STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. BUILDING _____ B. WING _____	C 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	**859 WEST BAY AVE BARNEGAT, NJ 08005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint # NJ 00145779 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. Standard CENSUS: 78 SAMPLE: 20+2 closed A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=D	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	F 584		7/24/21

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

Electronically Signed | 07/01/2021

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

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F 584	Continued From page 1 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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that the facility failed to maintain a clean and sanitary environment. This deficient practice was identified for the [Executive Order 26, 4.b], [Executive Ord] floors in the facility, and was evidenced by the following: On 6/10/21 at 11:18 AM, the surveyor observed an oxygen concentrator in room [Executive] to have a brown colored dried stain, crumbs and paper debris in the center space where the oxygen	F 584	F584 Safe/Clean/Comfortable/Homelike Environment The oxygen concentrator in room [Executive] was thoroughly cleaned immediately. All stains, crumbs and debris have been removed. The oxygen concentrator in room [Executive] was thoroughly cleaned immediately. All stains, crumbs and paper debris have been removed. The privacy curtain in room [Executive] was	

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F 584	Continued From page 2 tubing connects to the adaptor. On 6/10/21 at 12:52 PM, the privacy curtain in Room [redacted] was observed with brown dried debris/stains as well as yellow marks. There were scattered dark marks on the privacy curtain as well. The wall behind the curtain had brown dried splatters. On 06/11/21 at 8:27 AM, the oxygen concentrator in Room [redacted] was observed to have same brown colored dried stain, crumbs and paper debris in the center space where the oxygen tubing connects to the adaptor. On 6/11/21 at 10:15 AM, the surveyor observed the following on the second floor; 1. the wall between rooms [redacted] and [redacted] with streaks of dried debris, tan in color. 2. the wall on the high hall side by the entrance to the nurse's station has splatters of red and brown debris. 3. the medication cart on low hall [redacted] with hair/fuzz on wrapped on 2 of the 4 wheels. 4. in room [redacted] there were two overbed tables, one with rusted areas, peeling paint and dried red debris on the base of the table. The other table had dried yellow debris on the base of the table. There was dried brown debris on the wall behind the table. On 6/11/2021 at 8:55 AM the surveyor observed an enteral feeding pump in room [redacted] The top of the pump and the tube feed chamber were covered with an unidentifiable brown/tan	F 584	changed same day. The wall behind the curtain was cleaned and all dried spatters removed immediately. The hall wall between rooms [redacted] & [redacted] was cleaned immediately and is free of tan streak marks. The [redacted] hall wall on the high side by the nursing station has been cleaned immediately and is free of red and brown spatters. The [redacted] medication cart on the low hall had the wheels removed and cleaned of any hair/fuzz wrapped around them on 6/11/21. The overbed tables/bases in room [redacted] were cleaned immediately. The rusted overbed table/base has been replaced with a non-rusted table/base on 6/11/21. The brown debris on the wall had been removed immediately. The feeding pump in room [redacted] has been cleaned and is free of the brown/tan substance. All residents residing on the [redacted] have the potential to be affected. A facility wide in-service was immediately given to the Nursing and Housekeeping staff by the Infection Preventionst on providing and maintaining a safe and clean environment as well as reporting any safety issues that present as a potential problem in the residents living area. All staff were re-educated on the purpose of the Maintenance logs. Staff education stressed that everyone is responsible for the resident's environment.	

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F 584	Continued From page 3 substance. On 6/15/2021 at 8:48 AM the surveyor observed the same enteral pump in room [redacted] The top of the pump was observed to be covered with an unidentifiable brown/tan substance. During an interview on 6/14/21 at 12:31 PM, Certified Nursing Assistant (CNA #1), said the resident rooms get cleaned every day. CNA #1 went on to say they (housekeeping) do carbolize the rooms mostly when a resident moves. We tell the nurse if something needs to be cleaned. During an interview on 6/16/21 at 10:55 AM, the housekeeper on [redacted] said all rooms are cleaned daily and the halls are mopped daily. He went on to say that the only time he knows rooms are carbolized are when a resident changes rooms or discharges. He also said the porter is responsible to clean hallway handrails and walls every day. The housekeeper said they only clean the top of over bed table surface, not the legs. He said the curtains are done with carbolizations or if they look like they need cleaning or if the housekeeper sees they are dirty. During an interview on 6/16/21 at 11:22 AM, the Director of Housekeeping (DH) said resident rooms are cleaned everyday along with the bathroom (BR). The housekeeper dry mop then wet mop floors. DH went on to say we start high and go low dust light shades, windowsills, tops of doors, around windows, inside windows are cleaned at least twice a week. We don't clean the actual beds on regular basis. We clean bedside tables and over bed tables and rails if needed. Full room carbolization is done if a resident is discharged or moved to another room or if we are asked by the nurse or Administration or resident request. The DH said the carbolization process	F 584	The Housekeeping Director/designee will be responsible to monitor the resident's living environment daily x 4 weeks and then weekly x 8 weeks. Results of the audits will be forwarded to the Quality Assessment and Performance Improvement Committee for review and action as appropriate. The Quality Assurance/Performance Improvement committee meets quarterly. The Committee will determine the need for further audits and or action plans. Completion Date: 7-24-2021	

