STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315257	A. BUILDING _____ B. WING _____	C 02/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING & RESPIRATORY CARE	**1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS CENSUS: 157 SAMPLE SIZE: 32 Complaint #NJ00131575 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete the Minimum Data Set (MDS), an assessment tool, used to facilitate the management of care accurately. This deficient practice was identified for 5 of 32 residents reviewed (Residents #134, #102, #51, #166, and #27), and was evidenced by the following: 1. Resident #134 was admitted to the facility on [redacted] with diagnoses that included [redacted] and a Physician's order for [redacted] at an off-site [redacted] center. The surveyor reviewed the [redacted] Admission MDS and observed that it did not identify that the resident was on [redacted]. When interviewed on 2/13/2020 at 12:28 PM, the MDS Coordinator said the resident was not on [redacted]	F 641	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE. Resident #134 Admission MDS on [redacted] was modified to indicate resident is on [redacted] Resident #51 Quarterly MDS from [redacted] was modified to show correct weight. Resident #102 Quarterly MDS from [redacted] was modified to include the resident was on [redacted] Resident #166 Significant Change MDS	4/13/20

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

Electronically Signed | 03/12/2020

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F 641	Continued From page 1 when he/she came into the facility. On 2/20/2020 at 4:30 PM, the survey team reviewed their MDS findings with the Director of Nursing (DON). During a follow-up meeting on 2/21/2020 at 9:33 AM, the DON said Resident #134 was on [redacted] upon admission to the facility, and it should have been coded on the [redacted] Admission MDS. 2. The surveyor reviewed Resident #51's "Weights and Vitals Summary" sheet and observed that their August 2019 weight was [redacted] pounds, which reflected a weight gain of [redacted] in the last month. The surveyor reviewed the MDS for Resident #51 and observed that the [redacted] Quarterly MDS noted that Resident #51 weighed [redacted] without a [redacted] weight gain or loss in the last month or [redacted] weight gain or loss in last 6 months. When interviewed on 2/18/2020 at 12:56 PM, the Dietician acknowledged that the information was inaccurate on the [redacted] MDS. At 1:58 PM, the MDS Coordinator also acknowledged the information on the [redacted] MDS was inaccurate. 3. Resident #102 had been receiving hospice care since 1[redacted]. The resident was discharged briefly and then admitted again to the facility on [redacted]. When admitted, the resident was receiving [redacted]. Upon review, the surveyor observed that the [redacted] quarterly review of the MDS for Resident #102, did not include that the resident was on [redacted] When interviewed on 2/13/2020 at 11:42 AM, the MDS Coordinator stated, "admissions would code it[redacted]) on the census line of the payer source in the medical record." The MDS Coordinator stated, "It's not my fault because it's not on the census line." The MDS Coordinator stated she	F 641	from [redacted] was modified to include resident was on [redacted] Resident #27 MDS from 1[redacted] was modified to indicate that resident is a [redacted] HOW THE FACILITY WILL IDENTIFY THE OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THE SAME DEFICIENT PRACTICE. All residents on [redacted] and those identified as [redacted] have the potential to be affected by the deficient practice. All residents on [redacted], [redacted] and those identified as [redacted], recent MDS□s have been audited to ensure MDS□s have been coded accurately. No further deficient practiced identified. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR. Regional Nurse re-educated MDS coordinator on the importance of collaborating with IDT team to ensure MDS□s are code accurately prior to submitting. Regional Dietitian will educate facility dietitian on the need to communicate with MDS and nursing management when she has identified erroneous information in a residents medical record.	

