STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315336	A. BUILDING _____ B. WING _____	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS AT MONROE HEALTHCARE AND REHABILITATION, T	189 APPLEGARTH ROAD MONROE TOWNSHIP, NJ 08831

(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 STANDARD SURVEY: 7/19/19 CENSUS: 100 SAMPLE SIZE: 24 + 11 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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to notify and document the refusal of a diabetic management medication in accordance to professional standards of practice. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized	F 658	A. Physician notified Resident #52 refused [redacted] medication. Documentation noted in the medical record. Nurse Practitioner reviewed Resident #52's medical record, reassessed resident and discussed plan of care with PMD. Per PMD continue to offer [redacted] as ordered. Monitor [redacted] and [redacted] levels. Care Plan on [redacted] Management initiated. Nurse involved in this deficient practice educated and counseled. Nurses in-serviced regarding Physician Notification of Medication Refusal and Documentation. B. Any resident with 3 day medication refusal	8/12/19

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

Electronically Signed | 08/01/2019

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F 658	Continued From page 1 physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; 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." This deficient practice was identified for 1 of 24 resident's reviewed (Resident #52) and was evidenced by the following: On 7/16/19 at 9:26 AM, the surveyor observed Resident #52 awake in bed watching television. The surveyor attempted to interview the resident, but the resident refused. On 7/16/19 the surveyor reviewed the medical record for Resident #52 which revealed the following: A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] reflected the resident had a brief interview for mental status	F 658	is potentially affected by this deficient practice. C. In order to assure compliance the facility will: In-service nursing staff regarding Physician Notification of Medication Refusal and Documentation upon hire and annually. D. DON/Designee will randomly audit 5 Medication Administration Record for any refusal of medication, if Physician was notified and documentation in place. This will be done monthly for 3 months, then quarterly thereafter. Results of these audit will be reported in the quarterly QAA meeting.	

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F 658	Continued From page 2 (BIMS) score of [redacted]. A review of the Order Summary Report (OSR) for July 2019 reflected an order dated 5/16/19 for [redacted] The order specified to give one tablet by mouth one time per day. A review of the corresponding electronic Medication Administration Record (eMAR) for July 2019 was signed to reflect the resident refused the [redacted] on 7/1/19, 7/2/19, 7/3/19, 7/4/19, 7/5/19, 7/6/19, 7/7/19, 7/8/19, 7/9/19, 7/10/19, and 7/11/19. On 7/17/19 at 11:09 AM, the surveyor interviewed the Registered Nurse (RN) who stated that if a resident refused medications, then the nurse informed the physician. The nurse would then document the physician's notification in the nurse's notes. The RN stated that she could not speak to the resident refusing the [redacted], but she would follow-up. A further review of the Interdisciplinary Progress Notes, did not reflect a nurse's note corresponding with the dates above for the refusal of the [redacted] or that the physician was notified of the refusal. On 7/19/19 at 9:16 AM, the Director of Nursing (DON), in the presence of the facility's administration and the survey team, stated that the 3:00 pm to 11:00 pm nurse administered the [redacted]. The nurse verbally on the physician's rounds "one day", informed the physician about the resident's refusal of the	F 658		

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F 658	Continued From page 3 [redacted], but the nurse forgot to document the notification in the notes. The DON stated that the physician was aware that the resident was refusing the medication, but wanted to continue offering the [redacted] daily. The DON stated that a "general rule" of practice was that if a dose of medication was refused for three days, the nurse needed to notify the doctor and write a note. A review of the facility's Medication Refusal Policy dated and revised 3/19, included that the documentation relative to the refusal of a medication or treatment must be recorded in the resident's medical record. The documentation should include the date and time the physician was notified and the physician's response, as well as the resident's condition and any adverse effects due to the refusal. NJAC 8:39-11.2 (b)	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) appropriately address a resident's constipation	F 684	Resident #17 A.	8/12/19

