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	315157	A. BUILDING _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS STANDARD SURVEY: 9/19/19 CENSUS: 186 SAMPLE SIZE: 35 (Plus 3 closed records) 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 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that residents' dignity was maintained. The deficient practice was evidenced by 1 individual interview with Resident #48, and 3 of 6 residents in attendance at the 9/13/19 resident council group meeting. This deficient practice was evidenced by the following: Resident #48 approached the surveyor on 9/11/19 at 11:45 AM. The surveyor observed the resident in a wheelchair on the elevator going	F 557	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? " Staff education was provided to Center Departments on speaking English in all common and patient care areas to address resident concerns regarding speaking foreign language in common areas. How will the facility identify other residents having the potential to be affected by the same deficient practice?	11/10/19

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/10/2019

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F 557	Continued From page 1 from the [redacted]-floor nursing unit to the [redacted]-floor main dining room. The resident stated Certified Nursing Assistants (CNAs) frequently speak to each other in a foreign language in the resident's presence. The resident expressed feeling uncomfortable with this, thinking the staff was talking about him/her. The surveyor reviewed Resident #48's [redacted] quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. The resident was assessed to have no long or short term memory deficits, scoring [redacted] on the Brief Interview for Mental Status examination and evaluated with [redacted] The facility arranged the resident council group meeting for 9/13/19 at 10:30 AM. The facility self-selected six residents who were assessed by the facility to have [redacted]. Three of the six residents in attendance expressed that they were concerned with staff speaking in a foreign language in front of them. One resident stated, "I don't feel like I'm a part of the conversation, and it's disrespectful." The surveyor reviewed page 38 of the 4/2019 Individual Performance Improvement Process, which indicated, "English is the common language to be used by all employees in patient and resident care areas." On 9/16/19 at 1 PM, the survey team met with the Administrator and Acting Director of Nursing and discussed the above observations and concerns. There was no additional information provided. NJAC 8:39-4.1(a)12	F 557	" Residents in the center have the potential to be affected. " Staff education was provided to Center Departments on speaking English in all common and patient care areas to address resident concerns regarding speaking foreign language in common areas by ADON and Department Heads What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? " Staff education was provided to Center Departments on speaking English in all common and patient care areas to address resident concerns regarding speaking foreign language in common areas. " Department heads/ management team will address any further infractions. " Residents will be asked during monthly resident council meeting for input on staff compliance. " Annual in-services will incorporate education regarding speaking English in all common and patient care areas. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? " Data from resident council meetings will be analyzed and reported in monthly and quarterly QAPI meetings x 6 months	

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F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		11/10/19

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F 584	Continued From page 3 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the surveyor determined that the facility failed to a) ensure that the resident's physical environment was maintained in a safe, clean and homelike condition for 4 of 5 units; and, b) maintain a clean and sanitary resident rooms for Resident #56,76,42, 7 and 77; 5 of 157 rooms. This deficient practice was evidenced by the following findings: During a tour of the building in the presence of the facility's Maintenance Director, Regional Maintenance Director and Regional Housekeeping Director on 9/16/19 and 9/17/19 from 10:00 AM to 1:30 PM, the surveyor observed the following issues on the following units: [redacted] Floor: - The vinyl floor covering in the elevator had large gauges, exposing the floor of the blackened subfloor surface. The surveyor identified the same condition for the floor in Nurses' supply closet. - A section of the ceiling in the corridor in front of the nurses' station had two ceiling tiles that were observed stained with a dark brown substance. The surveyor also identified this in the staff bathroom (2 ceiling tiles). - The floor behind the refrigerator in the pantry had multiple packs of sugar imbedded in a substantial build-up of dirt. Also, the floor in the clean linen storage room had an accumulation of	F 584	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? " Roof was inspected and leaks repaired on 9/24/19. " Window frames are being repaired and painted " Ceiling tiles affected have been replaced. " Quote has been received re: repair of flooring in affected areas of elevators, bathrooms and storage rooms.. " Furniture repairs were completed on 10/3/19 " Toilets will be replaced in mentioned rooms/ shower rooms after flooring has been replaced. " A quote and samples have been requested to replace door frame covers on all units with an estimated completion date for the project within 60 days. Old door frame covers will be removed and door jams painted in the interim. " Dirty floors in [redacted] floor pantry and linen storage, [redacted] floor supply/dayroom closet and pantry, [redacted] floor soiled utility room sink was cleaned and walls to soiled utility room have been cleaned, repaired and painted. " Soiled feeding poles for residents #42, #7, and #77 were cleaned. How will the facility identify other residents having the potential to be affected by the	

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F 584	Continued From page 4 loose trash and dirt build-up which had collected under the bottom shelf of a storage unit. - The surveyor observed doorframes to resident rooms covered with vinyl doorframe covers used to protect doorframes from damage. Many doorframes were damaged, warped and or detached from the doorframes thus, causing the entire unit to appear unsightly. [redacted] Floor: - The floors in the nursing supply room, dayroom storage closet, and pantry (behind ice machine and refrigerator) were dirty and had an accumulation of trash debris. - The painted surface on the wooden window frame in resident room [redacted] was peeling. - A toilet in the shower room had a dark stain around the interior of the bowl. The hot water fixture on the sink was corroded and stained at the base. Also, a wooden window frame had peeling paint on the surface. [redacted] Floor: - The laminated edges of many nightstands in resident rooms [redacted], and [redacted] were missing and exposed the raw subsurface resulting in an unsightly appearance. - Resident rooms [redacted] had toilets stained with a dark brown substance in the bowl. - The surveyor observed a rotted corner of the wooden window frame in resident room [redacted]. Also, the painted surface of the window frame in resident room [redacted] was peeling. - The surveyor observed the bathroom floor in the resident rooms [redacted], and [redacted]. The bathroom floor had a sheet of linoleum that buckled around the perimeter and did not fit flush against the wall. Also, the edge of the bathroom linoleum floor in resident room [redacted] did not have a transition strip	F 584	same deficient practice? " Center Residents have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? " Director of Housekeeping reviewed with Housekeeping staff the room cleaning process in which rooms are cleaned daily using the seven-step cleaning procedure. Pantry, Soiled and clean linen rooms as well as supply closets will be added to the monthly complete room schedule/ calendar. " Director of housekeeping educated staff on including all medical equipment in residents rooms in daily cleaning routine. " Unit managers and staff have been in-serviced on using the electronic notification system for maintenance and housekeeping issues. " A unit round monitoring tool has been placed in affect for daily use. " Center management will conduct bi-monthly environmental rounds to identify and correct areas in need of servicing/repair. " Center manager will monitor daily and District manager will conduct weekly inspections. " Electronic reports for maintenance and housekeeping requests will be monitored for completion weekly How will the facility monitor its corrective actions to ensure the deficient practice will not recur? " Bi-monthly environmental rounds, Unit	

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F 584	Continued From page 5 where it adjoined the vinyl tile floor in the resident bedroom. The edge of the linoleum floor was secured in place with five screws that caused an uneven transition and a section to be raised 1-inch higher at the threshold. - The walls in the soiled utility room were covered with unidentifiable dried spills and needed to be re-painted. Also, the basin of the sink contained unidentifiable crud. [redacted] Floor: - The bathroom floor in the resident rooms [redacted] and [redacted] was covered with a sheet of linoleum that had buckled around the perimeter, and did not, fit flush against the wall. The space between the edge of the linoleum flooring and wall, in bathroom [redacted], had started to collect water around the perimeter. - The soiled utility room had water leaking through the ceiling tiles from pipes located directly above it. The ceiling tiles had collapsed and fallen into the sink and surrounding floor area. Water had pooled on the floor. The water to the sink was not connected. This area did not have paper towels, and large clumps of a dried brown substance was observed on the wall by the trash container. - The surveyor observed doorframes to resident rooms covered with vinyl doorframe covers used to protect doorframes from damage. Many doorframes were damaged, warped and or detached from the doorframes thus, causing the entire unit to appear unsightly. The facility's Maintenance Director, Regional Maintenance Director, and Regional Housekeeping Director acknowledged the above findings in a group interview during the observations. The Maintenance Director stated	F 584	rounding tool, and housekeeping request follow ups will be reviewed/data tracked and will be reported at monthly and quarterly meetings to the QAPI committee x 6 months .	