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F 641	Continued From page 2 would talk to the Unit Manager (UM) regarding the resident's [redacted] status. When interviewed further on 2/13/20 at 12:28 PM, the MDS Coordinator confirmed that the resident went on [redacted] on [redacted]. The MDS Coordinator also confirmed that [redacted] should have been coded on the [redacted] MDS. 4. During a review of the medical record of Resident #166, the surveyor observed a Physician's order for "[redacted]" dated [redacted]. During further review of the medical record, the surveyor reviewed the resident's [redacted] significant change MDS and observed that it did not include that the resident was receiving [redacted] care." During an interview on 2/13/2020 at 11:42 AM, the surveyor asked the MDS coordinator if Resident #166 was receiving [redacted] care. The MDS coordinator stated, "I'm not sure. I will have to check." The MDS coordinator returned to the conference room moments later and stated, "[Resident #166] is receiving [redacted] but it's not my fault because the other MDS coordinator filled out [Resident #166's] MDS." 5. During the entrance conference on 2/11/2020 at approximately 9:45 AM, the Director Of Nursing provided the surveyor with a list of current [redacted] in the facility. Resident #27 was the only [redacted] in the facility as the facility was a [redacted] facility, and Resident #27 was "grandfathered" in from a prior administration. When interviewed on 2/11/2020 at 10:38 AM, Resident #27 confirmed that [Resident #27] out to [redacted] daily. On 2/20/2020 at 9:34 AM, the surveyor reviewed	F 641	HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, I.E. WHAT PROGRAMS WILL BE PUT IN PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. Regional Nurse or Social Services will conduct an audit of 10% of MDS□s submitted weekly x4, then monthly x 3 Results of audits will be submitted to monthly QAPI meeting for review monthly x 3 to ensure compliance and reassessed for further action.	

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F 641	Continued From page 3 the resident's [redacted] MDS and observed that it identified Resident #27 as not a "current [redacted] user." When interviewed on 2/21/2020 at 4:30 PM, the DON confirmed that Resident #27 was an active [redacted]r. The surveyor informed the DON that Resident #27's [redacted] MDS had Resident #27 identified as a [redacted] user. The DON stated, "I will have the MDS coordinator modify the [redacted] MDS to reflect that Resident #27 is a current [redacted] NJAC 8.39-11.1	F 641		
F 698 SS=D	[redacted] CFR(s): 483.25(l) §483.25(l) [redacted] The facility must ensure that residents who require [redacted] receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow their [redacted] policy for 1 of 2 residents (Resident #116) reviewed for [redacted] This deficient practice was evidenced by the following: During a review of Resident #116's medical record, the surveyor observed an 11/26/19 Physician's Order for [redacted] treatment (3) times a week on ([redacted]) at (name of [redacted] center) at (time of appointment). Transported by	F 698	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE. The deficient practice was noted for resident #116 when on [redacted] the [redacted] binder was reviewed and communication from [redacted] center found that resident was seen by [redacted] who recommended to have [redacted] to rule out [redacted]. The recommendation was not carried out. On [redacted] licensed nurse	4/13/20

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F 698	Continued From page 4 (name of the transport company). Pick-up at (time of pick-up)." On 2/19/2020 at 9:32 AM, the surveyor reviewed Resident #116's [redacted] communication book. The "Skilled Nursing Facility Communication Log" provided by the [redacted] on [redacted], noted the following in the "COMMENTS" section: "Seen by [redacted] recommended to have [redacted]) Re: R/O (rule out) [redacted] The surveyor then reviewed the Medical Record and was unable to find documentation that an appointment had been made for the [redacted] procedure. On 2/19/2020 at 10:34 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) concerning the [redacted] communication process between the facility and dialysis center. During the interview, the RN/UM stated, "The nurse who is in charge of that resident's care would be responsible to look in the resident's communication book and read the information upon return to the facility." The surveyor also interviewed the RN/UM concerning the [redacted] center's [redacted] recommendation for the [redacted]. The RN/UM stated, "the 3-11 nurse received the information. I think the nurse said that the resident could not go to have the [redacted] because there was some insurance issue." When the surveyor requested documentation by the 3-11 nurse on [redacted], the RN/UM stated, "I guess she didn't document it. Let me find out the information, and I will get back to you."	F 698	contacted physician to set up [redacted]. [redacted] was completed on [redacted] HOW THE FACILITY WILL IDENTIFY THE OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THE SAME DEFICIENT PRACTICE. The Director of Nursing has reviewed current residents receiving [redacted] and identified six total residents receiving [redacted] at risk to be affected by the deficient practice. Audits of the six residents dialysis binders were completed with no issues noted regarding dialysis center communication recommendations. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR. The Staff Educator/Assistant Director of Nursing will in-service all licensed nursing staff regarding the policy and procedure for residents receiving [redacted] and the dialysis communication binders. The unit managers will complete weekly audit x 4 then monthly x 3 of [redacted] communication binder to ensure the following: The resident returned to the facility with the [redacted] communication binder. The [redacted] communication sheet is completed by the [redacted] center nurse. The licensed nurse calls the [redacted]	