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F 684	Continued From page 4 after the resident had no bowel movement for three days, b.) provide preventative measures for the skin integrity for a resident with hand contractures, and c.) accurately transcribe and administer a newly admitted resident's medications. This deficient practice was identified for 3 of 24 residents reviewed for quality of care (Resident #17, #41, and #292) and was evidenced by the following: 1. On 7/15/19 at 10:03 AM, the surveyor observed a Certified Nursing Aide (CNA) propel Resident #17 in a wheelchair to the unit's Shower Room. The CNA #1 stated that the resident was very confused but had indicated to him that he/she had to have a [redacted]. At that time, the surveyor observed the CNA #1 transfer the resident from the wheelchair to the toilet, and closed the curtain for privacy. At that time, the resident began grunting as though straining to have a [redacted] and was tightly grabbing the hand rails. At 10:08 AM, the CNA #1 told the surveyor, "It's hard for [him/her]" to move the bowels. The CNA #1 informed the surveyor that the resident was [redacted]" and that the resident would typically strain to have a bowel movement and that was normal for him/her. The CNA #1 stated that the resident had other behaviors which included using foul language toward staff. At that time, Resident #17 stated that only air was passing through and no stool. The resident began trying to strain again, and the CNA #1 told the resident to take his/her time. At 10:10 AM, the resident told the CNA #1 in the	F 684	Resident # 17 was given [redacted] p.o. daily to be added to resident's [redacted] Care Plan for Risk for [redacted] initiated for Resident #17. Staff In-serviced regarding reporting of [redacted] to the nurse. Staff In-serviced regarding [redacted] as outlined in the policy. B. No other resident affected by this deficient practice. C. In order to assure compliance the facility will: In-service staff regarding reporting of [redacted] to the nurse upon hire and annually thereafter. In-service staff to initiate "[redacted]" as outlined in the Policy upon hire and annually thereafter. Facility will modify CNA Documentation Form to include stool consistency in the log. D. DON/Designee will randomly observe 5 resident's CNA Documentation Form to ensure the [redacted] was implemented. This will be done monthly for 3 months, then quarterly thereafter. Result of these audits will be reported quarterly in the QAA meeting. Resident #292 A. Physician clarified [redacted] dose for Resident #292 to [redacted]	

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F 684	Continued From page 5 presence of the surveyor, "I can't" and the CNA #1 assisted the resident to stand and transfer back to wheelchair. At that time, the CNA #1 stated back to the resident that he/she did pass a small amount of stool and that it appeared to be "very hard." After the resident was cleaned and transferred into the wheelchair, the surveyor observed the small hard stool at the base of the bowl. The CNA #1 praised the resident for moving his/her bowels. The surveyor reviewed the medical record for Resident #17. A review of the Admission Record face sheet (an admission summary), reflected the resident was admitted to the facility on [redacted] with diagnoses which included [redacted] A review of a significant change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident was [redacted]. The assessment indicated that the resident had a [redacted] The assessment reflected that the resident was frequently incontinent of bowel, was not on a bowel toileting program, and was not constipated. The medication assessment reflected that the resident received a [redacted] 7 out of the last 7 days. A review of the electronic Order Summary Report	F 684	packet for Breakfast and Lunch and 2 packs for Dinner. Nurse who transcribed the order was educated and counseled. Nurse who completed the chart check was educated and counseled. Staff In-serviced regarding Medication Transcription of Admission Orders and Medication Reconciliation. B. No other resident affected by this deficient practice. C. In order to assure compliance, the facility will: In-service staff on Medication Transcription of Admission Orders and Medication Reconciliation upon hire and annually thereafter. Pharmacy Consultant will conduct Medication Reconciliation of all admission/readmission orders. D. DON/Designee will randomly observe 3 resident's admission order to ensure Medications are transcribed and reconciled accurately. This will be done monthly for 3 months, then every other month thereafter. Results of the audits will be reported in the quarterly QAA meeting. Resident #41 A. Resident re-evaluated by Occupational Therapist to determine appropriateness of washcloth to hands as previously recommended to maintain skin integrity related to bilateral hand contracture.	

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F 684	Continued From page 6 (OSR) for July 2019 reflected the following physician's orders (PO): A PO dated 10/6/17 for a [redacted] one tablet by mouth daily for [redacted]). A PO dated 3/29/19 for another [redacted] by mouth daily for [redacted] A PO dated 10/22/18 for a [redacted], [redacted] administer two (2) tablets by mouth daily for [redacted], and hold for [redacted] There were no other PO for [redacted] or [redacted] either routinely and/or as needed for [redacted]. In addition there was no evidence in the OSR that the resident was on a fluid restriction, and/or evidence of a need to increase fluid intake in the OSR. A review of the Interdisciplinary Care Plan revised on 2/20/19 reflected that the resident exhibited a significant change in status on [redacted] and was frequently [redacted] and had a decline in [redacted] noted this assessment. The care plan indicated "Part of it may be due to [his/her] behavior" in that if the resident wanted something he/she will do it, but that if he/she does not want to be assisted or toileted the resident may exhibit yelling or screaming. Interventions included to continue with routine incontinence care. There was no evidence for interventions specific to the resident's risk of [redacted] with being on two different diuretics and history of straining to have a bowel movement. A review of the CNA Care Plan Book reflected a CNA care plan for Resident #17. The care plan	F 684	Resident's nail trimming was placed on a schedule and was added to the Care Plan for Skin Integrity. Rehab and Nursing Staff In-serviced to communicate Rehab Recommendation to Nursing staff and queue appropriate orders in Electrical Medical Record as noted in the "Orders for Therapy Policy and Procedure" B. No other resident affected by this deficient practice. C. In order to assure compliance the facility will: In-service Rehab and Nursing staff to communicate Rehab Recommendation to Nursing staff and queue appropriate orders in Electronic Medical Record as noted in the "Orders for Therapy Policy and Procedure" upon hire and annually thereafter. Rehab Screen Form modified to include Nurse's Signature and Date recommendation was submitted by Rehab Staff. D. DON/Designee will randomly review 3 medical records to ensure therapy recommendation is communicated to the nursing staff. This will be done monthly for 3 months, then quarterly thereafter. Results of these audits will be reported in the QAA meeting quarterly.	

