STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315136	A. BUILDING ______ B. WING ______	11/26/2019

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MERIDIAN NURSING & REHAB AT SHREWSBURY	**89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702**

(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: 11/26/19 CENSUS: 121 SAMPLE SIZE: 25 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 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical	F 604		12/15/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/13/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 604	Continued From page 1 symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to conduct and document on-going re-evaluation of the need for or reduction of restraints for 1 of 1 resident reviewed for restraints (Resident #17). This deficient practice was evidenced by the following: Review of the Resident Face Sheet revealed that Resident #17 was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted]. Review of the resident's Quarterly Minimum Data set (MDS), an assessment tool dated [redacted], revealed Resident #17 had a Brief Interview for Mental Status (BIMS) of [redacted] The MDS also revealed there resident needed extensive assistance of two or more staff to transfer, did not walk in the room or corridor on their own and was totally dependent on staff for locomotion on and off the unit. The MDS also revealed the resident had a trunk restraint; no symptoms noted of being short-tempered or easily annoyed and no behaviors of physical, verbal or other noted. Review of the resident's Annual MDS, dated [redacted], revealed Resident #17 had a BIMS of	F 604	1. We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions: a. Immediate evaluation was completed on resident #17 and the need for the continual lap buddy was identified. b. All nursing team members educated on the Restraint policy. 2. How will we identify other residents having the potential to be affected by the same deficient practice: a. All residents requiring restraints have the potential to be affected. 3. Measures put in place or systemic changes made to ensure that the deficient practice will not recur: a. Staff Educator or designee will complete annual education to all nursing team members regarding restraint use and monitoring. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: a. Director of Nursing or designee will audit all residents requiring restraints to ensure documentation follows our Restraint policy. These audits will occur weekly for one month, bi-monthly for three	

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F 604	Continued From page 2 [redacted] The MDS also revealed that the resident needed extensive assistance of two or more staff to transfer, did not walk in the room or corridor on their own and was totally dependent on staff for locomotion on and off the unit. The MDS also revealed the resident had a trunk restraint; no symptoms of being short-tempered or easily annoyed and no behaviors of physical, verbal or other noted. The MDS also revealed a fall narrative that the resident had been free of falls this quarter; used a lap buddy (cushioned restraint that spans across the residents lap) and that there had been no ill effects related to the use of the lap buddy. The MDS also revealed a physical restraints narrative to use the resident's lap buddy when appropriate; no harm or ill effects related to the use of restraint; free from falls this quarter and resident had a tendency to stand unassisted and is restless. Review of the Physician's order, dated 01/26/17, revealed a lap buddy restraint while in the wheelchair. Release and remove the restrictive device for care and skin checks and as appropriate. Review of the Care Plan (CP) for restrictive devices/alternatives, dated effective 4/22/16, revealed "re-evaluation at least monthly for need of restraint and for the restraint reduction." The surveyor reviewed Resident #17's electronic medical record (EMR), and was unable to find any monthly documented re-evaluation of the need or reduction of the lap buddy. On 11/18/19 at 10:19 AM, the surveyor observed	F 604	months and monthly thereafter. b. Director of Nursing or designee will report findings to the QAPI Committee quarterly.	

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Resident #17 in the [redacted] floor day room, in a wheelchair. Resident #17 had a [redacted] lap buddy that was attached to the resident's wheelchair.

On 11/19/19 at 10:48 AM, the surveyor observed Resident #17 in the [redacted] floor unit day room in the wheelchair with the lap buddy across the wheelchair. Resident #17 was sleeping.

On 11/21/19 at 10:35 AM and 12:04 PM, the surveyor observed Resident #17 in the [redacted] floor unit day room by a table. Resident #17 had a lap buddy across the wheelchair. Resident #17 was calm during the observations.

On 11/22/19 at 9:33 AM, the surveyor observed Resident #17 in the [redacted] floor unit day room eating breakfast with staff assistance. Resident #17's lap buddy was across the wheelchair and the resident was calm.

On 11/25/19 at 8:50 AM, the surveyor observed Resident #17 in the [redacted] floor unit day room with the lap buddy across the wheelchair. Resident #17 had his/her eyes closed.

During an interview with the surveyor on 11/25/19 at 9:00 AM, the Certified Nursing Assistant (CNA) stated the lap buddy was usually on at all times. The CNA stated they can feed the resident without the lap buddy but the resident sometimes gets fidgety. The CNA stated the staff can take the lap buddy off for care sometimes.

During an interview with the surveyor on 11/25/19 at 9:08 AM, Resident #17's direct care Registered Nurse (RN) stated the resident used the lap buddy for agitation and to prevent the resident from getting up. The RN stated the resident had

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not felt good for a while and therefore had been calm. The RN stated the lap buddy should be taken off every few hours. The RN stated that nursing and the Unit Manager (UM) would be responsible for re-evaluation of the use of the lap buddy and to initiate a change in the care plan if needed.

