STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061531	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

(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) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 15 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	This plan of correction is the facility's credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. 1. All facility residents have the potential to be affected by this deficient practice. The facility continues to actively seek	12/23/21

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

Electronically Signed | 11/25/21

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. 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 CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and 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 CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 10/17/21 to 10/23/21 and 10/24/21 to 10/30/21, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 10/17/21 had 12 CNAs for 124 residents on the day shift, required 16 CNAs. 10/18/21 had 12 CNAs for 124 residents on the day shift, required 16 CNAs. 10/19/21 had 11 CNAs for 124 residents on the day shift, required 16 CNAs. 10/20/21 had 12 CNAs for 124 residents on the day shift, required 16 CNAs. 10/21/21 had 13 CNAs for 125 residents on the day shift, required 16 CNAs. 10/22/21 had 12 CNAs for 125 residents on the day shift, required 16 CNAs.	S 560	CNA□s in a relentless effort to comply with and maintain all required minimum direct care staff to resident ratios aggressively and vigorously. No residents have been adversely affected. 2. Facility administration shall continue to make every effort possible to satisfy at a minimum the requirement to have one direct care staff to every 8 residents for the day shift. Additionally, facility administration shall continue to make every effort to maintain all required minimum direct care staff to resident ratios for all shifts indicated in this standard. The facility Administrator shall review the requirements indicated in these standards with the facility Human Resources Director, Director of Nurses and Assistant director of Nurses. 3. The Facility□s recruitment and retention strategies and efforts to satisfy and maintain these minimum direct care staff to resident ratios indicated in this standard include but are not limited to the following. a. Recruitment bonus to encourage referrals from current facility staff. b. Daily and weekly bonuses as an incentive to satisfy day, evening and night shift required minimum direct care staff to resident ratios. c. Aggressive social media and online presence with multiple employment websites and platforms. d. Enrollment and compensation of appropriate candidates in various vocational schools to certify and staff these individuals as CNA□s. e. Ongoing utilization of multiple staffing agencies.	

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S 560	Continued From page 2 10/23/21 had 10 CNAs for 121 residents on the day shift, required 16 CNAs. 10/24/21 had 11 CNAs for 121 residents on the day shift, required 16 CNAs. 10/25/21 had 11 CNAs for 121 residents on the day shift, required 16 CNAs. 10/26/21 had 12 CNAs for 121 residents on the day shift, required 16 CNAs. 10/27/21 had 13 CNAs for 122 residents on the day shift, required 16 CNAs. 10/28/21 had 11 CNAs for 122 residents on the day shift, required 16 CNAs. 10/29/21 had 12 CNAs for 122 residents on the day shift, required 16 CNAs. 10/30/21 had 9 CNAs for 121 residents on the day shift, required 16 CNAs. NJAC 8:39-5.1(a)	S 560	4. The facility Administrator, HR Director, Director of Nurses, Assistant Director of Nurses and Administrative Assistant shall conduct a QAPI Performance Improvement Project to monitor progress and identify areas of improvement/corrective action in the various strategies outlined in column #2 of this plan of corrections. This QAPI Committee shall meet once weekly for 30 days and once a month thereafter for a total of 90 days to review and assess effectiveness of this QAPI PIP. All findings identified on these QAPI Committee meetings shall be presented to the facility Quality Assessment and Assurance Committee on a quarterly basis.	

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F 000	INITIAL COMMENTS Survey Date: 11/10/21 Census: 122 Sample: 24 +3 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 658 SS=D	Services Provided Meet Professional Standards 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 review of pertinent facility documents, it was determined that the facility failed to ensure the reconciliation and notification of the physician for the clarification of an enteral feeding order in accordance with professional standards of nursing practice. This deficient practice was identified for 1 of 24 resident reviewed for professional standards of nursing practice (Resident [redacted]. 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	F 658	This plan of correction is the facility's credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. 1. All Residents receiving enteral feedings have the potential be affected by this deficient practice. Resident [redacted] was	12/25/21