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F 698	Continued From page 5 On 2/19/20 at 10:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) in regards to Resident #116's [redacted] communication. On interview, LPN #1 stated, "Usually [redacted] will contact Resident #116's [redacted] and coordinate appointments. We usually do not make the appointments. I will call the [redacted] center and see if they already made the appointment. I would have called the next day to see if they made the appointment, but whoever was on duty that day may have thought [redacted] already made the appointment. I'm gonna call now and see what's going on." On 2/19/20 at 11:02 AM, LPN #1 told the surveyor she had contacted the [redacted] center and stated, [redacted] did not make the appointment. I just made the appointment for (Resident #116) to get the [redacted] on (date and time of appointment). I contacted [redacted] on the phone, and [redacted] said they didn't set up the appointment because [redacted] has had problems with (a transportation company) in the past. On 2/20/20 at 3:06 PM, the surveyor interviewed the 3-11 shift LPN #2, who had been assigned to Resident #116 on [redacted]. On interview, LPN #2 stated, "I worked a double shift that day. I worked on the [redacted] unit from 7-3, and then I did not get over to the [redacted] until around 3:30 because I was giving a report. The 7-3 nurse on the [redacted] would have been responsible for checking his/her [redacted] communication book because the resident returned on their shift. The nurse did not endorse me any communication concerning resident #116." On 2/20/2020 at 4:00 PM, the surveyor interviewed the 7-3 shift Registered Nurse who	F 698	center for report, if the resident did not return with the communication binder or incomplete communication sheet. The receiving licensed nurse will sign off on [redacted] communication log to ensure that no further recommendations were sent to facility from dialysis communication log. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, I.E. WHAT PROGRAMS WILL BE PUT IN PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. Findings will be reported weekly then monthly to the Director of Nursing for review. The QAPI Committee will meet monthly x 3 and determine further actions and audits based on trends and analysis reviewed.	

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F 698	Continued From page 6	F 698		

had been assigned to care for Resident #116 on [redacted]. On interview concerning Resident #116's [redacted] communication sheet on [redacted] the RN stated, "I worked 7-3 on B unit on the [redacted]. I don't remember Resident #116, returning to the facility. I did fill out the [redacted] communication form prior to the resident leaving the facility for [redacted]. I gave report at approximately 3:30 PM, and I didn't notice the resident returning to the unit. I'm not really sure what to do when [redacted] residents return to the facility because I have only been here a few weeks." When interviewed further, the RN stated, "I was oriented prior to working in the facility, yes." When the surveyors asked the RN if she had had previous experience at other facilities with [redacted] residents, the RN stated, "I have worked at other facilities, and we usually would be alerted to when the resident returned, and I would check their communication book for any orders, recommendations or changes." The surveyor then asked the RN what she did after she gave report to LPN #2, and she stated, "After report, I either did a few notes or clocked out, I'm not sure, to be honest. I did not endorse the resident to the 3-11 nurse. I'm not gonna lie. She probably knew (Resident #116) better than I did to be honest."