During an interview with the surveyor on 11/25/19 at 9:16 AM, the RN/UM stated she had just started at the facility and didn't know anything about Resident #17.

During an interview with the surveyor on 11/25/19 at 9:27 AM, the Director of Nursing (DON) stated the monthly re-evaluation was in the nursing progress notes because nursing was responsible for the re-evaluations. The DON accessed the computer in the presence of the surveyor and was unable to provide any monthly re-evaluation note. The DON stated the UM would do the re-evaluation and the staff would discuss it as a team. The DON stated that the re-evaluation should entail that the lap buddy would be removed and the resident monitored for their behaviors. The DON stated that the results of monthly evaluation should be documented in the progress notes.

During an interview with the surveyor on 11/25/19 on 9:54 AM, the DON stated they only have monthly restraint notes and could not locate any re-assessments or evaluation for the need of the restraint. The DON stated that Physical Therapy (PT) department would also be involved. The DON stated the evaluations should include the behavior when the restraint was removed and that would help to determine if a resident still needed the restraint. The surveyor requested any

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re-evaluations for need for the last six months but the facility was unable to provide any. The DON stated she had reviewed the resident's records and there had not been a fall in over a year.

During an interview with the surveyor on 11/25/19 at 10:21 AM, the PT Director stated Resident #17 had not been on therapy for a long time. The PT Director stated that they only do quarterly screens, which involved interviewing the CNA and nurses to see if there were changes with the resident. The PT Director stated they would review the residents during meetings with the nursing staff but that nursing did the removal trials for re-evaluation of the restraints.

During an interview with the surveyor on 11/25/19 at 10:35 AM, the restorative CNA stated that she knew Resident #17. The restorative CNA stated the resident didn't take steps anymore but would stand and pivot with help and that the nurse would do the re-evaluation for the use of the lap buddy.

During an interview with the surveyor on 11/26/19 at 10:20 AM, the DON stated that if the resident had behaviors, they should be documented in the progress notes but since the staff was so familiar with Resident #17, they hadn't documented the behaviors. The DON stated a re-evaluation and trial of removal of the lap buddy were being done now but acknowledged that none had been done prior to surveyor inquiry.

Review of the Monthly Restraint Meetings, dated 01/19 through 11/19, revealed no documentation that the lap buddy was removed with behaviors noted and no documentation of any attempts to reduce the use of the lap buddy.

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F 604	Continued From page 6 Review of the facility's "Restraint Policy," dated 03/19, revealed the policy was to use the least restrictive option for the least amount of time and document ongoing reevaluation of the need for a restraint. Additionally, the policy stated gradual reduction of the restraint will be attempted to prevent negative outcomes associated with restraint use. NJAC 8:39-27.1(a)(c)(13(i-ii)	F 604		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program 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	F 880		1/1/20

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procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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F 880	Continued From page 8 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to a.) apply Personal Protective Equipment (PPE) for 2 of 2 residents (Resident #32 and #171) on isolation precautions and b.) handle linens to prevent the spread of infection for 1 of 2 residents (Resident #171) on isolation precautions. This deficient practice was evidenced by the following: 1. According to the Resident Face Sheet, Resident #171 was admitted to the facility on [redacted] with diagnoses that included but were not limited to; [redacted]. Review of the resident's Brief Interview for Mental Status (BIMS), dated [redacted], revealed that the resident had a score of [redacted]. Review of the resident's laboratory report, dated 11/20/19 at 10:44 AM, revealed that the resident's [redacted] Review of the resident's Physician Orders, dated 11/20/19 at 11:14 AM, revealed that the resident was on strict isolation precautions related to [redacted]. Review of the resident's Care Plan (CP), dated 11/20/19, revealed that the resident was on strict isolation related to [redacted]. The CP	F 880	1. We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions: a. The underlying cause was human factor due to lack of mindfulness in the presence of the state surveyor(s). b. Immediate education was provided to the nurse involved with Resident #171 regarding PPE use. c. Immediate education was provided to the EVS team member cleaning room of Resident #32 Regarding PPE use. d. Physician order to discontinue isolation precautions on Residents #32 was received on 11/22/2019. e. Care Plan for Resident #32 was updated to include the discharge of isolation precautions on 11/22/2019. f. Immediate education was provided to the Recreation staff member involved with resident #171 regarding safety concerns pertaining to items left on the floor. g. Immediate education was provided to all team members regarding isolation practices and infection control. 2. How we will identify other residents having the potential to be affected by the same deficient practice: a. All residents requiring isolation have the potential to be affected. 3. Measures put in place or systemic changes made to ensure that the deficient practice will not recur:	

