STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315214	A. BUILDING _____ B. WING _____	08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT CEDAR OAKS	1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080

(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: 8/2/19 CENSUS: 216 SAMPLE SIZE: 38 + 7 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		9/6/19

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

Electronically Signed | 08/23/2019

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F 656	Continued From page 1 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to develop a comprehensive person-centered care plan for: a.) a resident with limited mobility with associated pain, and b.) a resident who was incontinent of bowel and bladder. This deficient practice was identified for 2 of 38 residents reviewed for comprehensive care plans (Resident #160 and #187), and was evidenced by the following: 1. On 7/23/19 at 1:06 PM, the surveyor observed Resident #160 in bed. At that time, the surveyor interviewed the resident who stated that he/she was [redacted] and preferred to only get out of bed on Mondays, Wednesdays, and Fridays. The resident stated that he/she wanted someone to [redacted] The resident continued that staff would assist with [redacted] when being changed, and the movement	F 656	*Resident #160-The careplan was immediately updated to reflect residents [redacted]. The resident was evaluated by therapy and was reestablished on the RNP program for ROM. Resident 187-the careplan was updated to reflect the families input , the residents incontinence and the residents behavior regarding voiding and defecating in inappropriate areas. *All residents have the potential to be affected. *Systemic changes: Education for all staff who contribute to careplans to include measureable interventions and timetables, and to address problem areas and risk factors. *Monitoring: DON or designee will audit careplans of readmissions on a weekly basis. On a weekly basis 4 LTC careplans with recent quarterly will be audited. On a quarterly basis all LTC	

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F 656	Continued From page 2 caused him/her [redacted]. The resident stated that he/she received [redacted] as needed from the nurse, including a [redacted] A review of the resident's medical record reflected the following: The Admission Record (an admission summary) reflected that the resident was re-admitted to the facility on [redacted] with diagnoses which included [redacted] The quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] The resident's individualized comprehensive care plan with an initiated date of 12/22/17 did not include the resident's [redacted]. There was no evidence that the care plan was updated upon his/her readmission on 2/10/19 regarding the limited mobility and associated pain. On 7/30/19 at 9:07 AM, the Certified Nursing Aide (CNA) informed the surveyor that the resident was total care for activities of daily living and required a "hoyer lift" (a device used for surface-to-surface transfers). The CNA stated that the resident preferred to get out of bed only on Mondays, Wednesdays, and Fridays. The CNA stated that she will check on the resident every two hours and that she will sometimes turn and reposition the resident to his/her side. The	F 656	careplans will be reviewed by all disciplines and updated as needed . On a monthly basis findings will be reported to the administrator at the QAPI meeting and QAPI will determine if any further action is required.	

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CNA stated that she performed range of motion exercise during morning care including bending the legs and documents it in the resident's medical record.

At 12:18 PM, the Rehabilitation Director informed the surveyor that the resident was not currently on therapy. The resident received passive range of motion exercises daily to the lower extremities.

At 12:38 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that he completed the care plans, but the Social Worker and Dietitian also participated in care planning. The LPN/UM added that care plans topics included falls, medications, behaviors, and medical conditions, and they were updated quarterly and as needed. The LPN/UM stated that he would review Resident #160's care plan.

On 7/31/19 at 12:02 PM, the LPN/UM informed the surveyor that the resident's care plan should include [redacted]. He acknowledged it wasn't documented in the resident's care plan.

On 8/1/19 at 1:21 PM, the Director of Nursing (DON) stated that care plans can be created and updated by anyone including the DON, Assistant-DON (ADON), Social Services, Dietitian, and nurses, but usually the UM completed the care plan.

On 8/2/19 at 10:47 AM, the DON informed the survey team that the care plan for Resident #187 did not include the resident's [redacted] The DON clarified that the resident's diagnosis as [redacted].

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2. On 7/24/19 at 12:43 PM, the surveyor observed Resident #187 sitting at a table in the dayroom. The resident had just finished eating lunch. The surveyor attempted to interview the resident, but the resident did not respond to the surveyor's inquiry. The resident just smiled.

A review of the resident's medical record reflected the following:

A review of the Admission Record reflected that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted]

A review of the quarterly MDS dated [redacted] reflected that the resident had a BIMS score of [redacted] The assessment reflected that the resident was occasionally [redacted]

On 7/30/19 at 9:25 AM, the surveyor observed Resident #187 ambulating behind the nurse's station. The Certified Nursing Aide (CNA) easily redirected the resident back to his/her bedroom.

On 7/31/19 at 10:30 AM, the surveyor observed Resident #187 in the dayroom dancing to music.

At 1:36 PM, the surveyor interviewed the Resident #187's family representative in the presence of the survey team. The family representative stated that he/she was visiting this past weekend, and acknowledged that Resident #187 had bowel movement on the floor. The family representative further explained that the resident was not incontinent, and didn't want

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him/her to wear incontinent briefs.

The surveyor continued to review the resident's medical record.

A review of the electronic Progress Notes reflected the following:

A Behavior Note dated 5/8/19 at 11:10 PM indicated that the resident was walking around dropping fecal matter in various places in the hallway.

A Behavior Note dated 5/28/19 at 3:49 PM indicated that the resident was refusing to use the bathroom, and was noted urinating on the floor.

A General Note dated 6/12/19 at 8:12 PM indicated that the resident was walking in the hallway dropping fecal matter.

A General Note dated 6/14/19 at 7:54 PM indicated that the resident was walking around the hallway passing urine.

A review of the resident's individualized, comprehensive care plan initiated on 1/7/19 did not address that the resident had episodes of incontinence in the hallway, and/or interventions to address the resident's incontinence.