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included that the resident was [redacted] in the [redacted] and required an extensive one-person assist with activities of daily living (ADL). It further included that the resident was "incontinent bladder, continent bowel." The care plan did not address the resident's risk for constipation and/or that he/she tends to strain when having a bowel movement.

A review of the Nursing Assistant's Documentation Record for July 2019 reflected that the CNA's were documenting each shift if the resident had either a "0 = No BM [Bowel Movement]; S=Small; M=Medium; L=Large" bowel movement. There was no documented evidence or area to plot BM consistency (i.e., loose, soft, formed, and/or hard stool).

A review of the bowel log for July 2019 reflected that the resident had a medium sized bowel movement on 7/11/19 during the 3 PM to 11 PM shift. A review of the subsequent documentation reflected the resident had no bowel movement on the next shift of the 11 PM - 7 AM that day, and continued to have no bowel movement on 7/12/19, 7/13/19 and 7/14/19 for all three shifts. The surveyor then observed the resident on 7/15/19 at 10:03 AM, straining to have a bowel movement. The CNA documented that the resident had a "Medium" bowel movement during the 7 AM to 3 PM shift that day on 7/15/19.

On 7/16/19 at 12:03 PM, the surveyor observed Resident #17 in bed in a [redacted]. There was no evidence of a water pitcher at the resident's bedside and/or within reach. There was an untouched lunch tray on a table in the resident's room out of reach of the resident. The tray contained chopped chicken and peas, sweet

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potatoes, raspberry water ice and a six ounce mug of coffee. There were no other liquids on the resident's tray. The surveyor attempted to interview the resident, but the resident just stared at the surveyor and did not respond.

On 7/16/19 at 12:19 PM, the surveyor interviewed the resident's primary CNA #2. The CNA #2 stated that the resident was confused and mostly continent of bowel. The surveyor asked if the resident typically strains to have a BM, and the CNA #2 stated that Resident #17 "strains sometimes." The surveyor further asked what she does if she observes the resident having difficulty passing stool, and the CNA #2 did not respond. The surveyor inquired if she reports it to the nurse, and the CNA #2 stated, "she knows." The surveyor asked how the nurse knows, and CNA #2 stated, "I tell them." CNA #2 stated that the resident did not have a bowel movement today and was not on a fluid restriction. She stated that she assists with passing out water to the residents, and could not speak to the where the resident's water was at his/her bedside.

On 7/16/19 at 12:25 PM, the surveyor interviewed the resident's Registered Nurse (RN) who stated that she is the full time day nurse and was familiar with the resident. She stated the resident was confused and was not aware of any issues of constipation for the resident. The surveyor asked if a CNA ever reported to her that the resident was straining to have a bowel movement, and the RN stated "No." She stated that had she known that the resident strains, she would need to look at the electronic Medication Administration Record (eMAR) to see if the resident had a PO for a stool softener or laxative, and if not, she would call the attending Physician to get an order.

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The surveyor and the RN reviewed the resident's eMAR for July 2019 together. The RN confirmed the resident only had an order for [redacted] two tablets daily for [redacted]. She confirmed the eMAR did not reflect that the resident received a one time dose of any [redacted] She confirmed the resident also was on two [redacted]. The RN acknowledged that [redacted] place the resident at risk for [redacted]. The surveyor and RN also reviewed the resident's bowel log which indicated the resident did not have a BM for over three days, and on 7/15/19 the surveyor and CNA #1 observed the resident straining to have a BM. She confirmed that while she didn't work on 7/15/19, the CNA should have informed the nurse and the nurse should have contacted the physician to get an order for a [redacted] or [redacted]. She indicated that three days without a bowel movement is the cut off to address a resident's [redacted]. She confirmed the eMAR and OSR did not reflect evidence of an as needed (PRN) medication administered for [redacted].