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F 584	Continued From page 6	F 584		

that the facility has a computerized preventive maintenance system for staff to use for reporting maintenance issues. The Maintenance Director further said that staff did not always use this system. Housekeeping addressed the problems mentioned above, but the facility was unable to provide any additional information as to why they had occurred.

The surveyor verbally informed the facility's Administrator of these findings during the Life Safety Code exit conference at 1:45 PM.

2. On 9/10/19 through 9/13/19 at various times, the surveyor observed the base of the [redacted] in Resident #56's room [redacted] Resident # 56 was not interviewable.

3. On 9/10/19 through 9/13/19 at various times, the surveyor observed the [redacted] in Resident #76's room [redacted] Resident #76 was not interviewable.

4. On 9/10/19 at 10:09 AM, 9/11/19 at 9:16 AM, 9/12/19 at 8:51 AM, and on 9/13/19 at 9:39 AM, the surveyor observed a build-up of dirt on the floor in Resident #42's room. There was [redacted] on the base of the [redacted], which was consistent with the [redacted] that was used for the resident's [redacted]

On 9/13/19 at 9:50 AM, there was a build-up of dirt in the corners of the room and [redacted] on the base of the [redacted] in Resident #7's room.

On 9/13/19 at 9:57 AM, there was a build-up of dirt in the corners in the room and [redacted]

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F 584	Continued From page 7 [redacted] on the base of the [redacted] in Resident #77's room. On 9/13/19 at 9:39 AM, the surveyor interviewed Housekeeper #1 assigned to the [redacted] of the [redacted]-floor unit who stated it was her responsibility to clean the resident's floor, table, window, nightstand, bathroom and to remove garbage daily. At that same time, the surveyor and Housekeeper #1 entered Resident #42's room. The surveyor asked Housekeeper #1, who was responsible for cleaning the base of the [redacted]? Housekeeper #1 stated, "not me." She further said, "I don't know who cleans, but not me." A review of the cleaning schedule revealed that Housekeeper #1 was assigned to clean Resident #42 and Resident #7's rooms. On 9/13/19 at 9:44 AM, the surveyor interviewed the Registered Nurse/Unit Manager #1 (RN/UM #1) who stated it was the housekeepers' responsibility to clean the [redacted] and resident rooms. At that same time, the surveyor and the RN/UM #1 entered Resident #42's room. The RN/UM #1 stated, "it's my responsibility to check the resident rooms for cleanliness. She further stated, "I don't check the rooms every day, and I haven't been paying attention lately. I should have checked it." On 9/13/19 at 9:57 AM, the surveyor interviewed Housekeeper #2 who was assigned the [redacted] side of the [redacted]-floor unit. The Housekeeper acknowledged that it was her responsibility to clean the floor and the base of the [redacted]	F 584		

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F 584	Continued From page 8 [redacted] for Resident #77 daily. On 9/16/19 at 12:38 PM, the surveyor interviewed the Housekeeping Manager (HM). The HM informed the survey team that it was housekeeping's responsibility to clean the residents' room, including the base of the [redacted] daily. She stated that it was her responsibility to make sure to check every day that the rooms were cleaned accordingly. She further said, "I don't know what happened and why the resident rooms weren't clean. I should have checked it." On 9/16/19 at 12:53 PM, the surveyor met with the Administrator, Acting Director of Nursing, and the Regional Officer and discussed the above observations and concerns. A review of the facility Cleaning: Resident/Patient Areas Policy provided by the Acting DON with an effective date of 11/1/07 indicated "All resident/patient areas are cleaned at least daily and include resident/patient rooms, dining rooms, day rooms, lunges, tubs/showers, therapy rooms, etc," and "Cleaning is accomplished using the Seven-step cleaning Procedure which includes the following cleaning procedures: High dusting, spot cleaning and surface sanitizing, bathroom cleaning, waste collection, floor dust mopping, floor wet mopping, and room inspection-visually inspect room after completing all tasks and correct any issues before leaving the room."	F 584		
F 637 SS=E	NJAC 8:39-31.2(e) and 31.4(a) Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)	F 637		11/10/19

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F 637	Continued From page 9 §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a) code a Minimum Data Set (MDS) to reflect [redacted] services for a total of one year and assure that a significant change assessment was completed for a [redacted] Resident, (Resident #122); and, b) complete a Significant Change in Status Assessment (SCSA) Minimum Data Assessment (MDS) for Resident # 70 reviewed. This deficient practice was identified for 2 of 38 residents, as evidenced by the following: 1. On 9/10/19 at 10:02 AM, the Registered Nurse/Unit Manager #1 (RN/UM#1) informed the surveyor that Resident #122 was on [redacted] care. On that same day at 10:18 AM, the surveyor observed the resident lying on a specialized mattress with eyes closed. Resident #122's Face sheet reflected that the resident was admitted to the facility on [redacted]	F 637	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? " Appropriate correction/modifications completed to Resident #122 MDS dated for [redacted] to include [redacted] services. " MDS in progress with a target completion date for [redacted] will indicate significant change in condition for Resident #87. How will the facility identify other residents having the potential to be affected by the same deficient practice? " Residents receiving [redacted] services have the potential to be affected. " An audit will be completed for residents currently on [redacted] services to ensure Services have been included on the MDS and a significant change has been completed appropriately " Residents with recent removal of	

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F 637	Continued From page 10 and had diagnoses that included [redacted] A review of the September 2019 Order Summary Report revealed an order dated 6/22/18 for [redacted] evaluation and treatment. A review of the 2/18/19 Care Plan Meeting notes showed that the resident was on [redacted] services since [redacted]. Review of the MDS, an assessment tool used to management of care revealed a Significant Change in Status dated [redacted]. There was no significant change assessment completed within 14 days from the resident's [redacted] admission on [redacted] Review of the Quarterly MDS dated [redacted], [redacted] and [redacted], revealed it was not coded for [redacted] services. On 9/16/19 at 12:53 PM, the survey team met with the Administrator, Acting Director of Nursing, and the Regional Center Executive Director (RCED) and discussed the above observations and concerns. On 9/17/19 15 9:13 AM, the surveyor interviewed the Registered Nurse/MDS Coordinator in the presence of the survey team. The RN/MDS Coordinator stated that a significant change should have been completed within 14 days after the resident's admission to [redacted]. She said that that the facility followed the RAI (Resident Assessment Instrument) manual as its policy in doing a Significant Change. She further noted that the Clinical Reimbursement Coordinator	F 637	[redacted] have the potential to be affected. " An audit will be completed on current residents to ensure Significant change MDS was completed if they had a [redacted] removed. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? " Residents will be reviewed at morning clinical meeting, UR and at IDCP meetings and evaluated for appropriateness of a SCSA. " MDS will submit schedule for IDCP meetings and MDS submissions weekly to CNE and CED. " CNE will audit weekly submissions by MDS coordinator to ensure that all residents meeting the clinical criteria are scheduled for/ have a SCSA completed. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? " Schedules will be evaluated and data analyzed monthly and reported to the QAPI committee monthly and quarterly for review x 6 months	

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F 637	Continued From page 11 (CRC) knew that the resident was on [redacted] and, "just missed it." On that same day at 9:32 AM, the CRC informed the surveyor in the presence of the survey team, "I missed it because probably something came up at that time, and that it should have been done when [redacted] services were initiated." On 9/18/19 at 12:52 PM, there was no additional information provided by the facility. Review of the RAI Version 3.0 Manual indicates a significant change is required to be performed when a [redacted] program or changes [redacted] providers and remains a resident at the nursing home. The Assessment Reference Date (ARD) must be within 14 days from the effective date of the [redacted] election. 2. On 9/11/19 at 9:00 AM, the surveyor observed Resident # 87 awake, out of bed sitting in a wheelchair in his/her room. Resident # 70 was alert and oriented and was able to answer questions appropriately. A review of the resident's quarterly MDS revealed that Resident # 87 was admitted to the facility on [redacted] with diagnoses that included [redacted] The surveyor reviewed the 1/17/19, Admission MDS, which reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] n. Section O of the MDS indicated [redacted] and section K of the MDS indicated the resident had a [redacted].	F 637		

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Further review of the resident's medical record reflected that the [redacted] was removed on [redacted] at the bedside by the respiratory therapist.