On 8/1/19 at 10:27 AM, the CNA informed the surveyor that Resident #187 had [redacted]. The resident refused to be toileted, unless the resident wanted to use the toilet. The CNA further explained that the resident was sometimes able to communication toileting

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needs, and he/she would be brought into the bathroom to void, but will immediately walk out. The CNA added that resident had a history of going to the bathroom on the floor or in a trash can because he/she was [redacted]. The CNA added that resident's family representative did not want the facility to use incontinent briefs.

At 10:32 AM, the Licensed Practical Nurse (LPN) informed the surveyor that the resident has [redacted] The resident was not easily re-directed, and only does what he/she wants to do, when they want to do it. The LPN added that the resident was incontinent of bowel and bladder, but the resident's son/daughter did not want them to wear incontinent briefs or pull-up incontinent briefs, and that the resident refused to be toileted, even though staff try to toilet the resident at least every two hours.

At 10:44 AM, the Social Worker (SW) informed the surveyor that the resident was [redacted] and paces back and forth through the hallway. The resident had occasional episodes of urinating or passing a bowel movement in the hallway. The resident's family representative did not want the resident to use incontinent briefs or pull-up incontinent briefs because he/she felt that the resident was physically able to use the bathroom. The SW added that staff attempt to toilet the resident, but the resident often refused to be toileted due to his/her [redacted]. The SW continued to explain that the facility has been educating the family member on [redacted] and the progression of the disease.

At 11:05 AM, the LPN/UM informed the surveyor

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that the resident had [redacted]. The LPN/UM stated that the family representative believed that the resident was continent of bowel and bladder and did not want the facility to use incontinent briefs on the resident. The LPN/UM added that resident would go to the bathroom on the floor or in a garbage can because he/she was [redacted]. The staff would bring the resident into the bathroom, but the resident would just walk out and use expletive that included the word "No!" The surveyor asked the LPN/UM if this should be included in the resident's care plan, the LPN/UM acknowledged that it should be in there.

At 1:21 PM the Director of Nursing (DON) stated that care plans can be created and updated by anyone including the DON, ADON, Social Services, Dietitian, and nurses, but usually the UM completed the care plan.

On 8/2/19 at 10:54 AM in the presence of the survey team, the DON acknowledged that the care plan did not address the resident's incontinence. The DON confirmed that incontinence should have been included in the care plan prior to surveyor inquiry. The DON acknowledged that the facility had been working on improving care plans, and it was an ongoing matter.

A review of the facility's undated Care Plan - Comprehensive policy included that an individualized patient centered comprehensive care plan are developed and should include measurable activities and timetables to meet the resident's medical, nursing, mental, and physiological needs. The policy also included that care plans should incorporate identified

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F 656	Continued From page 8 problem areas, risk factors, reflect treatments goals, specialized services, and identify the professional services that are responsible for each element of care. NJAC 8:39-27.1(a)	F 656		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis 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: a.) sequence medication in order to accommodate a resident's hemodialysis schedule in a timely manner, and b.) maintain ongoing communication records with the dialysis facility. This deficient practice was identified for 1 of 2 residents reviewed for hemodialysis services (Resident #413) and was evidenced by the following: On 7/24/19 at 12:19 PM, the surveyor observed Resident #413 in his/her room. The resident stated that he/she was dependent on [redacted] and went to the [redacted] center on Monday's, Wednesday's, and Friday's. The resident further stated that he/she left the facility to go to the [redacted] center early in the	F 698	*Resident 413- Medication times were changed on 7/22/19 to be administered when resident was not at [redacted] Nursing staff were educated on proper timing of meds with HD residents. The dietician contacted [redacted] facility for needed information. *All [redacted] residents have the potential to be affected. *Systemic changes: Admission checklist will be developed to address medication times and specific orders and needs for a HD resident. A standardized form will be developed for communication book for HD residents to be used by both the facility and the HD facility. Staff will be educated on both forms. *Monitoring : Unit manager, DON or designee will audit both forms on a weekly basis. On a monthly basis findings will be reported to the administrator at the QAPI	9/6/19

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F 698	Continued From page 9 morning and returned to the facility between 10:45 AM and 11:00 AM. On 7/31/19 at 12:59 PM, the surveyor conducted a follow-up interview with the resident in his/her room. The resident had just finished eating lunch and stated to the surveyor that "maybe" he/she brought a communication book with him/her to the [redacted] treatment center. The surveyor reviewed the medical records for Resident #413. The resident's face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included but were not limited to: [redacted]. The surveyor attempted to review the resident's most recent admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, but the assessment reflected it was still in progress, as the resident was admitted to the facility less than [redacted]. The resident's individualized comprehensive person-centered care plan dated 7/20/19 reflected a focus area that the resident had potential for complications due to [redacted] and went to [redacted] center three times a week. The goal of the resident's care plan was that the resident would remain free from complications and the resident's [redacted] would remain [redacted]. The interventions included to allow rest upon return from treatment and to send a communication book to the [redacted]	F 698	meeting and QAPI will determine if any further action is required.	

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F 698	Continued From page 10	F 698		

center and ensure it was returned after each session, so the facility had communication concerning weights, labs, medications, and general health.

A review of the Medication Review Report for July 2019 reflected a physician's order (PO) dated 7/20/19 with instructions for the resident to go to [redacted] center every Monday, Wednesday, and Friday.

A review of the corresponding Medication Administration Record (MAR) for July 2019 reflected physician orders dated 7/20/19, and in the MAR the following medications were signed to reflect the resident received the medications on Monday 7/22/19 at 9 AM:

[redacted]

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Further review of the MAR for July 2019 reflected that the following physician orders dated 7/20/19, and the MAR reflected the following medications were not administered on 7/22/19 at 9 AM:

1. A [redacted]. The MAR reflected to see the corresponding Progress Note (PN). A review of the corresponding PN dated 7/22/19 and timed at 11:09 AM reflected that the resident was at the [redacted] center and the time of the medication would be changed.