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F 584	Continued From page 4 consists of everything stripped off beds by aides, resident belongings out of drawers and closets if resident allow, clean beds mattress's, rails, windows, window sills, air conditioner wiped off by housekeeper and maintenance cleans the filters, night stands, take down the privacy curtains. He went on to say we do two rooms every day 1 each on 1st and 2nd floor and are just getting back into this in past few week, We have an actual schedule that hasn't been able to be used and goes based on need. The schedule is posted downstairs for the housekeepers in 2 places. The DH said housekeeping is supposed to wipe down medical equipment if they see it and yes this is part of our daily cleaning routine. We wipe down oxygen concentrators as well, filters cleaned by maintenance and housekeeping does actual outside of concentrator. A review of the carbolization schedule for June 2021 indicated room [redacted] was to have been carbolized on Monday 6/14/21. On 6/16/21 12:07 PM, the privacy curtain and wall in room [redacted] were observed with the same stains and marks were present. During an interview on 6/16/2021 at 11:32 AM, the DH stated, "We are responsible for cleaning IV poles and tube feed machines. It should be done daily as part of our cleaning routine, or if requested by nursing." A review of a facility Deep Clean Checkoff List with a revised date of 6/2016, revealed under 10. Wipe down all walls...under 25. Inspect curtains for spills or damage and alert management so they can get replaced. NJAC 8:39-31.4(a)	F 584		

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F 641	Continued From page 5	F 641		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to accurately assess the status of a resident in the Minimum Data Set (MDS). This deficient practice was identified for 3 of 22 sampled residents, (Resident #11, Resident #44, Resident #71) and was evidenced by the following: 1. On 6/11/2021 at 9:34 AM, the surveyor observed Resident #11 in the hallway with a Executive Order 26, 4.b. on his/her Executive Order 26, 4.b. . According to the Executive Order 26, 4.b., Resident #25 was Executive Order 26, 4.b. A review of the June/16/ 2021 Medication Review Report for Resident #11, had a Physician Order (PO) dated Executive Order 26, 4.b. to apply a Executive Order 26, 4.b. to Executive Order 26, 4.b. and check placement every shift. A review of the Admission MDS dated Executive Order 26, 4.b. and Quarterly MDA dated Executive Order 26, 4.b. for Resident # 11, indicated under Section P0200 for alarms was coded as 0 indicating there was no Executive Order 26, 4.b. During an interview on 6/15/2021 at 12:53 PM,	F 641	F641 Accuracy of Assessments Residents # Executive Order 26, 4.b. had their MDS modified and corrected the same day. All residents who have alarms/safety devices have the potential to be affected by this practice. Education was provided to the MDS Coordinators on the coding of Section P. The Director of Clinical Reimbursement/designee will be responsible to monitor the MDS accuracy weekly x 4 weeks and then monthly x 8 weeks. Results of the audits will be forwarded to the Quality Assessment and Performance Improvement Committee for review and action as appropriate. The QAPI committee meets quarterly. The Committee will determine the need for further audits and or action plans Date of completion: 7/24/2021	7/24/21

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F 641	Continued From page 6 the MDS Coordinator acknowledged that Resident #11's Admission and Quarterly MDS should have been coded as having a Executive Order 26, 4.b. . 2. On 6/11/2021 at 8:53 AM, the surveyor entered Resident #44's room. Resident #44 was not in the room, however the surveyor observed the bed in medium height position. A Executive Order 26, 4.b. was on the floor to the Executive Order 26, 4.b. of the Executive Order 26, 4.b. and a Executive Order 26, 4.b. on Executive Order 26, 4.b. to the Executive Order 26, 4.b. . On 6/11/2021 at 9:05 AM, the surveyor observed Resident #44 in their wheelchair in front of the Executive Order 26, 4.b. nurses station eating breakfast. A Executive Order 26, 4.b. was observed on the Executive Order 26, 4.b. of Resident #44's wheelchair. According to the Admission Record Resident #44 was Executive Order 26, 4.b. . A review of the June 17, 2021 Order Summary Report revealed that Resident #44 had the following PO's, dated Executive Order 26, 4.b. Executive Order 26, 4.b. to the Executive Order 26, 4.b. check placement and function q (every) shift and Executive Order 26, 4.b. to the wheelchair, Executive Order 26, 4.b. Executive Order 26, 4.b. and function q shift. A review of the Quarterly MDS dated 5/1/2021, indicated under section P0200 that A. Executive Order 26, 4.b. and section B. Executive Order 26, 4.b. were coded 0, which indicated "Not used." During an interview on 6/15/2021 at 12:59 PM, the MDS coordinator stated, "I will pull his/her	F 641		

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F 641	Continued From page 7	F 641		

worksheet to see if it was an oversight." On 6/15/2021 at 1:43 PM the MDS coordinator acknowledged that she had made an oversight and that the alarm should have been coded as "used daily."

3. On 06/10/21 at 10:28 AM, during the initial tour of the facility, the surveyor interviewed Resident #71 in his/her room. During this time, Resident #71 showed the surveyor a [redacted]

According to the Admission Record, Resident #71 has Executive Order 26, 4.b. [redacted]

A review of the Order Summary Report, revealed Resident #71 had the following PO, dated [redacted] "Executive Order 26, 4.b. Check for function daily on the 3-11 shift. Every evening shift for safety precaution." The report further revealed Resident #71 had another PO dated, [redacted]: Executive Order 26, 4.b. Staff to check q shift for placement. Every shift for safety precaution."

A review of the Admission MDS dated [redacted], revealed under Section P0200 that alarms was coded as [redacted] indicating there was no Executive Order 26, 4.b. alarm.

During an interview on 06/15/21 at 12:53 PM, the MDS Coordinator stated, "I will look into it and get back to you." On the same date at 1:44 PM, the MDS Coordinator stated to the surveyor, "You are correct, and I corrected it."

