Puree Carrots: surveyor: 125.6 degrees F; FSD 120.9 degrees F; Mashed Potatoes: surveyor: 135.5 degrees F; FSD 127.7 degrees F; At this time, the surveyor interviewed the facility Registered Dietitian (RD) regarding the food temperatures. The RD stated the hot food should be 140 degrees F when delivered to the resident. The surveyor asked the RD about the acceptability of the temperatures of the test tray and the RD stated those temperatures were "not okay." At 12:10 PM, the surveyor, accompanied by the FSD, returned to the kitchen and observed the meal preparation line in progress. The surveyor requested the food temperature log for the meal. The FSD provided the surveyor with a Food Temperature Log Dated 10-3. The lunch meal temperatures were blank. The surveyor interviewed the cook during the observation. The cook stated he did not take the temperatures of the food prior to serving the meal to the residents. He stated he would usually take the temperatures of the food after the meal service was completed and that he had not yet completed the meal service. The FSD stated the food temperatures for the meal should have been taken and recorded by the cook prior to meal service. NJAC 8:39-17.4 (a)2	F 804	x3mths to ensure all hot foods in steam table are recorded and maintained above 140°F. The Food Service Director and/or Dietitian will conduct weekly food temperature test tray audits to ensure food temperatures are maintained and served. The Food Service Director will present and review the steam table temperature logs audits and point of service test tray audits at the monthly center QAPI committee meeting for the next 3 months. The QAPI Committee will review the results and revise the processes if a need is identified.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		11/11/19

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F 812	Continued From page 21 §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 document review, it was determined that the facility failed to maintain a.) equipment in a manner to minimize microbial growth and cross-contamination, and b.) receive food in a manner to ensure that safe food temperatures were maintained. This deficient practice was evidenced by the following: On 09/26/19 at 9:40 AM, the surveyor, accompanied by the Food Service Director (FSD), observed an ice machine located in the facility main dining room. The FSD stated the ice machine is used to dispense ice during meals. The surveyor observed a dark substance accumulated in an interior portion of the ice	F 812	The ice machine located in the [redacted] was immediately taken out of service. The ice in the machine was disposed. The ice machine was then cleaned and sanitized. The can opener was immediately cleaned and sanitized. All refrigerated items located on the large pallet outside the kitchen on the loading dock area on 10/3/2019 at 9:35am were immediately discarded. 2. All center Ice machines, can openers and refrigerated food products have the potential to be affected. The center's Maintenance Director immediately checked the other two center ice	

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F 812	Continued From page 22	F 812		

machine where the ice was located. The FSD used a white napkin to wipe the dark substance and the substance was easily removed and on the napkin. The FSD stated the machine was cleaned once per month.

On 10/03/19 at 9:31 AM, the surveyor accompanied by the FSD observed a can opener affixed to a metal table in the kitchen. The can opener had debris on the blade and the base was heavily soiled with debris.

At 9:35 AM, the surveyor observed the loading dock area outside of the kitchen. A large pallet, identified by the FSD as containing a food order, was observed unattended. The pallet had plastic wrapped around food items and boxes and a 5-pound (lb) container of sour cream was observed on the top and in the middle of the pallet of food. The surveyor felt the five pound container of sour cream and it did not feel cool to the touch.

The FSD stated the refrigerated foods should be received at 41 degrees (F) or less. The surveyor utilized a calibrated thermometer to check the temperature of the sour cream and the temperature of a randomly selected cold item from the pallet of food which was 4 ounces (oz) of yogurt. The sour cream was 56 degrees F and the yogurt was 52.4 degrees F.

The FSD stated they have not been checking the food temperatures upon delivery.

On 10/03/19 at 10:50 AM, the FSD provided the surveyor with a copy of the invoice for the food items received on the pallet of food on 10/03/19. The invoice revealed that there were 115 cases of

machines. Both were clean.
A sanitation audit of all other kitchen appliances, areas and utensils was completed. No other appliances, areas or utensils were found to be unsanitary.
All refrigerated food products in the center were tested for proper refrigerated temperatures. All food products requiring refrigeration tested at 40' F or below.