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

Electronically Signed | 11/25/2021

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F 658	Continued From page 1 treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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." The evidence was as follows: On 11/3/21 at 10:47 AM, during the initial tour, the surveyor observed Resident # [redacted] lying in bed resting. The surveyor was unable to interview the resident as he/she was not interviewable. The surveyor reviewed the medical record for Resident [redacted]. A review of the Admission Record face sheet (an admission summary) included that the resident was admitted to the facility in [redacted] with diagnoses which included: [redacted])	F 658	evaluated by the RN to determine any adverse effects related to not receiving clarification of enteral feeding. No adverse effects were identified. The Physician was notified of the occurrence and that no adverse effects were relayed by resident # [redacted]. RN was provided with re-education related to the reconciliation and notification of the physician for the clarification of medication administration and physician orders in accordance with professional standards of nursing practice. 2. All residents receiving enteral feeding shall be assessed to make certain that all measures are taken by the licensed nurse to ensure proper medication administration. Re-education on proper medication administration and physician's orders and the reconciliation and notification of the physician for the clarification of medication administration and physician orders will be completed for all licensed nurses. 3. Education of medication administration of licensed nurses will be conducted by the pharmacy consultant and nurse educator monthly for a duration of 90 days or three consecutive months. The facility Director of Nurses or designee shall observe medication administration via the medication observation tool monthly for a duration of 90 days and all findings shall be documented and incorporated into the facility Quality Assurance and Performance Improvement program. 4. The Facility Administrator, Director of Nurses, Assistant Director of Nurses as	

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F 658	Continued From page 2 [redacted]). A review of the resident's individualized care plan created [redacted]1, included that the resident required [redacted]) of [redacted] milliliters (ml) [redacted] n) four (4) times daily to be given only if [redacted]) [redacted] was less than [redacted] of meals related to [redacted]. In addition, the resident had an [redacted] status related to diagnoses of [redacted] status. The interventions included to give medications as ordered. A review of the [redacted] Medication Administration Record (MAR) for Resident [redacted] reflected a physician's order (PO) dated [redacted], for enteral feeding four times a day related to gastrostomy status; give [redacted]) [redacted] at [redacted]. [redacted] was greater than or equal to [redacted]; the order was discontinued on 1[redacted] The new PO started on [redacted], for the [redacted] four times a day related to [redacted]. Hold [redacted] intake was [redacted] On 11/5/21 at 10:22 AM, the surveyor interviewed the Registered Nurse (RN). The RN stated Resident [redacted] had an [redacted] only if he/she did not eat their meal. She confirmed that the resident had received a [redacted] (administration of a certain amount of [redacted] during her shift. On 11/8/21 at 9:02 AM, the Licensed Practical	F 658	well as the pharmacy consultant shall participate in monthly QAPI meetings regarding this QAPI PIP (Performance Improvement Project) for a duration of 90 days or three consecutive months. All findings/corrective actions identified shall be documented and presented to the facility Quality Assurance and Assessment Committee on a quarterly basis.	

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F 658	Continued From page 3	F 658		

Nurse (LPN) stated Resident [redacted] did not eat his/her breakfast and therefore would receive [redacted] that morning.

On 11/8/21 at 9:21 AM, the LPN went into the electronic medical record (EMR) to review the PO. The LPN verified that the [redacted] of [redacted] for Resident [redacted] and confirmed that the resident did not eat breakfast and would be given the [redacted]. The LPN stated the resident does take his/her medications by mouth and the [redacted] was a supplement for when the resident does not eat. The LPN further stated she was going to be administering a [redacted] before and a [redacted] after the [redacted].

On 11/8/21 at 9:23 AM, the surveyor observed the LPN prepare for the administration of the bolus feed. The LPN performed hand hygiene with an alcohol-based hand rub (ABHR), applied a pair of gloves and disinfected her stethoscope. She removed her gloves and applied ABHR. The LPN took out a new [redacted] and dated the package. The LPN then proceeded into the resident's room.