At 12:31 PM, the surveyor interviewed CNA #1. CNA #1 stated that he signs in the CNA Care Plan book every shift for each resident he cares for. He stated that he was not the primary CNA for the resident, and that CNA #2 always had the resident. He stated he was just helping out yesterday on 7/15/19. He stated he did know that the resident strains. The surveyor and CNA #1 reviewed the bowel log together and stated that they don't need to document BM consistency in the record.

On 7/16/19 at 12:44 PM, the surveyor interviewed

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the Registered Dietician (RD). The RD stated that the resident was alert to self, and can vocalize what he/she wants. The RD stated the resident likes coffee as fluids and was not aware of the resident being on a fluid restriction. The RD and surveyor reviewed the resident's bowel log for July 2019 together, and the RD acknowledged there was no bowel movement consistency that gets documented. The RD indicated that while she reviews the bowel log, she mostly spends the time talking to staff who know the resident best. The RD acknowledged that when a resident is on diuretics, it does put the resident at risk for constipation. She stated that she was not aware that the resident exhibited episodes of straining. The RD added that typically if she knew of straining or issues related to constipation, she would make recommendations regarding bowel management. She stated that when she reviewed the resident's labs recently he/she had no evidence of dehydration. She stated she would review the information and get back to the surveyor.

On 7/16/19 at approximately 1:50 PM, the surveyor interviewed the Administrator, Director of Nursing (DON) in the presence of the survey team, and the surveyor requested additional documents regarding the resident's risk assessment for constipation and interventions to prevent and/or treat constipation, when the two CNA's indicated to the surveyor that Resident #17 strains at times to have a BM. The DON stated she would look into it and get back to the surveyor. The surveyor requested a copy of the facility's bowel regimen protocol/policy.

On 7/18/19 at 12:01 PM, the surveyor interviewed the RD a second time. The RD confirmed that

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the resident was not on a fluid restriction, however the Physician was notified and due to the resident's history of [redacted], the Physician did not want to increase fluid intake. The RD stated that the resident likes cola, the ensure nutritional supplement, and orange juice, and does not like water, as this was confirmed by the resident's family representative. She stated they were going to add fiberstat and trial prune juice in the mornings for the resident. The RD added that the general guideline we follow if there was no bowel movement for three days, nursing would review and call the Physician for an order to promote softening of the stool, if there was no current order for a [redacted]. The RD acknowledged that she was not aware of the resident having episodes of straining until surveyor inquiry.

On 7/18/19 at 2:00 PM, the surveyor interviewed the DON in the presence of the survey team who acknowledged that the resident did not get a [redacted] when he/she did not have a BM over three days and he/she was observed straining the fourth day. She confirmed that CNA's did not have to document stool consistency in the bowel records. The DON stated that the resident always strained to have a bowel movement in accordance with the family representative. The DON acknowledged this was not documented in the resident's medical record. The Assistant Director of Nursing (ADON) who was present in the conference room, acknowledged that straining to have a bowel movement can lower the resident's [redacted] and confirmed the resident was also on [redacted] that lower the resident's [redacted].

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A review of the facility's Bowel Protocol policy revised 3/2019 included, CNA's will document on the CNA Documentation Form every shift when the resident has a bowel movement. The 3 PM - 11 PM shift nurse will review CNA documentation daily. Upon review of the CNA Documentation Form, if there was no bowel movement for 3 consecutive days, the nurse will administer Either of the following: [redacted]

2. On 7/16/19 at 8:50 AM, the surveyor observed Resident #292 seated in a chair in his/her room. The resident stated to the surveyor that he/she had been admitted to the facility a few weeks ago, and went to [redacted] every Monday, Wednesday, and Friday in the afternoon. The resident further stated that before he/she was admitted to the facility, he/she took [redacted] three times a day with meals. The resident stated to the surveyor that the nurses working at night time never administered him/her the medication with dinner.

On 7/17/19 at 11:24 AM, the surveyor conducted a follow-up interview with the resident in his/her room. The resident stated to the surveyor that he/she had been dependent on [redacted] for a few years. The resident further discussed the medication [redacted] with the surveyor. The resident stated the medication could be taken in pill or packet form and that he/she took the medication in its packet form. The resident further stated that a lot of people that required [redacted] needed to take the medication [redacted] because

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it helped the body with the absorption of food.

The surveyor reviewed the medical records for Resident #292.

A review of the resident's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted].

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the MDS assessment was still in progress, as the resident was recently admitted to the facility.

