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	315222	A. BUILDING _____ B. WING _____	08/09/2019

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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 STANDARD SURVEY: 8/9/19 CENSUS: 99 SAMPLE SIZE: 26 + 1 Closed Record 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 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other facility documentation it was determined that the facility failed to implement identified interventions to address a [redacted] for 1of 6 residents reviewed, (Resident #72) and was evidenced by the following: The Admission Record (AR) dated [redacted],	F 686	Preparation, submission, and implementation of this plan of correction do not constitute an admission of or agreement with the facts and conclusions set forth on requirements the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all state and federal regulatory	9/25/19

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

Electronically Signed | 09/13/2019

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

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F 686	Continued From page 1 reflected that Resident #72 was admitted to the facility with the medical diagnoses of [redacted]. The quarterly Minimum Data Set (MDS) dated [redacted], indicated that the resident had [redacted]). The MDS also indicated that the resident had [redacted] On 08/04/19 at 11:13 AM and 1:25 PM, the surveyor observed the resident lying in the bed with his/her hands-on top of the covers. His/her [redacted] and [redacted] were observed on the resident's [redacted] The surveyor was unable to interview Resident #72 because the resident was [redacted] The facility form titled, "Weekly Skin Check" dated 7/29/19, reflected that Resident # 72's skin was intact. The surveyor reviewed the medical record for Resident #72 and the following was noted: The Physician's Order Sheet (POS) dated 7/30/19, reflected an order for Resident # 72 to [redacted] to [redacted] at all times to prevent skin breakdown and to remove to check skin integrity on every shift during care. The Care Plan dated 7/31/2019, indicated that the resident had a history of skin breakdown and	F 686	1. Resident #72 was evaluated by therapy and determined staff may use [redacted]. A skin assessment has been completed on resident #72 and the skin on [redacted] remains intact. The care plan and Kardex of resident #72 have been updated. 2. All residents who have been determined as at risk for skin breakdown have the potential to be affected by this practice. A facility audit has been completed to review what residents are at risk by nursing and what residents have adaptive equipment in use by therapy. 3. Therapy has completed a full audit for all residents with adaptive equipment that are at risk for skin breakdown. Therapy will submit this report weekly to the Unit Managers and DON ongoing. Licensed nurses and CNAs will be re-educated regarding signing for adaptive equipment including to visualize that the equipment is in place. 4. The Unit Manager/designee will check daily x 2 weeks for compliance of all adaptive equipment being in place, followed by monthly x 3. Therapy will conduct audits of residents with adaptive equipment that are at risk for skin breakdown. Audits will be conducted weekly x 4, then monthly x 3 with the results reported to the DON/designee and presented at the monthly Quality Assurance Performance Committee for review.	

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was to [redacted] to be applied in the AM and to be removed in the PM, however the POS and the TAR reflected that the resident was to [redacted] at all times to prevent skin breakdown and to remove to check skin integrity during care.

The Treatment Administration Record (TAR) dated August 2019 indicated that Resident #72 was to [redacted] at all times to prevent [redacted] and to check skin integrety every shift.
According to the TAR dated 8/4/19 and 8/5/19, the nurses were signing signatures to indicate that the [redacted] were intact to the residents hands, however the surveyor did not observe the resident [redacted].

On 08/05/19 at 10:15 AM and 12:46 PM, the surveyor did not observe [redacted] in the resident [redacted] as ordered by the physician.

On 08/06/19 at 09:55 AM, the surveyor observed that Resident #72 was not [redacted] as ordered by the physician. The surveyor interviewed the Certified Nursing Assistant (CNA) who was caring for the resident at this time, who stated that she had been working in the facility for approximately [redacted] and has not seen any [redacted] on the resident's [redacted]. The CNA added that there is no skin impairment on the resident's [redacted]

On 08/06/19 at 10:41 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who reviewed the physician's order sheet in the presence of the surveyor. She stated that the physician's order indicated that Resident #72 was to [redacted] at all times on every

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shift. The LPN accompanied the surveyor to the resident's room and could not find the [redacted] in the resident's drawers or closets.
The LPN added that the resident did not have any skin breakdown on the hands which was also observed by the surveyor.
The surveyor and the LPN went to the therapy department and the Occupational Therapist (OT) provided the LPN with the appropriate [redacted] for the resident's hands. The LPN then went back into the resident's room and found the other [redacted] in the resident's drawer. The LPN then applied the [redacted] to the resident's [redacted] as ordered.