2. A [redacted] by mouth two times a day for supplement. The MAR reflected to see the corresponding PN. A review of the corresponding PN dated 7/22/19 and timed at 11:20 AM did not reflect that the resident was administered the medication.

3. A [redacted] by mouth two time a day for supplementation. The MAR reflected to see the corresponding PN. A review of the corresponding PN dated 7/22/19 and timed at 11:08 AM reflected that the resident was at the [redacted] center, and the time of the medication would be changed.

4. A [redacted] by mouth three times a day for [redacted]. The July 2019 MAR was signed to reflect that the resident was not administered the medication at 9 AM and 11:30 AM on 7/22/19. Instructions in the MAR reflected to see the corresponding PN. A review of the corresponding PN dated 7/22/19 and timed at 8:08 AM reflected that the resident was at the [redacted] center, and the time of the medication would be changed.

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A review of the PN dated 7/22/19 and timed at 11:09 AM reflected that the resident returned from the [redacted] center at 10:40 AM that day.

A review of the resident's [redacted] communication notebook reflected that the resident was to bring the [redacted] communication book with him/her to the [redacted] treatment center and to return the book to the facility with the resident after [redacted] treatment. A further review of the [redacted] communication notebook reflected that the only date written in the book was for Monday 7/29/19. There was no evidence of communication with the [redacted] center on Monday 7/22/19, Wednesday 7/24/19, and Friday 7/26/19, during the resident's scheduled [redacted] days. The information dated 7/29/19 included pre- and post-weight, blood pressure, pulse, and temperature. The documentation did not reflect if the information written in the book was from the facility or the [redacted] treatment center.

On 7/31/19 at 1:12 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident was alert and oriented to person, place, and time and knew everything about his/her care. The LPN stated that the resident left for the [redacted] treatment center at 5:30 AM and returned to the facility around 10:45 AM on Monday's, Wednesday's, and Friday's. The LPN and surveyor reviewed the MAR together, and the LPN further stated that the resident's medications should have been plotted according to his/her [redacted] schedule. The LPN confirmed at 9 AM the resident would not be available to administer the medications if he/she was out at [redacted]. The LPN stated that if the facility had a concern, they would usually call the

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[redacted] treatment center and speak with the nurses there, rather than documenting in a communication book. The LPN further stated that they had a book that he/she would take with them to the [redacted] treatment center and it was required that the [redacted] center document in the book the care that the resident received.

On 7/31/19 at 1:25 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who state that the resident's medications needed to be plotted according to the resident's [redacted] schedule. The LPN/UM further stated that the communication book between the facility and the [redacted] center was an important tool to document the care that the resident received at [redacted], and should be brought with the resident every time the residents left the facility for the [redacted] treatment center. The LPN/UM could not speak to why 7/29/19 was the only date with documentation with the [redacted] center.

On 8/02/19 at 10:28 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team. The DON stated that a resident's medications should be plotted according to their [redacted] schedule, and the residents should be bringing the communication book to and from the facility to the [redacted] center. The DON acknowledged the surveyors findings.

A review of the facility's undated [redacted], Care of Resident's with Policy and Procedure reflected, "2. Education and training of staff includes, specifically: f. Timing and administration of medications, particularly those before and after [redacted]" A review of the facility's undated [redacted], Care of

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F 698	Continued From page 14 Resident's with Policy and Procedure further reflected, "4. Agreements between this facility and the contracted [redacted] facility include all aspects of how the resident's care will be managed, including: b. How information will be exchanged between the facilities." NJAC 8:39-2.9; 2.10	F 698		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		9/6/19

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F 755	Continued From page 15 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to: a.) remove a controlled drug [redacted] from active inventory labeled for an unsampled resident that had expired in the facility in March of 2019, b.) maintain the accountability and reconciliation of two bottles of a controlled drug [redacted] stored in the refrigerator, and c.) remove a controlled drug [redacted] from active inventory upon manufacturer expiration. This deficient practice was identified for 1 of 2 refrigerated medication storage units on 1 of 4 floors [redacted] Unit), and was evidenced by the following: 1. On 7/25/19 at 10:46 AM, the surveyor with the Licensed Practical Nurse (LPN) reviewed the medications stored in the refrigerator on the [redacted] nursing unit. At that time, the surveyor with the LPN observed in the refrigerated locked box a [redacted] in a plastic bag with the Controlled Drug Administration Record (CDAR) (a declining inventory sheet used for the accountability of controlled substances). The bottle was unopened and the bottle and CDAR were labeled for an unsampled resident. The LPN stated that the unsampled resident had expired in the facility, but was unsure as to when the death occurred. The	F 755	*Medication [redacted] for the expired resident was removed immediately and destroyed as per policy. Medication [redacted] for resident #179 was removed and destroyed as per policy as it was expired. *All residents have the potential to be affected. *Systemic changes: All nursing staff to educated on (1)narcotic accountability (2)removal of meds from refrigerator upon death or discharge. *Monitoring: Pharmacy consultant to include narcotic audit for refrigerator on a monthly basis and report to DON. Audit to be done by DON or designee weekly for narcotic accountability and monitor removal of medications for deceased and/or discharged residents. . On a monthly basis findings will be reported to the administrator at the QAPI meeting and QAPI will determine if any further action is required.	

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LPN also stated that the [redacted] should have been removed upon the death of the resident and given to the Assistant Director of Nursing (ADON) for destruction. The LPN added that the CDAR was usually kept in a binder locked in the medication cart, and the LPN was not sure why the CDAR was with the [redacted] in the plastic bag. The LPN stated that a controlled drug inventory for each medication cart was done using the CDAR's that were kept in the binders on each medication cart.