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F 641	Continued From page 8	F 641		
F 656 SS=D	NJAC 8.39-11.1 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 future discharge. Facilities must document whether the resident's desire to return to the	F 656		7/24/21

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F 656	Continued From page 9 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, record review and review of other facility documentation, it was determined that the facility failed to develop a person-centered comprehensive care plan (CP) addressing oxygen use for [redacted] resident's reviewed for [redacted] (Resident #3 and Resident #20). This deficient practice was evidenced by the following: 1. During the initial tour of the [redacted] on 6/10/21 at 11:18 AM, Resident #3 was observed lying in bed with [redacted] in use. The [redacted] was dated [redacted]. Resident #3 said he/she [redacted]. According to the Admission Record, Resident #3 was [redacted] A review of the most recent Minimum Data Set (MDS), an assessment tool dated [redacted] indicated Resident #3 was [redacted] while a resident. A review of the Order Summary Report (OSR) dated [redacted], revealed a physician order with an initiated date of [redacted] to [redacted]	F 656	F656 Develop/Implement Comprehensive Care Plans Residents [redacted] both had a care plan implemented for the use of [redacted]. Any resident who uses oxygen has the potential to be affected by this practice. All nurses have been re-educated on the process of implementing a Compressive Care Plan that includes areas of concerns for the resident. As per the policy, care plans will be updated according to the identified Care Assessment Areas with input from the Interdisciplinary Care Team, Resident, and/or Resident Representative. The Director of Nursing/designee will attend/audit Care Plan meetings weekly x 4 weeks, followed by bi-weekly x 8 weeks. The Director of Nursing will aggregate findings from these rounds monthly and review the findings with the Administrator. Quarterly on an ongoing basis the Director of Nursing/designee will provide a report of his findings to the Quality Assurance committee for action as appropriate. Completion Date: 7-24-2021	

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F 656	Continued From page 10 Executive Order 26, 4.b. The OSR also showed a physician order dated Executive Order 26, 4.b. to change Executive Order 26, 4.b. [redacted] A review of Resident #3's CP did not include documentation for Resident #3's Executive Order 26, 4.b. [redacted] During an interview on 6/14/21 at 12:18 PM, the Licensed Practical Nurse Unit Manager (LPNUM#2) for Resident #3, said I do the care plans. She went on to say she would have a care plan for a resident with Executive Order 26, 4.b. During a follow-up interview with on 6/16/21 at 11:52 AM, LPNUM #2, who said she checked to see if Executive Order 4 was there (on the CP for Resident #3) and it was under the Executive Order 26, 4.b. [redacted] LPNUM #2 said this was dated 6/11/21 and may have just updated it. The surveyor then asked what date was this originally put on the care plan and she said 6/11/21 and confirmed it was not there before 6/11/21. 2. A On 06/10/21 10:32 AM, the surveyor observed Resident #20 sitting in a wheelchair, applying makeup. The resident had a Executive Order 26, 4.b. [redacted]. The resident stated that he/she has been using Executive Order 26, 4.b. According to the Admission Record, Resident #20 was Executive Order 26, 4.b. [redacted]	F 656		

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F 656	Continued From page 11	F 656		

Executive Order 26, 4.b.

The most recent MDS dated 4/3/21, indicated Executive Order 26, 4.b. was provide while the resident was in the Executive Order 2

A review of the June 2021 Order Summary Report for Resident #20 revealed a Physician Order (PO) dated 2/2/21, to Executive Order 26, 4.b.

A review of Resident #20's care plan did not include documentation for Resident #20's use of Executive Order 26, 4.b.

During an interview on 6/16/21 at 11:44 AM, LPNUM #1 said that the unit manager was ultimately responsible for the initiation and review of the CP.

During an interview on 6/16/21 at 1:08 PM, the Director of Nursing (DON) stated that the CP is the responsibility of the unit manager but that the MDS Coordinator, DON, and all supervisors participate and check the CP for accuracy.

A review of the facility policy titled Care Plans-Comprehensive, with a revised date of "3/32/21" revealed under the procedure section An individualized, patient centered Comprehensive Care Plan that includes measurable objectives and timetables to meet the residents medical, nursing, mental and psychological needs is developed for each resident consistent with the Resident Rights. The policy further indicated under the Policy and Interpretation Guidelines section 4. The resident's

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F 656	Continued From page 12 Comprehensive Care Plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). NJAC 8:39-27.1(a)	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690		7/24/21

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F 690	Continued From page 13 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that an indwelling Executive Order 26, 4.b. (Executive Order 26, 4.b. was secured in a manner to prevent contamination for 1 of 1 resident reviewed for a Executive Order 26, 4.b. (Resident #8). The deficient practice was evidenced by the following: During the initial tour of the unit on 06/10/21 at 10:16 AM, Resident #8 was in bed with a Executive Or in contact with the floor. It was not secured to the bed frame. During an interview with Resident #8 on 06/15/21 at 09:00 AM, the surveyor observed the Executive Order 26, 4 in contact with the floor. It was not secured to the bed frame. A review of the most recent annual Minimum Data Set (MDS), an assessment tool used to manage care dated Executive Order 26, 4.b, revealed Resident #8 had an Executive Order 26, 4.b. . The MDS also revealed that Resident #8 was Executive Order 26, 4.b. During Resident #8 wound care observation on 06/15/21 at 11:03 AM, the surveyor observed the Executive Order 26, 4.b. in contact with the	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI Resident Execut had the Executive Order 26, 4.b changed. The Executive Order 26, 4.b. was Executive Order 26, 4.b. Executive Order 26, to Executive Order 26, 4.b. Any resident who has a catheter has the potential to be affected by this practice. All nursing staff has been in-serviced by the Infection Preventionist to immediately replace any foley that is observed on the floor and to always maintain a foley in a manner to prevent contamination. The Unit Manager/designee will conduct daily audits x 4 weeks then x 8 weeks. The Director of Nursing/designee will aggregate findings from these rounds monthly and review the findings with the Administrator. Quarterly on an ongoing basis the Director of Nursing/designee will provide a report of the findings to the Quality Assurance committee for action as appropriate. Completion Date: 7-24-2021	

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F 690	Continued From page 14 floor. It was not secured to the bed frame. Licensed Practical Nurse (LPN #2) attempted to secure the [redacted] to the bed frame using a Velcro strap attached to the bag. When interviewed by the surveyor, LPN #2 stated that the [redacted] not be on the floor. During an interview on 06/16/21 at 11:48 AM, the Infection Prevention nurse stated, "[redacted] A review of a facility policy title "Urinary Catheters" revealed under "General Guidelines" number 9: "Be sure the catheter tubing and drainage bag are kept off the floor." N.J.A.C. 8:39-19.4(a)	F 690		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693		7/24/21