3. The policy on sanitization; food storage and receiving food were reviewed. The policy on receiving food was modified to include recording the temperature of 2 food items upon food delivery receipt, results will be recorded on log and maintained in dietary office. The Maintenance Director will in-service the Maintenance Staff on the Monthly Cleaning procedures for the center ice machines. The center maintenance department will monitor the cleanliness of the center ice machines weekly and address any sanitation issues found immediately. The Maintenance Department will routinely clean the center ice machines monthly. The ice machine monthly cleanings will be documented.
The Food Service Director will in-service the Dietary staff on ensuring the can opener is clean and free of debris after each time it is used. The Food Service Director or designee will audit cleanliness of the can opener and ensure the can opener area is free of debris daily.
Weekly kitchen sanitation audits will be completed by the Food Service Director. These audits will be documented.
The Food Service Director will in-service

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F 812	Continued From page 23 various food items on the pallet. The cold food items items on the pallet included: two, 30 pack of 1-lb cheddar cheese; one, 5-lb sour cream; 30-dozen of medium eggs; 48 pack of 4-oz blueberry yogurt; 48 pack of 4-oz cherry vanilla yogurt; and 48 pack of 4-oz strawberry/banana yogurt. Review of the Dietary Department Receiving Policy, revised 04/19, revealed Perishable foods will be received to the following standards: Frozen foods, 0 degrees or below, store in freezer upon receipt. Refrigerated foods, 41 degrees or below except shell eggs and milk, store under refrigeration upon receipt. Review of the Food and Nutrition Services Sanitization Policy, revised 09/19, revealed the food service area shall be maintained in a clean and sanitary manner. Equipment will be disassembled as necessary to allow access of the detergent/solution to all parts and removable components will be scraped to remove food particle accumulation and washed. NJAC 8:39 17.2(g)	F 812	the Dietary staff to ensure all delivered food products which require refrigeration must have a temperature of at least 40'F or less at the time of delivery. Any food item requiring refrigeration of 40'F or less that is delivered at a temperature above 40'F will not be accepted. Temperatures of food items requiring refrigeration will be documented at time of delivery. 4. The Maintenance Director will report the results of the weekly ice machines cleanliness audits and monthly ice machine cleanings to the Center's QAPI committee meeting held each month for the next 3 months. The Food Service Director will report the results of weekly kitchen sanitation audits including the cleanliness of the can opener to the Center's QAPI committee meeting held each month for the next 3 months. The Food Service Director will report the results of the refrigerated food temperatures at the time of delivery to the Center's QAPI committee meeting held each month for the next 3 months. The Center's QAPI committee will review the results of each of the audits for the next 3 months and determine if compliance has been sustained and/or if additional corrective actions are required.	
F 880 SS=E	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	F 880		11/11/19

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designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be 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

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F 880	Continued From page 25 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain infection control standards to address the risk of infection transmission by failing to: a.) perform hand hygiene and complete a sanitary [redacted] treatment on a resident who was infected with [redacted]) for 1 out of 5 residents reviewed for infections (Resident #273); b.) maintain a shared [redacted] monitoring device in a sanitary manner for 1 of 4 residents observed during a medication pass review (Resident #181); c.) store a [redacted] treatment [redacted] in a sanitary manner for 2 of 4 residents reviewed for [redacted]	F 880	1. RN #1 was immediately in-serviced regarding hand washing hygiene and completing a sanitary [redacted] treatment on a resident who has an infection. RN #1 will be scheduled to complete a full competency program and successful return demonstration before she will be able to assume future nurse assignments. LPN #2 subsequently cleaned the [redacted] with a bleach wipe. The [redacted] for resident #123 was immediately changed, dated and covered. The [redacted] for resident #207 was changed, dated and covered.	