There was no Significant Change in Status Assessment (SCSA) completed within 14 days after the removal of the residents [redacted]

Further review of the resident's medical record reflected that the [redacted] was removed on [redacted] There was no SCSA completed within 14 days after the [redacted].

On 9/18/19 at 1:00 PM, the surveyor interviewed the MDS coordinator who stated, "we did not complete the significant change assessment in February because the resident only had improvement in one area of care and needs to have improvement in two areas of care."

The surveyor asked why a SCSA wasn't completed after the [redacted]. The MDS coordinator stated, "the team plans to do a significant change in status now because he/she gained 5 pounds in July."

Review of the RAI Version 3.0 Manual indicates a significant change is a major decline or improvement in a resident's status that:
1. Will not normally resolve itself without intervention by staff implementing standard disease-related clinical interventions, the decline is not considered "self-limiting;"
2. Impacts more than one area of the resident's health status; and,
3. Requires interdisciplinary review and/or

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F 637	Continued From page 13 revision of the care plan. NJAC 8:39-11.1 NJAC 8:39-11.7	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		11/10/19

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F 656	Continued From page 14 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to implement a comprehensive, resident centered care plan to address the use of a physician-ordered [redacted] for the management of [redacted]. This deficient practice was identified for 1 resident, Resident #159, of 38 residents reviewed and was evidenced by the following: The surveyor observed Resident #159 awake in bed on 9/10/19 at 11:00 AM. The resident stated he/she had sustained a [redacted] in 2008 and was affected with [redacted]. The surveyor observed the resident [redacted]. The resident's [redacted] was empty and positioned in a [redacted]. The surveyor reviewed the resident's Treatment Administration Record (TAR) and observed a 6/10/19 physician's order for placement of a [redacted] after morning care at 11 AM, and removal at 4 PM, for [redacted] management. The surveyor returned to the resident's room on 9/10/19 at 12:30 PM. The resident was in a wheelchair in the bathroom, brushing his/her teeth with the [redacted]. The [redacted],	F 656	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? " Plan of care was updated for resident #159 to include the [redacted] How will the facility identify other residents having the potential to be affected by the same deficient practice? " Residents requiring [redacted] have the potential to be affected " Physician order review will be completed for each resident regarding [redacted] orders and the plan of care will be updated if indicated. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? " Unit Managers will monitor New Orders for [redacted] and validate update to plan of care " Unit Managers will monitor for application of [redacted] per orders and plan of care during walking rounds	

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F 656	Continued From page 15 empty, and resting on the resident's lap. The surveyor asked the resident if the staff provided the resident with a [redacted]. The resident responded, "not usually." The surveyor asked the resident for permission to look in the dresser drawer for a [redacted]. The resident replied, "Be my guest." The surveyor observed a [redacted] with two velcro straps stored in the top drawer of the chest of drawers. The surveyor observed the resident the following day on 09/11/19 at 11:55 AM. The Certified Nursing Assistant (CNA) stated she was done with morning care and left the resident's room. The surveyor observed the [redacted] in the top dresser drawer. The surveyor observed the resident on the same day on 9/11/19 at 12:20 PM, seated in a wheelchair in the day room for the lunch meal. The resident was not wearing a [redacted]. The surveyor reviewed the resident's care plan on 9/11/19. The nursing staff failed to implement a care plan for the use of a [redacted]. On 9/12/19 at 1:08 PM, the surveyor discussed concerns regarding the application of the [redacted] with the Administrator and the Acting Director of Nursing. On 9/13/19 at 12:30 PM, the Administrator stated the resident should have been care planned for the use of a [redacted] management. NJAC 8:39-11.2(e)1	F 656	How will the facility monitor its corrective actions to ensure the deficient practice will not recur? " The Director of Nursing or designee will audit [redacted] list monthly for compliance with Physician orders/care plans and application of the [redacted]. " Results of the audit will be analyzed monthly and reported to the QAPI committee on a monthly and quarterly basis x 6months.	
F 658	Services Provided Meet Professional Standards	F 658		11/10/19

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F 658 SS=E	Continued From page 16 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility nursing staff failed to a) maintain standards of clinical practice regarding the documentation of missed dental appointments, document when the resident left and returned from dental appointments, retrieve dental consult paperwork from the resident upon return from the dental clinic, communicate with the dental clinic to obtain consult reports, and follow-up with the clinic regarding the status of new upper and lower dentures. This was identified for 1 of 35 residents (Resident #98), b) monitor for [redacted] according to the physician's order, for 1 of 5 residents (Resident #14), and failed to c) follow a physician's order during the administration of medications for 1 of 5 residents (Resident #335) reviewed for standards of nursing clinical practice. The deficient practice was evidenced by the following: 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	F 658	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? " Resident #98 was seen by speech and diet was upgraded per Speech recommendations. " Resident #14 the order to monitor for [redacted] has been discontinued related to no longer needed. " Resident #335 in regards to the [redacted] administration was monitored for bleeding per the Pharmacy Consultant recommendations and medication continued per order. Physician was made aware of 9am medications given late with no new orders given. How will the facility identify other residents having the potential to be affected by the same deficient practice? " Residents with [redacted] consults, Orders to monitor for [redacted] and Medication administration have the potential to be affected. " Unit Managers will validate by completing a center audit of the orders to ensure monitor for [redacted] have been entered correctly to pull over to the TAR.	

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F 658	Continued From page 17 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." 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." 1. The surveyor interviewed Resident #98 on 9/10/19 at 9:56 AM. The resident stated he/she does not wear his/her dentures because they do not fit properly. The resident said he/she received soft foods and had no difficulty chewing. The surveyor reviewed the [redacted] Quarterly and [redacted] Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. During the quarterly and annual assessment reference periods, the resident was assessed to have had [redacted]. The Brief Interview of Mental Status (BIMS) examination scored [redacted]); evaluated to have had no significant weight gains or losses, and was prescribed a mechanically altered and therapeutic diet. Medical diagnoses listed in the quarterly and annual MDS assessments included [redacted]	F 658	" Unit Managers will Complete Center audit to validate [redacted] consult information has been followed up on appropriately. " RN #3 received education on time management and the importance of giving medications at the scheduled times for maximum effectiveness and to reduce complications. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? " Education was provided to the nursing staff on the proper protocols for transcribing Physician orders onto the eMAR and eTAR by ADON " Unit Managers will review all consults for new orders and ensure that follow up is completed appropriately. " Nursing staff received re-education by ADON on time management and the importance of giving medications at the scheduled times for maximum effectiveness and to reduce complications. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? " Director of Nursing or Designee will complete a weekly audit x 4 weeks then monthly x 3 months to monitor for appropriate order transcription. " Unit Manager or Designee will complete observation of Medication pass regarding time of administration 3 x a	

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F 658	Continued From page 18 [redacted]. A review of the resident's current care plans failed to reveal a care plan related to the use of [redacted]. The surveyor reviewed the 12/19/18 Speech Therapy (ST) Initial Evaluation. The Speech Therapist documented, "Pt. receiving [redacted] 12/31. . . ST recommending continuation of dysphagia advanced solids and thin liquids with re-evaluation upon pt [patient] receiving [redacted]." The surveyor reviewed the 1/9/19 Nutrition Progress Note. The Registered Dietician documented the resident was prescribed a mechanically altered diet, "...related to ease of chewing. Resident reports [his/her] teeth have been pulled and is supposed to get [his/her] [redacted] in February." Further review of speech therapy and nutrition notes through 9/17/19, failed to reveal any additional references to the resident's wearing of [redacted]. The surveyor interviewed the Registered Nurse/Unit Manager #1(RN/UM #1) on 9/16/19 at 9:54 AM, regarding the status of the resident's [redacted]. The RN/UM stated she was unsure and would look into it and provide the surveyor with additional information. The surveyor interviewed the Administrator and the Acting Director of Nursing (DON) on 9/16/19	F 658	week for 4 weeks. " Director of Nursing or designee will complete a weekly audit x 4 weeks then monthly x 3 months regarding [redacted] consults to monitor for appropriate follow up. " Director of Nursing/Unit Managers will report data from the above findings to CNE/ designee monthly for analysis and findings will be reported to the QAPI committee q month and quarterly x 6 months. .	

