| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>CENSUS: 83<br><br>SAMPLE SIZE: 21 +14<br><br>A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. | F 000 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences<br>CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident had a.) a call bell placed within reach, and b.) the appropriate call bell for his/her assessed functioning level. This deficient practice was identified for 1 of 18 residents reviewed (Resident #56), and was evidenced by the following:<br><br>On 10/14/20 at 11:24 AM, the surveyor observed Resident #56 in bed, and the resident's [redacted] was bent toward the [redacted] and he/she had a [redacted]. The surveyor observed that the button call bell was wrapped around the [redacted] rail of the bed, hanging toward the floor and out of reach for the resident. The resident informed the surveyor that he/she currently had to communicate a need to the nurse. The | F 558 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>The facility will continue to ensure resident rights to reside and receive services in the facility with reasonable accommodation of resident needs and preference except when to do so would endanger the health and safety of the resident or other residents.<br><br>a). Resident #56s call bell was placed within reach and staff members were re-educated on call bell placement on 10/21/2020. | 11/23/20 |

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

Electronically Signed | 11/03/2020

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| F 558 | Continued From page 1<br>surveyor asked the resident about the call bell and the surveyor observed the resident reach with his/her [redacted] in an attempt to reach the call bell hanging toward the floor on the resident's [redacted], but the resident was unable to reach it. The surveyor observed that the resident did not use his/her [redacted] while trying to access the call light. At that time without accessing the call bell, a Certified Nursing Aide (CNA) knocked and entered the resident's room and Resident #56 informed the CNA of his/her need.<br><br>At 12:45 PM, the surveyor returned to the resident's room, and observed Resident #56 in bed. The call bell was still wrapped around the [redacted] rail hanging toward the floor as it had been at 11:24 AM that morning.<br><br>The surveyor reviewed the medical record for Resident #56.<br><br>A review of the Admission Record face sheet (an admission summary) included that the resident was admitted with diagnoses which included [redacted]<br><br>A review of the annual 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] indicating a [redacted] impaired cognition with forgetfulness. It further included that the resident required a total two-person assist for bed mobility and | F 558 | b). Resident #56 was assessed by the Occupational Therapist on 10/21/2020 and provided with a [redacted]<br><br>2. How will you identify other residents having the potential to be affected by the same deficient practice?<br><br>The facility recognizes that residents with impaired mobility can potentially be affected by the same deficient practice.<br><br>3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur? Who is responsible?<br><br>A checklist was developed and implemented for all residents identified with impaired mobility. The checklist includes call bell placement, appropriateness of call bell, and required assessment for accommodations.<br><br>Staff members across disciplines were provided education of the centers policy for Accommodations of Needs on 10/26/2020 and 10/27/2020.<br><br>The Center Nurse Executive or designee will identify each resident with impaired mobility and utilize the checklist implemented to ensure proper call bell placement and appropriateness of call bell. Results will be tracked utilizing an audit tool. | |

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| F 558 | Continued From page 2<br>transfers and that he/she had range of motion limitations to the both the [redacted] and [redacted].<br><br>A review of the resident's individualized care plan revised [redacted] included that the resident was dependent on staff for care due to contractures with a decline in function and cognition. Goals included that the resident's care needs will be anticipated and met through the next review period. There was no reference to the resident's impaired ability to use a call bell. An intervention dated [redacted] included to place the call light within reach while in bed or close proximity to the bed to prevent falls.<br><br>A review of the resident's Kardex (individualized plan of care for CNAs) effective as of [redacted] did not address the resident's use of a call bell.<br><br>A review of the electronic Progress Notes (ePN) and the resident's medical record did not address the resident's functional use or non-use of the call bell, or if any adaptive call bell had been trialed.<br><br>The surveyor continued to make observations and interviews, which revealed the following:<br><br>On 10/16/20 at 10:10 AM, two surveyors observed Resident #56 in bed. The CNA stated that she had just finished assisting Resident #56 with morning care. The surveyor observed the button call bell wrapped around the [redacted] rail hanging toward the ground, and out of reach for the resident. At that time, the CNA informed the surveyor that the resident was able to make his/her needs known, but that he/she was dependent on staff for all care and was unable to | F 558 | 4. How the corrective action(s) will be monitored to ensure the deficient practice does not recur? Include how often the facility will monitor.<br><br>The Center Nurse Executive or designee will conduct random audits of residents with impaired mobility for call bell placement daily x4 weeks, then weekly x4 weeks, then monthly x2 months until substantial compliance is identified.<br><br>The Center Nurse Executive or designee will report findings at the monthly Quality Assurance Performance Improvement Meeting. | |

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| F 558 | Continued From page 3 | F 558 | | |

independently reposition in bed due to [redacted] After the surveyors interviewed the CNA, the CNA continued to walk down the hallway without placing the call bell in reach of the resident.

At 10:15 AM, the two surveyors returned to the resident's room and interviewed the resident. The surveyor asked the resident about the use of the call bell, and the resident turned with his/her [redacted] in an attempt to reach the call bell that was hanging toward the floor on the [redacted] and the resident was again unable to reach the call bell. The surveyor asked if he/she was able to use the call bell, and the resident showed the surveyors that he/she was able to move the [redacted] and the resident began making a [redacted] pressing-motion. The resident acknowledged that the call bell was not in reach. The surveyor asked how he/she would communicate with staff if the call bell was out of reach, and the resident replied, "[redacted]" that staff would anticipate his/her needs and come into the room on their own accord. The resident could not recall a time in which he/she was negatively affected by not being able to access a call bell.

On the same day at 11:45 AM, the surveyor observed the Licensed Practical Nurse (LPN) enter the resident's room to perform a medical treatment. The resident's call bell was still out of reach on the [redacted] and in the same position as it was at 10:10 AM when the CNA finished performing morning care.

At 12:21 PM, after the LPN performed the medical treatment, the LPN unwrapped the call bell from the [redacted] rail and placed it closely to

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| F 558 | Continued From page 4 | F 558 | | |

the resident's [redacted] within reach. The LPN informed the resident that she was placing the call bell in reach and told the resident that if he/she needed anything, to press the button.

On 10/20/20 at 9:39 AM, two surveyors observed Resident #56 in his/her room sitting in a reclined [redacted] chair watching TV. The resident appeared comfortable. The surveyors observed the resident's call bell out of reach, wrapped around the resident's [redacted] rail hanging toward the floor and behind the resident's [redacted] chair.

At 9:44 AM, the surveyor attempted to interview the CNA but the CNA was unavailable for an interview. At that time, two surveyors interviewed the LPN who stated that prior to exiting a room, the CNA's and nurses are responsible to make sure any resident has access to a call bell. The surveyor asked if Resident #56 was able to use a call bell, and the LPN stated that she was unsure if the resident was able to functionally use the button call bell because he/she was forgetful. She stated that she believed that sometimes the resident will ask for help by calling out. She stated that we have to "remind" the resident to use the call bell, and even if he/she forgets to use it, the call bell "should be next to [him/her] either way." The LPN confirmed the resident did not have use of his/her [redacted] due to [redacted] and that the call bell should be placed on the [redacted] and not the [redacted].