On 08/06/19 11:46 AM the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) who could not explain why the resident had been observed by the surveyor on three different days, not wearing the physician ordered [redacted], when the order specifically stated that the [redacted] were to be worn at all times except for skin checks. The RN/UN then stated that the [redacted] were "probably not applied because the primary care CNA was not there." The RN/UM could not answer why the nurses were signing the TAR indicating that the [redacted] were intact, when they were not observed on the resident and not available in the resident's room.

On 8/9/19 at 1:00 PM, the surveyor interviewed the Director of Nursing who could not provide any additional information as to why Resident # 72 was not wearing the physician ordered [redacted] on three different days as ordered by the physician

The facility's undated policy titled, "Prevention of [redacted]/Injuries indicated that support

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F 686	Continued From page 4 devices should be provided as needed. N.J.A.C 8:39-27.1 (e)	F 686		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation provided by the facility, it was determined that the facility failed to date and dispose of expired medications from the medication carts and the refrigerator on	F 761	Preparation, submission, and implementation of this plan of correction do not constitute an admission of or agreement with the facts and conclusions set forth on requirements the survey	9/25/19

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F 761	Continued From page 5 accordance with facility policy. This deficient practice was observed for 1 of 4 medication carts and 1 of 2 refrigerators inspected and was evidenced by the following: On 8/5/19 at 10:30 a.m., the surveyor inspected the medication cart on the [redacted] floor in the presence of the Unit Manager (UM). The following was noted: The surveyor inspected the 1 medication cart on the [redacted] floor [redacted] hallway which contained: -One vial of [redacted] open and not dated. -One vial of [redacted] open not dated. -One vial of [redacted] with an expiration date of 7/16/19 and used on 8/5/19. -One vial of [redacted] with an expiration date of 7/29/19. -One vial of [redacted] with an expiration date of 7/25/19. On 8/5/19 at 10:30 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the expiration dates on the [redacted] and she revealed that she administered the [redacted] on 8/5/19 but she did not check the expiration date on the [redacted] prior to administration. She further stated that she should have verified every [redacted] for the expiration date. That same day at 11:30 AM, the surveyor inspected the refrigerator with the Licensed Practical Nurse Unit Manager (LPN/UM) and observed one vial of [redacted] opened and not dated. The LPN/UM confirmed that the [redacted] vial should have been dated once opened. The Unit Manager stated, "the facility's policy is to date all [redacted] vials when	F 761	report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all state and federal regulatory 1. All expired and unlabeled medications found on 8/5/19 have been discarded including [redacted] 2. All residents receiving [redacted] and/or [redacted] have the potential to be affected by this practice. 3. A facility wide inspection was completed on all medication carts and the med room refrigerators. All [redacted] and [redacted] observed by the Unit Managers were found to be in compliance with labeling and dating. An in-service with the facility pharmacy was done on September 11, 2019 for all nurses with emphasis on labeling, dating and disposing of medications. There will be ongoing education for any nurse who did not attend the in-service. 4. Medication cart and med room audits have been completed daily x 2 weeks by the Unit Managers. The attention was focused on expired and unlabeled medications including [redacted]. These audits will continue weekly x 8 weeks and then monthly x 3. The Pharmacy also conducts their monthly audit for review. The audits will be reviewed by the DON weekly x 8 and then monthly x 3 for any	

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F 761	Continued From page 6 opened." A review of the facility's policy titled, "Medication Disposal" initiated 3/1/17, reflected that: "Medications that are discontinued, expired or unused will be disposed of in a safe, environmentally friendly manner." The facility policy was not being followed. NJAC 8:31- 29.4 (f)	F 761	trends with presentation given at the monthly QAPI.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		9/25/19