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at 1:14 PM. The facility was not aware the resident had received [redacted].

The RN/UM #1 documented in a 9/17/19 (12:19 PM) nursing progress note that the resident told her he/she was not wearing the [redacted] because they were uncomfortable and made it difficult to swallow. The facility nurse practitioner was made aware, and a referral was sent to ST to evaluate and treat for the use of [redacted]. A subsequent [redacted] clinic appointment was made for [redacted].

The surveyor interviewed the Administrator, the Administrator in Training, and the RN/UM #1 on 9/18/19 at 9:15 AM. The Administrator stated she had obtained and reviewed hospital [redacted] clinic records the previous afternoon on 9/17/19. She summarized that over several months in 2018, all of the resident's [redacted]. The completed [redacted] were to be provided to the resident on 12/31/18. The resident self-canceled the 12/31/18 appointment and self-canceled the subsequent 2/1/19 appointment. The Administrator stated the hospital [redacted] clinic records indicated the resident received the f[redacted] [redacted].

The RN/UM #1 informed the surveyor that the resident made the dental appointments and the nursing department was responsible for arranging transport to the [redacted] clinic. The RN/UM #1 further stated that appointments should be logged into the appointment book. The day appointments should be posted at the nursing desk so that staff are aware that the resident was going out that day. Paperwork is given to the resident or attendant to give to the clinic/doctor's office. When the resident leaves and returns, the unit

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nurse documents in the notes section of the medical record, when the resident left, and when the resident returned. The unit nurse gives the paperwork from the consult to the RN/UM #1 or the charge nurse. The information is then carried out by the unit manager or charge nurse. The RN/UM #1 was unable to explain why this process did not occur for the resident's canceled [redacted] appointments or the receipt of the new [redacted]

The surveyor reviewed the hospital [redacted] clinic records provided by the Administrator on 9/18/19. The records revealed that 3/12/18 and 3/18/18 recommendations were made for [redacted]. The [redacted] began on [redacted] and continued through [redacted] were taken on 10/4/18 and 11/2/18. The resident presented on 11/29/18 for try on, and adjustments were required. The resident did not show for appointments on 12/31/18 and 2/1/19. The resident received the [redacted].

The surveyor interviewed the Registered Dietician (RD) on 9/18/19 at 10:26 AM. The RD stated she did not know the resident had received [redacted] until the previous day when the Administrator had spoken to [redacted] The RD further stated the resident was on an advanced dysphasia diet due to [redacted]. The RD also said the resident told her he/she was getting [redacted] but did not know when the resident was getting them. The RD did not recall when the resident said this to her. The RD further stated the resident had been tolerating the dysphasia advanced diet with no complaints. The RD said she had reviewed the resident's food preferences and communicated these to the kitchen. She stated the resident had some weight

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fluctuations which were due to fluid shifts and not due to decreased intake. The RD said if she had been aware the resident had received the dentures, she would have assessed the resident to see how he/she was doing with them. She further stated that if the resident were having a problem with the [redacted] or wanted to change from a dysphasia advanced diet to a regular diet, the RD would have referred the resident for an ST evaluation.

On 9/18/19, the surveyor requested from the Acting DON the facility policies regarding the use of [redacted] and the procedure for medical consultations. The Acting DON explained there were no facility policies for dentures or consultations.

2. On 9/18/19 at 11:52 AM, the surveyor observed RN #3 preparing medications on the [redacted] floor in the [redacted] wing for Resident #335. The surveyor saw that the electronic Medical Administration Record (e-MAR) screen was pink. RN #3 stated that the color pink indicated the medications "were late." The surveyor, in the presence of RN #3, reviewed the September 2019 E-MAR for Resident #335, which revealed, the following medications were ordered to be administered at 9:00 AM:

[redacted]

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[redacted].

On that same day and time, the surveyor asked RN #3 why she was administering the medications nearly 3 hours past the ordered administration time. The RN stated that she was "busy." The Unit Manager told RN#3 that she saw her preparing for [redacted] treatments that morning and further noted, that the medication pass should have taken priority over the treatments.

On that same day at 12:45 PM, in the presence of the acting Director of Nursing, the surveyor called the facility's Pharmacy Consultant who stated that the late administration of Resident #335's [redacted] would not cause any significant adverse reactions. She further indicated that she would speak with the Acting Director of Nursing and recommend that nurses monitor Resident #335 for [redacted] and continue with [redacted] administration every 12 hours.

On 9/18/19 at 12:51 PM, the survey team met with the Administrator and Acting Director of Nursing and discussed the above observations and concerns.

The surveyor reviewed Resident #335's medical record which revealed the following:

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According to the Admission Record, Resident #335 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses that included [redacted]

On 9/19/19 at 11:00 AM, the surveyor reviewed the Medication Administration Audit report for Resident #335 which revealed that on 9/18/19 RN #3 administered all of Resident #335's 9:00 AM medications between 11:44 AM and 12:13 PM.

The surveyor reviewed the Medication Administration Policy dated 1/1/04 and revised 7/1/19, which reflected that Medication doses would be administered within one hour of the prescribed time unless otherwise indicated by the prescriber.

3. On 9/10/19 at 10:21 AM, the surveyor observed Resident #14 seated in a wheelchair in the day room. The Registered Nurse/Unit Manager #1 (RN/UM#1) informed the surveyor that the resident was [redacted] and required maximum assistance of one with ADLs (activities of daily living).

A review of the resident's Face sheet reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included [redacted]

A review of the [redacted] Quarterly MDS, reflected a Brief Interview for Mental Status (BIMS) score of [redacted]. The quarterly MDS identified that the resident had an [redacted]

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F 658	Continued From page 24 [redacted] A review of the September 2019 Order Summary Report revealed an order dated 8/24/19 for, "Watch for [redacted], do [redacted] A review of the August and September 2019 electronic Treatment Administration Record (e-TAR), revealed that the above order for monitoring [redacted] was not transcribed to indicate the order was carried out. On 9/12/19 at 9:53 AM, the RN/UM #1 informed the surveyor that the resident used to have a [redacted]. She stated that there was no [redacted] observed after removing the [redacted] in August 2019. At that same time, the RN/UM #1 informed the surveyor that the 8/24/19 order for monitoring [redacted] should have been transcribed onto the eTAR. She further stated it was the nurses' responsibility to watch the resident for [redacted] according to the physician's order and, "It should have been in the eTAR." On 9/12/19 15 10:10 AM, the surveyor interviewed the Nurse Practitioner (NP) who informed the surveyor that she ordered to monitor the resident for [redacted] status post [redacted] in August 2019. She stated that she comes to the facility Monday through Friday, and the nurses had reported to her that there was no [redacted]. She further said that she was not aware that the order was not carried over to the eTAR because she	F 658		

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F 658	Continued From page 25 expected the nurses to sign off to indicate that it was done according to the order. On that same day at 11:43 AM, the Licensed Practical Nurse (LPN) who transcribed the above order, had no answer why the August and September 2019 eTAR did not capture the order to monitor the resident for [redacted] She stated that the above order should have been transcribed onto the eTAR. On 9/12/19 at 1:03 PM, the survey team met with the Administrator, Acting Director of Nursing, and discussed the above observations and concerns. On 9/13/19 at 12:29 PM, the survey team met with the Administrator, Acting DON, and Regional Center Executive Director (RCED). The acting DON stated the order for monitoring the resident for [redacted] should have been in the eTAR and that the nurse should have followed the physician order. She further noted that the nurses were monitoring the resident for [redacted], but there was no documentation of it. On 9/16/19 at 12:53 PM, there was no additional information provided by the facility. A review of the Transcription of Orders Policy provided by the Acting DON with a review date of 3/1/16 indicated, "Orders from an authorized licensed independent practitioner are transcribed by a licensed nurse." NJAC 8:39-27.1(a); 11.2(b)	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		11/10/19