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F 880	Continued From page 9 also revealed, "I have an active highly contagious infection and requires strict isolation to prevent spread of infection." Interventions included but were not limited to; Apply PPE outside upon entry to the room. Review of the resident's Progress notes written by Licensed Practical Nurse (LPN) #1, dated 11/20/19 at 12:04 PM, revealed that the resident's [redacted] Review of an additional Progress note written by the infection control nurse, dated 11/20/19 at 12:17 PM, revealed that the resident had a [redacted] and that the resident was having difficulty with the [redacted] and [redacted] was on the bed and on the resident's hands. The resident was on strict isolation and PPE was on the door for staff and visitors to put on prior to entering the room. On 11/20/19 at 11:30 AM, the surveyor observed a "strict isolation" sign outside of the resident's door and PPE hanging on the door. The isolation sign read, "stop contact precautions" and "strict isolation. Gown and gloves required for all persons entering the room, limit traffic to essential staff." At that time, the surveyor observed LPN #1 inside of the resident's room, talking to the resident's roommate. LPN #1 was explaining to the resident's roommate that the resident was to be moved to another room because Resident #171 had an [redacted]. LPN #1 did not have PPE on and stated to the resident's roommate that she "technically" should be wearing PPE inside the room. LPN #1 left the room.	F 880	a Staff Educator or designee will complete ongoing education to all team members on proper isolation practices. b. Director of Nursing will implement an audit surveillance tool to use for monitoring individual team member isolation practices. c. Staff Educator or designee will complete education to all team members on mindfulness. 4. How the corrective actions will be monitored to ensure that the deficient practice will not recur: a. Director of Nursing or designee will monitor the audits weekly for one month; will monitor bi-monthly for three months; will monitor monthly thereafter. b. Director of Nursing or designee will report findings to QAPI Committee quarterly.	

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During an interview with the surveyor on 11/20/19 at 12:26 PM, a Certified Nurse Aide (CNA) #1 assigned to the resident, stated she was told that morning that the resident was on strict isolation. CNA #1 stated that when a resident was on isolation, staff cannot walk into the room without PPE. CNA #1 stated she was not sure why the resident was on isolation but that the resident required assistance with toileting and using the [redacted]

During an interview with the surveyor on 11/20/19 at 12:37 PM, LPN #1 stated Resident #171 was placed on strict isolation for [redacted] and was placed on strict isolation because the resident [redacted]. LPN #1 stated staff were to wear PPE which included a gown and gloves prior to entering the room. LPN #1 acknowledged that she was not wearing PPE prior to entering resident #171's room and stated she should have.

On 11/21/19 at 11:13 AM, the surveyor observed a bag of linen sitting on the floor by the door way of Resident #171's room. A recreational staff member entered the room, put on PPE and stepped over the bag to speak to the resident. The staff member then stepped over the bag to remove PPE, stepped over the bag to wash her hands and stepped over the bag to leave the room. The staff member then notified CNA #2 of the bagged linen on the floor. At that time, CNA #2 walked over, put on gloves and placed the linen in the soiled linen cart.

During an interview with the surveyor on 11/21/19 at 11:28 AM, CNA #2 who was assigned to Resident #171, stated when linens are removed, they are placed in a plastic bag and then in the

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linen cart. CNA #2 stated bagged linen cannot be on the floor due to infection control and didn't remember why she left it on the floor in the resident's room.

During an interview with the surveyor on 11/21/19 at 11:47 AM, the infection control nurse (ICN) stated that the facility used strict and modified isolation guidelines. The ICN stated that when the resident is placed on isolation, isolation signs are placed outside the resident's door, PPE is provided, the CP is updated and the staff are informed. The ICN stated all staff were required to wear PPE prior to entering any type of isolation room. ICN stated Resident #171 was placed on strict isolation because of the [redacted], and that the resident had difficulty using the [redacted] and would get [redacted] on the resident's hands and bed sheets. The ICN stated once linens were removed, they should be bagged and placed directly into the soiled linen cart and not on the floor.

During an interview with the surveyor on 11/25/19 at 10:21 AM, the Registered Nurse Unit Manager (RN/UM) stated Resident #171 was placed on strict isolation for [redacted] of the [redacted] because the resident had difficulty using the [redacted] and [redacted] would spill on the resident. The RN/UM stated that anyone who entered any type of isolation room should put on PPE prior to entering. The RN/UM stated when linen was removed it should be bagged and taken directly out of the room to the linen shoot.