At 9:46 AM, the two surveyors observed the LPN unwrap the call bell from the [redacted] and place it in the resident's [redacted]. She stated that the CNA should have placed the bell in the hand after getting him/her up from the bed to the

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| F 558 | Continued From page 5<br>chair.<br><br>On 10/21/20 at 10:19 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that she had only worked at the facility for about a month. She confirmed Resident #56 had [redacted]. She confirmed that a call bell should always be placed in reach to the resident's [redacted] side but confirmed she was not sure if the resident knew how to use it or if he/she was capable of using it. She could not speak to if the resident had a always had a button call bell or if that was appropriate for the resident's level of functioning. She acknowledged that the CNA's and nurses were responsible for making sure the call bell was in reach.<br><br>On 10/21/20 at 10:45 AM, two surveyors observed Resident #56 in bed and the button call bell was in the resident's reach. At that time, the surveyor asked if the resident was able to press the call bell. The resident responded appropriately and picked up the call bell with the [redacted] and tried to squeeze it with the [redacted] The resident wasn't sure if that made the light go on or not, and asked the surveyors, "Did it work?" The surveyor asked the resident if he/she was able to press the button with the thumb, and the resident attempted to press the button but the was unable to press it hard enough to activate the bell.<br><br>At 10:47 AM, the surveyor interviewed the CNA and brought the CNA into the resident's room. The CNA was unsure if the resident was able to activate the call bell using the call button. The CNA asked the resident to press the button on | F 558 | | |

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the call bell in the presence of the two surveyors. The surveyors observed that the resident was attempting to press the button but was unable to press the [redacted] hard enough to activate the call bell. The CNA stated to the surveyors that "the call bell is very hard to push" for some residents, and that a button call bell wasn't the most appropriate for the resident. The CNA stated that the facility had a sensor call bell that if it was tapped, it could activate a bell which the CNA stated would be worth trying for the resident. She confirmed that she was not aware of any time that the resident had trialed an adaptive call bell that accommodated the resident's needs. She stated that she checked on the resident frequently.

On 10/22/20 at 11:00 AM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. The DON confirmed she had only been employed at the facility for approximately one month since September. The DON confirmed that the button call bell was not appropriate for the resident's functional ability due to [redacted] and [redacted]. She stated that the facility provided the resident a "squeeze call bell" yesterday, but stated that she was not sure if the resident would remember to use it. The DON confirmed there was no documented evidence that another adaptive call bell had been trialed to see if the resident would be able to use it. The DON stated that she believed the resident had a [redacted] call bell that he/she was using prior to the COVID-19 pandemic, but it was discontinued. The DON was unable to provide documented evidence that the resident had a [redacted] call bell or that the resident had been assessed for another adaptive

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| F 558 | Continued From page 7<br>call bell until surveyor inquiry. The DON acknowledged that the call bell should be within reach and adaptive, if necessary for all residents in the facility.<br><br>A review of the facility's policy Accommodation of Needs reviewed 12/05/19 included that the "Residents have the right to reside and receive services in the Center with reasonable accommodation of needs and preferences, except when the health or safety of the individual or other residents would be endangered.." It further included that "The Center must provide...adaptations of the patient's bedroom and bathroom furniture and fixtures as necessary to ensure the patient can (if able): ...Perform other desired tasks such as turning a table light on and off, using the call bell, etc."<br><br>NJAC 8:39-4.1(a)11; 31.1(b) | F 558 | | |
| F 658 SS=E | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that the facility failed to ensure: a.) the reconciliation, accountability, and notification of the physician for the use of a [redacted] in accordance with professional standards of nursing practice. and b.) a resident-designated [redacted] vial was not shared with another resident during a medication pass observation. | F 658 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>The facility will continue to ensure comprehensive care plans: the services provided or arranged by the facility, as outlined by the comprehensive care plan, | 11/23/20 |

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| F 658 | Continued From page 8<br><br>This deficient practice was identified for 2 of 18 residents reviewed for professional standards of nursing practice (Resident #20 and Resident #50).<br><br>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."<br><br>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."<br><br>The evidence was as followed:<br><br>1. On 10/14/20 at 10:49 AM, the surveyor observed Resident #50 lying in bed on a low air loss mattress watching television. During interview, Resident # 50 stated he/she had a | F 658 | must meet professional standards of quality.<br><br>a). The [redacted] order for Resident #50 was clarified with the nurse practitioner and discontinued on [redacted] by the Unit Manager. Resident #50s medical record was updated to reflect the discontinuation in the eMAR, eTAR, orders and care plan. Re-education was provided to the nursing staff on Resident #50s plan of care on 10/21/2020 by the Unit Manager.<br><br>b). Resident #20s insulin was received from the pharmacy. The nurse that shared a designated [redacted] during medication pass received re-education regarding center procedure when medication is not available on 10/16/2020 by the Nurse Practice Educator.<br><br>2. How will you identify other residents having the potential to be affected by the same deficient practice?<br><br>The facility recognizes that residents with splint orders can potentially be affected by the same deficient practice.<br><br>The facility recognizes that residents with [redacted] orders can potentially be affected by the same deficient practice.<br><br>3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur? Who is responsible? | |

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| F 658 | Continued From page 9<br>[redacted] affecting his/her [redacted]. The resident stated and demonstrated he/she could move the [redacted]. The surveyor observed a [redacted] in the resident's chair in the room. During interview Resident #50 stated he/she was unaware of the [redacted].<br><br>The surveyor reviewed the medical record for Resident #50.<br><br>A review of the Admission Record face sheet (an admission summary) included that the resident was admitted with diagnoses which included but not limited to: [redacted]). Resident #50 admitted to [redacted] on [redacted]<br><br>According to the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], the resident's Brief Interview Mental Status (BIMS) was [redacted]. BIMS score 15 out of 15 indicates the resident had an intact cognition. It further included the resident required a total one person assist for bed mobility and transfer and that he/she had range of motion limitations to [redacted] of the body to both the [redacted].<br><br>A review of the resident's individualized care plan revised [redacted], included that the resident had a [redacted]<br><br>A review of the electronic progress notes since | F 658 | A checklist was developed and implemented for all residents identified with [redacted] orders. The checklist includes verification of the order, documentation on eMAR/ eTAR, and corresponding care plan.<br><br>A checklist was developed and implemented for all residents identified with [redacted] orders. The checklist includes medication reorder dates.<br><br>Licensed Nurses will be provided re-education by the Nurse Practice Educator on the centers policy for 24 hour chart checks to ensure reconciliation, accountability, and notification of the physician for [redacted] usage.<br><br>Licensed Nurses will be provided re-education by the Nurse Practice Educator on the centers procedure when medication is not available.<br><br>The Center Nurse Executive or designee will identify each resident with splint orders and utilize the checklist implemented to ensure reconciliation, accountability, and notification of the physician for [redacted] usage. Results will be tracked utilizing an audit tool.<br><br>The Center Nurse Executive or designee will identify each resident with insulin vial orders and utilize the checklist implemented to ensure reorder dates are identified to ensure timely reorder of [redacted] vials. Results will be tracked | |

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| F 658 | Continued From page 10<br>July 2020 did not reflect documented evidence for the use or refusal of the [redacted], accountability, or if it was discontinued.<br><br>A review of the current physician's Order Summary Report (OSR) for October 2020 for Resident #50 reflected there was a physician's order (PO) dated [redacted] to apply a [redacted] during day shift and remove after four (4) hours.<br><br>A review of the electronic Treatment Administration Record (eTAR) and electronic Medication Administration Record (eMAR) for July, August, September, and October 2020 did not reflect evidence of the accountability of the right-hand splint.<br>A review of the the 24-Hour Chart Check accountability form from July through October 2020 showed multiple blanks. In July there were five (5) blanks, in August there were seven (7) blanks, in September there were twenty-five (25) blanks and in October there were currently eleven (11) blanks.<br><br>On 10/19/20 at 11:00 AM, the surveyor observed Resident #50 lying in bed. The resident was not wearing the [redacted]. The [redacted] was in a chair in the resident's room.<br><br>At 11:04 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) regarding the hand splint. The CNA stated the [redacted] was used to help with the [redacted]. The CNA furthered stated Resident #50 was on [redacted] services and had a [redacted]. She added the resident refused the [redacted] on the [redacted] for months, but the CNA stated she performed exercises with Resident #50 instead | F 658 | utilizing an audit tool.<br><br>4. How the corrective action(s) will be monitored to ensure the deficient practice does not recur? Include how often the facility will monitor.<br><br>The Center Nurse Executive or designee will conduct random audits of residents with [redacted] orders weekly x4 weeks, then monthly x 3 months until substantial compliance is identified.<br><br>The Center Nurse Executive or designee will conduct random audits of residents with [redacted] orders weekly x4 weeks, then monthly x3 months until substantial compliance is identified.<br><br>The Center Nurse Executive or designee will report findings at the monthly Quality Assurance Performance Improvement Meeting. | |

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of using the [redacted]. The CNA stated Resident #50 has not worn the [redacted] for a long time, because it caused the resident [redacted]. The CNA stated that the nurse was aware that the resident was refusing the [redacted]. The CNA acknowledged there was no accountability for the [redacted] on the restorative log book.