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F 684	Continued From page 26 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to consistently provide a physician ordered [redacted] management for 1 of 35 residents, (Resident #159) reviewed. The deficient practice was evidenced by the following: The surveyor observed Resident #159 awake in bed on 9/10/19 at 11:00 AM. The resident stated he/she had sustained a [redacted] and was affected with [redacted]. The surveyor observed the resident [redacted] The resident's [redacted]. The surveyor reviewed the resident's Treatment Administration Record (TAR) and observed a 6/10/19 physician's order for placement of a [redacted] after morning care at 11 AM, and removal at 4 PM, for [redacted] management. The surveyor returned to the resident's room on 9/10/19 at 12:30 p.m. The resident was in a wheelchair in the bathroom, brushing his/her teeth with the [redacted] The [redacted] was	F 684	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? " OT services were reviewed and [redacted] remains appropriate for Resident # 159. Plan of care regarding [redacted] application was updated. [redacted] is being applied as ordered. How will the facility identify other residents having the potential to be affected by the same deficient practice? " Residents with [redacted] and requiring [redacted] have the potential to be affected. " Physician order review will be completed for each resident regarding [redacted] orders and the plan of care will be updated if indicated. " RN # 1 received re-education on Assessments regarding [redacted]. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?	

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F 684	Continued From page 27 [redacted]. The surveyor asked the resident if the staff provided the resident with a [redacted] device. The resident responded, "not usually." The surveyor asked the resident for permission to look in the dresser drawer for a [redacted]. The resident replied, "Be my guest." The surveyor observed a [redacted] stored in the top drawer of the chest of drawers. The surveyor observed the resident the following day on 09/11/19 at 11:50 AM. The Certified Nursing Assistant (CNA) stated she was done with morning care and left the resident's room. The surveyor observed the [redacted] in the top dresser drawer. The surveyor observed the resident on that same day on 9/11/19 at 12:20 PM, seated in a wheelchair in the day room for the lunch meal. The resident was not wearing a [redacted]. The surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #159. The LPN stated she was the responsible person for placing a [redacted] on the resident when "the resident gets out of bed." The surveyor asked the LPN to check the resident in the day room for [redacted] usage. The LPN looked at the resident and stated to the surveyor, "it's not on." The surveyor inquired as to why the LPN did not apply the [redacted] after morning care. She stated, "I didn't know [the resident] was out of bed." The surveyor interviewed the Registered Nurse Manager/Unit Manager #1 (RN/UM #1) on 9/11/19 at 12:30 PM. The RN/UM #1 stated the [redacted] order was to place the [redacted] after morning care was	F 684	" Unit Managers will monitor New Orders during clinical meeting for [redacted] and validate update to plan of care along with appropriate documentation regarding [redacted] " Unit Managers will monitor for application of [redacted] per orders and plan of care during walking rounds " Re-education completed with Nurses by ADON regarding monitoring [redacted] are applied as ordered and including [redacted] assessment if noted. " Re-education completed with the CNA□s by ADON regarding importance of applying [redacted] as ordered. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? " The Director of Nursing or designee will audit [redacted] list weekly x 4 weeks then monthly x 3 for compliance with Physician orders/care plans/musculoskeletal assessment and application of the [redacted]. " Results of the audit will be analyzed monthly and reported to the QAPI committee on a monthly and quarterly basis x 6months.	

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completed. The surveyor informed RN/UM #1 that the [redacted] was not applied after morning care on 9/10/19 and 9/11/19. RN/UM #1 stated she would look into it.

On 9/11/19 at 12:31 PM, the surveyor again asked the resident if the [redacted] was placed on [redacted] each day after morning care. The resident replied, "No, not usually."

The surveyor interviewed the Physical Therapist (PT) on 9/12/19 at 9:37 AM. The PT stated the resident was re-evaluated for the use of the [redacted] the previous afternoon on 9/12/19, by the Occupational Therapist (OT). The surveyor requested to speak to the OT for specific information. The Rehabilitation Director responded instead. The Director stated the OT evaluation had not yet been completed. She said the resident would be re-assessed and staff re-educated for restorative nursing. The Director noted the resident had been discharged from rehabilitation in April 2019, with instructions for nursing to apply a [redacted] each day after AM care and to remove after dinner. The OT Discharge Summary for the period from 3/14/19-4/24/19 was provided to the surveyor. The OT documented in the Discharge Summary, "Nursing trained in proper donning/doffing of [redacted] ....equipment recommended upon discharge [redacted] "

The surveyor reviewed the 9/12/19 Order Summary Report, which included a 9/11/19 physician order for Occupational Therapy to be performed 3-5 times per week for 30 days for orthotic management.

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The surveyor reviewed the resident's care plan on 9/11/19. The resident's range of motion care plan, last revised on 6/17/19, failed to include an intervention for the use of a [redacted]

The surveyor reviewed the Nursing Documentation-V 5 report documented and signed by the Registered Nurse/Unit Manager #1(RN/UM #1) on 8/22/19. Section K included an evaluation of the [redacted]. The assessment failed to identify the presence of [redacted].

The quarterly, [redacted] Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated the resident usually made self-understood; understands others; had [redacted] as evidenced by a score of [redacted] on the Brief Interview for Mental Status examination; had no behavioral symptoms; and experienced [redacted] Section I medical diagnoses included [redacted]. Section O indicated that passive or active range of motion was not performed and assistance with the placement of a [redacted] was not performed.

The surveyor reviewed the Nursing Documentation-V 5 report documented and signed by the RN/UM #1 on 9/12/19. The RN/UM #1 documented in Section K, that the resident had [redacted]. The RN/UM #1 did not indicate that a [redacted] was in use.

On 9/12/19 at 1:08 PM, the surveyor discussed

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F 684	Continued From page 30 concerns regarding the application of the [redacted] with the Administrator and the Acting Director of Nursing. On 9/13/19 at 12:30 PM, the Administrator stated the Occupational Therapy department was taking over the donning/doffing of the [redacted] while the resident was being re-evaluated. No further information was given as to why the unit nurse was not applying the [redacted]. NJAC 8:39-27.1(a); 27.2(m)	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		11/10/19

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irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined that the facility failed to act upon the Consultant Pharmacist (CP) report of irregularities found while reviewing the drug regimen. This deficient practice was identified for 1 of 38 residents, (Resident#149), during closed record review and was evidenced as follows:

During the medication review for Resident #149, the physician's order revealed a [redacted] medication order dated 7/23/19 for [redacted] to give [redacted] every 6 hours (hrs) as needed (prn) for [redacted] to give one tab [redacted] every 6 hrs prn for [redacted], and [redacted] to give one tab PO every 6 hrs prn for [redacted].

A review of the July and August 2019, electronic Medication Administration Record (eMAR) for the above prn orders, did not indicate the sequence of use for the prn pain medications.