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F 693	Continued From page 15 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other documentation, it was determined that the facility failed to provide water flushes, according to the physician's order for Executive [redacted] residents (Resident #45) reviewed for tube feeding and this deficient practice was evidenced by the following: On 6/10/2021 at 10:44 AM, during the initial tour of the facility, the surveyor observed Resident #45 in their room receiving an Executive Order 26, 4.b. [redacted] Certified Nursing Assistant (CNA#2) stated, "He/she receives pleasure feeds, sometimes he/she will accept and sometimes not. I will feed him/her, or the speech therapist will." According to the Admission Record, Resident #45 was Executive Order 26, 4.b. [redacted] A review of the quarterly Minimum Data Sets (MDS), an assessment tool, dated 5/2/2021, revealed Resident #45 Executive Order 26, 4.b. [redacted] Resident #45 had a Executive Order 26, 4.b. [redacted]	F 693	F693E Tube Feeding Mgmt/Restore Eating Skills The attending Physician of resident Executive [redacted] was notified of the Executive Order 26, 4.b. [redacted]. Physician changed the order from Executive Order 26, 4.b. [redacted]. Any resident who has ordered water flushes via gastrostomy tube may be affected by this practice. The licensed nurses have been in-serviced by the Director of Nursing/Supervisor on following Physician orders for water flushes. The in-service included the procedure for fluid administration via Gastrostomy tubes or Jejunostomy tubes. The Director of Nursing/designee will audit all ordered water flushes daily x 4 weeks, then weekly x 8 weeks. The findings will be discussed immediately with the Unit Managers and assigned nurses. The Director of Nursing/designee aggregate findings from these rounds monthly and review the findings with the Administrator. Quarterly on an ongoing basis the Director of Nursing/designee will provide a report of his findings to the Quality Assurance committee for action as	

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F 693	Continued From page 16 Executive Order 26, 4.b. . A review of the Order Summary Report, dated Executive Order 26, 4.b. Resident #45 had a Executive Order 26, 4.b. Executive Or for "Offer additional Executive Order 26, 4.b. A review of the Other Medication Administration Record (OMAR) for the periods of Executive Order 26, 4.b. revealed that Resident #45 did not consistently receive the physician ordered additional Executive Order 26, 4.b. The following dates/times did not include documentation to indicate the Executive Order 26, 4.b.	F 693	appropriate. Completion Date: 7-24-2021	

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F 693	Continued From page 17	F 693		

Executive Order 26, 4.b.

A review of the 4/30/2021 Quarterly Nutrition Review Note revealed that Resident #45 [redacted]"

During an interview on 6/16/2021 at 8:48 AM, the Licensed Practical Nurse (LPN #4) who was assigned to Resident #45 on that shift stated, " The resident's Executive Order 26, 4.b. . I will check the order; I think it's [redacted] [Resident name] is [redacted] and we work hard to keep his/her [redacted]. Executive Order 26, 4.b. [redacted]

During an interview on 6/16/21 at 8:51 AM, with the Certified Nursing Assistant (CNA#2) CNA#2 stated "When I feed him/her it's usually just [redacted]. I do not give him/her [redacted]."

During an interview on 6/16/2021 at 9:27 AM, the LPN/Unit Manager (LPNUM #2) of the [redacted] nursing unit, which Resident #45 resided on, stated, "[redacted] are delivered by [redacted] at this facility. My expectation is that they would be delivered or performed as ordered by the physician."

During an interview on 6/17/2021 at 10:35 AM, with the facility Registered Dietitian (RD), regarding Resident #45's Executive Order 26, 4.b. [redacted] stated, "The [redacted] is to meet Executive Order 26, 4.b. [redacted]. If the [redacted] are not provided as ordered, they should be provided as ordered. The potential if not delivered as ordered would be that the resident would not be meeting 100% of their hydration needs."

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F 693	Continued From page 18 During an interview with the Director of Nursing (Don) on 06/22/21 at 10:17 AM revealed "My expectation is that they should be following the physician's orders. The [Executive Order 2] are to ensure [Executive Order 26; 4.b.]. They need to follow the order to maintain resident [Executive Order 26; 4.b.]" On 6/22/2021 at 11:00 AM an interview was requested by the facility Regional Director of Clinical Services (RDOCS). On interview the RDOCS stated, "We have reviewed the total amount of [Executive Order 2] that the resident [Executive Order 26; 4.b.] The labs were not abnormally affected by the [Executive Order 2] [Executive Order 2]." The surveyor questioned the RDOCS whether the facility followed a physician's order. The RDOCS responded, "No, but I'm just trying to show you that there was no effect on the resident's labs." A review of the facility policy titled: Enteral Feedings, with a revised date of 3/21/2021, under the Policy section revealed: "To ensure that Gastrostomy or Jejunostomy tube feedings are administered safely and in accordance with physician's orders." Under the PROCEDURE For Continuous Tube Feeding by PUMP section the 1. "Obtain physician orders for enteral feeding and orders. The order must include: a. Diagnosis b. Name of Nutrient c. Tube feeding method/frequency d. Volume and frequency of flushes (as recommended by dietary after assessment of needs). e. Tube size and replacement order (if appropriate). The policy further revealed at 14. "Water flushes may need to be given to resident as ordered by physician to meet fluid requirements and to help	F 693		