On 10/20/20 at 09:28 AM, the surveyor observed Resident #50 eating breakfast using the [redacted]. The surveyor observed the [redacted] in the chair in the resident's room.

On 10/21/20 at 10:00AM, the surveyor interviewed the Registered Nurse (RN). The RN stated Resident #50's [redacted] was ordered to [redacted]. The RN stated Resident #50 wore the [redacted] sometimes and added currently Resident #50 had been refusing the [redacted]. The RN further stated the CNA should place the [redacted] on the resident in the morning during the day shift, but she was not sure if they were documenting it. The surveyor reviewed the PO for the [redacted] dated [redacted] with the RN. The RN reviewed the eTAR for October 2020 and confirmed there was no accountability. The RN stated she was not sure why there was no accountability and that maybe the order was discontinued. The RN was not aware of the last time the [redacted] was place on Resident #50. The RN stated the process was to document the resident refused it and if the resident refused it three times, then she would inform the Unit Manager (UM) and the Primary Physician. The RN stated she reported to the previous UM back in August or September that Resident #50 refused the [redacted]. The RN was not sure if the UM or the night shift nurse reconciled orders.

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On the same day at 10:19 AM, the Unit Manager/Registered Nurse (UM/RN) stated that the nurse should document if the resident refused a [redacted] and notify the Primary Physician. The UM/RN stated the CNA was responsible for placing the [redacted] and the nurse was responsible to make sure it was in place and document if the resident refused it in the eTAR. The UM/RN stated the reason the current [redacted] order was not showing up in eTAR, was likely because of an order entry error. The UM/RN stated the process for reconciliation included, the nurse who receives an order puts it in the electronic health record (EHR) and the night shift nurse performs a 24-Hour Chart Check and signs the accountability sheet. The night shift nurse should be reviewing both the paper chart and the EHR. The UM/RN further stated the nurse is responsible for notifying the Physician or Nurse Practitioner (NP) of the resident's refusal.

At 11:32 AM, the surveyor and the UM/RN reviewed the 24-Hour Chart Check accountability form from July through October 2020 and the UM/RN acknowledged there were multiple blanks. The UM/RN further acknowledged there was no evidence for the accountability of the splint.

On 10/21/20 at 1:11PM, the surveyor interviewed the License Nursing Home Administrator (LNHA) and the Director of Nursing (DON) in the presence of the survey team. The LNHA and the DON stated if a resident refused a [redacted], the nurse should notify both the hospice service company and the Primary Physician. They further stated the night shift nurse was responsible for reconciliation of the charts and

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they should be reviewing both the paper chart and EHR to ensure they are accurate and match in both locations.

On 10/22/20 at 10:50 AM, the DON acknowledged there was no accountability for the [redacted] even though, there was a PO for a [redacted] dated [redacted]. She further explained the NP was aware of the refusal due to the fact the resident was on [redacted] The DON was unable to provide the documented evidence the order had been discontinued and evidence of accountability.

A review of the facility's policy Physician/Advanced Practice Provide (APP) Notification revised 11/1/19 included, "Upon identification of a patient who has a change in condition, ... ...a licensed nurse will perform .....and report to Physician/Advanced Practice Provider (APP). If unable to contact attending Physician/APP, the Medical Director will be contacted. The Purpose to communicate a change in patient's condition to Physician/APP and initiate interventions as needed/ordered."

A review of the facility's policy [redacted] revised 3/1/18 included, "Healthcare staff will offer the supportive services of a [redacted] program as requested by patients or their health care decision maker (HCDM), or as identified as a necessary resource by the interdisciplinary team ... ...The center must immediately notify the hospice ... ...clinical complications suggesting a need to alter the patient's plan of care ....ensuring that the level of care provided is appropriate based on the individual patient's needs .....The center is responsible for .....communicating with [redacted] representatives

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| F 658 | Continued From page 14<br>and other providers regarding the provision of care ...."<br><br>2. On 10/16/20 at 8:08 AM, the surveyor approached the Licensed Practical Nurse (LPN) at the medication cart who stated that she was preparing medications for Resident #20. The LPN stated that she had to administer five (5) units of [redacted] because that was a standing physician's order (PO) to be administered every morning. The LPN added that she had to also obtain the [redacted]) results from the resident to see if additional [redacted] was required in accordance with the PO for a [redacted]<br><br>On 10/16/20 at 8:26 AM, the surveyor observed the LPN obtain a [redacted] result of [redacted] from Resident #20.<br><br>Upon returning to the medication cart, the LPN stated that according to the PO she would have to add [redacted] to the [redacted] of [redacted] which would total [redacted]. The LPN stated that Resident #20 did not have a [redacted] in the medication cart and would have to use another resident's [redacted]. The surveyor observed the LPN remove a [redacted] from the medication cart labeled for Resident #29. The LPN measured [redacted] from Resident #29's [redacted] at the medication cart.<br><br>At that time, the LPN stated that she was unsure | F 658 | | |

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why Resident #20 did not have his/her own [redacted]. The LPN stated that she thought the provider pharmacy was notified for a refill order for [redacted] for Resident #20 yesterday. The LPN added that she would have to call the pharmacy provider to find out why there was a delay. The LPN also stated that she was allowed to borrow another resident's [redacted] as long as it was the same type of [redacted] because [redacted] had to be administered before the meal.

The surveyor reviewed the medical record for Resident #20.

A review of the electronic Medication Administration Record (eMAR) for October 2020 reflected that there was a PO dated [redacted] for [redacted] before meals for [redacted]

In addition, the eMAR for October 2020 reflected a PO dated [redacted] and notify physician, [redacted] before meals and at bedtime for [redacted] coverage for [redacted], must take [redacted] prior to administration."

On 10/16/20 at 12:05 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) in the presence of the two Registered Nurses/Unit Managers (RN/UM) in the Nursing Office. The ADON stated that there was no back-up supply for [redacted]. The RN/UM of Wing 3 and 4 stated that she thought there had been a

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back-up supply of [redacted] in the nursing office refrigerator.

At that time, the surveyor in the presence of the ADON and both RN/UM's, observed the medication refrigerator in the nursing office which revealed there was no back up supply of [redacted]. The RN/UM of Wing 1 and 2 stated that when [redacted] was not available for a resident the provider pharmacy would have to be called and the [redacted] would have to be delivered stat (as soon as possible). The UM added that she was unaware of any issue with the [redacted] for Resident #20.