Review of the CP's 7/25/19 and 8/23/19, monthly Medication Regimen Review (MRR), indicated

How will corrective action be accomplished for those residents found to have been affected by the deficient practice?
" Resident #149 is no longer in the center

How will the facility identify other residents having the potential to be affected by the same deficient practice?
" Residents with PRN pain medications have the potential to be affected.
" Unit Managers or designee will complete an audit of each PRN pain medication to ensure appropriate sequencing is in place.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?
" Unit Managers will review new pain medication orders in morning clinical meeting for appropriate sequencing.
" Monthly pharmacy consultant reports

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F 756	Continued From page 32 the CP documented to clarify the sequence of use for the prn [redacted] medications. The facility did not address the CP's 7/25/19 and 8/23/19 MMR report for Resident #149. On 9/18/19 at 10:44 AM, the Acting Director of Nursing informed the surveyor that it was the Unit Manager's (UM) responsibility to respond to the CP's MMR recommendations by following up with the physician and the completed MRR report would then be submitted to the Director of Nursing (DON). On that same day at 12:00 PM, the surveyor interviewed the Registered Nurse/ Unit Manager #2 (RN/UM #2), who informed the surveyor that it was her responsibility to follow up with the physician for recommendations and reports of medication irregularities made by the CP in the MRR. She further stated, "I don't know what happened. I don't know why the 7/25/19 and 8/23/19 recommendations for the prn [redacted] medications sequencing was not followed." On 9/18/19 at 12:52 PM, the survey team met with the Administrator, Acting Director of Nursing and Regional Center Executive Director and discussed the above concern. On 9/19/19 at 1:10 PM, there was no additional information provided by the facility. A review of the facility's Medication Regimen Review (MRR) Policy, provided by the Acting DON with an effective date of 11/28/16, indicated "Facility may request MRR upon admission or based on the resident's condition," and "Facility should encourage Physician/Prescriber or other	F 756	will be completed by Unit managers and submitted to CNE for review and audit. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? " CNE/ Designee will complete an audit of new pain mediation orders weekly x 4 weeks then monthly x 3.to review for proper sequencing of medications. " Data will be analyzed and reported to the QAPI committee monthly and quarterly x 6 months.	

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F 756	Continued From page 33 Responsible Parties receiving the MRR and the DON to act upon the recommendations contained in the MRR." NJAC 8:39-29.3 (a) (1)	F 756		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a) store potentially hazardous foods in a manner to prevent foodborne illness; b) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a foodborne illness; and, c) failed to follow high and low-temperature dishwashing	F 812	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? " Items identified in the dry storage area, refrigerators and freezers that were not dated appropriately were discarded " Temperature logs were corrected. " Electrical conduit, baffle panel and	11/10/19

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F 812	Continued From page 34 machine procedure according to manufacturer's specification when not reaching appropriate temperature. This deficient practice was evidenced by the following: On 9/10/19 at 8:58 AM, in the presence of the District Manager (DM), the surveyor observed the following: 1. In the dry storage area, the surveyor observed one plastic bag of unopened cracker crumbs no date, one bag of rice crispies and one loaf of cinnamon raisin bread open and no "use-by date." 2. On a shelf in the standing refrigerator number one, the surveyor observed seven, one-ounce (oz) cups of pudding with no "use-by dates." 3. The September 2019 Temperature Log for refrigerator number one was blank from 9/5/19 through 9/10/19. The surveyor observed refrigerator number one's temperature was 38 degrees. 4. On a shelf in the standing refrigerator number two, the surveyor observed one full tray of cooked lasagna with a "use-by date" of 9/7, one hotdog wrapped in a saran wrap and one full tray of macaroni salad half-covered by saran wrap with no "use-by date." 5. On a shelf in the walk-in freezer, the surveyor observed one bag of frozen uncooked meatballs open and no "use-by date." 6. In the cooking area, the surveyor observed the	F 812	extinguishing nozzle of the hood were cleaned 9/10/19 and outside company brought in that evening. " Outside vendor was called in immediately to address the dishwashing machine and was switched to low temp machine 9/10/19 " Sandwiches were discarded and appropriate substitute was provided to address temp issues and hand washing issue How will the facility identify other residents having the potential to be affected by the same deficient practice? " Residents receiving meals from the Dietary department have the potential to be affected. " All refrigerators and Dry storage were inspected for proper storage of all food and non-food products. " All temperature logs were inspected to ensure compliance. " Hoods were inspected for cleanliness. " Dishwasher inspected and outside vendor was called to service immediately What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? " Nutritional Service department was re-educated on the following: -Handwashing, Required dating of food items, Procedure for sanitizing of dishes using the dishwasher and the sanitizing solution which includes temperature validation and Ph test strip usage. Department cleaning log	

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F 812	Continued From page 35 electrical conduit, baffle panel, and extinguishing nozzle of the hood with a substantial build-up of grease. 7. On a shelf in the lower level building freezer, the surveyor observed two loaves of rye bread with no "used by date" with an expiration date of 8/7/19. 8. The surveyor observed the high-temperature dishwashing machine was not reaching to appropriate temperatures. The DM was not able to show the surveyor how to change the high-temperature dishwashing machine to low-temperature in order to use the sanitizing solution. At that time, the DM informed the surveyor that according to the dishwashing manufacturer's specifications, the facility utilized a sanitizing solution for appropriate dishware cleaning when the high-temperature dishwashing was not able to reach the proper temperature. On that same day and time, the DM informed the surveyor that the Ph test strip regular reading should be between 50-100 PPM (parts per million), which is appropriate according to the manufacturer's specifications. A review of the provided Dish Washing Log for September 2019 by the DM revealed that there were 6 out of 14 times the sanitizing solution was used that was out of normal range reading which read as 200 PPM. On 9/11/19 at 8:40 AM, the DM informed the surveyor that she was not sure if the kitchen staff had previous in-service (s) on the proper use of dishwashing sanitizing solution. She stated, "I	F 812	schedule.Procedure for maintaining food at proper temperatures and documentation on temperature logs. " Managers daily checklist implemented " Department Cleaning schedule updated How will the facility monitor its corrective actions to ensure the deficient practice will not recur? " Nutritional Service Director will complete Sanitation audit and temperature log audit 3 times a week x 4 weeks then weekly. " Nutritional Service Director will complete audit of proper food temperatures 3 times a week x 4 weeks then weekly " Nutritional Service Director will complete audit regarding dishwasher function and usage of Ph testing strips appropriately 3 times a week for 4 weeks then weekly. " Dietician will complete Sanitation and temperature log audit weekly " CED will complete Sanitation and temperature log audit weekly x 4 weeks " Audits will be analyzed/reported to the QAPI committee on a monthly and quarterly basis x 6months.	

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should have caught that" regarding the build-up of grease on the stove hood. She further said that there was no specific policy with regards to cleaning of stove hood, cleaning, and drying of pots and pans. In addition, she stated that the above food items should have had a "use-by date."

On 9/11/19 at 11:29 AM, in the presence of the DM, the surveyor observed the following:

1. The surveyor observed the DM perform handwashing in the dishwashing area for 13 seconds. There was no garbage receptacle in the handwashing area.

2. During the lunch tray line service, the surveyor observed the DM checked the tuna salad sandwich under the ice with a temperature (temp) 58 degrees. The DM stated that the temp should be below 41 degrees. She further said that she would ask her staff to cool it in the refrigerator.

3. On a shelf in the standing refrigerator number two, the surveyor observed the DM checked the temperature of the large tray of tuna salad sandwich with a temperature of 50 degrees. The DM stated that she would transfer the tray of tuna salad sandwiches to the freezer to cool it off for a few minutes before serving.

On 9/12/19 at 1:03 PM, the survey team met with the Administrator, Acting Director of Nursing, and discussed the above observations and concerns. The Administrator acknowledged that there was no cleaning log for the stove hood and stated that it was only "yesterday" that the facility had created and initiated a Department Cleaning Schedule. She noted that the tuna salad sandwiches were

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F 812	Continued From page 37 discarded immediately after the surveyor informed the Administrator of the above concern. She further stated that handwashing should have been performed for at least 20 seconds. A review of the "Use by" dating Guidelines provided by the DM with a revision date of 12/1/15, indicated "Guidelines assume that food is properly stored, covered and handled," and "The manufacturer's expiration date, when available is the "use by" for unopened items and the manufacturer's instructions for "use by" date of opened items overrides these guidelines." A review of the Cleaning Standards Policy provided by the DM with a revision date of 6/15/18 indicated "To ensure all food service equipment and areas are clean and sanitary," and "Employees utilize the cleaning procedures when completing assigned cleaning duties." On 9/16/19 at 12:53 PM, the survey team asked if the facility had any additional information to provide regarding the concerns mentioned above. The facility provided no other information.	F 812		
F 880 SS=E	NJAC 8:39-17.2(g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		11/10/19

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F 880	Continued From page 38 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 39 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the surveyor determined that the facility failed to a) maintain proper infection control procedures to minimize the risk of the spread of infection for 2 of 2 residents (Resident # 335 and Resident # 171) reviewed for transmission-based precautions; b) follow appropriate infection control practices during the administration of medications for 1 of 1 residents (Resident #335); and, c) maintain proper infection control practices during a [redacted] treatment observation for 1 of 2 residents, (Resident #40) reviewed. This deficient practice was evidenced by the following: 1. On 09/10/19 at 12:15 PM, the surveyor observed Resident #335 laying in bed watching TV with a [redacted]. There	F 880	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? " Isolation bin was placed outside of resident room #335 and #171 " RN #1 received education by ADON regarding infection control during medication pass and [redacted] in regards to an open [redacted]. " In regards to resident #40, RN received education by ADON regarding infection control and hand washing as it relates to [redacted] care. How will the facility identify other residents having the potential to be affected by the same deficient practice? " Residents in the center time of survey had the potential to be affected.	