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F 880	Continued From page 26 (Residents #207 and #123); and d.) store soiled linen in an appropriate manner. This deficient practice was evidenced by the following: On 09/26/19 at 11:10 AM, the surveyor was in Resident #273's room when a Registered Nurse (RN) #1 entered the resident's room to perform a [redacted] treatment on the resident's [redacted] before the resident was discharged. The surveyor observed that RN #1 did not wash her hands or perform hand hygiene upon entering the resident's room. RN #1 stated that she was doing a [redacted]) treatment on the resident's [redacted] and then placed the [redacted] care supplies directly on top of the resident's bedside table located next to the resident's bed. The resident's meal tray was observed on the resident's window sill. The [redacted] care supplies included an open package of gauze pads, an unwrapped ace bandage, an applicator stick, a roll of tape, a tube of [redacted], and gloves. RN #1 did not clean off the bed side table prior to placing the [redacted] care supplies directly on top of the table and there was no barrier between the [redacted] care supplies and the bedside table. Resident #273 was alert and oriented and observed lying in bed with his/her head elevated. The resident held his/her [redacted] over his/her [redacted] area to provide RN #1 with a view of the [redacted] to complete the [redacted] treatment. No barriers were observed between the resident's bed and the [redacted] treatment. The resident's [redacted] was in the air and the [redacted] was propped up on resident's the [redacted] for support. The surveyor noted there was no garbage bag to	F 880	The [redacted] and [redacted] was changed, dated and covered. The two clear plastic bags on the top of resident #207□s bed were removed and placed in the soiled linen room. The bed linens of resident #207 were changed and replaced with clean linen. 2. All residents have the potential to be affected by the practices. The center infection control nurse made rounds. No other nurses were found to be deficient in hand washing hygiene and/or [redacted] treatment procedures. No other [redacted] were identified as requiring cleaning. All other resident [redacted] was found dated and properly covered. All other resident [redacted] and [redacted] was found dated and covered. No other clear plastic bags of soiled linen were found on resident beds. 3. A review of the center□s Infection Control Policy and Procedure was completed. No changes to the policy were determined to be necessary. All center staff have been in-serviced on proper hand hygiene. All center RNs and LPNs have been in-serviced on properly completing a sanitary [redacted] treatment on a resident who has an infection. All center RNs and LPNs have been in-serviced on properly cleaning [redacted] after usage. All center nursing staff have been in-serviced on properly changing, dating and covering [redacted]. All center nursing staff and [redacted] staff have been in-serviced on proper storage of soiled linen. The center unit managers, nursing supervisors and/or the infection control	

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F 880	Continued From page 27 dispose of soiled items. Without performing hand hygiene or handwashing, RN #1 donned gloves and removed the soiled [redacted] dressing. She placed the soiled dressing directly on top of the bedside table. RN #1 then used the same pair of gloves to blot the [redacted] with a gauze pad. The surveyor observed that the resident had an open [redacted] on the residents [redacted] and a small amount of drainage was observed on the gauze pad. RN #1 removed the soiled gloves, placed the soiled gloves directly on top of the bedside table, and then donned a new pair of gloves without performing hand hygiene or handwashing. She placed the [redacted] on an applicator stick and applied the [redacted] the [redacted]d. She then removed her gloves, placed them on the bedside table and then donned a new pair of gloves, without performing hand hygiene or handwashing. She placed gauze directly on the [redacted] and then wrapped the [redacted] with kling (self adherent wrap). Using the same gloves, RN #1 placed a piece of tape on the kling, used a black marker to write directly on the tape, and then wrapped the resident's [redacted] with an [redacted]. RN #1 removed her gloves and walked out of the resident's room without performing hand hygiene or handwashing. The surveyor interviewed RN #1 at that time regarding cleaning the bedside table and performing hand hygiene or handwashing. RN #1 stated she usually wiped the bedside table down with [redacted] but she "didn't have them." She further stated that she would usually wash hands before and after performing the [redacted] treatment. She did not state a reason why she didn't perform	F 880	nurse will make daily rounds to ensure staff follow proper hand hygiene procedures, RNs and LPNs follow proper wound treatment procedures for residents who have an infection, [redacted] [redacted] are appropriately cleaned after usage, all [redacted] is properly dated and stored, all [redacted] is properly dated and stored and no clear plastic bags of soiled linen bags are found placed on resident beds. 4. The Director of Nursing and/or designee will conduct weekly infection control audits to ensure proper hand hygiene, proper [redacted] care procedures, proper cleaning of [redacted], proper changing, dating, covering of [redacted] and [redacted] proper storage of soiled linen. The results of these audits will be presented to the Center Monthly QAPI Committee for the next 3 months. The Center□s QAPI Committee will review the results and follow up as determined.	

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handwashing prior to or after the [redacted] treatment.