On 10/20/20 at 10:33 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that medications should not be borrowed between residents. The CP added that [redacted] should also not be borrowed. The CP added that he did not review the back-up medications and was not sure if there was a back-up supply of [redacted]

On 10/21/20 at 12:42 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The DON stated that the facility does not have a back up supply of [redacted] for use and that the provider pharmacy was called regarding the delay in receiving the [redacted] for Resident #20. The DON added that the [redacted] had been requested for refill on [redacted] and there was a discrepancy with the pharmacy as to when the [redacted] had been delivered. The DON added that there had been insurance issues in the past but that the provider pharmacy would contact the unit manager if there was an issue. The DON also stated that if [redacted] was not available for a

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| F 658 | Continued From page 17<br>resident then the nurse should notify the physician first and call the provider pharmacy to resolve the issue and have the [redacted] sent as soon as possible.<br><br>A review of the facility policy dated as revised 11/1/19 for "Medication Administration General" reflected that [redacted] was not to be used for more than one individual. In addition, the policy reflected if discrepancies occurred the physician was to be notified. | F 658 | | |
| F 695 SS=D | NJAC 8:39-11.2(b)<br>Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that the facility failed to ensure: a.) infection control procedures were followed while performing [redacted] care, b.) the resident was assessed for [redacted] and [redacted] status prior to [redacted] in accordance with the physician order, c.) the [redacted] was [redacted] to prevented irritation, d.) the physician orders and care plan reflected the resident's current [redacted] size, and e.) that the resident was explained of the [redacted] | F 695 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>The facility will continue to provide respiratory care, including [redacted]. The facility will continue to ensure that a resident who needs [redacted] care, including [redacted] is provided such care, | 11/23/20 |

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| F 695 | Continued From page 18<br>procedure prior to passing the [redacted]. This deficient practice was identified for 1 of 1 residents reviewed with a [redacted] (Resident #12).<br><br>The evidence was as follows:<br><br>On 10/19/20 at 9:25 AM, two surveyors observed Resident #12 in bed, awake and smiling and appeared comfortable. The resident had a [redacted], and was receiving [redacted] by way of a [redacted]. Upon closer observation of the [redacted] used to supply the [redacted], the surveyors observed a moderate amount of [redacted] the empty space of the [redacted]. The [redacted] were noted to be [redacted] and dripping onto the resident's [redacted]. At that time, the surveyors observed the resident breathing through the [redacted], and there were [redacted] and [redacted] being actively [redacted] through the resident's [redacted]. The surveyors also observed a [redacted] on the resident's nightstand that was covered with a clear plastic bag, but the [redacted] to the [redacted] was coiled up on the floor.<br><br>At 9:29 AM, the two surveyors interviewed the resident's assigned Registered Nurse (RN). The RN stated that she had last been in the resident's room at 8 AM to check the resident's vital signs and that Resident #12 had a [redacted] status of [redacted] the [redacted]. She stated that the resident had no [redacted] at that time. The | F 695 | consistent with professional standards of practice, the comprehensive person centered care plan, and the residents goals and preferences.<br><br>The licensed nurse providing care to Resident #12 was provided with competency evaluation and re-education by the Nurse Practice Educator on 10/19/2020 on the following:<br>a). Infection control procedures while performing [redacted] care including hand hygiene timing and technique, hand hygiene after the removal of gloves, sterile glove use, and use of pre-packaged [redacted] kits;<br>b). Assessing for [redacted] status pre and [redacted] in accordance with the physician order;<br>c). [redacted] prevent irritation;<br>d). Validating physician orders and care plan to ensure they are reflective of residents current [redacted] size; and<br>e). Explaining the [redacted] procedure prior to passing the [redacted].<br>f). Documentation when [redacted] was performed and post assessment.<br><br>Resident #12s physician orders and care plan were updated to reflect the resident□s current [redacted] size on 11/2/2020 by the Unit Manager.<br><br>The [redacted] connected to the [redacted] was discarded and replaced with [redacted] on 10/19/2020 by the Unit Manager. | |

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| F 695 | Continued From page 19<br>RN added that the resident's vital signs were stable and that he/she had required more [redacted] lately and that the physician had ordered a [redacted] and that it was within normal limits for the resident. At that time, the surveyor asked the RN to observe the resident together with the surveyors and the RN entered the resident's room and observed the [redacted]. The RN stated that this was "normal" for Resident #12 and that she was going to wait to do the [redacted] e when she was done with medication pass at 10:00 AM. The RN confirmed there was [redacted] but that it was okay to return in 30 minutes to do the [redacted]<br><br>At 9:36 AM, the two surveyors interviewed the Unit Manager/Registered Nurse (UM/RN) and asked her to come to the room of Resident #12. The UM/RN observed the [redacted] inside the [redacted] r, and lifted the collar using a gloved hand. she stated the resident "clearly needed to be [redacted] but that this this was "normal" for the resident and that he/she had "[redacted] ...and was [redacted] multiple times during the night." The UM/RN stated that she would describe the [redacted] as a [redacted] but that the resident appeared comfortable. The surveyor asked when [redacted] should be performed for this resident, and she stated that it should happen no, and that it was [redacted]" The UM/RN stated that she would check with the resident's assigned RN to see why she was going to wait to [redacted] the resident. The surveyor and UM/RN observed the resident produce [redacted] through the [redacted]. | F 695 | 2. How will you identify other residents having the potential to be affected by the same deficient practice?<br><br>The facility recognizes that residents with a [redacted] can potentially be affected by the same deficient practice. The facility conducted an audit of other tracheostomys in the facility.<br><br>3.What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur? Who is responsible?<br><br>Licensed Nurses will be re-educated by the Center Nurse Practice Educator or designee on [redacted] This re-education will include competency of assessing for [redacted] status pre and [redacted] in accordance with the physician order; validating physician orders and care plan to ensure they are reflective of residents current [redacted] size and documentation when [redacted] was performed and post assessment.<br><br>A checklist was developed and implemented to ensure licensed nurses complete [redacted] competencies. This checklist will be reviewed weekly by the Center Nurse Practice Educator or | |

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| F 695 | Continued From page 20<br>At 9:40 AM, the UM/RN returned to the surveyor and stated that the RN was on her way in to [redacted] the resident, and that the RN had to just finish one thing before she could be back.<br><br>The surveyor reviewed the medical record for Resident #12.<br><br>A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted with diagnoses which included [redacted]<br><br>A review of the most recent quarterly Minimum Data Set (MDS), an admission tool use to facilitate the management of care, dated [redacted] reflected that the resident was unable to perform a brief interview for mental status (BIMS) interview because the resident was rarely or never understood, so staff assessed the resident to have a [redacted] impaired [redacted] capacity. The assessment reflected that the resident had a [redacted] and was [redacted].<br><br>A review of the resident's individualized care plan dated [redacted] included that the resident was at risk for [redacted] complications related to his/her [redacted]. Interventions included to monitor and report [redacted] levels as ordered and as needed, and to s[redacted] f[redacted] as needed. The care plan did not address the [redacted] of the resident's [redacted].<br><br>A review of the Physician's Orders for October 2020 included a physician's order (PO) dated [redacted] for [redacted] as needed Pre/Post Treatment: evaluate heart rate, | F 695 | designee.<br><br>A checklist was developed to ensure that residents with a [redacted] have a physician order and care plan that reflect the residents current [redacted] size. This checklist will be reviewed weekly.<br><br>The Center Nurse Practice Educator or designee will identify each licensed nurse and utilize the checklist implemented to ensure re-education and competency on [redacted]<br><br>The Center Nurse Executive or designee will identify each resident with a [redacted] and utilize the checklist implemented to ensure physician order and care plan reflect the resident□s current [redacted] size. Results will be tracked utilizing an audit tool.<br><br>4. How the corrective action(s) will be monitored to ensure the deficient practice does not recur? Include how often the facility will monitor.<br><br>The Center Nurse Practice Educator or designee will conduct random audits of staff competency for [redacted] weekly x 4 weeks, then monthly x 3 months until substantial compliance is identified. The Center Nurse Practice Educator or designee will report findings at the monthly Quality Assurance Performance Improvement Meeting. | |