The surveyor reviewed the facility policy titled [redacted] Care Nursing Manual-Nursing Care," version No. 2.0, and reviewed/revised 12/2019. The Policy section revealed the following:

I. "The facility will be responsible for the overall care delivered to the resident, monitoring of the resident prior to and after the completion of each [redacted] treatment, and providing for all [redacted] needs of the resident including

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F 698	Continued From page 7 during the time period when the resident is receiving [redacted] NJAC 8:39- 27.1 (a)	F 698		
F 732 SS=E	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. §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.	F 732		4/15/20

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F 732	Continued From page 8 §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 post the daily staffing numbers as required. This was cited at a level E as there was no evidence that staffing had not been posted in the facility since at least August 2019. This deficient practice was evidenced by the following: During an initial tour of the facility on 2/11/2020, the surveyors were unable to find the posting of the staffing. Throughout the following days on 2/12/2020, 2/13/2020, 2/14/2020, and 2/18/2020, the surveyors continued to look for the posting of the staffing and were still unable to find it. On 2/19/2020 at 9:14 AM, the surveyor asked the Director of Nursing (DON) where the staffing was posted. The DON said she didn't know. The DON and the surveyor then went to the Staffing Coordinator's (SC) office. The DON asked the SC where the staffing was posted. The SC said staffing was not posted. When the surveyor questioned the SC further, the SC said she didn't know it was supposed to be posted. The SC further stated that she had never posted it. The DON told the surveyor that the SC was new and was learning. When asked when she started, the SC told the surveyor she had started working in the facility in "August." The surveyor then said, "so the staffing hasn't been posted since at least	F 732	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE. Staffing was immediately posted on 2/19/2020 and staffing has been posted daily. HOW THE FACILITY WILL IDENTIFY THE OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THE SAME DEFICIENT PRACTICE. All residents have the potential to be affected by the deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR. Director of Nursing educated the staffing coordinator on the Posted Nursing Staffing Information and posting requirements. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT	

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F 732	Continued From page 9 August?" The SC said, "NO." NJAC 41.2 (a,d)	F 732	RECUR, I.E. WHAT PROGRAMS WILL BE PUT IN PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. DON and/or Administrator will audit staffing posting area daily to ensure staffing information is posted. Results of audits will be submitted to monthly QAPI meeting for review monthly x 3 to ensure compliance and reassessed for further action.	
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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Complaint #NJ00131575	F 812	HOW THE CORRECTIVE ACTION WILL	4/13/20

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F 812	Continued From page 10 Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous food and maintain kitchen sanitation safely and consistently to prevent foodborne illness. This deficient practice was evidenced by the following: On 2/11/2020 from 8:11 AM to 8:56 AM the surveyor, accompanied by the Cook and Account Manager (AM), observed the following in the kitchen: 1. Upon entrance to the kitchen, the surveyor observed a Dietary Aide (DA) exiting the kitchen through the double doors and walking into the dietary office. The DA had a baseball-style hat on her head. The hat only partially covered her hair and left the lower third of her hair exposed. The surveyor observed the hair to be exposed down to the shoulders, and no hairnet was present. 2. On the storage rack outside the dish room entrance, a cleaned and sanitized beverage dispenser was not in an inverted position and was exposed. In an interview, the AM stated, "That should be stored inverted, and it should be stored in the banquet storage area." 3. In the food preparation area, a cleaned and sanitized stand-up mixer was covered with a plastic bag and was not in use. Upon removal of the plastic bag, the surveyor observed unidentified food debris on the upper hook attachment. During the interview, the AM stated,	F 812	BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE. The Dietary Aide immediately placed a hairnet on her head and was educated on staff attire policy. The beverage dispenser was immediately washed, re-sanitized and stored in an inverted position. The stand-up mixer was immediately re-cleaned, re-sanitized and bagged again for future use. The bagels and waffles were immediately thrown away. The bags of cookies on Unit B were immediately thrown away. All pantries were checked for undated foods. No further deficient practice noted. The Styrofoam cups and plastic lids were immediately thrown away. All other pantries were checked. No further deficient practice noted. Dietary aide immediately placed beard guard on and educated on HSCG policy on staff attire. HOW THE FACILITY WILL IDENTIFY THE OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THE SAME DEFICIENT PRACTICE.	