A review of the OSR for July 2019 reflected a PO dated 6/30/19 for [redacted]. The order specified to give one packet by mouth two times a day with breakfast and lunch for [redacted].

A review of the corresponding electronic Medication Administration Record (eMAR) reflected that the resident was administered the [redacted] packet by mouth two times a day with breakfast at 0800 (8:00 AM) and lunch at 1200 (12:00 PM).

A review of the resident's admission paperwork reflected a medication list that indicated the resident had a PO for [redacted]; give one packet three times a day with breakfast, lunch, and dinner. The PO also indicated to give an additional packet of the [redacted] with dinner to equal two packets in total administered with dinner.

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A review of the resident's Interdisciplinary Progress Notes (IPN) from 6/30/19 to 7/15/19 did not reflect that the physician made changes to the resident's admitting medication regimen.

A review of the resident's Interdisciplinary Care Plan dated 7/17/19 reflected that the resident had a focus area of [redacted]. The goal indicated that the resident would not develop complications related to [redacted] treatment or [redacted] devices. The interventions included that the resident went to [redacted] three times a week every Monday, Wednesday, and Friday with a sitting time of 3:45 PM, administer medications per physician order, and the facility would discuss with the physician and [redacted] treatment center any changes in medication administration times and dosage pre-[redacted] as needed.

On 7/17/19 at 1:35 PM, the surveyor interviewed the resident's Registered Nurse (RN). The RN stated that the resident was very alert and oriented and was able to communicate his/her needs to staff. The RN stated that the resident was administered Renvela with breakfast and lunch. The RN further stated that when a resident was newly admitted to the facility, the admitting nurse would review the resident's admitting medication list with the physician. The RN stated that if the admitting physician wanted to make changes to the medications, the nurse would clarify the medication orders with the physician and document the changes the physician made in the resident's medical record.

On 7/17/19 at 1:44 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that when a resident was newly admitted to

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the facility, the nurse would receive a transfer form and a medication list from the hospital or from wherever the resident was admitted from. The admission nurse would then call the resident's physician and review the admitting medication list with the physician to verify the admitting medication orders. The RN/UM further stated that if the physician wanted to make changes to the medications specifically related to timing, dosage, or discontinuing of the medication, it would be documented by the nurse in the resident's medical record. The nursing staff would also review the resident's medications with them if they were alert and oriented.

On 7/19/19 at 9:15 AM, the DON in the presence of the faciliy's administration and the survey team, stated that the resident's physician was made aware of the medication discrepancy. The physician ordered two packets of Renvela to be administered daily with dinner.

A review of the facility's Care of Resident with ESRD on [redacted] Policy and Procedure dated 3/2019 included, "Nursing will verify orders with the Attending MD."

3. On 7/15/19 at 8:44 AM, the surveyor observed Resident #41 in bed. The Certified Nursing Aide (CNA) had just completed morning care, and he was waiting for another CNA to help assist him in transferring the resident from the bed to their wheelchair. The resident's hands were both clenched in a fist position with nothing visible in the palm of his/her hands. The surveyor attempted to interview the resident, however, the resident did not respond.

On 7/16/19 at 8:45 AM, the surveyor observed

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Resident #41 sitting in their wheelchair with his/her fists clenched in the dayroom. There was nothing visible in the resident's hands. The surveyor asked the resident if he/she could open their hands, and the resident replied yes. When the surveyor asked the resident to open his/her hands, the resident did not comply.

On 7/16/19 the surveyor reviewed the medical record for Resident #41 which revealed the following:

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included [redacted].

A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] reflected that the resident was unable to complete a brief interview for mental status (BIMS) and staff has to assess the resident's cognitive status. The assessment indicated that the resident had a [redacted]. The assessment reflected that the resident had a [redacted].

A review of a therapy Screen/Referral Form dated 6/28/19, reflected that the resident was seen today due to a nursing concern regarding the resident's skin integrity due to his/her [redacted] most of the time. [redacted] had been attempted in the past, but due to the

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resident's "behavior" the resident was unable to tolerate the [redacted]. It further indicated a recommendation to use [redacted] Staff and nursing were educated to use the washcloth fold after A.M. care and when doing hygiene."

A review of the Interdisciplinary Care Plan for Physical Therapy revised 5/16/19 had not reflected the use of w[redacted] in[redacted] for skin integrity.

A review of the Interdisciplinary Care Plan revised on 2/20/19 reflected a risk for skin breakdown due to incontinence and needs to assist with mobility. The care plan had not reflected the resident's risk for skin breakdown due to the resident's [redacted] being in a [redacted] most of the time.