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| F 695 | Continued From page 21<br>respiratory rate, pulse oximetry and breath sounds." In addition, there was an order dated [redacted] care every shift as per policy and as needed. The physician's orders did not address the [redacted] of the resident's [redacted]<br><br>A review of the electronic Treatment Administration Record (eTAR) for October 2020 included the corresponding physician's orders dated [redacted] care every shift and [redacted] as needed. The eTAR did not reflect documented evidence that the resident's [redacted] y was [redacted] as needed.<br><br>A review of the electronic Progress Notes (ePN) for October 2020 did not reflect documented evidence that the resident's [redacted] had been [redacted].<br><br>A review of the electronic Health Record (eHR) and paper chart for Resident #12 did not reflect evidence of any [redacted] infections or [redacted].<br><br>On 10/19/20 at 9:47 AM, the RN returned to the resident's room. The RN donned a pair of gloves and wiped down the bedside table with a disinfecting wipe, and placed a clear plastic bag over the bedside table to act as a barrier. The RN showed the surveyors that inside the resident's night stand was a new sterile [redacted] The RN confirmed this tracheostomy kept at the bedside was for emergency purposes and was the size the resident required and what the resident currently had in place. | F 695 | The Center Nurse Executive or designee will conduct random audits of residents with a [redacted] to ensure the physician order and care plan reflect the residents current [redacted] weekly x4 weeks, then monthly x 3 months until substantial compliance is identified. The Center Nurse Executive or designee will report findings at the monthly Quality Assurance Performance Improvement Meeting. | |

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At 9:50 AM, the RN entered the nurse's station bathroom to perform hand hygiene, and the surveyor observed that the RN turned on the faucet, applied soap and placed her hands immediately under the running water rinsing off all the soap. She rubbed her hands together under the running water for 20 seconds and dried her hands with a paper towel. She turned the faucet off with a dry paper towel. She then donned a new pair of clean gloves from a box.

At 9:52 AM, the RN opened multiple individually packaged sterile 4 x 4 gauze pads and placed them in two separate piles directly on the clear plastic bag barrier. She then poured sterile water over on pile of the sterile gauze. She then adjusted the resident's bed, removed her gloves, used hand sanitizer and donned a new pair of clean gloves from a box.

At 9:55 AM, the RN opened two more packages of sterile gauze pads and placed them on the plastic bag barrier creating a third pile of sterile gauze. She then removed her gloves and donned a new pair of clean gloves without performing hand hygiene. Using clean gloves, the RN picked up the moistened sterile gauze and began cleaning the white [redacted] from underneath the [redacted]. She then removed her gloves, and donned a new pair of clean gloves without performing hand hygiene and continued to clean the [redacted] under the [redacted] and around the [redacted] site using a new sterile gauze pad.

At 9:59 AM, the surveyor observed the RN opened two more sterile gauze pads and placed

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them on the clear plastic barrier and poured sterile water on top of it. Using disinfected scissors, she cut two sterile gauze pads to create a drain sponge that would fit around the [redacted]. The RN was not using a prepackaged Tracheostomy kit or using sterile drain sponges to go around the [redacted] site. The RN stated to the surveyor that she had to "improvise" and cut her own drain sponges because the facility was '[redacted]. After cutting the sterile gauze pads, she removed her gloves and donned a new pair of clean gloves without performing hand hygiene and placed the manually cut gauze pad around the resident's [redacted] site. As the RN applied the gauze pad, the resident began to lightly [redacted] e [redacted] through the top of the [redacted]

At 10:02 AM, the RN opened one more sterile gauze, cut it, and placed it around the resident's [redacted] site. She then removed her gloves and donned a new clean pair of gloves without performing hand hygiene between the glove changes. She then covered the resident with a blanket, adjusted his/her head, and lowered the bed. She then cleaned the area and stated that she was done with the resident, but the RN did not [redacted] the [redacted]. The surveyor asked the RN about [redacted] and when/if that gets performed and she stated that the resident didn't need [redacted] until 2 hours after she feeds the resident and that the resident was due to be fed through the [redacted]. She stated that if she [redacted] the resident after [redacted] it causes the resident to produce [redacted]. The surveyor asked then why does she not first [redacted] before

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administering a [redacted], if the resident cannot be [redacted] two hours after a [redacted] The RN stated that she didn't think the resident needed it right now because she cleaned the resident's [redacted] site. Then RN then exited the resident's room.

From 10:02 AM through 10:16 AM, the two surveyors remained in the resident's room, and observed the resident continue to produce [redacted]y, causing [redacted] to form at the tip of the [redacted]

At 10:16 AM, the RN entered the resident's room and began to prep the resident's bedside table. The RN donned a pair of clean gloves, picked up the [redacted] from the floor and coiled it around the [redacted] machine. She then turned on [redacted] and opened a sterile [redacted] kit. While wearing the same gloves, the RN donned the sterile gloves overtop of the clean gloves she was wearing. She then obtained the sterile [redacted] from the kit and applied it to the [redacted] that had previously been on the floor. Without performing a [redacted] assessment prior to suctioning and without explaining to the resident what she was going to do, the RN removed the [redacted] from the resident's [redacted] and immediately made an intermittent [redacted]g pass into the resident's tracheostomy causing an expected slight gag-reflex of the resident. The RN did not pre-lubricate the tip of the [redacted] or prime the [redacted] using the sterile water before passing into the resident's [redacted] A small amount of [redacted] were [redacted] through [redacted]. The RN

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made a total of three [redacted] passes into the resident's [redacted] waiting approximately 20 seconds between each pass, without attempting to communicate with the resident. After the three passes, the RN then primed the [redacted] and turned off the [redacted] machine, doffed her sterile gloves and collected the trash from the room.

At 10:22 AM, the surveyor observed the RN go to the sink and turn on the faucet. She applied soap and washed her hands for seven (7) seconds outside of running water and rinsed them off, dried her hands with a paper towel and turned the faucet off with a dry paper towel.

At 10:27 AM, the surveyor interviewed the RN, who provided the surveyor an unopened [redacted] kit. The RN confirmed she does not pre-lubricate the [redacted] and the RN also acknowledged that the [redacted] kit did not come with a pre-lubricated [redacted] or lubrication. She stated that the resident tolerated the suctioning well. The surveyor interviewed the RN to see what else she had to do before and after [redacted] and the RN stated that she had to go check the resident's [redacted] status to make sure it was stable after [redacted]. The RN added that sometimes [redacted] can cause bleeding if precautions aren't taken. There was no documented evidence in the resident's medical record that indicated the resident had any evidence or history of [redacted]

At 10:32 AM, the RN obtained the [redacted] device and checked the resident's [redacted] which read [redacted]. The RN stated that the

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| F 695 | Continued From page 26<br>[redacted] within [redacted] limits. The RN did not assess [redacted] prior to [redacted] or after [redacted] in accordance with the physician's order.<br><br>The RN did not sign the eTAR after the [redacted] care and suctioning as of 11:41 AM that morning.<br><br>On 10/19/20 at 1:17 PM, the surveyor discussed the findings with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The DON and surveyor entered the Central Supply together where there was multiple [redacted] care kits. The DON opened a kit which included sterile gloves and [redacted] The DON stated that the RN is a brand new nurse but she should have used the [redacted] that the facility has available and not cut the [redacted] in half when performing [redacted] care. She also confirmed that [redacted] care should be done using sterile technique because sterile gloves were in the kit. The DON acknowledged that hand hygiene should be performed between glove changes using the appropriate technique in accordance with U.S. Centers for Disease Control and Prevention (CDC) guidelines. The DON acknowledged that the [redacted] kits did not come with pre-lubricated [redacted]. The DON and LNHA stated that the nurse should inform the resident of the plan to [redacted] even if the nurse thinks the resident may not understand. The DON acknowledged that the nurse may have been nervous but she should have communicated with the resident. The DON also acknowledged the physician's order to assess the resident's [redacted] system pre- and post- [redacted] in accordance | F 695 | | |

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with the physician's order. The LNHA and DON acknowledged that the resident has not had any [redacted] infections, and that the recent [redacted] was normal.