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F 693	Continued From page 19 keep the feeding tube patent." NJAC 8:39-17.4 (a) (1.)	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and other facility documentation, it was determined the facility failed to follow Physician Orders (PO) for [redacted] changes for 1 of 2 residents reviewed for [redacted] care, (Resident #3) This deficient practice was evidenced by the following: During the initial tour on 6/10/21 at 11:18 AM, Resident #3 was observed lying in bed with [redacted] in use. The [redacted] was dated 5/30. Resident #3 said he/she uses [redacted] all the time. According to the Admission Record, Resident #3 was [redacted]. A review of the most recent Minimum Data Set (MDS) dated 5/24/21, indicated Resident #3 was	F 695	F695 Respiratory/Tracheostomy Care & Suctioning Resident [redacted] had the [redacted]. The nurse received a 1:1 education on signing out the TAR and not completing the task. All residents who require oxygen have the potential to be affected by this practice. The Infection preventionist in-serviced all licensed nurses on the practice/policy of all respiratory tubing changes and storage. The Unit Manager/designee will conduct daily audits x 4 weeks then weekly x 8 weeks. The Director of Nursing/designee will aggregate findings from these rounds monthly and review the findings with the Administrator. Quarterly on an ongoing	7/24/21

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F 695	Continued From page 20 on [redacted] while a resident. A review of the Order Summary Report dated 6/1/21, revealed a physician order to maintain [redacted]. The POS showed an order to [redacted]. A review of the June 2021 Treatment Administration Record (TAR) showed the physician order to change the [redacted]. The TAR also contained documentation on 6/6/21 that indicated the [redacted] had been changed. During an interview on 6/11/21 at 8:53 AM, the assigned Licensed Practical Nurse (LPN) said she changes [redacted]). She went on to say the 11 PM-7 AM supervisors change them frequently, label and bag them. During an interview on 6/11/21 at 9:03 AM, the LPN Unit Manager (LPNUM #2) revealed that [redacted] is to be [redacted]. She further said if the [redacted] on the [redacted] The surveyor, accompanied by the LPNUM #2, went to Resident #3's room and LPNUM #2 was shown the [redacted]. LPNUM #2 said it is not supposed to be dated like that, I will change it. A review of a facility policy titled Oxygen Therapy with a revised date of 3/1/21, revealed under the Procedure section 11. All tubing is to be changed weekly/PRN as needed. NJAC 8:39-27.1(a)	F 695	basis the Director of Nursing/designee will provide a report of findings to the Quality Assurance committee for action as appropriate. Completion Date: 7-24-2021	

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F 812	Continued From page 21	F 812		
F 812 SS=E	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 review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner. This deficient practice was evidenced by the following: On 6/10/2021 from 9:20 AM to 10:06 AM the surveyor, accompanied by the Account Manager (AM), observed the following in the kitchen: 1. In the dietary fridge a black, unidentifiable substance was observed on the bottom of the fridge. On interview the AM stated, "We clean it once per week or as needed."	F 812	1. The black, unidentifiable substance was immediately cleaned 2. The lids that were left inside the container with the lid off were discarded. The container was immediately cleaned and sanitized 3. The Broccoli that was exposed was discarded and the floor was swept to remove any debris 4. The window air conditioner unit was immediately cleaned and sanitized. 5. The plates that were not inverted were not served and the cart was returned to the kitchen. All plates were rewashed. A set of plates, covered during transport,	7/24/21

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F 812	Continued From page 22 2. On a middle shelf of the storage rack, a plastic container contained plastic lids. The lids were removed from their original container and were exposed. The AM directed the Dietary Aide (DA) to "remove those lids." The DA was observed to remove the lids from the plastic container. 3. On a middle shelf in the walk-in freezer a box contained frozen broccoli. The box was opened, and the broccoli was exposed. The AM stated, "That should be closed." The floor of the freezer was covered with unidentified debris. On interview the AM stated, "It was cleaned on Monday, but we should clean it when there are obvious signs of needing to be cleaned." 4. A window unit air conditioner was observed above the three-compartment sink. The surveyor wiped their finger across the air vents and observed a brown dust/debris on their finger. The air conditioner was on and the air was directed onto the cleaned and sanitized dishware that was in a plastic rack stored on the three-compartment shelf next to the sanitizing sink. The air was blowing on the cleaned and sanitized dishware. On interview the AM stated, "I'm not sure if that is on our cleaning schedule or if maintenance cleans it. We just put it in recently." On 6/10/2021 at 11:50 AM, during the lunch meal on the Executive Order 2 -floor dining room, 4 stacks of cleaned and sanitized plates used to serve resident meals were stacked on a mobile cart. The plates were not in the inverted position and the eating surface was exposed. When interviewed the cook stated, "The plates should be covered with plastic, so they are not exposed." On further interview with the District manager	F 812	was brought up to the dining room 6. Immediately following the interview, the Cook performed hand hygiene (washed his hands and changed his gloves 7. All food that was out of the day was immediately thrown out. 8. All cups that were exposed were immediately thrown out. The chips in the closet that wasn't dated was thrown out. All residents have the potential to be affected. 1. Monitoring of the fridge cleanliness and adherence to cleaning schedule has been added to the Manager's Daily Checklist. 2. Monitoring of proper food storage has been added to the Manager's Daily Checklist. Dietary Aide job flows have been updated to include reclosing of storage containers after each use 3. Staff was In-serviced on the Dry Storage Policy and the importance of covering food to prevent cross contamination. Monitoring of proper food storage was added to the Manager's Daily Checklist. 4. Staff was In-serviced on the updated cleaning schedule. Monitoring of cleanliness of these units was added to the Manager's Daily Checklist. 5. Staff was Re In-serviced on the Meal Distribution & Infection Control Policies. In-Servicing will continue 1x/month for 3 months and then return to bi-monthly. 6. Staff was Re In-serviced on Proper	