A review of the resident's CNA Care Plan had not reflected the use of washcloths folded in the resident's [redacted] after morning care and when doing hygiene.

On 7/17/19 at 9:04 AM, the surveyor observed Resident #41 sitting in the dayroom with his/her [redacted]. The surveyor observed that the resident's [redacted] were both long in length and no washcloths were in the resident's [redacted]

At 11:59 AM, the Rehab Director informed the surveyor that therapy would receive referrals from nursing staff if there was a decline or change in a resident's functional status. The therapy department would then screen the resident to see

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if therapy would be appropriate for that resident. "If therapy had a recommendation, the therapist would notify the nurses to carry out the recommendation and notify the physician. Generally speaking, a recommendation would be carried out unless an order was needed from a doctor. If a recommendation was for gauze or a washcloth, then nursing would just need to be notified to do after care."

At 12:24 PM, the CNA informed the surveyor that when he tries to [redacted] Resident #41's [redacted], he/she would scream. The CNA stated that he does not cut his/her fingernails because the resident will scream. The CNA stated that he does not put anything inside the resident's [redacted] after morning care.

At 12:26 pm, the Registered Nurse (RN) informed the surveyor that in the past, therapy was working with Resident #41. Therapy in the past had tried to utilize [redacted] for the resident, but the intervention was unsuccessful. The resident was currently on a restorative nursing program three to five times a week for strengthening and positioning. The RN stated that she was unaware of any recent recommendation from therapy. She continued that if therapy had a recommendation, then therapy would let nursing know so they could carry out the recommendation and inform the physician.

At 12:31 pm, the Director of Nursing (DON) informed the surveyor that she was unable to speak to the resident's [redacted] without looking at the chart. The resident does have a history of behaviors that were care planned for. The DON stated that if the nurses or the CNAs observed a development in limitation

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in [redacted], then they would notify the therapy department who would perform a screen of the resident. Therapy also evaluates the residents quarterly and if there is a recommendation, then therapy would document that. The DON stated that the care plan would only be initiated for a [redacted]) if it interferes with the overall care of the resident. If the [redacted] do not affect the overall condition and the quality of life for the resident, no care plan would be generated. The resident's nails would be expected to be cut short unless there is a documented behavior, which would then be included in the care plan.

At 12:39 PM, the surveyor reviewed the therapy Screen/Referral Form dated 6/28/19 with the DON and the RN. Both the DON and the RN acknowledged that they were unfamiliar with this recommendation for the washcloths in the resident's hands after morning care. Both the DON and RN accompanied the surveyor into Resident #41's room. The DON informed the resident that she needed to open their [redacted] to check the skin integrity. The surveyor observed that the resident's skin was intact, however, their fingernails were long in length and discolored. The DON stated that she was able to tell that staff was trying to cut the resident's fingernails because the thumbnail was short. The surveyor observed that the resident's thumbnail was long in length and questioned the DON with regards to the nail length. The DON stated that the thumbnail was "shorter" than the fingernails in the closed fist.

On 7/19/19 at 9:21 am, the DON in the presence of the facility's administration informed the survey

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F 684	Continued From page 20 team that the facility conducted an interdisciplinary meeting to discuss Resident #41's contractures. The physician ordered a routine fingernail trim for the resident. The facility also initiated a care plan to trim the resident's fingernails. The DON stated that the washcloth recommendation was not followed because the therapist "just filed the recommendation in the chart without informing the nursing staff." The DON stated that the therapist informed her that she documented that she educated nursing staff on this recommendation, however, she did not. This was determined because she was unable to identify who she communicated the recommendation to. The DON stated that the facility's process was that therapy communicate any recommendations to the nursing staff. A review of the facility's Orders for Therapy policy dated and revised 3/19, included that a therapy recommendation will be communicated to the nursing department. The policy included this would be done by a physician order obtained from the medical doctor, training and education would be provided to the staff, and the care plan would be updated. NJAC 8:39-27.1	F 684		
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.	F 880		8/12/19

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F 880	Continued From page 21 §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 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 22 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, it was determined that the facility failed to perform a treatment to pressure ulcers in accordance with professional standards for infection control practices. This deficient practice was identified during a [redacted] treatment observation for 1 of 2 residents reviewed for [redacted] (Resident #9) and was evidenced by the following: On 7/15/19 at 9:58 AM, the surveyor observed Resident #9 in a bed located near the window, on an air mattress with his/her eyes closed. The Certified Nursing Aide (CNA) was finishing the resident's morning care. The CNA stated that the resident was not able to be interviewed due to his/her cognitive (mental) status and that the resident had a "[redacted]." The CNA	F 880	A. Nurse involved in this deficient practice educated and counseled. CNA involved in this deficient practice educated and counseled. Nursing Staff In-serviced regarding proper Wound Treatment Procedure, Utilization of PPE and Hand Hygiene. B. No other resident affected by this deficient practice. C. In order to assure compliance, the facility will: In-service staff regarding proper [redacted] Treatment Procedure, Utilization of PPE and Hand Hygiene upon hire and annually. Facility will install glove holders to all	