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F 880	Continued From page 40 was a "Stop Report to Nurse Before Entering" sign on the resident's door. The Licensed Practical Nurse (LPN #1) and Unit Manager (UM #1) reported that Resident #335 was on standard and contact Isolation Precautions for a diagnosis of [redacted] The surveyor asked the UM why there wasn't a bin with personal protective equipment (PPE) outside of Resident #335's door. The UM stated that all PPE was kept in the supply room. The surveyor reviewed the medical record for Resident #335. According to the Admission Record, Resident #335 was admitted to the facility on [redacted] and readmitted on [redacted], with diagnoses that included [redacted]. The September 2019 physician's orders revealed an order for infection precautions-standard plus contact during direct care [redacted] and an order dated 8/28/19 for [redacted] every 8 hours for [redacted] site for 28 days. A review of the Admission Minimum Data Set (MDS), an assessment tool dated [redacted], indicated a Brief Interview for Mental Status (BIMS) score of 12 which reflected that the resident's cognition was [redacted]. Resident #335's care plan dated 8/20/19, identified a focus area indicating the resident had an infection that included [redacted]	F 880	" ADON placed isolation bins outside of those residents identified/meeting protocol for isolation. " RN received education by ADON regarding infection control and hand washing as it relates to [redacted] care. " RN #1 received education by ADON regarding infection control during medication pass and [redacted] in regards to an open [redacted]. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? " Education was completed with Nursing staff by ADON and Nursing Supervisors regarding infection control practices " Education was provided with the Nurses by ADON and Nursing Supervisors regarding infection practices specific to [redacted] care, medication pass, and managing a [redacted] when a resident has a [redacted] in regards to infection control " Unit Managers will monitor for infection control compliance during daily rounds on the units and provide just in time education if needed. " IP will complete weekly documented infection control rounds How will the facility monitor its corrective actions to ensure the deficient practice will not recur? " Unit Manager or Designee will complete observation for infection control	

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F 880	Continued From page 41 [redacted]). On 9/11/19 at 9:56 AM, the surveyor interviewed the Infection Control Registered Nurse (RN) who stated that the facility follows the Center for Disease Control (CDC) recommendations for Isolation and Contact Precautions. She said if a resident had [redacted] the staff placed a bin for PPE outside of Resident rooms. She further stated if the infection was [redacted], the facility used standard precautions with contact precautions when handling the [redacted] for a resident with a diagnosis of [redacted]. The staff was instructed to wear gowns and gloves from the supply room. On 9/12/19 at 12:25 PM, the surveyor observed Resident #335 seated in a wheelchair in his/her room with the [redacted] with the [redacted] The resident stated he/she had their [redacted]. The surveyor observed [redacted] The [redacted] was full of [redacted]. The strap used to keep the [redacted] in place caused an indent in Resident #335's [redacted] On that same day and time, the surveyor brought the observations to the attention of the Registered Nurse (RN#1) who was assigned to the resident. RN #1 stated she had not assessed or observed the Resident's [redacted] that morning. RN #1 entered Resident #335's room without wearing a gown, washed her hands, and donned gloves. The surveyor observed RN #1 empty the [redacted] and loosen the strap on the [redacted]	F 880	technique during medication pass [redacted] treatment and [redacted] care 3 x a week for 4 weeks. " Audits and infection control rounds will be analyzed/reported to the QAPI committee on a monthly and quarterly basis x 6months.	

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F 880	Continued From page 42 [redacted]. RN #1 removed her gloves, washed her hands, and left the room. The surveyor observed that RN #1 [redacted] of the [redacted] on the [redacted]. At that same time, the surveyor asked RN #1 why she didn't move the [redacted] and why she [redacted] The RN said, " oh sorry" and moved the [redacted] away from the [redacted] still leaving it on the [redacted]. On 9/16/19 at 12:18 PM, the surveyor interviewed RN #1 who stated she knew she should have worn a gown when she emptied Resident #335's [redacted], but the PPE bin was not outside of the room to remind her to wear the gown. She further stated when she last worked on "Monday" the PPE bin was outside of the resident's room but when she came back on "Thursday" it had been removed. On 9/16/19 at 12:25 PM, UM #1 stated that the staff should have been wearing gowns and gloves when providing [redacted]. On 9/16/19 at 12:30 PM, the surveyor interviewed RN #2, who stated that she was not aware that Resident #335 was on contact precautions for [redacted]. The RN#2 said she didn't know because there was no sign on the door and no PPE outside of the room. The surveyor showed RN#2 the sign on the door. The RN stated the sign must be new and that she didn't realize it was a Stop sign as it looked just like the facility's red oxygen signs. She further stated that the previous signs were much larger. On 9/18/19 at 12:51 PM, during an interview, the	F 880		

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Acting Director of Nursing and Administrator stated that the PPE bin should have been placed outside of Resident #335's room when Contact Precautions were ordered, and that the staff should have been wearing gowns and gloves when providing care.

2. On 9/18/19 at 11:52 AM, the surveyor observed RN #3 preparing medications for Resident #335 on the [redacted] floor in the [redacted] wing. The RN #3 removed a multi-use blister pack from the medication cart, broke the seal, and then removed the pill using her bare hands. The surveyor then observed RN#3 remove another multi-use blister pack, break the seal and again remove the tablet with her bare hands.

At that time, the surveyor asked RN #3 why she was handling the medication with ungloved hands. RN #3 stated that she should not have touched the tablets. RN #3 identified the two tablets as [redacted].

The surveyor reviewed Resident #335's medical record. According to the Admission Record, Resident #335 was admitted to the facility on [redacted] and readmitted on [redacted], with diagnoses that included [redacted]

A review of the September 2019 physician's orders revealed an order dated 8/28/19, for "Infection Precautions-standard plus contact during direct care for [redacted]" An order dated 8/28/19 fo [redacted]

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[redacted].

A review of the Admission Minimum Data Set (MDS), an assessment tool dated [redacted], indicated a Brief Interview for Mental Status (BIMS) score of [redacted].

A review of the facility's Medication Administration Policy provided by the Administrator, dated 1/1/04 and revised 7/1/19, revealed Acceptable Standards of Practice would be followed, and Standard precautions maintained.

On 9/18/19 at 12:51 PM, the survey team met with the Administrator and Acting Director of Nursing and discussed the above observations and concern.

3. On 9/11/19 at 9:41 AM, the surveyor observed Resident #171 lying in bed. There was a red stop sign posted at the top part of the left side of the door that read, "Stop Report to Nurse Before Entering."

At that same time, RN #1 told the surveyor that the resident was on contact precautions due to [redacted]. There was no PPE at the door.

A review of the resident's face sheet revealed the resident was admitted to the facility on [redacted], with diagnoses which included [redacted].