On 11/8/21 at 9:29 AM, the LPN measured the [redacted] before the [redacted] and the [redacted] for after the [redacted]. The surveyor asked the LPN the total amount to be given. The LPN went back to the EMR because she stated she was "not sure of the amount" that should be given. The LPN reviewed the PO, and the LPN stated the PO was not clear on the total amount to be given and she needed to get clarification from the physician.

On 11/8/21 at 9:34 AM, the LPN discarded the opened [redacted] cal/ eight (8) [redacted]

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F 658	Continued From page 4	F 658		

[redacted]): [redacted] ml) container and the water for the [redacted] She removed her gloves and used ABHR and proceeded to the nursing station. The LPN then paged the dietician but there was no answer. She then called the Assistant Director of Nursing (ADON) and informed her the order needed to be clarified. The LPN then called the physician's office and left a message.

On 11/8/21 at 9:38 AM, the Registered Nurse/Unit Manager/Infection Preventionist (RN/UM/IP), informed the surveyor that the previous order of [redacted] from [redacted] was discontinued. She further stated that the order needed clarification from the physician to see if the order stayed the same of [redacted] or [redacted] ml. The RN/UM/IP put another call out to the physician to get clarification on the [redacted]

On 11/8/21 at 9:46 AM, the RN/UM/IP informed the surveyor and the LPN that she spoke with the primary physician for clarification of the [redacted] and the physician reinstated the [redacted] ml order.

On 11/8/21 at 9:53 AM, the LPN administered the [redacted] of [redacted].

On 11/9/21 at 9:03 AM, the RN/UM/IP stated all nurses were responsible for the reconciliation of the PO, but it was the primary task for the night shift 11 PM - 7 AM. She stated the original order on [redacted] was to give the [redacted] ml and then they updated the PO on [redacted] to include both the amount of [redacted] and [redacted] but the staff "forgot" to include the [redacted] ml. The RN/UM/IP stated all nurses were aware of the [redacted] order

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F 658	Continued From page 5	F 658		

of [redacted] ml and they continued to give the [redacted] according to that order. The surveyor and the RN/UM/IP reviewed the electronic MAR and it reflected on [redacted] and [redacted] during breakfast the nurse administered the [redacted] without getting clarification of the amount from the primary physician. She further stated that she clarified the order on [redacted]/21 with the primary physician to include the [redacted] ml as the total amount for the [redacted].

On 11/9/21 at 9:23 AM, the Director of Nursing (DON) stated the 11 PM - 7 AM shift nurses conducted the reconciliation of physician orders. The DON acknowledged she was not sure what happened with the order and why the [redacted] ml amount was not carried over when the order was updated on [redacted]. She stated she always had the same nurses on the units, and they know their residents. She further stated that the nurses knew the original order from [redacted] was to give [redacted] ml. The DON acknowledged if a new nurse was on the unit and caring for Resident [redacted] the order needed to be clarified to include the total amount to be given. She confirmed that Resident [redacted] generally does not eat in the morning but does eat lunch and dinner which the staff documents accordingly.

On 11/9/21 at 10:12 AM, the surveyor interviewed the RN. The RN stated she was caring for the resident on [redacted] and [redacted] and had administered the [redacted] ml because the resident ate less than [redacted] of their meal. The RN further stated she was familiar with the resident and the original order was to give [redacted] ml. The RN acknowledged that she should have notified the primary physician to clarify the PO. In addition, she should have notified the

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F 658	Continued From page 6 dietician regarding the [redacted] ml was missing in the order when it was transferred over to show [redacted] amount and [redacted] amount. On 11/10/21 at 9:48 AM, the DON stated in the presence of the Licensed Nursing Home Administrator and survey team that the RN/UM/IP changed the order on [redacted] because the [redacted] ml was "missed" during the reconciliation of Resident [redacted] orders. The DON acknowledged the order should have been clarified prior and the staff failed to ensure the supplementary documentation to show the amount of the [redacted] ml was included in the updated PO. A review of the facility's unnamed and undated policy included, "All verbal, phone and written orders will be reviewed by the 11 PM - 7 AM nurse in order to avoid potential medication discrepancy ... ...11 PM - 7 AM nurse will document findings of chart check by initialing if there were no issues noted, if discrepancy noted and if attending medical doctor was notified of need to modify or order clarified." A review of the facility's [redacted]" policy updated 10/2019, included ....."Verify ...physician's order ...Check the [redacted] label against the order before administration. Check the following: ....(g) [redacted])." NJAC 8:39-11.2(b), 29.2(b)	F 658		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4)	F 712		12/24/21