The surveyor reviewed the medical record for Resident #273 which revealed the following:

An Admission Record revealed the resident was admitted on [redacted] with diagnoses that included [redacted]

An Admission Minimum Data Set (MDS), an assessment tool to facilitate care, dated [redacted] revealed the resident was admitted on [redacted] and had a Brief Interview for Mental Status Score of [redacted] which indicated the resident was [redacted] intact. The MDS also revealed the resident had a [redacted] infection, [redacted] that required a dressing to the [redacted] and the resident was infected with a [redacted]

A Care Plan (CP), dated [redacted] revealed a "Focus area" of "Resident has infection [redacted]." The goals revealed the "Resident will be free of infection by review date" and the "Resident will have no complications of infection through review date." The interventions revealed "Evaluate site of infection and report findings to MD," "[redacted] as ordered," and "Provide medication/treatment as ordered."

The September 2019 Treatment Administration Record (TAR) revealed a treatment order, dated [redacted] Apply to [redacted] topically every day shift for [redacted] care, cleanse with [redacted], apply [redacted] and [redacted]

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and cover with abd pad (thick gauze) and wrap with kling. The treatment was signed off by the RN, as administered on [redacted]

On 10/03/19 at 1:47 PM, the surveyor in the presence of the survey team, interviewed the facility Registered Nurse/Infection Preventionist (RN/IP) regarding the procedure for completing a [redacted] treatment. The RN/IP stated the nurse must wash hands prior to entering the room where the [redacted] treatment will be conducted and the nurse needed to wipe the bedside table with a bleach wipe and either use a bag or chuck to cover the bedside table. She continued that dirty items will be placed in a trash bag and it was never acceptable to place wound supplies directly on top of a bedside table or to not clean hands between a dirty dressing and a clean dressing.

Review of the [redacted] Treatment Policy, revised 11/19, revealed the steps in a treatment procedure which included to wash hands before treatment, apply gloves, remove soiled dressing and place in opened plastic bag and remove gloves and place in the plastic bag, wash hands, apply gloves, place date, time and initials of nurse on dressing, remove and discard gloves and wash and dry hands thoroughly.

Review of the Handwashing/Hand Hygiene Policy (HHHP), revised 01/19, revealed to use an alcohol-based hand rub, or alternatively, soap (antimicrobial or non-antimicrobial and water for the following situations; before and after direct contact with residents, before donning sterile gloves, before handling clean or soiled dressings, gauze pads, etc. and before moving from a contaminated body site to a clean body site during resident care, after removing gloves, and

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before and after entering isolation precaution settings. The policy also indicated the "use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections."

Review of the Isolation and Categories of Transmission-Based Precautions Policy (TBPC). Revised: 1-19, revealed Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. [redacted] Precautions for residents known or suspected to be infected with microorganism that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. The policy also revealed that gloves are worn when entering the resident room and gloves are changed when contact with [redacted] drainage and gloves are removed and hand washing is performed. Additionally, a disposable gown must be worn upon entering the [redacted] Precaution room or cubicle and after the gown is removed clothing should not be allowed to contact potentially contaminated surfaces.

b.) On 09/30/19 at 9:38 AM, the surveyor observed Licensed Practical Nurse (LPN #2) administer medication to Resident #181. LPN #2 applied the [redacted] monitor to Resident #181's [redacted], obtained a measurement and removed the [redacted] monitor from the resident's [redacted]. The LPN then placed the [redacted] on top of the medication cart. The surveyor observed that

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F 880	Continued From page 31 LPN#2 did not clean the [redacted] prior to or after applying the device to Resident #181's [redacted] At that time, the surveyor interviewed LPN #2 who stated that he/she usually cleans the [redacted] before and after every resident use with bleach wipes. On 10/01/19 12:14 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) who stated the [redacted] machine should be wiped down before and after each resident's use with [redacted] alcohol wipes or bleach wipes. On 10/03/19 at 1:48 PM, the surveyor interviewed the RN/IP who confirmed the [redacted] cuffs were to be wiped with bleach wipes before and after each resident use. Review of the facility's "Cleaning and Disinfecting Equipment" policy, revised 02/19, reflected that the "Purpose" was to ensure resident-care equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. The policy further revealed that "non critical items" are those that meet intact skin but not mucous membranes including [redacted] and can be decontaminated where they are used as opposed to being transported to a central processing location. The policy also revealed that reusable resident care equipment will be decontaminated between residents according to manufacturers' instructions. c.) On 09/26/19 at 10:31 AM and 09/30/19 at 10:06 AM, the surveyor observed that Resident #207's [redacted] was lying on the floor between the bedside dresser and privacy curtain.	F 880		