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F 812	Continued From page 11 "That's dirty still. We are going to re-clean it, sanitize it and bag it before we use it again." The surveyor observed the AM instruct a dietary staff to re-clean the stand-up mixer. 4. In the walk-in freezer on a middle shelf, a plastic bag contained 3 frozen bagels. The bag was opened, and the bagels were exposed. In an interview, the AM stated, "I'm throwing those out." The AM threw the bagels in the trash. On a lower shelf, a box of [redacted]" waffles were opened and exposed. Also, at the bottom of an opened cardboard box on a lower shelf, a bag of frozen biscuits was opened and exposed. During an interview, the AM stated, "They're exposed. I'm getting rid of them and the waffles and the bagels." On 2/18/2020 from 9:48 AM to 9:59 AM the surveyor, accompanied by the Registered Nurse/Unit Manager (RN/UM), observed the following in the [redacted] pantry: 1. In an upper cabinet, a plastic zip lock bag contained two cookies. The bag of cookies had no dates. In addition, another zip-lock plastic bag contained one cookie and had no dates. On interview, the RN/UM stated, "They shouldn't be in there, they have no dates. Housekeeping and nursing are responsible for monitoring the area." The RN/UM threw the cookies in the trash. 2. On a lower shelf in the same cabinet, a Styrofoam cup was removed from its original container and was exposed. Several plastic lids had also been removed from their original container and were exposed. During the interview, the RN/UM stated, "I'm gonna throw those in the trash." The RN/UM took the	F 812	All residents have the potential to be affected by the deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR. The Dietary Food Director will educate the dietary staff on the following policies: Freezer policy, Equipment Policy, Food Receiving Policy, Food Storage: Cold Foods Policy and Staff Attire. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, I.E. WHAT PROGRAMS WILL BE PUT IN PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. The Director and/or NHA will conduct sanitation audits in the kitchen weekly x4, then monthly x3. Results of audits will be submitted to monthly QAPI meeting for review monthly x 3 to ensure compliance and reassessed for further action.	

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F 812	Continued From page 12	F 812		

Styrofoam cup and plastic lids and threw them in the trash.

On 2/20/2020 from 10:17 AM to 10:34 AM the surveyor, accompanied by the AM, observed the following in the kitchen:

1. Upon entry to the dish room, the surveyor observed a DA with a lengthy beard pushing a cart of cleaned and sanitized dishes out of the dishwashing room. The DA did not have a beard guard, and the beard was exposed. During an interview, the AM stated, "I thought that since he was only scraping dirty dishes that he didn't need one since he wasn't working with food." The surveyor questioned the AM whether their policy and procedure stated that beard guards were not necessary to be worn when washing or scraping dishes. The AM stated, "I don't think our policy and procedure can cover that."

The surveyor reviewed the facility policy titled "Freezer Policy," undated. Review of the facility policy revealed the following:

4) "If items come out of the box, the receiving date should be transcribed onto the individual bag."

5) "Dispose of any opened items."

The surveyor reviewed the [redacted]. and its subsidiaries [redacted] policy 027 titled "Equipment," Revised 9/2017. The Policy Statement included the following:

"All food service equipment will be clean, sanitary, and in proper working order."