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

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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F 880	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of medical records and other facility documentation it was determined that the facility failed to maintain adequate infection control practices as well as prevent cross-contamination during medication administration. This deficient practice was evidenced by the following: 1. On 8/5/19 at 8:15 AM.; the surveyor observed a Licensed Practical Nurse (LPN #1) on [redacted] floor administer medication to Resident #25. One of the tablets dropped on top of the medication cart. The nurse picked up the tablet with her bare hands, put the tablet in the cup and administered the tablet to the resident. The surveyor interviewed the LPN #1 at 11:30 AM regarding the above observation. The nurse told the surveyor that the top of the medication cart was clean and if the medication had fallen on the floor, she would not have administered the medication to the resident. She further stated that she was unsure if touching the medication with her bare hands was an issue. A review of the facility's policy titled, " Medication Administration" dated 02/2009, under General Infection Control Guidelines during Med Pass, indicated the following: #5 "Dropping a pill, tablet or any medication either on the cart or on the floor must be destroyed. Do not administer a dropped medication to the resident." 2. On 8/5/19 at 9:20 AM, the surveyor observed LPN #2 on the [redacted] floor administer medications	F 880	Preparation, submission, and implementation of this plan of correction do not constitute an admission of or agreement with the facts and conclusions set forth on requirements the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all state and federal regulatory 1. LPN #1 and LPN #2 received proper education on Infection Control guidelines during med pass. 2. All residents have the potential to be affected by this practice. 3. The 2 LPNs received in-servicing on the Infection Control guidelines during med pass by the staff educator on 8/8/19. Both LPNs were then observed during med pass which showed their compliance. All nurses are being educated the Infection Control guidelines during med pass. 4. The Staff educator/designee will complete 5 med pass observations per week x 4 weeks, then monthly x 3 to audit for infection control compliance during med pass. Results will be reviewed by the Director of Nursing/designee for presentation at the monthly Quality Assurance Performance Committee.	

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to Resident #6. The resident shared the room with another resident that was on contact isolation for [redacted] The nurse used his personal clipboard as a serving tray to transport the medications into the room.
The surveyor observed the nurse place the clipboard on the windowsill of an isolation room, administer the medications, then pick up the clipboard, walk out of the room and place the clipboard on top of the medication cart. He did not disinfect the clipboard after coming in contact with the windowsill in the room.

At 9:30 AM that same day, LPN #2 was observed entering another resident's room with the same clipboard. LPN #2 then placed the clipboard directly on the resident's bed, administer the medications, then exit the resident's room and place the clipboard on top of the medication cart. The nurse did not disinfect the clipboard after coming in contact with the resident's bed.

On 8/5/19 at 9:45 AM, the surveyor observed LPN #2 knock a cup containing mouth swabs used for cleaning a resident's mouth from the medication cart onto the floor. The survyeor then observed LPN #2 pick the swabs and cup from the floor and return them to the top of the medication cart.

The surveyor interviewed the LPN #2 at 11:40 AM regarding the above issues and the nurse did not have any comments regarding the use of his personal clipboard being used room to room without disinfecting. LPN #2 then disposed the cup of mouth swabs in the receptacle bin at this time.

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F 880	Continued From page 10 The Director of Nursing (DON) and the Administrator were made aware of the issues with infection control during the medication administration. The DON stated to the team that this is not the facility practice. According to the the staff "In-Service Record" provided to the surveyor dated 8/8/19, contained a form titled "Under General Infection Control Guidelines during Med Pass" indicated: 1.) Use of personal items to help with medication pass, (ie. Clipboards or a serving tray of any kind) must be wiped down with PDI (disinfecting wipes) between each medication pass and 2.) Be sure that all equipment coming in contact with the resident is being wiped down in and between residents. NJAC: 8-39-19.4 (a)	F 880		