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F 880	Continued From page 32 The [redacted] was uncovered and not dated. On 10/03/19 at 11:39 AM, the surveyor observed that Resident #207's [redacted] and [redacted] was on the resident's bedside dresser secured to the back of the [redacted]. The [redacted] were not dated or covered with a bag. The surveyor observed that the clear bag to cover the [redacted] was empty and located on top of the [redacted]. According to the "Admission Record," Resident #207 was admitted to the facility on [redacted] with diagnoses that included [redacted] and [redacted]. Review of the Significant Change MDS, dated [redacted], revealed a BIMS score of [redacted] which indicated Resident #207 had [redacted] cognitive impairment. The MDS also indicated the resident received [redacted] therapy and was on [redacted] care. Review of the Medication Review Report (MRR) revealed a physician's order with a start date of [redacted], to [redacted] as needed for [redacted] The MMR also showed a physician's order for [redacted] milliliters (ml) [redacted] ml [redacted] orally via [redacted] r every six hours for [redacted] g. Review of the September 2019 Treatment Administration Record (TAR) revealed a physician order to [redacted] as needed for [redacted]. The TAR revealed empty boxes dated 09/04/19 to	F 880		

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F 880	Continued From page 33 09/30/19. Review of the October 2019 Medication Administration Record (MAR) revealed a physician order for [redacted] ml [redacted] orally via [redacted] every 6 hours for [redacted]. The MAR revealed that the resident was administered a [redacted] treatment on 10/03/19 at 0000 (midnight) and 0600. During an interview on 09/30/19 at 10:13 AM, LPN #4 stated the [redacted] should not be on the floor. LPN #4 proceeded to pick up the [redacted] from the floor and stated that it should have been in a bag and dated with tape. LPN #4 confirmed that the [redacted] was contaminated by the floor and the facility policy was to place opened suction tubing in a bag and write the date on the bag. During an interview on 10/03/19 at 11:43 AM, LPN #5 stated the resident received [redacted] [redacted] four times a day. LPN #5 confirmed that the [redacted] and [redacted] on the bedside table was uncovered and stated that the resident was [redacted] as needed and had not been [redacted] in weeks. LPN #5 continued to state that a [redacted] treatment was administered to the resident prior to her shift and that she should have checked the [redacted] at the start of the shift. She further stated the night nurse should have taken off the [redacted] and put it back into the holder that was connected to the [redacted], and then covered it with a bag. LPN #5 stated the bag was dated 09/30/19 "but the [redacted] should be in the bag so it doesn't get dirty or fall on the floor."	F 880		

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	315174	A. BUILDING _____ B. WING _____	10/08/2019

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F 880	Continued From page 34 On 10/08/19 at 1:45 PM, the Director of Nursing (DON) stated the facility did not have a [redacted] policy. On 09/26/19 at 10:38 AM, the surveyor observed that Resident #123's [redacted] and was wrapped around the right upper side rail and hanging off the bed. The [redacted] was not dated. During an interview with the resident at that time, the resident stated that he/she was on [redacted] at [redacted] at night and the [redacted] was changed every Sunday. On 10/03/19 at 9:18 AM, the surveyor observed the [redacted] tubing lying across the resident's bed. The [redacted] was not dated and uncovered. The resident stated the [redacted] was changed last night on the 11 PM to 7 AM shift. On 10/04/19 at 9:07 AM, the surveyor observed that the [redacted] was connected to the [redacted] with the [redacted] lying across the resident's bed not dated and uncovered. The resident stated that the [redacted] was the same [redacted] from yesterday. According to the Admission Record, Resident #123 was admitted to the facility on [redacted] with diagnoses that included: [redacted] Review of the Quarterly MDS, dated [redacted] revealed a BIMS score of [redacted] which indicated the	F 880		