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F 812	Continued From page 23 stated, "We are going to get new plates from the kitchen." On 6/10/2021 at 11:56 AM, the cook assigned to the [Executive Order 2]-floor dining room was observed to doff (removed) a pair of disposable gloves after placing pans of food onto the steam table for the lunch meal service. The cook then donned (put on) a new pair of gloves. The cook did not perform hand hygiene between glove changes. When interviewed the cook stated, "I should perform hand hygiene when I take my gloves off before I put a new pair of gloves on. I didn't wash my hands." On 6/16/2021 from 11:57 AM to 12:20 PM, the surveyor, accompanied the Licensed Practical Nurse Unit Manager (LPNUM #1) observed the following on the first-floor pantry: 1. On a shelf in the refrigerator the surveyor observed 2 clear plastic containers with lids. One container appeared to contain black raspberries and one contained an orange liquid that appeared to be a broth-based soup. The containers were dated 6/13/21. An additional plastic container contained ACME carrot cake. The ACME label on the cake stated, "Packed On: Jun.06.21 Sell Thru: Jun.12.21" The cake had a facility label that identified the date placed in the refrigerator as 6/13/21 and 112B. The LPN/UM threw the foods in the trash. 2. A middle cabinet above the pantry counter contained 2 stacks of Styrofoam cups. One stack of cups was observed in the inverted position while the second stack of cups were not inverted. The cups were removed from their original packaging and were exposed. In addition, 3	F 812	Handwashing & Glove Use. In-Servicing will continue 1x/month for 3 months and then return to bi-monthly 7. Staff were Inservice about cups being exposed. 8. The Dietary director monitor the pantry daily for compliance. 1. Monitoring of the cleaning schedule, pantry, storage policy to wrap and cover food storage items, the window AC units and cleaning schedule, and Manager's Daily Checklist completion will continue to ensure compliance and will be recorded on the QA checklist 2x per week for 3 months by Food Service Director, Register Dietician and District Manager. Findings will be reported at the quarterly QA meetings 2. Monitoring of handwashing & glove use will be spot checked by Department Heads 3x/week for 3 months. Findings will be reported at the quarterly QA meetings 3. Monitoring of meal service and distribution will be spot checked by Department Heads 3x/week for 3 months Findings will be reported at the quarterly QA meetings. 4. QA Committee will review and make determination of how to proceed Completion Date: 7-24-2021	

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F 812	Continued From page 24	F 812		

stacks of plastic beverage lids used to put on Styrofoam cups were removed from their original packaging and were exposed. In the cabinet to the right of the middle cabinet, the surveyor observed a bag of Tostitos Scoops. The bag was opened and had no dates. In addition, a bag of Lays Original Party Size potato chips on the same shelf was opened and had no dates. On interview the LPNUM #1 stated, "I'm gonna throw them in the trash. The nursing staff on 11-7 is responsible for checking temperatures and anybody can remove expired foods." LPNUM #1 further stated, "I'm going to throw the plastic lids and cups away also. They should be covered or not removed from the plastic sleeve and sealed up."

The surveyor reviewed the facility policy titled "Food Storage: Dry Goods, revised 9/2017. Under the heading Policy Statement, the following was revealed:

"All dry goods will be appropriately stored will be appropriately stored (sic) in accordance with the FDA Food Code."

The surveyor reviewed the facility policy titled Food Storage: Cold Foods, HCSG Policy 019, revised 4/2018. The following was revealed under the heading Policy Statement: "All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code." In addition, the policy revealed under the heading Procedures at 5. "All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination."

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F 812	Continued From page 25	F 812		

The surveyor reviewed the facility policy titled Equipment, HCSG policy 027, revised 9/2017. The following was revealed under the heading Policy Statement: "All foodservice equipment will be clean, sanitary, and in proper working order." In addition, the following was revealed under the the Procedures section at 4. "All non-food contact equipment will be clean and free of debris."

The surveyor reviewed the facility policy titled Environment, HCSG Policy 028, revised on 9/2017. The following was revealed under the heading Policy Statement: "All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition." In addition, under the Procedures section the following was revealed: 1. "The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation." 2. "The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces." 4. "The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces."

The surveyor reviewed the facility policy titled Food: Safe Handling for Foods from Visitors, revised 10/08/2020. The following was revealed under the Procedure heading: 4. "When foods are intended for later consumption, the responsible staff will: Ensure that the foods are in sealed container to prevent cross-contamination. Label foods with the resident's name and current date." In addition, the following was revealed at 5. "Refrigerator/freezers for storage of foods brought by visitors will be properly maintained

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F 812	Continued From page 26 and: Daily monitoring for refrigerated storage duration and discard any food items that have been stored for 48 hours. (Storage of frozen foods and certain shelf stable items may be retained longer. This would include dated yogurt.)" The surveyor reviewed the facility policy titled Healthcare Services Group Handwashing Procedure for Dining Services, undated. The following was revealed under the Purpose heading: "Gloves are not meant to be used as a replacement for handwashing. They are only effectively (sic) if proper handwashing is completed." "Employees must wash their hands immediately after they remove gloves or other Personal Protective Equipment." In addition, the following was revealed under the heading the following is a list of some situations that require hand hygiene: "After removing gloves or aprons" "In between glove changes (for example, when changing tasks)" "After removing gloves (for example, when exiting the kitchen or at the end of your shift)" "Before putting on a fresh pair of gloves (for example, when beginning your shift)" NJAC 8:39-17.2(g)	F 812		
F 836 SS=E	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c)	F 836		7/24/21

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F 836	Continued From page 27 §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation, the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state	F 836	F836 All residents have the potential to be affected by this practice	

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F 836	Continued From page 28 of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth	F 836	Rates have been significantly increased for C.N.A.s Ads updated to reflect increases. Job Fair Banners are put by the facility to advertise that we need more staff. The call out policy has been reviewed and the staff have been reeducated Staffing policy updated to reflect staffing mandate. The DON to have weekly meetings to determine upcoming schedules to anticipate needs. The DON/designee will report findings to the Administrator. The DON/designee will aggregate findings from these rounds monthly and review the findings with the Administrator/designee. Quarterly on an ongoing basis the DON/designee will provide a report of his findings to the QA committee for action as appropriate. Completion Date: 7-24-2021	