On 7/25/19 at 11:04 AM, the surveyor interviewed the Unit Manager (UM) who stated that the unsampled resident had a death in the facility and was unsure of the date of the death. The UM added that she was unaware that the [redacted] had remained in the refrigerator with the CDAR stored in the bag. The UM added that the CDAR should be kept in the binder on the medication cart.

On 7/25/19 at 1:14 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that she was responsible for coordinating the controlled drug destruction. The ADON added that the nurses would give her any controlled drugs with the corresponding CDAR when removed from inventory. The ADON stated that the CDAR was suppose to be kept in the binder in each medication cart corresponding to the controlled drugs that would be inventoried each shift. The ADON also stated that she had received the Ativan for the unsampled resident for destruction but was unaware that the CDAR had been kept with the [redacted] and not in the binder. The ADON was unaware of any narcotic discrepancies.

On 07/30/19 at 1:04 PM, the surveyor reviewed the electronic medical records (EMR) for the

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F 755	Continued From page 17 unsampled resident. The EMR indicated that the unsampled resident had a death in the facility dated [redacted] On 7/31/19 at 8:15 AM , the surveyor reviewed the monthly Consultant Pharmacist (CP) unit inspection reports provided by the Director of Nursing (DON). The reports dated for the months from April 2019 to July 2019 for the nursing unit indicated that there were no discrepancies found in the spot check of the controlled drug count and no expired medications found in the refrigerator. On 8/1/19 at 10:50 AM, the surveyor conducted a phone interview with the CP who stated that she was not the CP who had performed the unit inspections but could speak on her behalf. The CP stated that she may not know which residents were no longer remaining in the facility and therefore may not realize a medication needed to be removed. On 8/2/19 at 9:52 AM, the survey team met with the facility administrative team. The DON acknowledged that the [redacted] should have been removed from active inventory as soon as possible and that the CDAR should not be stored with the controlled drug. A review of the undated facility policy for "Controlled Substances" provided by the DON included that the facility will comply with all laws related to storage and documentation of controlled substances. In addition, the nurse coming on duty and the nurse going off duty must count controlled drugs and document and report any discrepancies to the DON. 2. On 7/25/19 at 10:46 AM, the surveyor with the	F 755		

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Licensed Practical Nurse (LPN) reviewed the medications stored in the refrigerator on the [redacted] nursing unit.

At that time, the surveyor with the LPN observed in the refrigerated locked box a [redacted] labeled for Resident #179. The LPN stated that she was not sure if the [redacted] for Resident #179 had been used because the bottle looked full but would be able to decipher by reviewing the CDAR. There was no observation of a date when the bottle was opened.

On 7/28/19 at 10:56 AM, the surveyor with the LPN reviewed the [redacted] CDAR for Resident #179 that was kept in a binder locked in the medication cart. According to the CDAR the [redacted] had a received date of 3/19/19 and had been administered for the first time on 3/19/19 and as of the date 4/28/19 the remaining amount was 2.25 ml. The LPN then stated that the amount remaining on the CDAR was incorrect and should have been 29.25 ml based on the visual inspection of the amount remaining in the bottle. The LPN could not speak to why the CDAR was incorrect. The LPN then stated that a controlled drug count was completed and signed for every shift on the "Monthly Narcotic Sign In/Out Sheet" and if there were any discrepancies the nurses had to inform a supervisor right away. The LPN also stated that the inventory was done by two nurses for each controlled drug in the medication cart using the CDAR's in the binder.

On 7/29/19 at 9:50 AM, the surveyor with the UM reviewed the [redacted] CDAR for Resident #179 which indicated on the label, "Discard opened bottle after 90 days." The UM acknowledged that

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the [redacted] for Resident #179 had been opened on 3/19/19 and had an expiration date of 90 days after opening which would have been 6/19/19 and had remained in the refrigerator. The UM also acknowledged that Resident #179 had not received the [redacted] since 4/28/19. The UM added that she was unaware of a discrepancy in the amount remaining. The UM added that a monthly unit inspection was performed by the Consultant Pharmacist (CP) and usually told the nurses if a medication was expired.

On 7/29/19 at 12:30 PM, the surveyor interviewed the ADON who stated that she had received the [redacted] for Resident #179 to be destroyed. The ADON stated that she was unaware that the [redacted] had expired. The ADON also stated that once opened the [redacted] should be dated and it was the responsibility of the nurses when completing the controlled drug shift to shift count to check for accuracy and expiration dating. The ADON also stated that when the nurses completed a controlled drug count if there were any discrepancies the nurses needed to report to a supervisor and the discrepancy would be resolved immediately. The ADON added that the [redacted] should have been removed before the expiration date and the discrepancy for the amount remaining should have been resolved.

On 7/31/19 at 8:15 AM , the surveyor reviewed the monthly Consultant Pharmacist (CP) unit inspection reports provided by the Director of Nursing (DON). The reports dated for the months from April 2019 to July 2019 for the nursing unit indicated that there were no discrepancies found in the spot check of the controlled drug count and no expired medications found in the refrigerator.