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F 880	Continued From page 35 resident's cognition was [redacted] Review of the MRR revealed a physician's order with a start date of [redacted] to change the [redacted] weekly, every night shift, every Thursday for [redacted] change, date and place in plastic bag. The MRR also showed a physician order for [redacted] at [redacted] every 24 hours as needed for [redacted] less than [redacted] Review of the October 2019 TAR revealed a physician order to change the [redacted] weekly every night shift every Thursday for [redacted] change date and place in plastic bag. The TAR revealed a check mark with an initial for 10/03/19, on the 11 PM-7 AM shift. On 10/08/19 at 1:15 PM, the Administrator provided an additional copy of Resident #123's respiratory Care Plan that revealed interventions to provide [redacted] per physician orders and to maintain/change [redacted] per protocol. During an interview on 10/04/19 at 9:15 AM, LPN #5 stated that the resident used [redacted] at night and that the [redacted] should be dated with tape, placed in a bag when not in use, and the bag dated. LPN#5 confirmed that the [redacted] was not dated. During an interview on 10/08/19 at 12:17 PM, in the presence of the surveyor, the DON reviewed Resident #123's October 2019 TAR, and stated that on [redacted], the 11 PM-7 AM nursing shift had documented that the [redacted] was changed. The DON stated it was documented as being done and that if the box had no check mark or initial then it was not done. The Administrator	F 880		

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F 880	Continued From page 36	F 880		

was present during the interview and stated that it was the nurses resposibility to label and date the [redacted]

Review of the facility [redacted] Policy (#CO-1), revised 08/19, indicated that [redacted], [redacted] is changed weekly and prn (as needed)."

d.) On 09/30/19 at 10:06 AM, the surveyor observed two clear plastic bags on the top of Resident #207 bed. The bags were filled with linen and untied. One bag had a sheet that hung outside of the bag and was lying on the resident's bed. The bed was neatly made. The surveyor interviewed the resident about the two clear plastic bags and the resident responded that it was dirty clothes.

During an interview on 09/30/19 at 10:13 AM, LPN#4 stated the [redacted] aide provided morning care to Resident #207 and that she was not sure if the two clear bags of linen were clean or dirty. LPN #4 further stated that "staff are not to leave dirty linen on residents' beds." LPN #4 stated the linen should have been discarded in the soiled linen room. LPN #4 confirmed the two bags were untied and a sheet was located outside of the bag. The LPN placed the sheet back into the bag, tied both bags and took them to the soiled linen room.

On 10/03/19 at 2:10 PM, during an interview with the RN/IP, she stated that dirty linens are bagged and placed in the soiled utility room and that was draped on top of the staff should not put dirty linens on a bed.

Review of the facility "Soiled Linen Policy,"

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F 880	Continued From page 37 revised 3/2019, revealed that soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. NJAC 8:39-19.4 (a)	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/03/19, in the presence of facility management, it was determined that the facility failed to provide a nurse call system to resident accessible bathrooms. This deficient practice was evidenced by the following: At 11:10 AM, the surveyor and the Director of Maintenance (DM) observed that the door to the administration corridor bathroom was open. Further observations revealed that there was no nurse call system provided in the bathroom and there were two residents observed in the corridor. In an interview at the time of the observation, the DM stated that the door was left open, keys are available with administration and maintenance,	F 919	1. A new auto-locking lock was installed on the bathroom door to ensure the bathroom door remains closed and locked at all times. 2. All residents have the potential to be affected. All other bathrooms located by resident accessible bathroom were checked to ensure a proper call bell system was put in place. 3. All Maintenance staff was educated on the need to have all resident accessible bathrooms have a functioning call bell system in place. Maintenance Director will conduct daily rounds to ensure the administration corridor bathroom door is closed and locked at all times. an audit tool has been created to monitor the daily checks. 4. Maintenance director or designee will	11/11/19

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F 919	Continued From page 38 and that residents were instructed not to use this bathroom. NJAC 8:39-31.2(e)	F 919	complete monthly audits x 3 ensuring there is functioning call bell systems in all resident accessible bathrooms. Maintenance director or designee will complete monthly audits x 3 ensuring the administration corridor bathroom door remains closed and locked at all times. findings will be brought to the QAPI committee meetings monthly for review and follow up.	