On 10/22/20 at 10:30 AM, the DON and LNHA were unable to provide documented evidence that [redacted] as needed had been performed during the night shift in October 2020 as the UM/RN and RN had informed the surveyor.

A review of the facility's Hand Hygiene policy reviewed 11/15/19 included, that hand hygiene should be performed "Before patient care; before an aseptic procedure; after any contact with blood or other body fluids, even if gloves are worn; after patient care; after contact with the patient's environment." Hand hygiene techniques included, "To wash hands with soap and water: wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously outside the stream of water for 20 seconds covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use clean, dry disposable towel to turn off faucet."
(The policy did not specify performing hand hygiene between glove changes)

A review of the facility's [redacted] y Care policy revised 11/1/19 included, to "Gather supplies...sterile [redacted] kit, [redacted] care kit..." It further included to "explain the procedure... Evaluate patient' [redacted] effort...." [redacted], if clinically indicated." It further added that when removing gloves, discard in waste bag and cleanse hands, and "open sterile trach kit using aseptic

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| F 695 | Continued From page 28<br>technique...put on sterile gloves..." It also included after the procedure to "evaluate patient's respiratory rate, heart rate, breath sounds, pulse oximetry and cough effort.... remove gloves and cleanse hands" and document in the resident's medical record.<br><br>NJAC 8:39-24.2 (b), c(4) | F 695 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record | F 761 | 1. What corrective action will be | 11/23/20 |

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| F 761 | Continued From page 29<br>review, it was determined that the facility failed to ensure that a.) a discontinued medication used to treat [redacted] in the blood were removed from active inventory and b.) expired over-the-counter stock medications were removed from active inventory from a unit refrigerator, a medication cart and the central supply storage area. This deficient practice was identified for 1 of 3 medication refrigerators ([redacted] 1 of 2 medication carts [redacted] 1 of 1 central supply storage areas that were inspected.<br><br>The evidence was as follows:<br><br>On 10/15/20 at 10:12 AM, two surveyors and the Registered Nurse/Unit Manager (RN/UM) of [redacted], inspected the Wing 1 medication refrigerator. The surveyors observed an opened bottle of [redacted]) capsules with an expiration date of 4/2020 in the refrigerator. The RN/UM stated that there were no residents currently on that medication and the expired [redacted] bottle should have been removed and discarded. The RN/UM then took the [redacted] expired bottle for disposal. The RN/UM then stated that the [redacted] was an over-the-counter (OTC) stock medication and was obtained from the central supply that was kept in the nursing office.<br><br>On 10/15/20 at 10:33 AM, the two surveyors inspected the central supply of OTC stock medications stored in the nursing office with the RN/UM.<br><br>The surveyors observed two (2) bottles of [redacted] for | F 761 | accomplished for those residents found to have been affected by the deficient practice?<br><br>The facility will continue to ensure drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>a). The discontinued medication used to treat [redacted] in the [redacted] was removed from active inventory and destroyed on 10/15/2020 by the Unit Manager.<br><br>b). The expired over-the-counter stock medications were removed from active inventory from the unit refrigerator on [redacted] on, the medication cart on [redacted] and the central supply storage area and were destroyed on 10/16/2020 by the Unit Manager.<br><br>2. How will you identify other residents having the potential to be affected by the same deficient practice?<br><br>The facility recognizes that residents with ordered over-the-counter medications can potentially be affected by the same deficient practice.<br><br>3. What measures will be put into place or systemic changes made to ensure that | |

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| F 761 | Continued From page 30<br>[redacted]) labeled for Resident # 1 stored in the cabinet with the OTC stock medications. The RN/UM was not sure why the medication was stored there.<br><br>The surveyors observed the following OTC stock medications with expired dates:<br><br>-3 of 10 unopened bottles of [redacted] (MG) tablets dated expired 3/2019.<br><br>-8 of 8 boxes o[redacted] dated expired 6/2020 with 1 box dated as opened 8/23/20 (two months after expiration).<br><br>- 1 of 9 unopened bottles of [redacted] dated expired 1/2020,<br><br>-1 opened box containing six [brand redacted] [redacted] dated expired 9/30/2020.<br><br>At that time, the RN/UM stated that there was a staff member responsible for the OTC stock medications but was currently off from work. The RN/UM added that the expired medications should be discarded. The RN/UM stated that there was an "OTC Medication Order Sheet" but was not sure if that listed all the OTC medications that were on hand in the central supply.<br><br>On 10/15/20 at 12:29 PM, the surveyor in the presence of another surveyor, interviewed the Scheduling Manager (SM) who stated that she helped out with the central supply OTC | F 761 | the deficient practice would not recur? Who is responsible?<br><br>Nursing staff will be provided education on removing discontinued medication from active inventory by either destroying or returning to the pharmacy when applicable.<br><br>Nursing staff will be provided education on monitoring medications for expiration dates during regular medication administration.<br><br>A checklist was developed and implemented to ensure all medication storage areas are monitored weekly for expired medications. The 11-7 RN Supervisor or designee will be responsible for monitoring the checklist.<br><br>The Center Nurse Executive or designee will utilize the checklist implemented to ensure medications are being regularly monitored for expiration dates and removed from active inventory as necessary. Results will be tracked utilizing an audit tool.<br><br>4. How the corrective action(s) will be monitored to ensure the deficient practice does not recur? Include how often the facility will monitor.<br><br>The Center Nurse Executive or designee will conduct random audits of medication storage areas weekly x4 weeks, then monthly x 3 months until substantial | |

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| F 761 | Continued From page 31<br>medications when the regular staff member was out because she was familiar with the system. The SM stated that expiration dates should be checked and that OTC stock medications should follow the first in, first out (FIFO) method. The SM explained that when receiving an order, the OTC medications should be put away with the oldest expiration dating being put in the back. The SM also stated that if a nurse took part of a package or box then the date of opening would be indicated on the opened package. The SM added that the "OTC Medication Order Sheet" was not a complete list and there were no par levels. The SM added that the ordering was based on what was needed and visually seeing what OTC medications were low.<br><br>On 10/16/2020 at 9:42 AM, the surveyor, in the presence of the Registered Nurse (RN) inspected the medication cart on [redacted]. The surveyor observed four (4) [redacted] mg suppositories on the medication cart with an expiration date of 6/2020. The LPN stated that the [redacted] were an OTC stock medication kept on the cart and would have to discard the expired [redacted]. The RN stated that the nurses were responsible for removing expired medications from the medication cart.<br><br>On 10/19/20 at 12:48 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The DON stated that she thought the [redacted] for Resident #1 was ongoing being ordered frequently at one time but would have to review. The DON also stated that the [brand redacted] [redacted] was used for the prior [redacted] season and had received new [redacted] the | F 761 | compliance is identified. The Center Nurse Executive or designee will report findings at the monthly Quality Assurance Performance Improvement Meeting. | |