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F 755	Continued From page 20 On 7/31/19 at 9:22 AM, the surveyor conducted a phone interview with the CP who stated that she was not the CP who had performed the unit inspections but could speak on her behalf. The CP stated that the unit inspection reports may not always have the specific medications that were found expired because there was also verbal communication to the nurses. The CP acknowledged that the Ativan concentrate expires 90 days after the date of opening as per the manufacturer, and needed to be removed after the 90 days. On 8/2/19 at 10:10 AM, the survey team met with the facility administrative team. The DON acknowledged that the [redacted] for Resident #179 should have been removed and discrepancies resolved prior to surveyor inquiry. NJAC 8:39- 29.4(g),29.4(k), 29.7(c)	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		9/6/19

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F 757	Continued From page 21 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to appropriately administer medications used to management blood pressure in accordance with physician orders. The deficient practice was identified for 2 of 8 residents reviewed for medication management (Resident #4 and #95), and the evidence was as follows: 1. On 7/23/19 at 10:25 AM, the surveyor observed Resident #95 lying in bed. The resident stated that he/she was having some pain and thought it was from a fall that he/she had had the day before. The resident explained that he/she had bent over to pick up a spoon and fell out of the wheelchair. The resident stated that he/she did feel lightheaded sometimes but that wasn't why he/she had fallen. The resident added that the nurses gave him/her medications. On 7/31/19 at 9:55 AM, the surveyor interviewed the Certified Nursing Aide (CNA) who stated that the resident was alert and oriented and could tell her his/her needs. The CNA added that the resident had been complaining of pain recently and sometimes complained of feeling dizzy. The CNA stated that the resident would sometimes say that the reason for the dizziness was that his/her blood sugar or blood pressure "felt low." The CNA added that she would tell the nurses	F 757	*Resident #95- was seen by MD regarding evaluating [redacted]. Resident #4 [redacted] evaluated by NP and prn [redacted] was discontinued. * All residents taking medications with parameters have the potential to be affected. *Systemic change: All nurses educated regarding parameters, correct documentation in the EMR. * Monitoring: Pharmacy consultant will audit monthly for incorrect parameter holds and report to DON and administrator. DON or designee will audit 4 random MAR's per week that have hold parameters. . On a monthly basis findings will be reported to the administrator at the QAPI meeting and QAPI will determine if any further action is required	

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whenever the resident complained of pain or dizziness.

On 7/31/19 at 9:57 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that the resident's [redacted] had been fluctuating and sometimes complained of feeling dizzy. The LPN added that the resident had a physician's order (PO) for [redacted] to increase the [redacted] and the resident's [redacted] was taken prior to each dose.

At that time, the surveyor with the LPN reviewed the electronic Medication Administration Record (eMAR) which indicated that there was a PO dated 7/27/19 for [redacted] which indicated to hold the [redacted] if the [redacted]) was greater than [redacted] The LPN stated that the resident had been readmitted on [redacted] to the facility because the resident had been sent to the hospital with a diagnosis of [redacted] The LPN added that she rarely administered the [redacted] in the morning because the resident's [redacted] was usually greater than [redacted].

The surveyor reviewed the electronic health records (EHR) for Resident #95.

A review of the resident's Admission Record face sheet (an admission summary) revealed an initial admission date of [redacted] with a readmission date of [redacted] with diagnoses which included [redacted]

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the

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management of care dated 5/25/19, reflected the resident had a brief interview for mental status (BIMS) score of [redacted]

A review of the PO indicated there was an original physician order dated 5/26/19 and renewal order for 7/27/19 for [redacted] give one tablet two times a day, hold for [redacted] "

A review of the June 2019 eMAR was signed to indicate that the [redacted] was administered outside the hold parameters at 7:30 AM on 6/22/19 for a [redacted]

A review of the July 2019 eMAR was signed to indicate that the [redacted] was administered outside the hold parameters at 7:30 AM on 7/6/19 for a [redacted], 7/19/19 for a [redacted], and 7/23/19 for a [redacted].

A review of the July 2019 eMAR was signed to indicate that the [redacted] was administered at 4:30 AM on 7/1/19 for a [redacted], 7/2/19 for a [redacted], 7/23/19 for a [redacted] and 7/26/19 for a [redacted].

A review of the resident's individualized, comprehensive care plan (CCP) dated 5/27/19, revised on 7/29/19 reflected that there was no interventions to monitor the blood pressure.

A review of a Nurse Practitioner Progress Note dated 7/24/19 reflected that the resident had a history of [redacted].

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F 757	Continued From page 24 On 8/1/19 at 9:30 AM, the surveyor reviewed the eMAR with the Unit Manager (UM) who stated that according to the PO the [redacted] should have been held when the [redacted] was greater than [redacted]. The UM could not speak to why the nurses had administered the [redacted] on the dates reviewed. The UM added that she didn't think the CCP needed to include the fluctuations in [redacted] Further review of the EHR revealed the Pharmacist Consultant (CP) note dated 6/14/19 indicated to "plot [redacted] for hold parameters." On 8/1/19 at 10:50 AM, the surveyor conducted a phone interview with the CP who stated that she was not the CP who had written the reports but could speak on her behalf. The CP stated that the facility had been working on making sure that the hold parameters were being followed correctly. The CP added that she was able to review the eMAR and the [redacted] doses should have been held in accordance with the physician orders. The CP stated that the electronic, greater-than arrow symbol should be written out to prevent any confusion. On 8/2/19 at 9:52 AM, the surveyor team met with the facility administrative team. The Director of Nursing (DON) stated that she had reviewed the eMAR's for Resident #95 and had identified the nurse(s) involved in incorrectly administering the [redacted]. The DON also stated that the CCP should have been updated to include [redacted]. The DON added that the CP had identified there was a problem with the nurses	F 757		

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properly following hold parameters and there was an in-service done for nurses on 6/19/19 and 7/12/19. The DON was unable to provide documented evidence in the EHR as to why the nurses were administering the medication outside the physician hold parameters.

A review of an undated facility policy for "Administering Medications" provided by the DON revealed that medications shall be administered in a safe manner as prescribed and medications must be administered in accordance with orders.

2. On 7/23/19 at 11:16 AM, the surveyor observed Resident #4 lying in bed with a family representative in the room. The family representative stated that he/she had a concern that Resident #4 had not been receiving medications correctly. The family representative was unable to provide the surveyor with specifics, including dates and times.

The surveyor reviewed the medical record for Resident #4.