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F 836	Continued From page 29 place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of the facility provided Nursing Home Resident Care Staffing Reports from 6/2/21 to 6/21/21 which included the following staff to resident ratio for each shift: 6/2/21-(Census-78) Day Shift 1 Certified Nursing Assistant (CNA):9.8 residents 6/3/21-(Census-74) Day Shift 1 CNA: 9.3 residents 6/4/21-(Census-77) Day Shift 1 CNA: 9.6 residents 6/5/21-(Census-77) Day Shift 1 CNA: 12.8 residents 6/6/21-(Census-77) Day Shift 1 CNA: 11 residents 6/7/21- (Census-78) Day Shift 1 CNA: 13 residents 6/8/21-(Census-76) Day Shift 1 CNA: 9.5 residents	F 836		

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F 836	Continued From page 30 6/9/21-(Census-78) Day Shift 1 CNA 9.8 residents 6/10/21-(Census-78) Day Shift 1 CNA: 8.7 residents 6/11/21-(Census-78) Day Shift 1 CNA: 8.7 residents 6/12/21-(Census-78) Day Shift 1 CNA: 11.1 residents 6/13/21-(Census-78) Day Shift 1 CNA: 9.8 residents 6/15/21-(Census-77) Day Shift 1 CNA:8.6 residents 6/16/21-(Census-77) Day Shift 1 CNA: 8.6 residents 6/17/21-(Census-80) Day Shift 1 CNA: 10 residents 6/18/21-(Census-80) Day Shift 1 CNA: 11.4 residents 6/19/21-(Census-81) Day Shift 1 CNA: 13.5 residents 6/20/21-(Census-80) Day Shift 1 CNA: 11.4 residents 6/21/21-(Census-81) Day Shift 1 CNA: 11.6 residents 19 of 20 day shifts did not meet the minimum required ratio of 1 CNA to 8 residents. 6/4/21-Evening Shift 1 CNA: 11 residents 6/5/21-Evening Shift 1 CNA: 11 residents 6/7/21-Evening Shift 1 CNA: 11.1 residents 6/8/21-Evening Shift 1 CNA: 12.7 residents 6/9/21- Evening Shift 1 CNA: 11.1 residents 6/10/21-Evening Shift 1 CNA: 13 residents 6/11/21-Evening Shift 1 CNA: 11.3 residents 6/12/21-Evening Shift 1 CNA: 11.1 residents 6/13/21-Evening Shift 1 CNA: 13 residents 6/14/21-Evening Shift 1 CNA: 12.7 residents 6/15/21-Evening Shift 1 CNA: 12.6 residents	F 836		

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F 836	Continued From page 31 6/16/21-Evening shift 1 CNA:11 residents 6/18/21-Evening Shift 1 CNA:11.4 residents 6/19/21-Evening Shift 1 CNA :13.5 residents 6/21/21-Evening Shift 1 CNA:13.3 residents 15 of 20 evening shifts did not meet the minimum required ratio of 1 CNA to 10 residents. 6/2/21-Night Shift 1 CNA: 19.5 residents 6/3/21-Night Shift 1 CNA: 14.8 residents 6/4/21-Night Shift 1 CNA: 19.3 residents 6/5/21-Night Shift 1 CNA: 19.3 residents 6/6/21-Night Shift 1 CNA: 25.7 residents 6/7/21-Night Shift 1 CNA: 15.6 residents 6/8/21-Night Shift 1 CNA: 19 residents 6/9/21-Night Shift 1 CNA: 19.5 residents 6/10/21-Night Shift 1 CNA: 19.5 residents 6/12/21-Night Shift 1 CNA:15.6 residents 6/13/21-Night Shift 1 CNA: 19.5 residents 6/14/21-Night Shift 1 CNA: 25 residents 6/15/21-Night Shift 1 CNA: 15.4 residents 6/16/21-Night Shift 1 CNA: 20 residents 6/17/21-Night Shift 1 CNA:20 residents 6/18/21-Night Shift 1 CNA:20 residents 6/19/21-Night Shift 1 CNA:20.3 residents 6/20/21-Night Shift 1 CNA:20 residents 6/21/21-Night Shift 1 CNA:20 residents 19 of 20 night shifts did not meet the minimum requires ratio of 1 to 14 residents. During an interview on 06/10/21 at 10:56 AM, CNA #2 said we had three (CNA) this morning but when you guys (surveyors) got here they gave us two more so now we have five. We are always short. It's really hard, these people need a lot of care. During an interview on 06/11/21 at 1:05 PM, the facility staffing coordinator (SC) stated yes I am	F 836		

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F 836	Continued From page 32 aware that CNA to resident staff ratio has recently changed in past few months, but I don't have it memorized. She went on to say it changed around November. The SC said we are doing our best to meet the ratios and on an ideal day we are. We are not meeting them every day on every shift. I am responsible to make sure the ratios are met. She also said the facility does utilize agency CNA's. During an interview on 06/11/21 at 1:18 PM, with the Director of Nursing (DON) and the Administrator, the Administrator said they were aware of the staffing ratios and we try our best to get to the ratios. The Administrator said I know there are staffing challenges and we make sure residents get their care. The DON said no we are not meeting the CNA staffing ratios. During a follow up interview on 06/15/21 at 8:33 AM, with the SC revealed that she is in charge of hiring CNA's. She also said we hired only 1 nurses aide (NA) who is now a CNA. She also said she was unsure if the facility advertised for NA's. She went on to say that the facility used NA's thru the agency during Covid 19 outbreaks but are not currently using agency NA's. A review of a facility policy titled Staffing, with a revised date of March 2021, did not include information regarding the state mandated minimum direct care staff (CNA) to resident ratio. A review of a facility policy titled Staff Availability During Emergency/Disaster/Outbreak, undated, did not include information regarding the state mandated minimum direct care staff (CNA) to resident ratio. N.J.A.C. 8:39-5.1(a)	F 836		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/24/21