A review of the Admission MDS dated [redacted], reflected that the resident had a brief interview for mental status (BIMS) score of [redacted]

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F 880	Continued From page 45 A review of a physician's order dated 8/27/19, revealed an order for infection precautions-contact related to [redacted]. On 9/11/19 at 10:20 AM, the RN #1 stated, "We do not place a PPE caddy or bin by the door for contact precautions because we only gown to go into the room if direct care was given to the resident. The [redacted] is in the [redacted]; there is no need to gown if the person is not touching the [redacted]." RN #1 further stated, "if the visitor comes to the nurse's station, we always keep all the PPE's in the central supply room." On 9/18/19 at 10:00 AM, the surveyor observed a PPE bin with gowns, gloves, and masks at the doorway entrance. A review of the facility's Infection Control Policies and Procedures titled Contact Precautions dated 2/15/01 and revised 6/15/19 revealed, "In addition to Standard Precautions, Contact Precautions would be used for a disease transmitted by direct or indirect contact with the patient or the patients environment. State regulations would be followed when applicable. Procedure #3 indicated to "Instruct staff, patient and his/her representative, and visitors regarding Precautions and the use of Personal Protective Equipment (PPE)." Procedure #4 indicated, "Staff must use barrier precautions when entering the room." Procedure 4.1 indicated to wear gown and gloves and,	F 880		

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Procedure #8 indicated "Once the patient is no longer a risk for transmitting the infection discontinue precautions."

4. On 9/10/19 at 10:02 AM, the Registered Nurse/ Unit Manager#1 (RN/UM#1) informed the surveyor that Resident #40 was [redacted].

On that same day at 10:06 AM, the surveyor observed Resident #40 lying on a special mattress.

On 9/12/19 at 8:44 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who informed the surveyor that the resident was [redacted] and required total assistance with activities of daily living (ADLs). The CNA stated the resident was on a turning and positioning schedule, had a cushion for the wheelchair and gets out of bed for at least an hour to promote [redacted] healing.

A review of the resident's face sheet revealed that Resident #40 was admitted to the facility on [redacted] with diagnoses that included [redacted].

On 9/12/19 at 10:32 AM, during a [redacted] observation, the surveyor observed the Registered Nurse (RN) perform a [redacted] treatment to the resident's [redacted]. The surveyor saw the RN perform handwashing for 8 seconds (sec), 13 sec, 20 sec and 30 sec under the stream of running water.

During the [redacted] treatment observation, the

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surveyor observed that the RN did not place a barrier between the [redacted] site and Resident #40's used diaper. The RN did not sanitize the table after [redacted] treatment and left the garbage inside the resident's room.

On that same day and time, the RN stated, "I forgot" to sanitize the table and remove the garbage from the resident's room. The RN further noted that it was appropriate to perform handwashing directly under running water. She said that she was educated to do it that way. In addition, the RN informed the surveyor that the [redacted].

On 9/13/19 at 12:29 PM, the survey team met with the Administrator, Acting DON, and the Regional Center Executive Director. The Administrator informed the surveyors that the RN knew that hand washing should be done for at least 20 sec, but not under running water, and, "I don't know why she did it anyway." The Administrator acknowledged that the RN should have sanitized the table and disposed of the garbage after [redacted] the treatment.

The Centers for Disease Control and Prevention's (CDC), Hand Hygiene Guidelines for Healthcare Providers, updated 3/24/17, revealed hand hygiene performed with soap and water; hands should be scrubbed for at least 20 seconds away from running water.

A review of the facility policy for Hand Hygiene with a review date of 11/15/18, provided by the ADON indicated: "To wash hands with soap and water: wet hands with warm water, apply soap to hands, and rub hands vigorously outside the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 48 stream of water for 20 seconds covering all surfaces of the hands and fingers." A review of the facility policy for Treatments with a revision date of 11/28/17, provided by the Acting DON revealed: "A licensed nurse or medical technician, per state regulations, will perform ordered treatments and accepted standards of practice will be performed." NJAC 8:39-19.4 (a) (1, 2)	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/17/19, it was determined that the facility failed to ensure that the resident's emergency call system was functional for 1 of 5 units ([redacted]) inspected. This deficient practice was evidenced by the following: During a tour of the building, in the presence of the facility's Maintenance Director, Regional Maintenance Director and Regional Housekeeping Director, the surveyor observed that the emergency call system's console at the	F 919	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? " Call alert system company has been contacted and preliminary work completed and waiting for a part to restore system. " Tap bells were given to all residents on the [redacted] floor and 15 minute checks were initiated to monitor residents How will the facility identify other residents having the potential to be affected by the same deficient practice?	11/10/19

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315157	A. BUILDING _____ B. WING _____	09/19/2019

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F 919	Continued From page 49 [redacted]-floor nurses' station did not produce an audible signal when tested in one of five nurses units. At 11:00 AM, the surveyor conducted a transmission test by activating the call cord at resident bed areas and tracing the communication to the emergency call system's console on the [redacted]-floor nurses unit. Usually, the signal is verified by a light and beep, or other intermittent sound, from the console. The surveyor observed that the console failed to produce an audible signal when call cord and pull cord devices were activated. The testing was conducted on-call devices in multiple resident rooms on the [redacted] floor. The [redacted] floor was equipped with one call system, one console, thus affecting all residents in rooms [redacted] (72 residents). The facility's Maintenance Director attempted to adjust the volume on the console to no avail. The Maintenance Director acknowledged in an interview during this discovery that the console's audio feature did not work, and he was unaware of such. Also, the Maintenance Director indicated that the facility had a computerized preventive maintenance system that was utilized by staff to report maintenance concerns but, staff did not report this issue and quite often failed to report any issues. The surveyor verbally informed the facility's Administrator of these findings during the Life Safety Code exit conference at 1:45 PM. NJAC 8:39-31.2(e)	F 919	" Center call bell system was checked on all units and units 1, 2, 4, and 5 were found to be in working order. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? " Maintenance director will conduct weekly audits of the call bell alert system for both visual and audible alarms on each unit in the center. " Unit managers and staff have been in-serviced on using the electronic notification system for maintenance issues needing repair. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? " Call Bell alert system audits will be reviewed in monthly and quarterly QAPI meetings x 6 months	
F 924	Corridors have Firmly Secured Handrails	F 924		11/10/19

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315157	A. BUILDING _____ B. WING _____	09/19/2019

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F 924 SS=E	Continued From page 50 CFR(s): 483.90(i)(3)	F 924		

§483.90(i)(3) Equip corridors with firmly secured handrails on each side.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview on 9/17/19, it was determined that the facility failed to ensure that handrails were securely attached to corridor walls for 2 of 5 units inspected.

This deficient practice was evidenced by the following:

During a morning tour of the building, in the presence of the facility's Maintenance Director, Regional Maintenance Director and Regional Housekeeping Manager, the surveyor observed the following:

At 11:10 AM, the surveyor found a 4-foot linear section of handrail located on the [redacted] floor by resident rooms [redacted] and [redacted] was loose and not anchored securely to the wall when tested.

At 11:40 AM, a 12-foot linear section of handrail located on the [redacted] floor between the nurses' station and stairway exit was very loose and not anchored securely to the wall.

These findings were acknowledged and confirmed by the Maintenance Director in an interview during the observation. Also, the Maintenance Director indicated that the facility had a computerized preventive maintenance system that was utilized by staff to report maintenance concerns but, staff did not report this issue and quite often failed to report any

How will corrective action be accomplished for those residents found to have been affected by the deficient practice?
" Handrails identified as being loose were repaired

How will the facility identify other residents having the potential to be affected by the same deficient practice?
" Residents in the center have the potential to be affected.
" Hand rails throughout the center were inspected and if any repairs needed it was completed.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?
" Maintenance director will conduct weekly audits of all the hand rails on each unit and all common areas in the center x 4 weeks then monthly
" Unit managers and staff have been in-serviced on using the electronic notification system for maintenance issues needing repair.
How will the facility monitor its corrective actions to ensure the deficient practice will not recur?
" Hand rail audits will be reviewed in monthly and quarterly QAPI meetings x 6 months

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F 924	Continued From page 51 issues. The surveyor verbally informed the facility's Administrator of these findings during the Life Safety Code exit conference at 1:45 PM. NJAC 8:39-31.2(e)	F 924		