A review of the resident's Admission Record face sheet revealed an initial admission date of [redacted] with diagnoses which included [redacted].

A review of the annual MDS dated [redacted] reflected the resident's BIMS [redacted].

A review of the PO indicated there was an order dated 4/7/19 a medication used to [redacted]

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ARISTACARE AT CEDAR OAKS	1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080

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[redacted]. The order specified to administer one tablet [redacted] two times a day for [redacted] and "hold for [redacted]

A review of the June 2019 eMAR revealed that the [redacted] was administered without regard to the physician-ordered hold parameters at 5:00 PM on 6/23/19 for a [redacted]

A review of the July 2019 EMAR revealed that the Norvasc was administered without regard to the physician-ordered hold parameters at 5:00 PM on 7/7/19 for a [redacted], 7/8/19 for a [redacted]3, 7/10/19 for a [redacted] 7/13/19 for a [redacted]f [redacted] and 7/24/19 for a [redacted].

A review of the PO indicated there was an order dated 4/7/19 for another medication used to [redacted] The order specified to administer [redacted] every 12 hours for [redacted] and [redacted]

A review of the June 2019 eMAR revealed that the [redacted] was administered without regard to hold parameters at 6:00 AM on 6/13/19 for a [redacted], 6/23/19 for a [redacted] and 6/24/19 for a [redacted]. In addition, the [redacted] was administered at 6:00 PM on 6/1/19 for a [redacted] and on 6/23/19 for a [redacted].

A review of the July 2019 eMAR revealed that the [redacted] was administered without regard to the hold parameters at 6:00 AM on 7/1/19 for a [redacted]. The [redacted] was administered at 6:00 PM on 7/7/19 for a [redacted], 7/13/19 for a [redacted], and 7/14/19 for a [redacted]

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F 757	Continued From page 27 On 7/29/19 at 8:47 AM, the surveyor interviewed the LPN who stated that she administers medications to Resident #4. The LPN added that the family was very involved and she takes a [redacted] prior to medication administration and would usually tell the family the results. On 7/30/19 at 10:51 AM. the surveyor with the UM reviewed the June and July eMAR together for Resident #4. The UM stated that the [redacted] and [redacted] should have been held according to the PO. The UM could not speak to why the medications were administered anyway. Further review of the EHR revealed a CP note dated 5/17/19 which indicated "watch holds." On 8/1/19 at 10:50 AM, the surveyor conducted a phone interviewed the CP who stated that she was not the CP who had written the reports but could speak on her behalf. The CP stated that the reports indicated that the CP was reviewing the hold orders. The CP also stated that the facility had been working on making sure that the hold parameters were followed correctly. On 8/2/19 at 9:52 AM, the surveyor team met with the facility administrative team. The DON stated that she had reviewed the eMAR's for Resident #4 and had identified the nurse(s) involved in inaccurately administering the [redacted] The DON added that the CP had identified there was a problem with the nurses properly following hold parameters and there was an in-service done for nurses on 6/19/19 and 7/12/19. She was unable to provide documented evidence within the resident's EHR as to why the nurses were administering the medication without	F 757		

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F 757	Continued From page 28 regard to the hold parameters, as specified by the physician. NJAC 8:39-27.1(a), 29.2(d)	F 757		
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; §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	F 880		9/6/19

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F 880	Continued From page 29 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. §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: a.) address a lab report which indicated a resident had a [redacted] b.) ensure that a resident's [redacted]	F 880	*Resident #1- Isolation was clarified with Infectious Disease NP. The resident was not treated for the [redacted] and it was determined that the resident was [redacted] and that only universal	

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F 880	Continued From page 30 [redacted] was stored in a way to prevent infection, and c.) perform appropriate infection control techniques to prevent infection during a [redacted] care treatment. This deficient practice was identified for 1 of 4 residents reviewed for infection control, (Resident #1, #103, and #211), and was evidenced by the following: 1. On 7/24/19 at 12:01 PM, the surveyor observed a plastic bin outside the room of Resident #1. The plastic bin contained personal protective equipment (PPE) which included disposable gowns, masks, and gloves. There was no stop sign outside of the resident's room to stop and see the nurse before entering. The resident was not in his/her room at that time. On 7/24/19 at 12:55 PM, the surveyor observed Resident #1 sitting in a wheelchair in his/her room. The surveyor applied PPE and entered the resident's room. The resident was holding a 4 x 4 dressing over his/her throat from a newly removed [redacted]. The resident stated to the surveyor that he/she had their [redacted] removed in the hospital about three weeks ago, then acquired [redacted] stayed in the hospital for nine more days, and required [redacted] in the hospital and they continued it at the facility. The resident further stated that he/she wasn't receiving the [redacted] for the [redacted] anymore and that the nurses would only apply the PPE when they went into the room to change him/her.	F 880	precautions were necessary. Resident #103-[redacted]. Staff was educated regarding proper storage of [redacted] Resident # 211 [redacted] was monitored for healing and nurse was immediate given education and a [redacted] care competency was done. *All residents have the potential to be affected. *Systemic change: All nursing staff to be educated. (1)Isolation precautions (2) review of lab results on a daily basis (3) proper storage of [redacted] and when appropriate to [redacted] (4)hand hygiene and [redacted] treatment. *Monitoring: (1) Lab reports will be monitored and addressed on a daily basis by all nursing staff (2) appropriate storage of [redacted] and wearing of [redacted] to be audited weekly by Unit Manager DON or designee. (3) [redacted] care competency to be done on hire and with annual evaluation (4)Hand hygiene and [redacted] care to be observed randomly 3 times a week by DON or designee. On a monthly basis all findings will be reported to the administrator at the QAPI meeting and QAPI will determine if any further action is required.	

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The surveyor reviewed the medical record for Resident #1.