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F 880	Continued From page 23 told the surveyor that the Licensed Practical Nurse (LPN) was coming in to do a [redacted] dressing change for the resident's [redacted] The surveyor observed a used basin on the bedside table and the CNA removed the basin from the table. At 10:18 AM, the surveyor observed the LPN prepare a [redacted] treatment at the treatment cart for Resident #9. The LPN stated that the resident had [redacted] and each [redacted] had the same treatment orders. The LPN stated that she had pre-medicated the resident for pain using the narcotic analgesic [redacted] At that time, the LPN removed a handful of gloves from a box and put them in her pocket. She proceeded to grab [redacted] The LPN then entered the resident room and provided privacy. She then proceeded to apply three thick white single-use drapes onto the resident's bedside table where the basin was. The surveyor observed a ring of water where the basin was, and the LPN did not disinfect the bedside table. The LPN placed the white cloth drapes on the edge of the bedside table to avoid getting them wet. She then placed the treatment supplies on top of the drapes. At that time she removed her gloves from her pocket and prepared the treatment. She did not perform hand hygiene prior to applying the gloves. At that time, the surveyor observed the CNA remove gloves from his pocket and apply them onto his hands to assist in turning the resident.	F 880	resident rooms. D. Infection Preventionist will randomly observe 1 nurse perform Wound Treatment Procedure to ensure proper Infection Control Practices are followed. Infection Preventionist will randomly observe 2 nursing staff properly utilize PPE and perform Hand Hygiene. This will be done monthly. Results of these audit will be reported quarterly in the QAA meeting.	

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The LPN asked the resident if he/she was in pain and the resident indicated "no." At that time, the LPN removed an old dressing from the resident's [redacted]. The [redacted] was [redacted]. The LPN cleansed the [redacted] and applied a new dressing with a bordered foam to the resident's [redacted] She then removed her gloves and threw them in the trash can, got a new pair of gloves from her pocket and proceeded to the [redacted] the resident's [redacted]. The LPN did not perform hand hygiene between the glove changes.

At 10:31 AM, the LPN removed the old dressing to the resident's [redacted] which was [redacted]. The LPN cleansed the [redacted] with the [redacted] and applied the new dressing with a bordered foam pad using the same gloves. After she finished the treatment to the [redacted] she removed and discarded the gloves. She then removed another pair of gloves from her pocket and donned them without performing hand hygiene.

At 10:36 AM, the surveyor observed the LPN remove a dressing on the resident's [redacted] The LPN stated that it was a [redacted] that was showing signs of healing. The LPN then cleansed the [redacted] with a [redacted] and gauze pads, and applied the new dressing and bordered foam to the resident's [redacted] using the same gloves. After she completed the treatment to the area, she discarded used supplies and her gloves in the resident's trash can. The LPN then exited the resident's room with the [redacted] cleanser and she performed hand hygiene using the hand sanitation station secured

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	315336	A. BUILDING _____ B. WING _____	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS AT MONROE HEALTHCARE AND REHABILITATION, T	189 APPLEGARTH ROAD MONROE TOWNSHIP, NJ 08831

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F 880	Continued From page 25	F 880		

on the wall at the door of the resident's room. The surveyor looked around the room, and there was no additional hand sanitizer in the room. The LPN stated to the surveyor that she was going to sign the electronic Treatment Administration Record (eTAR) then she was done.

The LPN did not disinfect the bedside table at the completion of the wound treatment.

At 10:40 AM, the surveyor interviewed the LPN. The LPN stated that she washed her hands before coming into the room, and that she used hand sanitizer before she left the room. She further stated that she puts on a new pair of gloves between glove changes and before going to the next [redacted] to protect the other [redacted] from infection. She confirmed she did not wash her hands between glove changes because "there is no sink in that room." She stated there was a hand sanitization station at the door but it wasn't near the resident.

On 7/16/19 at approximately 1:45 PM, the surveyor informed the facility Administration of these findings.