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F 712	Continued From page 7 §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) 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 ensure that the physician responsible for supervising the care of residents conducted face to face visits and wrote progress notes at least every thirty days for the first ninety days for new admissions or every sixty days after. This deficient practice was identified for [redacted] of 6 residents (Resident [redacted]) during the Resident Council group meeting and evidenced by the following: On 11/8/21 at 10:01 AM, the surveyor conducted a resident group meeting with [redacted] residents who were [redacted] and selected by the facility to attend the group meeting. [redacted] of the six residents complained to the surveyor that they do	F 712	This plan of correction is the facility's credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. 1. Residents [redacted] and [redacted] were seen and evaluated by the Physicians with supporting documentation completed in	

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F 712	Continued From page 8 not see their primary care physician (MD) or nurse practitioner (NP) regularly. Resident [redacted] stated that since admission, he/she has not seen their MD. On 11/8/21 at 11:03 AM, the Director of Nursing (DON) informed the surveyor that all MD and NP were conducting in-person visits for all residents at this time, unless the resident had an emergency, then a video visit would be conducted. The DON stated that MD and NP visits were conducted on a monthly basis and documented in the electronic medical record (EMR). At this time, the surveyor requested all MD and NP visits for the past six months for all [redacted] residents (Resident [redacted], and #[redacted] On 11/8/21 at 11:59 AM, the DON provided the surveyor with the requested medical records. At this time, the DON stated that all the residents were seen by their MD or NP but confirmed that all the residents were not seen monthly as they should by their MD or NP. The surveyor reviewed the medical records for the [redacted] residents above which revealed the following: 1. A review of Resident [redacted]'s Admission Record, reflected that the resident was admitted to the facility in [redacted] with diagnoses which included: [redacted]. A review of the most recent quarterly Minimum Data Set (MDS; an assessment tool) dated [redacted] reflected that the resident had a Brief	F 712	the E.H.R. 2. All residents have the potential to be affected by this deficient practice. The facility Medical Director as well as all facility attending physicians shall receive re-education on this standard and the requirement that all residents be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter in accordance with and as defined in CFR 483.30 (c)(2), (c)(3), and (c) (4) of this section. These visits shall be conducted face to face. A progress note associated with each visit shall be completed by the visiting physician. 3. The Facility Administrator, Director of Nurses, Assistant Director of Nurses, Medical Director, or designee shall conduct a QAPI Performance Improvement Project to monitor for compliance and root cause analysis. This QAPI Committee shall meet once a month to determine progress in this QAPI PIP as well as general compliance in this area. These monthly QAPI Meetings shall commence at the conclusion of one quarter or three months. 4. All findings/corrective actions identified on this QAPI PIP, shall be presented to the facility Quality Assessment and Assurance Committee on a quarterly basis.	

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	315265	A. BUILDING _____ B. WING _____	11/10/2021