A review of the resident's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] and re-admitted on [redacted] with diagnoses which included but were not limited to [redacted].

A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted].

A review of a [redacted] dated [redacted] reflected that the resident had a [redacted] report further included, '[redacted]

A review of the progress notes dated 7/30/19 and

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F 880	Continued From page 32 time stamped at 10:05 AM reflected that the Licensed Practical Nurse/Unit Manager (LPN/UM) called the Infectious Disease (ID) doctor to make them aware of lab results and would follow up. A further review of the progress notes did not reflect interventional follow up with the [redacted] or further follow up with the resident's primary care physician and/or ID physician. A review of the resident's comprehensive care plan did not address the resident had a [redacted]. On 7/30/19 at 11:53 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that she had been taking care of the resident since [redacted] when he/she was re-admitted to the facility from the hospital. The LPN further stated that the resident was on contact isolation for an [redacted] in his/her [redacted] and that the nurses would only have to apply PPE when they entered the resident's room to perform care. The LPN was unable to tell the surveyor what type of [redacted] the resident had in his/her [redacted]. On 8/1/19 at 9:28 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was awake, alert, and oriented to person place and time. The CNA further stated that she did not perform [redacted] care on the resident. On 8/1/19 at 9:34 AM, the surveyor conducted a follow up interview with the resident's LPN who stated that the resident also had an [redacted] in the [redacted] and had a [redacted] The LPN stated to the surveyor that	F 880		

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the resident needed his/her dressing changed on the [redacted] site a few times a day because the [redacted]. The LPN further stated that she was unsure if there was a physician's order regarding the [redacted] in the resident's [redacted] and the surveyor would have to ask the LPN/UM more about that. The LPN stated that she knew the resident was currently not taking an [redacted]c for the infection in his/her [redacted] so overall she was unsure.

On 8/1/19 at 11:55 AM, the surveyor interviewed the LPN/UM who stated that when the resident was re-admitted to the facility he/she was on contact isolation for a [redacted] that required contact precautions. The LPN/UM further stated that the resident was no longer on isolation for an [redacted], but the nurses would apply PPE when performing [redacted] for the resident because he/she had a [redacted], [redacted] a few times a day because it became soiled frequently. The LPN/UM stated that she called the resident's primary care physician and notified him/her of the [redacted]. The LPN/UM further stated that the resident's primary care physician told her to call the ID doctor. The LPN/UM further stated that she placed a call to the ID doctor and was waiting for a call back. The LPN/UM could not speak as to what type of [redacted] the resident had in his/her [redacted]

On 8/02/19 at 10:32 AM, the surveyor interviewed the Director of Nursing/Infection Preventionist (DON/IP). The DON/IP stated that the she was waiting for the resident to be followed up and

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F 880	Continued From page 34 seen by an ID doctor. The DON/IP further stated that on 7/29/19 the resident's primary care physician was made aware of the [redacted], but the ID doctor had not addressed it yet. The DON/IP stated that the facility put the resident on [redacted] to be safe in the meantime until the resident was followed up with by the ID physician because the resident had a [redacted], the 4 x 4 dressings needed to be changed by nursing staff several times a day, and the resident's [redacted]. The DON acknowledged that the facility utilized the Universal Transfer Form (UTF) from the hospital as a communication tool upon re-admission to the facility. The DON stated that she reviewed it, and it was illegible as to what isolation precautions the resident was on. The DON acknowledged there was no physician order for an [redacted] treatment for the [redacted] nor was there an order for the contact precautions. The DON was unable to provide documented evidence as to when the contact precautions were implemented. The DON stated that the resident had a [redacted] and no fever, therefore, there was no need to treat the [redacted] at this time. She acknowledged that the resident required frequent dressing changes due to a [redacted] that he/she was [redacted] The DON was unable to provide documented evidence of accountability for the contact precautions. A review of the facility's undated Isolation - Categories of Transmission- Based Precautions Policy and Procedure did not address [redacted]. 2. On 7/23/19 at 10:33 AM, the surveyor observed Resident #103 sitting in his/her	F 880		

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F 880	Continued From page 35 wheelchair in the day room on the unit. The surveyor did not see evidence of a [redacted]. The surveyor observed the resident speaking to a staff member on the unit in his/her [redacted] The resident was [redacted] On 7/23/19 at 10:34 AM, the surveyor knocked and entered the resident's room and observed a [redacted] stored in a plastic bag attached to a handrail in the resident's bathroom. The surveyor observed that the resident's [redacted] was uncapped, comingled, and in direct contact with the plastic bag and a [redacted] in the bag. The surveyor observed a small amount of [redacted] On 7/24/19 at 11:38 AM, the surveyor observed the resident laying in bed with his/her legs positioned at the same level as his/her [redacted]. The resident's eyes were closed, and he/she appeared to be sleeping. The surveyor did not see visible evidence of a [redacted] in use at that time, and was unable to determine if the resident was [redacted] On 7/24/19 at 12:38 PM, the surveyor observed the resident laying in bed with his/her eyes closed. The resident's legs were positioned at the same level of his/her [redacted] and the knees were positioned up toward his/her chest. The surveyor did not see evidence of a [redacted] The surveyor was unable to determine if the resident was wearing a [redacted]	F 880		

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F 880	Continued From page 36 On 7/24/19 at 1:20 PM, the surveyor observed the resident laying in the same position as he/she was at 12:38 PM in bed in his/her room. The surveyor was unable to determine if the resident was wearing a [redacted], and there was no [redacted] attached to the bedframe. On 7/29/19 at 11:57 AM, the surveyor entered the resident's room and observed a [redacted] stored in a plastic bag attached to a handrail in the resident's bathroom. The surveyor observed that the resident's [redacted] tubing was uncapped and comingled in the plastic bag with a urinal and in direct contact with the plastic bag and the [redacted]. The surveyor reviewed the medical record for Resident #103. A review of the resident's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included but were not limited to unspecified [redacted] A review of the resident's most recent admission MDS dated [redacted] reflected that the resident had a BIMS score of [redacted] A further review of the resident's MDS reflected that the resident had an [redacted]	F 880		