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| F 761 | Continued From page 32<br>coming season.<br><br>On 10/20/20 at 10:33 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that he did not inspect the stock medications stored in the nursing office. The CP stated that he inspected the medication refrigerators and medication carts but inspections were stopped from March 2020 until August 2020 due to COVID-19 restrictions. The CP added that he thought all expired medications were removed from the refrigerators and medication carts when the inspections started in 8/2020 and the [redacted] must have been missed.<br><br>On 10/21/20 at 12:42 PM, the survey team met with the LNHA and DON. The DON stated that she could not find any resident that was administered a [redacted] and was not sure why the box of [redacted] suppositories that expired 6/2020 was labeled as opened on 8/23/20 after the expiration date. The DON stated that the central supply staff member was supposed to check expiration dates for the OTC medications in central supply, as well as the nurses were responsible to check the expiration dates of the medications on the units. The LNHA and DON acknowledged that the expiration dates for the OTC stock medications were not being checked as should be and expired medications were not removed from active inventory.<br><br>On 10/22/20 at 10:38 AM, the surveyor reviewed the back-up supply list of prescription medications stored in the electronic back-up machine provided by the LNHA which revealed that [redacted] was available as a back up supply medication for the facility. | F 761 | | |

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| F 761 | Continued From page 33<br><br>On 10/22/20 at 11:57 AM, the DON stated that there was a physician's order to discontinue the [redacted] was Kayexalate labeled for Resident #1 still stored in the OTC medication supply.<br><br>A review of the facility policy dated as revised 10/31/16 for "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" provided by the LNHA reflected that the facility should destroy or return all discontinued, outdated/expired medications. In addition, the policy reflected that the facility should ensure that medications that are expired or discontinued should be stored separately until destroyed or returned to the pharmacy.<br><br>NJAC 8:39- 29.4 (c)(g)(h) | F 761 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and | F 880 | | 11/23/20 |

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable 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

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| F 880 | Continued From page 35<br>corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to: a.) ensure the appropriate timing and technique of performing hand hygiene while providing care and [redacted] care to a resident to prevent infection for 1 of 2 residents reviewed for [redacted] (Resident #56), and b.) surveil/trend their infection rates since July 2020. This deficient practice was evidenced by the following:<br><br>1. The surveyor reviewed the facility's Hand Hygiene policy reviewed 11/15/19 which included, that hand hygiene should be performed "Before patient care; before an aseptic procedure; after any contact with blood or other body fluids, even if gloves are worn; after patient care; after contact with the patient's environment." Hand hygiene techniques included, "To wash hands with soap and water: wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously outside the stream of water for 20 seconds covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use a clean, dry disposable towel to turn off the faucet." | F 880 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>The facility will continue to 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.<br><br>a). The nurse that provided wound care to the Resident #56 was provided re-education on 10/23/2020 by the Nurse Practice Educator on timing and technique of hand hygiene. The CNA that provided care to resident #56 was provided re-education on 10/23/2020 by the Nurse Practice Educator on timing and technique of hand hygiene.<br><br>b). The Center Infection Control Preventionist was provided re-education on surveillance and trending of infection rates on 10/29/2020 by The Center Nurse | |

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| F 880 | Continued From page 36<br><br>On 10/16/20 at 9:49 AM, the surveyor observed Resident #56 in bed. The Certified Nursing Assistant (CNA) had just finished performing morning care with the resident. There was a basin of soapy water at the resident's bedside table. The surveyor observed the CNA pick up the basin and take it to the resident's bathroom to empty it. After cleaning the basin of water, the CNA doffed her pair of gloves and returned to the sink to wash her hands.<br><br>At 9:52 AM, the surveyor observed the CNA turn on the faucet and apply soap and immediately put her hands under the running water and within five seconds, the CNA grabbed a paper towel to dry her hands and turn the faucet off. The CNA did not use friction, nor did she perform hand hygiene outside of running water in accordance with the facility's policy to prevent the spread of infection. She then donned a new pair of clean gloves, picked up the bag of soiled linens and took the bag to the soiled utility room in a large container designated for laundry services. The CNA returned to the sink in the resident's room to wash her hands.<br><br>At 9:56 AM, the CNA turned on the faucet, applied soap and rinsed the soap off immediately after applying it. Her hands were under the water for three (3) seconds, and she took a dry paper towel to dry her hands and and turned off the faucet and exited the resident's room. The CNA stated that the Licensed Practical Nurse (LPN) would be in shortly to perform a [redacted] care dressing change for the resident.<br><br>At 10:10 AM, the surveyor interviewed the CNA regarding the procedure for hand hygiene. The | F 880 | Executive.<br><br>2. How will you identify other residents having the potential to be affected by the same deficient practice?<br><br>The facility recognizes that residents receiving care have the potential to be affected by the same deficient practice.<br><br>The facility recognizes that residents have the potential to be affected by the deficient practice of not surveilling and trending infection rates.<br><br>3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur? Who is responsible?<br><br>Licensed nurses and CNAs will be provided re-education on timing and technique of hand hygiene.<br><br>A checklist was developed and implemented to conduct random audits of hand hygiene.<br><br>The Center Nurse Executive or designee will utilize the checklist implemented to ensure appropriate timing and technique of hand hygiene. Results will be tracked utilizing an audit tool.<br><br>The Center Infection Control Preventionist will update the centers surveillance and tracking document | |

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| F 880 | Continued From page 37<br>CNA stated that the procedure included to turn the water faucet on, and apply soap and "wash for 20 seconds" and "Scrub outside of running water." She appropriately continued that after scrubbing the hands for 20 seconds outside of running water, she would rinse her hands with water and dry them with a paper towel. She stated that she would turn the faucet off with a paper towel. The surveyor asked if that is what she had done after providing care to Resident #56, and the CNA stated, "I think that's what I did in there."<br><br>At 11:45 AM, the surveyor observed the LPN prepare supplies in order to do a [redacted] treatment for Resident #56 at the treatment cart. The LPN stated that the CNA would need to assist to position the resident during the treatment.<br><br>At 11:53 AM, the surveyor observed the same CNA go to the sink, turn on the faucet and apply soap. The CNA rubbed her hands for nine (9) seconds outside of running water and rinsed her hands of the soap. She dried her hands with a paper towel and turned of the faucet with the same paper towel. (This did not correspond with the interview at 10:10 AM which the CNA stated that she was suppose to wash and scrub her hands for 20 seconds outside of running water before rinsing off the soap).<br><br>At 11:54 AM, the LPN went to the sink and turned on the faucet. The LPN applied soap and scrubbed her hands outside of running water for 20 seconds and turned the faucet off with her bare hand. She then obtained a paper towel to dry her hands and discarded it. She donned a pair of clean gloves. | F 880 | weekly or as needed. The Center Nurse Executive will conduct weekly audits of the centers infection surveillance and tracking. Results will be tracked utilizing an audit tool.<br><br>4. How the corrective action(s) will be monitored to ensure the deficient practice does not recur? Include how often the facility will monitor.<br><br>The Center Nurse Executive or designee will conduct random audits of timing and technique of hand hygiene weekly x4 weeks, then monthly x 3 months until substantial compliance is identified. The Center Nurse Executive or designee will report findings at the monthly Quality Assurance Performance Improvement Meeting.<br><br>The Center Nurse Executive or designee will conduct random audits of infection surveillance and tracking weekly x4 weeks, then monthly x 3 months until substantial compliance is identified. The Center Nurse Executive will report findings at the monthly Quarterly Assurance Performance Improvement Meeting.<br><br>The Center Infection Control Preventionist will report at the monthly Quality Assurance Performance Improvement Meeting her findings related to surveillance and trending infections. | |