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F 812	Continued From page 13 Review of the Procedures section noted the following: 1. "All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials." 2. "All staff members will be properly trained in the cleaning and maintenance of all equipment." 3. All food contact equipment will be cleaned and sanitized after every use." 4. "All non-food contact equipment will be clean and free of debris." The surveyor reviewed the [redacted]. and its subsidiaries [redacted] Policy 017" titled "receiving," Revised 9/2017. The Policy Statement revealed the following: "Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items." Under the Procedures section, the following was observed: 5. "All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation." The surveyor reviewed the [redacted] and its subsidiaries [redacted] Policy 019" titled "Food Storage: Cold Foods," revised 9/2017. Under the Policy Statement, the following was observed:	F 812		

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F 812	Continued From page 14	F 812		

"All-Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code."

Under the Procedures section, the following was noted:

5. "All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross-contamination."

The surveyor reviewed the facility procedure posted on the outside of the double doorway entrance to the kitchen. The procedure revealed the following:

"ANYONE ENTERING THIS KITCHEN MUST WEAR A HAIRNET AND OR A BEARD RESTRAINT! THERE ARE NO EXCEPTIONS THANK YOU. THE DIETARY DEPT. HAIRNETS ARE LOCATED AT EVERY ENTRANCE"

The surveyor also reviewed the facility provided "Hairnet & Beard Restraint In-Service," dated January 2017. The in-service revealed the following:

"Starting immediately: All dietary staff with exposed facial hair IS REQUIRED TO WEAR A BEARD COVER in addition to a hairnet. You may use: White beard cover or Hairnet utilized upside down and wrapped over the ears (see attached). This is a reg from the 2013 Food Code: Hair Restraints 2-402.11 Effectiveness." The food code revealed the following:

"(A) Except as provided in paragraph (B) of this section, FOOD EMPLOYEES shall wear hair

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F 812	Continued From page 15 restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." The procedure further revealed, "There will be no exceptions, and the rule must be strictly enforced at all times." NJAC 8:39-17.2 (g)	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		4/15/20

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F 880	Continued From page 16 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 17 §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 review of facility documentation, it was determined that the facility failed to follow its Hand Hygiene policy during observation of a medication pass. This deficient practice was identified for 1 of 2 nurses administering medications and was evidenced by the following: On 2/11/2020 at 8:20 AM, the surveyor observed a Registered Nurse (RN) give medications to Resident #130. After administration, the RN went into the resident's bathroom to wash her hands. The RN turned on the water, put soap on her hands, ran her hands under the water as she scrubbed, and then rinsed her hands. The entire handwashing procedure lasted for a total of 14 seconds as timed by the stopwatch on the surveyor's smartwatch, which the surveyor used during each handwashing observation. On 2/11/2020 at 8:30 AM, the surveyor observed the same RN give medications to Resident #43. After administration, the RN went into the resident's bathroom to wash her hands. The RN turned on the water, put soap on her hands, ran her hands under the water as she scrubbed, and then rinsed her hands for a total of 13 seconds. The RN then left Resident #43's room to get a medication she didn't have in the cart. The RN returned and gave the resident the medication. After administration, the RN went to wash her hands. The RN turned on the water, put soap on her hands, ran her hands under the water as she scrubbed, and then rinsed her hands for a total of	F 880	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE. There were no adverse outcomes for residents #43, #101 and #130 related to the deficient practice. HOW THE FACILITY WILL IDENTIFY THE OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THE SAME DEFICIENT PRACTICE. RN identified was re-educated on the facility Hand Hygiene Policy. All residents have the potential to be affected by the deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR. The Educator/Infection Preventionist will re-educated the staff on the facility□s Hand Hygiene Policy. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION TO ENSURE	