During an interview with the surveyor on 11/25/19 at 12:24 PM, the Director of Nursing (DON) stated when a resident was placed on isolation, the ICN places the isolation signs on the

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	315136	A. BUILDING ______ B. WING ______	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN NURSING & REHAB AT SHREWSBURY	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

(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 12 resident's door which notifies staff and visitors of what type of PPE to wear prior to entering the resident's room. The DON stated staff were to wear PPE prior to entering the isolation rooms to protect themselves and other residents. Additionally, the DON stated that linen should be bagged in the resident's room, placed directly in the linen cart and should never be on the floor. 2. According to the Resident Face Sheet, Resident #32 was admitted to the facility on [redacted] with diagnoses that included but were not limited to; [redacted]). Review of the resident's BIMS, dated [redacted], revealed that the resident had a score of [redacted] Review of the resident's laboratory report, dated [redacted] at 2:40 PM, revealed that the resident's [redacted]." Review of the resident's [redacted] Progress Note, dated 11/11/19, reflected that the resident had [redacted]. Review of the resident's Physician Order's, dated 11/15/19 at 12:11 PM, revealed that the resident was on modified contact isolation related to [redacted]. Review of the resident's CP, dated 11/14/19, revealed that the resident had an infection of [redacted]. Further review of the CP reflected that on 11/15/19, the resident	F 880		

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F 880	Continued From page 13 was on modified contact isolation due to a contagious infection that required modified contact to prevent the spread of [redacted]. Review of the resident's Progress notes, written by the ICN dated 11/15/19 at 12:16 PM, revealed that the resident's [redacted] was [redacted] [redacted] and was placed on isolation with modified precautions. On 11/20/19 at 8:28 AM, the surveyor observed Resident #32 lying in bed. The room had a sign that indicated the resident was on isolation. On 11/22/19 at 9:01 AM, the surveyor observed an Environmental Services (ES) staff member enter Resident #32's room with gloves on but no gown. There was a sign that indicated the resident was on modified isolation precautions, The ES staff member went to the middle of the room and pulled the blood pressure machine closer to the door and proceeded to clean it with a wipe. During an interview with the surveyor at that time, the ES staff member stated that when a resident was on isolation, before he could enter a room, he should use hand sanitizer and put on gloves, a gown, and sometimes a mask. He also stated that was called PPE. The ES staff member then stated that a nurse told him that the isolation was discontinued and that he needed to clean the room. He could not state which nurse reported this to him. During an interview with the surveyor on 11/22/19 at 9:26 AM, the ICN stated that staff should have used PPE when cleaning an isolation room after it had been discontinued. She confirmed that Resident #32 had been discontinued from modified isolation that morning and that the ES	F 880		

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F 880	Continued From page 14 staff member should have been wearing PPE to clean the room. During an interview with the surveyor on 11/22/19 at 12:30 PM, the Director of Environmental Services stated that when a staff member cleaned a resident's room whose isolation had been discontinued, they must wear PPE. He further stated that if a staff member entered a room to retrieve a piece of equipment to clean, they must still use PPE, and that gloves would not have been enough. During an interview with the surveyor on 11/25/19 at 12:12 PM, the ICN stated that Resident #32 was on modified isolation because the [redacted] was able to be contained. She further stated that staff still needed to use PPE when entering the room. During an interview with the surveyor on 11/25/19 at 12:32 PM, the DON stated that during the cleaning process of a resident's room whereby isolation was discontinued, staff were required to wear PPE. During an interview with the survey team on 11/25/19 at 1:30 PM, the DON and Vice President of Nursing acknowledged that once a resident was discontinued from isolation, the room was still considered "dirty" and the ES staff would still be required to wear PPE to enter and clean the room. During an interview with survey team on 11/26/19 at 10:34 AM, the DON stated that the ES staff member should have used PPE to clean the resident's room. Review of the facility's Infection Prevention	F 880		

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F 880	Continued From page 15	F 880		

Review (which the facility used to educate staff), dated 2019, revealed [redacted] .. Policy-the facility follows the Center of Disease (CDC) and Association of Practitioners in Infection Control (APIC) recommendations for isolation precautions. Don PPE prior to entering a resident/patient room. Wear PPE at all times when entering an isolation room no matter why you are entering the room.

Review of a facility policy titled, "Linen Services Related to Infection Prevention," dated 02/18, included but was not limited to;
Procedure-Handling Soiled Linen: "All used linens shall be handled as potentially contaminated and use of standard precautions is needed: 1. Soiled linen shall not come in contact with the floor... 3. Contaminated laundry is bagged at the point of collection. (The location where it was used)... 8. Bag and store soiled linen in a designated area."

Review of a facility policy "Cleaning Isolation Room," approved date 05/2019, reflected that the facility should avoid cross contamination or the spread of infectious disease during the process. It further reflected that a gown, gloves and mask were required to be used according to the type of isolation the resident was on.

NJAC 8:39 19.1(b), 19.4(a)(2), 21.1 (b)