On 7/18/19 at 12:40 PM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN). The IP/RN stated that nurses must wash their hands using soap and water or an alcohol-based hand gel between glove changes, depending "if the hands were visibly soiled." The IP/RN continued to state that changing gloves by itself does not replace the need to perform hand hygiene between glove changes. She stated that nurses and CNA's must also not store gloves in pockets, and should remove them straight from the box due to the risk of cross contamination

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F 880	Continued From page 26 from other items that could be stored in the pockets of staff. Further, the IP/RN added that the bedside table top should be cleaned using an Environmental Protection Agency (EPA)-registered bleach wipe before and after use. A review of the facility's Infection Control Prevention Program revised 11/2018 included, "In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub...if hands are not visibly soiled..." instructions indicated to use for all the following situations: "before and after direct contact with residents...before handling clean or soiled dressings, before moving from a contaminated body site to clean body site during care; after contact with a resident's skin; after handling used dressings, contaminated equipment, etc; after removing gloves." NJAC 8:39-25.2 (b), (c); 27.1 (e)	F 880		
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation and interview in the presence of facility management on 7/15/19, it was determined that the facility failed to ensure that resident rooms measured at least eighty (80) square feet per resident in multiple resident bedrooms, and at least one hundred (100) square feet in single resident rooms. This deficient practice was evidenced by the following:	F 912	Corrective Action; No specific residents identified. Systemic change and monitoring; All rooms will be evaluated to ensure safe use and appropriate placement. Environmental rounds will be conducted daily by Housekeeping and Nursing staff to ensure safety and continual	7/26/19

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F 912	Continued From page 27 At 8:25 AM, the surveyor and the facility's Director of Maintenance reviewed resident rooms [redacted] through [redacted], a total of 24 rooms, for square footage and possible occupancy. The surveyor determined the following: Rooms [redacted] measure 114 sq ft each. Each room currently houses 1 resident. The facility is requesting a variance so that each room can hold 2 residents, which would require 160 sq ft. Room [redacted] measures 133 sq ft. This room currently houses 1 resident. The facility is requesting a variance so that the room can house 2 residents, which would require 160 sq ft. Room [redacted] measures 123.5 sq ft. This room currently houses 1 resident. The facility is requesting a variance so that the room can house 2 residents, which would require 160 sq ft. Room [redacted] measures 133 sq ft. This room currently houses 1 resident. The facility is requesting a variance so that the room can house 2 residents, which would require 160 sq ft. Room [redacted] measures 123.5 sq ft. This room currently houses 1 resident. The facility is requesting a variance so that the room can house 2 residents, which would require 160 sq ft. Rooms [redacted] measure 142.5 sq ft. each. These rooms currently houses 1 residents in each room. The facility is requesting a variance so that these room can house 2 residents, which would require 160 sq ft. each.	F 912	compliance. Accordingly, the facility requests the continuation of the waiver for rooms [redacted], and [redacted] that was in existence since 1985. The facility will use these rooms for 1 resident when possible. The need to use these rooms for 2 residents would be for emergency or quality of life issues. Our emergency plan and 1135 waiver would include these beds.	

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F 912	Continued From page 28 Room [redacted] measures 123.5 sq ft. This room currently houses 1 resident. The facility is requesting a variance so that the room can house 2 residents, which would require 160 sq ft. Room [redacted] measures 114 sq ft. This room currently houses 1 resident. The facility is requesting a variance so that the room can house 2 residents, which would require 160 sq ft. Room [redacted] measures 150 sq ft. This room currently houses 1 resident. The facility is requesting a variance so that the room can house 2 residents, which would require 160 sq ft. Room [redacted] measures 138 sq ft. This room currently houses 1 resident. The facility is requesting a variance so that the room can house 2 residents, which would require 160 sq ft. Room [redacted] measures 150 sq ft. This room currently houses 1 resident. The facility is requesting a variance so that the room can house 2 residents, which would require 160 sq ft. Room [redacted] measures 120 sq ft. This room currently houses 1 resident. The facility is requesting a variance so that the room can house 2 residents, which would require 160 sq ft. Rooms [redacted], and [redacted] have the required square footage to house the residents the rooms are set up to receive and require no variance. Room [redacted] has 161.5 sq ft and can house 2 residents. Room [redacted] has 264 sq ft and can house 3 residents.	F 912		

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F 912	Continued From page 29 Room [redacted] has 208 sq ft and can house 2 residents. Room [redacted] has 170 sq ft and can house 2 residents. Room [redacted] has 207 sq ft and can house 2 residents. Room [redacted] has 368 sq ft and can house 3 residents Room [redacted] has 253 sq ft and can house 3 residents Room [redacted] has 117 sq ft and can house 1 resident In an interview, at 1:30 PM, the facility's Administrator stated he would apply for the continuance of the previously granted waiver/variance. NJAC 8:39 - 31.2(e)	F 912		