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F 712	Continued From page 9 Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which indicated a [redacted]. A review of the resident's physician visits provided by the facility, revealed that the resident had the following physician visits in the past six months: [redacted] consultation, 7/14/21 [redacted] consultation, 8/10/21 MD visit, 9/8/21 MD visit, 9/23/21 [redacted] consultation, 9/28/21 NP visit, 10/13/21 MD visit. On 11/9/21 at 10:54 AM, the surveyor interviewed the Medical Director via telephone who stated that all long term care residents were seen monthly by either the MD or the NP. The Medical Director stated that the MD and the NP could alternate visits, but the NP could not have consecutive monthly visits without the MD visiting. On 11/10/21 at 9:34 AM, the DON in the presence of the Licensed Nursing Home Administrator, Assistant Director of Nursing (ADON) and survey team stated that Resident [redacted]s MD was switched recently to the Medical Director. At this time, the surveyor requested all Physician Visits for the resident for the year of 2021. On 11/10/21 at 10:37 AM, the surveyor interviewed Resident [redacted] who stated that he/she recently switched MD since their previous MD retired. The resident stated that he/she within the past few months has seen the MD, but throughout the year has only seen specialty physicians such as a [redacted], [redacted], and [redacted]). The resident stated that he/she has had no medical changes this year which would have required a MD or NP visit.	F 712		

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F 712	Continued From page 10 On 11/20/21 at 10:55 AM, the DON confirmed that the resident was seen by specialty physicians throughout the year but was not seen regularly by their MD or NP. The DON confirmed that the 8/10/21 MD visit was the first well visit the resident received for 2021. 2. A review of Resident [redacted]'s Admission Record reflected that the resident was admitted to the facility in [redacted] with diagnoses which included: [redacted] A review of the admission MDS dated [redacted] reflected that the resident had a BIMS score of [redacted] out of [redacted] which reflected a [redacted]. A review of the EMR reflected a Health and Physical note dated [redacted] signed by the NP. A further review of the EMR reflected NP notes dated [redacted]. There was no documentation from the resident's MD. On 11/8/21 at 12:10 PM, the surveyor interviewed the resident's MD (MD #1) via telephone who stated that the NP (NP #1) was currently at the facility and that NP #1 discussed all the residents with her via telephone or video conference. MD #1 confirmed at this time, she has not been documenting in any of her residents' EMR, but NP #1 included in her notes that she reviewed with the MD. MD #1 acknowledged that she has	F 712		

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F 712	Continued From page 11	F 712		

not been at the facility and cannot recall the last time she was there because of personal issues, but she planned on returning to the facility.

On 11/9/21 at 10:54 AM, the surveyor interviewed the Medical Director via telephone who stated that all new admissions should be seen first by the MD for their health and physical and then monthly by either the MD or the NP, with alternating NP visits allowed.

On 11/10/21 at 9:34 AM, the DON in the presence of the LNHA, ADON, and survey team confirmed that the initial visit should be conducted by the MD and then monthly by the MD or NP. The DON stated that the NP could visit in between MD visits. The DON confirmed that MD #1 had spoken with NP #1 after each visit with Resident [redacted] but MD #1 was not physically here. The DON stated that after surveyor inquiry, MD #1 visited the facility.

3. A review of Resident [redacted] Admission Record reflected that the resident was admitted to the facility in [redacted] with diagnoses which included: [redacted].

A review of the most recent quarterly MDS dated [redacted] reflected a BIMS score of [redacted] which indicated a [redacted].

A review of the resident's EMR revealed the following MD visits in the past six months: 5/26/21 and 8/18/21. The were no additional NP visits in the past six months. There was no required sixty-day visit for July 2021 or October 2021.

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F 712	Continued From page 12 On 11/10/21 at 9:34 AM, the DON in the presence of the LNHA, ADON, and survey team confirmed that the resident was seen by the MD after surveyor inquiry. 4. A review of Resident [redacted]s Admission Record reflected that the resident was admitted to the facility in [redacted] with diagnoses which included: [redacted]. A review of the most recent quarterly MDS dated [redacted] reflected a BIMS score of [redacted] which indicated a [redacted] A review of the EMR reflected that the resident was seen by the MD in the past six months on 5/12/21 and 10/13/21. The EMR further revealed that the resident was seen by the NP in the past six months on the following dates: 6/28/21, 6/29/21, 6/30/21, 7/20/21, 7/28/21, 7/29/21, 7/31/21, 8/2/21, 8/4/21, 8/10/21, 8/11/21, 8/14/21, 8/18/21, 8/21/21, 8/23/21, 9/23/21, 9/28/21, 10/12/21, and 11/1/21. There was no evidence that the MD alternated the every sixty-day visit with the NP. On 11/10/21 at 9:34 AM, the DON in the presence of the LNHA, ADON, and survey team confirmed that the resident was seen by the MD after surveyor inquiry. A review of the facility's "Physician Services" policy dated updated 10/2019, included that the physician will perform pertinent, timely medical assessments; ... visit resident at appropriate intervals; and ensure adequate alternative	F 712		