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F 880	Continued From page 37 A review of the resident's individualized care plan revised on 5/21/19 reflected a focus area that the resident required a [redacted] The care plan indicated that this put the resident at risk for infection. The goal of the care plan reflected that the resident would not have signs or symptoms of a [redacted] for 30 days. The interventions of the care plan reflected to change the [redacted] as needed as per facility policy and position the tubing and the [redacted], below the resident's body level. A review of the resident's July 2019 Medication Review Report reflected that the resident had a physician's order (PO) dated 5/25/19 to change the [redacted] to a [redacted] daily when up out of bed, and change back to a [redacted] On 7/29/19 at 12:00 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA). The CNA and surveyor entered the resident's bathroom together and observed that the tubing of the resident's [redacted] was uncapped. The CNA stated that she could not find the cap to the resident's [redacted] that morning, so she stored it in the plastic bag uncapped. The CNA further stated that the resident liked to take a nap after lunch and whenever the resident took a nap after lunch, the staff would switch the [redacted]. The CNA stated that the [redacted] was to be stored below the level of the resident's [redacted] to keep the resident	F 880		

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F 880	Continued From page 38 comfortable. The CNA confirmed that the [redacted] was stored in the bathroom, and that the resident was not currently connected to a [redacted] On 7/29/19 at 12:05 PM, the surveyor interviewed the resident's LPN who stated that the resident was alert with periods of confusion. The LPN stated that the resident had a [redacted]. The LPN further stated that when the resident went back to bed after the lunch, the staff should change the resident's [redacted] so that the [redacted] was stored below the [redacted]. The LPN stated that the [redacted] should be capped when it was being stored, to prevent contamination and infection. On 7/29/19 at 12:12 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that the resident's [redacted] should have been stored in a plastic bag and capped to prevent the spread of infection when it was stored. The LPN/UM further stated that when the resident was lying in bed, the resident should not have had a [redacted] and the staff should have changed the [redacted] and stored it below the level of the resident's [redacted] to prevent [redacted]. On 8/02/19 at 10:13 AM, the surveyor interviewed the Director of Nursing/Infection Preventionist (DON/IP) who stated that all of the nursing staff was in-serviced on proper storage of the [redacted] related to the tubing being capped and to keep the [redacted] below the level of the [redacted]. The DON/IP further stated that the staff should have switched	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT CEDAR OAKS	1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080

(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 880	Continued From page 39	F 880		

the resident's [redacted] to a [redacted] when the resident was in bed. The DON/IP stated that the resident did not have any [redacted].

A review of the facility's undated [redacted] Disconnection for Brief Intervals Policy and Procedure included that the purpose of the policy and procedure was, "to provide guidelines to decrease the likelihood of [redacted] associated with the disconnection of [redacted].. Every attempt should be made to maintain a closed [redacted]... [and] a new sterile [redacted] should be used every time the regular straight drainage tubing is disconnected."

3. On 8/01/19 from 10:30 AM to 11:00 AM, the surveyor observed the Licensed Practical Nurse (LPN) perform a [redacted] treatment for Resident #211. The surveyor observed that the resident had various personal items stored on top of his/her overbed table. The personal items consisted of tomatoes, drinks, and napkins. The surveyor observed the LPN push the resident's personal items from one side of the resident's overbed table to the otherside and gathered the personal items together. The surveyor then observed the LPN wipe down the part of the overbed table that did not contain the resident's personal items with a wet paper towel and soap. No barrier was placed on the top of the resident's overbed table. The surveyor then observed the LPN prepare and place the treatment supplies to perform the resident's wound care treatment directly on top of the resident's overbed table with the food and personal items nearby.

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	315214	A. BUILDING _____ B. WING _____	08/02/2019

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ARISTACARE AT CEDAR OAKS	1311 DURHAM AVENUE SOUTH PLAINFIELD, NJ 07080

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F 880	Continued From page 40	F 880		

The LPN continued to perform the [redacted] care treatment on the resident. The surveyor observed a [redacted] on the resident's [redacted]. The surrounding skin was observed to be [redacted] with no visible evidence of [redacted]. The surveyor observed the LPN remove a new bordered guaze dressing from the packaging with her gloved hands, put her gloved hand in her pocket and take out a permanent marker to date the top of the bordered guaze dressing. The LPN then removed her gloves and put on a new pair of gloves without performing hand hygiene. The surveyor further observed the LPN apply a [redacted] to the dressing and apply it directly onto the resident's [redacted]. After the LPN completed the [redacted] treatment, the LPN did not disinfect the overbed table which she was using as a working surface for the [redacted] treatment.

On 8/1/19 at 11:05 AM, the surveyor interviewed the LPN who stated that usually she would apply a drape or a barrier to the overbed table prior to performing the [redacted] care treatment. The LPN stated, "I'll put a drape down. Today I used soap and water, but usually I would cleanse the table with a bleach wipe." The LPN further stated that she would perform hand hygiene with soap and water for 20 seconds after the removal of her gloves.

On 8/2/19 at 9:20 AM the surveyor interviewed the DON/IP who stated that nurses were required to wash their hands before and after the removal of gloves.

A review of the facility's undated [redacted] Care Policy and Procedure included, "1. Use disposable cloth (paper towel as adequate) to

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F 880	Continued From page 41 establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange supplies so they can be easily reached." 14. "Be certain all clean items are on clean field." NJAC8:39-31.4(a)	F 880		