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| F 880 | Continued From page 38<br><br>At 11:58 AM, two surveyors observed the LPN access [redacted] to the resident's left foot. The LPN cleansed the [redacted] and gauze pads. After cleansing the [redacted], the LPN removed her gloves and donned a new pair of gloves without performing hand hygiene between the glove change.<br><br>At 12:08 PM, the surveyors observed the CNA positioning the resident to his/her side while the LPN applied the [redacted] dressings to the [redacted] in accordance with the physician's order. She then dressed the [redacted] and removed her gloves. The surveyor observed the CNA also remove her gloves and go to the sink to wash her hands.<br><br>At 12:10 PM, the surveyor observed the CNA go to the sink. The CNA followed the same procedure of hand hygiene by turning on the faucet and applied the soap. The CNA rubbed her hands for nine (9) seconds outside of running water and rinsed her hands of the soap. She dried her hands with a paper towel and turned of the faucet with the same paper towel.<br><br>At 12:15 PM, the surveyors observed the LPN clean up the treatment area and did not disinfect the bedside table after the [redacted] care.<br><br>At 12:22 PM, the surveyor observed the LPN return to the sink to wash her hands. The surveyor observed the LPN wash her hands for 20 seconds outside of running water, and again turned the faucet off with her bare hand instead of using a paper towel to act as a barrier. She then dried her hands with a paper towel and immediately discarded it. | F 880 | | |

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At 12:25 PM, the surveyor interviewed the LPN who stated that she puts on clean gloves after washing her hands, and then applies a barrier. She stated the tables get disinfected with bleach wipes in the morning and that she had cleaned it after breakfast around 9 AM. She acknowledged she had not yet disinfected the table and that she would go back to do that. The surveyor asked the LPN regarding her hand washing procedure and the LPN stated that she was supposed to wash her hands for "two minutes." The surveyor asked the LPN regarding how many seconds she used to wash her hands outside of running water, and the LPN stated that she wasn't sure the number of seconds she was supposed to use when washing her hands so she just washed them for two minutes to be sure. The surveyor asked about turning off the faucet, and the LPN stated that she was supposed to use a paper towel to turn it off and acknowledged that she did not use one to turn it off both before and after the treatment. She stated she should have done that. The surveyor asked if she had to wash her hands between glove changes or between [redacted] and she stated that she did not have to do that, unless the gloves were "visibly soiled." She stated if there was no visible soilage than she could just remove and replace them. She further stated that since the [redacted]s were on the same part of the body ([redacted]), she didn't need to change her gloves between each [redacted].

The surveyor reviewed the medical record for Resident #56.

A review of the Admission Record face sheet (an admission summary) included that the resident was admitted with diagnoses which included

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[redacted].

A review of the annual 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], indicating a [redacted] impaired cognition with forgetfulness. It further included that the resident had a [redacted] currently being treated with medical ointments and comfort measures.

A review of the resident's individualized care plan revised [redacted] included that the resident was dependent on staff for care due to [redacted] It further included that the resident had [redacted]

There was no documented evidence of a [redacted] infection(s) in the resident's medical record.

On 10/22/20 at 10:38 AM, the surveyor interviewed the facility's Infection Preventionist (IP), who stated that she had just started working at the facility recently and was also the Assistant Director of Nursing (ADON). The IP stated the facility's hand washing policy coincided with the U.S. Centers for Disease Control and Prevention (CDC) guidelines. She stated that she had conducted many hand-hygiene in-service training's and that staff were to wash hands by turning on the faucet, rinse the hands with warm

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| F 880 | Continued From page 41<br>water, scrub/later for 20 seconds outside of running water, then rinse the hands. She stated the faucet was to be turned off with a paper towel and not the bare hand. She acknowledged that hand hygiene should be done between glove changes even if the gloves are not visibly soiled. She stated that hand hygiene can be done using alcohol-based hand gel if the hands are not visibly soiled, or using soap and water at the sink.<br><br>On 10/22/20 at approximately 11:00 AM, the surveyor discussed the findings with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) who acknowledged the surveyors findings. The administration confirmed that the resident did not have any history of a wound infection to either [redacted]. The surveyor asked for the facility's [redacted] care policy but the facility only provided a policy for [redacted] dressing changes using aseptic (sterile) technique.<br><br>A review of the facility's [redacted] Dressing: Aseptic policy revised 11/1/19, included a procedure for after applying the new dressing, to "Remove gloves and discard according to infection control procedure...cleanse hands."<br><br>2. On 10/22/20 at 9:50 AM, the surveyor reviewed the facility's infection control data surveillance and tracking.<br><br>The surveyor reviewed the Infection Control Monthly Line Listing for units [redacted] for July, August, September, and October 2020 The monthly infection data tracking included the name of the resident, the room number, the | F 880 | | |

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admission date and the onset date of the infection. It further included a section to track if the infection was a healthcare-associated infection or if it was community-acquired, but the designated spaces were blank for urinary tract infections (UTI), respiratory infections, sepsis (systemic infection), fungal infections, skin infections, and multi-drug resistant organisms (MDRO's) documented in the tracking sheet.

At 9:53 AM, the surveyor interviewed the IP who stated that she started working at the facility on [redacted]. She stated that her role as IP included conducting infection control training's and competencies with staff, conducting infection control (IC) handwashing audits, pioneering the antibiotic stewardship program and making sure infections were being tracked accordingly. The IP showed the surveyor the Infection Control Monthly Line listing for July, August, September and October 2020 and the IP stated that each unit had a binder in which any resident that had a current infection were added to the line list. She stated that the nurse was to immediately place it in the book upon identification of the infection, and then inform her of the infection. She stated that when the nurse fills out the form, they should be documenting if it was a healthcare-associated infection or if it was community-acquired on the form. She acknowledged they were blank on the forms. The surveyor asked who was responsible to track infection rates and trends over a period of time to evaluate/analyze the infection data, and the IP stated that she just started in July and that she was had not been doing that. The IP stated that she attended a quality assurance program meeting in which they reviewed infection control, but she acknowledged that without tracking infection rates and trends, she

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wouldn't be able to evaluate how the facility was doing on their infection control program and comparing it to various standards. She stated that the facility had a regional Infection Control Nurse that she could get information from, but the IP wasn't sure if the regional Infection Control Nurse was doing the tracking and trends over the period of time. The DON could not speak to the infection rate or provide a document of the each infection rate identified on the line listing since she started in July.

On 10/22/20 at 11:57 AM, the surveyor interviewed the DON and the LNHA in the presence of the survey team who confirmed that the facility was doing monthly infection tracking by unit but confirmed there was no cumulative data tracking the trends of infections over time. The LNHA provided the surveyor a copy of an infection data tracking sheet done in June 2020 but she confirmed there was no additional tracking since June 2020, despite infections occurring in July, August, September and October 2020. The DON and LNHA acknowledged that the IP was responsible for doing the monthly tracking of infection rates and rates over time of each infection. They also acknowledged that the facility should be tracking if the infections are healthcare associated infections or if they are community-acquired infections. The LNHA acknowledged that it was an oversight since the facility was transitioning between Infection Preventionist's.

A review of the facility's Infection Prevention and Control Program Description revised 3/11/19 included roles of the IP including, "Perform surveillance to monitor the rate of healthcare acquired infection and communicable diseases,

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| (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 44<br>analyze and develop action plan to address."<br><br>NJAC 8:39-19.1; 19.2; 19.4; 19.5; 21.1 | F 880 | | |