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F 712	Continued From page 13 coverage. The policy also included that physician visits, frequency of visits, emergency care of residents, ects, are provided in accordance with current OBRA (Omnibus Budget Reconciliation Act) regulations and facility policy. NJAC 8:39-23.2(d)	F 712		
F 812 SS=D	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 facility documentation, it was determined that the facility failed to maintain kitchen equipment in a manner to prevent microbial growth. This deficient practice was evidenced by the following: On 11/5/21 at 11:17 AM, the surveyor conducted	F 812	This plan of correction is the facility's credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of	12/23/21

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F 812	Continued From page 14	F 812		

a follow-up kitchen visit with the Dietary Director (DD) and observed the cook taking lunch food temperatures at the steam table. The surveyor observed the white steam table attached cutting board was deeply pitted and discolored black and reddish.

At this time, the DD stated that staff sanitize the cutting board prior to serving food. She was unable to respond when questioned if this cutting board should be used; when cutting boards should be replaced; or when the cutting boards were last replaced. The DD then showed the surveyor a small white cutting board that was pitted and discolored black.

On 11/5/21 at 11:21 AM, the surveyor interviewed the Regional Dietary Director (RDD) who stated that cutting boards should be replaced when there were scratches or indentations because bacteria growth could occur or quarterly. The RDD confirmed that both white cutting boards should not be in use and needed to be replaced.

At this time, the RDD showed the surveyors one large blue, one large yellow, one large red, and one large brown cutting boards that were in use. The cutting boards were all pitted and discolored. The RDD confirmed that these cutting boards should not be in use and needed to be replaced.

On 11/10/21 at 10:10 AM, the Licensed Nursing Home Administrator in the presence of the Director of Nursing and survey team stated that the RDD confirmed that the facility was using cutting boards that needed to be replaced.

A review of the facility's "Cleaning Instructions Cutting Board" policy dated April 2020, included

deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law.

1. All facility residents have the potential to be affected by this deficient practice. The white steam table attached cutting board, the small white cutting board, the large blue, yellow, red and brown cutting boards where all immediately removed and discarded. All dietary personnel where immediately in serviced regarding this deficient practice as well as regarding the facility "Cleaning Instructions Cutting Board" Policy and Procedure.

2. The facility RFSD (Regional Food Service Director) shall review all facility Policies and Procedures as they pertain to 483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety for accuracy and compliance. Furthermore, the RFSD shall Inservice the FSD (Food Service Director) as well as all facility Dietary Personnel regarding these facility Policies and Procedures. A competency evaluation for all Dietary Personnel shall be conducted by the facility RFSD and FSD.

3. The Facility Administrator or designee shall conduct unannounced routine audits at least twice weekly for 60 days to determine compliance in these facility Policies and Procedures. The facility RFSD shall conduct audits once a month for 90 days and bimonthly thereafter to determine compliance in these Policies and Procedures. Furthermore, the facility Administrator or designee RFSD, FSD

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F 812	Continued From page 15 that all cutting boards shall be replaced no later than every three months or when they become excessively worn or develop hard to clean grooves. NJAC 8:39-17.2(g)	F 812	and dietitian shall conduct a QAPI Performance Improvement Project to monitor for compliance and root cause analysis. This QAPI Committee shall meet once a month to determine progress in this QAPI PIP as well as general compliance in this area. These monthly QAPI Meetings shall commence at the conclusion of one quarter or three months. 4. All findings identified on the said audits as well as a result of the QAPI PIP, shall be presented to the facility Quality Assessment and Assurance Committee on a quarterly basis.	