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F 880	Continued From page 33 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of 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:	F 880		

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F 880	Continued From page 34 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility (1.) failed to perform hand hygiene in a manner to prevent the spread of infection for 1 of 1 resident reviewed for [redacted] care (Resident #8) and (2.) failed to properly store a [redacted] in a manner to prevent contamination for 1 of 1 resident reviewed for transmission-based precautions, (Resident #38). This deficient practice was evidenced by the following:	F 880	F880 Infection Prevention & Control The LPN was re-educated immediately on the proper hand washing procedure during a treatment change for resident [redacted] Executive Order 26, 4.b. [redacted] The resident was provided with a new bedpan which was placed in a clean plastic bag and stored on a shelf in his bedside drawer. All residents who receive a treatment or	

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F 880	Continued From page 35 1. According to Resident #8's medical record, he/she was Executive Order 26, 4.b. [redacted] On 06/15/21 at 11:03 AM, the surveyor observed Licensed Practical Nurse (LPN #2) perform wound care on Resident #8's Executive Order 26, 4.b. Executive Orde. LPN #2 donned disposable gloves and removed the old dressings from the resident's Executive Order 26, 4.b. [redacted] Executive Order 26, 4.b. [redacted] During the cleaning, treatment, and Executive Order 26, 4.b. [redacted] LPN #2 had four opportunities to perform hand hygiene between changing from dirty to clean gloves. LPN #2 did not perform hand hygiene during those opportunities. During an interview with the surveyor on 06/15/21 at 11:26 AM, LPN #2 stated, "I should have." when asked if she should have performed hand hygiene when changing from dirty to clean gloves. A review of the facility's "Handwashing/Hand Hygiene" policy with a review date of 02/2019,	F 880	use a bedpan have the potential to be affected by this practice. The Infection Preventionist has educated all nurses on proper hand hygiene during a treatment change. The Infection Preventionist has educated all nursing staff on the proper storage of a bedpan when not in use. In-services focused on Infection Control Guidelines. Directed In-service training completed- Module 1-Infection Prevention and Control for Topline Staff and Infection Preventionist CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! Completed for Frontline Staff Module 11B-Environmental Cleaning and Disinfection completed for All staff including Topline Staff and Infection Preventionist Module 7- Hand Hygiene completed for All staff including Topline Staff and Infection Preventionist A Root Cause Analysis was completed on the treatment. The staff member made was nervous because the surveyor was watching her and was corrected immediately. A Root Cause Analysis was completed on the bedpan. The staff member was distracted and was corrected immediately. The Infection Preventionist/designee will complete a treatment competency on 2 nurses per week x 4 weeks followed by 1 nurse x 8 weeks. The results will be discussed with the Director of Nursing/designee for presentation to the administrator monthly x 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. BUILDING _____ B. WING _____	C 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 36 revealed under "Policy Interpretation and Implementation" number 7.: "Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; g. Before handling clean or soiled dressings, gauze pads, etc.; k. After handling used dressings ...; m. After removing gloves." 2. During the initial tour of the facility on 06/10/21 at 10:50 AM, the surveyor observed Executive Order 26, 4.b. for Resident #38 on the bathroom floor of his/her room. During an interview with the surveyor on 06/11/21 at 09:45, Resident #38 stated he/she is Executive Order 26, 4.b. According to Resident #38's medical record, he/she was Executive Order 26, 4.b. [redacted] During an interview on 06/11/21 at 10:02 AM, Certified Nurse Assistant (CNA #3) stated that Resident #38 Executive Order 26, 4.b. . CNA #3 further stated that the Executive Order 26, should be stored in a plastic bag off the ground. During an interview on 06/11/21 at 10:20 AM, Licensed Practical Nurse (LPN #3), when asked if Executive Order 26, 4.b can be on the floor responded, "absolutely not, they are supposed to be tied to the rail in the bathroom."	F 880	The Infection Preventionist/Unit Managers will complete daily audits x 4 weeks for the proper storage of bedpans, followed by weekly x 8. The audits will be reviewed by the Director of Nursing/designee and presented to the administrator monthly x 3. The Quality assurance Committee meets quarterly. The findings will be presented at the quarterly meetings and the Quality Assurance Plan/ Improvement Committee will determine next steps. Completion Date: 7-24-2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. BUILDING _____ B. WING _____	C 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	**859 WEST BAY AVE BARNEGAT, NJ 08005**

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F 880	Continued From page 37 During an interview on 06/11/21 at 12:09 PM, the Director of Nursing (DON) stated, "Never." when asked if a [Executive Order 26] should ever be on the floor. During an interview on 06/16/21 at 11:46 AM, the Infection Prevention nurse stated, "Typically, if someone uses it [Executive Order 26, 4.b] you clean it, and store it in a bag either in a night stand or bathroom." The facility was unable to provide a policy that described how to store a bed pan. N.J.A.C. 8:39 - 19.4(a)	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315222 Y1	A. Building B. Wing Y2	8/4/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	859 WEST BAY AVE BARNEGAT, NJ 08005

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0641	Correction	ID Prefix F0656	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)	Completed
LSC	07/24/2021	LSC	07/24/2021	LSC	07/24/2021
ID Prefix F0690	Correction	ID Prefix F0693	Correction	ID Prefix F0695	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(g)(4)(5)	Completed	Reg. # 483.25(i)	Completed
LSC	07/24/2021	LSC	07/24/2021	LSC	07/24/2021
ID Prefix F0812	Correction	ID Prefix F0836	Correction	ID Prefix F0880	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70(a)-(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	07/24/2021	LSC	07/24/2021	LSC	07/24/2021
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/22/2021	☐ YES ☐ NO