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F 880	Continued From page 18 15 seconds. On 2/11/2020 at 8:42 AM, the surveyor observed the same RN give medications to Resident #101. After administration, the RN went into the resident's bathroom to wash her hands. The RN turned on the water, put soap on her hands, ran her hands under the water as she scrubbed, and then rinsed her hands for a total of 15 seconds. The surveyor interviewed the RN on 2/20/20 at 4:00 PM, regarding the facility's hand hygiene (handwashing) policy. The RN stated that she was supposed to wash her hands for 20 seconds. When asked how she knew how long she was washing her hands for, the RN said, "I count it in my head, I go 12345678910, like that. Why? Did I go too fast"? The RN had counted at a very rapid pace. The surveyor reviewed the facility's "Hand Hygiene" policy with "Date Revised February 2019," which was provided by the Director of Nursing on 2/20/2020 at 9:39 AM. The surveyor observed that the policy documented to, "Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least twenty (20) seconds..." NJAC 19.4 (a)1	F 880	THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, I.E. WHAT PROGRAMS WILL BE PUT IN PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. The Educator and/or Adon will conduct 6 hand hygiene competencies during medication pass weekly x 4, then monthly x3. Results of audits will be submitted to monthly QAPI meeting for review monthly x 3 to ensure compliance and reassessed for further action.	

New Jersey Department of Health

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S 000	Initial Comments The facility was not in compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S2315	8:39-31.6(i)(1-2) Mandatory Physical Environment (i) The administrator shall serve as, or appoint, a disaster planner for the facility. 1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan; or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management. 2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents. This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on	S2315	HOW THE CORRECTIVE ACTION WILL	4/15/20

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

Electronically Signed | 03/12/20

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S2315	Continued From page 1 2/11/20, in the presence of facility management, it was determined that the facility failed to review the emergency evacuation plan Annually with Emergency management officials. This deficient practice was evidenced by the following: A review of the facility's emergency evacuation plan documentation for the previous 12 months revealed that there was no documented review of the evacuation plan with the offices of emergency management. In an interview, at 10:15 AM, the facility's newly hired Director of Maintenance stated the facility had not reviewed the evacuation plan with emergency management officials but was in the process of sending it out for review.	S2315	BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE. No residents were found to be affected by the deficient practice. Disaster plan was completed and sent to OEM for approval. HOW THE FACILITY WILL IDENTIFY THE OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THE SAME DEFICIENT PRACTICE. All residents had the potential to be affected by the deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR. The Maintenance Director will schedule a meeting with the management team to review our emergency preparedness program and update accordingly. The meeting will be arranged annually. The Maintenance Director or NHA will contact the OEM of Gloucester County, the OEM of Monroe Township the municipality, and they will be given copies of our emergency preparedness program to be reviewed and signed off on. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, I.E. WHAT PROGRAMS WILL BE PUT IN PLACE TO MONITOR THE	

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S2315	Continued From page 2	S2315	CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. Facility Emergency Preparedness plan will be discussed at quarterly QA meeting.	
S2345	8:39-31.6(o) Mandatory Physical Environment (o) The facility shall conduct at least one evacuation drill each year, either simulated or using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 2/11/20, in the presence of facility management, it was determined that the facility failed to conduct an evacuation drill Annually. This deficient practice was evidenced by the following: A review of the facility's disaster drill documentation for the previous 12 months, revealed that the facility did not conduct an evacuation drill. In an interview, at 10:15 AM, the facility's newly hired Director of Maintenance stated the facility had not conducted an evacuation drill in the last year but would be scheduling one in the next few weeks.	S2345	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE. No residents were found to be affected by the deficient practice. Contacted OEM to schedule a disaster drill. HOW THE FACILITY WILL IDENTIFY THE OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED BY THE SAME DEFICIENT PRACTICE. All residents have the potential to be affected by the deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE DEFICIENT	4/15/20

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MEADOWVIEW NURSING & RESPIRATORY CARE	1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S2345	Continued From page 3	S2345	PRACTICE WILL NOT RECUR. The Maintenance Director contacted to schedule a joint emergency evacuation drill. All drills will be uploaded into the electronic maintenance system (TELS) After completion to keep an accurate log of recent exercise. Emergency Preparedness exercise and drills will be scheduled as needed. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR, I.E. WHAT PROGRAMS WILL BE PUT IN PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. Results of drills will be discussed in quarterly QA meeting to ensure compliance and reassessed for further action.	