STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING _____ B. WING _____	10/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(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: 10/14/2020 Census:125 Sample Size: 32 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		10/21/20

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

Electronically Signed | 11/13/2020

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 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility documentation review, it was determined that the facility failed to ensure the resident's right to be treated with dignity and respect. This deficient practice was identified for 2 of 25 residents observed; Resident #49 and #58. This deficient practice was evidenced by the following: 1. On 10/5/20 at 10:40 AM, the surveyor, observed Resident #49 in bed with their [redacted] and [redacted]. The alert resident greeted the surveyor, speaking [redacted] and informed the surveyor that they had [redacted] The surveyor reviewed the Admission Record indicating that Resident # 49 was admitted to the facility with diagnoses, including [redacted]	F 550	What corrective action will be accomplished for those residents affected by the deficient practice? On 10/5/20, the surveyor observed Certified Nursing Assistant (CNA)#1 enter Resident #49 room without knocking or obtaining permission before entering the room. Another CNA #2 was also observed without knocking and obtaining permission before entering the room. CNA#2 was again observed entering the Resident #58 room while the surveyor was in the room without knocking and said, “wrong room.” On 10/9/20, CNA#3 was observed with Resident #49 in the bathroom with door wide open and was not providing privacy. CNA#1 and CNA#2 were immediately	

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F 550	Continued From page 2 [redacted]).	F 550		

A review of the Quarterly Minimum Data Set (MDS), an assessment tool, indicated a Brief Interview for Mental Status (BIMS) score of [redacted] of [redacted], which reflected that the resident had [redacted] impaired cognition.

On 10/5/20 at 11:05 AM, the surveyor observed Certified Nursing Assistant (CNA) #1 enter Resident #49's room without knocking or obtaining permission before entering the room. When the surveyor questioned CNA#1, she responded that she was delivering ice water and was not the resident's assigned CNA.

On that same day at 11:06 AM, CNA #2 entered Resident #49's room without knocking or obtaining permission before entering the room. When the surveyor questioned CNA #2, she responded that she was assigned to Resident 49's care.

On that same day at 12:33 PM, during an interview, the surveyor asked CNA #2 if her routine practice was to enter resident rooms without first knocking. CNA #2 stated that she usually knocks on the door and should have knocked on Resident #49's door before entering.

On 10/9/20 at 11:53 AM, the surveyor interviewed CNA #1, who acknowledged that she should not enter resident rooms without knocking first, and that she should have knocked before she entered Resident
#49's room.

On 10/9/20 at 9:15 AM, the surveyor observed

in-serviced on knocking or obtaining permission before entering the resident's room.

CNA#3 was immediately in-serviced on providing privacy by closing the door or drawing the privacy curtains during care.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents have the right to be treated with dignity and respect.

An in-service was conducted on all Certified Nursing Assistant (CNA) to ensure they are knocking or obtaining a permission before entering the resident's room and providing privacy by closing the door or drawing the privacy curtains during care.

An audit of all Certified Nursing Assistant (CNA) entering the resident's room was conducted and was also observed if privacy was provided, all CNA are in compliance. No harm was noted on 10/5/20.
What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur?

Assistant Director of Nursing/Designee will in-service Certified Nursing Assistant (CNA) on knocking or obtaining permission before entering the resident's room and providing privacy by closing the

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F 550	Continued From page 3 Resident # 49's door open. The surveyor knocked on the door, and CNA #3 told the surveyor to "come in." The surveyor observed Resident #49 seated on the toilet in the bathroom with the door wide open. At that time, the surveyor asked CNA #3 why she had not closed Resident #49's bathroom door to ensure privacy. CNA #3 stated that she provided morning hygiene care for Resident #49 and left the bathroom to obtain powder. CNA #3 further acknowledged that she should have provided privacy by closing both the bathroom door and the resident's room door. 2. On 10/05/20 at 11:47 AM, the surveyor observed Resident #58 lying in bed. Resident #58 greeted the surveyor and agreed to an interview. After obtaining the resident's permission, the surveyor closed the door and began the interview. At that time, CNA#2 opened Resident #58's door without first knocking and said, "wrong room." CNA#2 then left the room, closing the door behind her. Resident #58 stated that sometimes staff enter the room without knocking and further said, "it's rude." The surveyor reviewed the Admission Record indicating that Resident #58 was admitted to the facility with diagnoses that include [redacted]. The surveyor reviewed the Annual Minimum Data Set (MDS), an assessment tool, that reflected a Brief Interview for Mental Status (BIMS) score of [redacted] indicating that Resident #58 was cognitively intact, alert, and oriented.	F 550	door and/or drawing the privacy curtains during care. This in-service will also be done for all employees and new hire orientation of employees. Unit Managers and Nursing Supervisors will be monitoring all employees knocking on the door and/or obtaining permission before entering resident's room, and providing privacy by closing the door and/or drawing the privacy curtains during care weekly x 4 weeks, then monthly x 6 months. Any significant concerns during audits will be addressed immediately to ensure compliance with standards of care. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Unit manager/Designee will be conducting audits by observing employees knocking on the door or obtaining permission before entering resident's room and providing privacy by closing the door or drawing the privacy curtains during care weekly x 4 weeks then monthly x 6 months unless any significant trends are identified. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meetings (Quality Assurance Performance Improvement). Any concerns during audits will be addressed immediately to ensure compliance with	

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F 550	Continued From page 4 On 10/5/20 at 12:33 PM, during an interview, the surveyor asked CNA #2 if her routine practice was to enter resident rooms without first knocking. CNA#2 stated that she usually knocked before entering and acknowledged that she should have knocked on Resident #58's door before entering. On 10/14/20 at 1:31 PM, the surveyor discussed the above observations and concerns with the Administrator, Director of Nursing (DON), and Regional Nurse. No further documentation was provided. On 10/15/20 at 11:46 AM, the surveyor and Team Coordinator spoke with the Administrator and DON via a phone conference call at the facility's request. The DON stated that residents' [room] doors should be closed when hygiene and personal care were being rendered. N.J.A.C. 27.1 (a)	F 550	standards of care. Monitoring will occur for 4 weeks and then monthly for 6 months unless any significant trends are identified. Date of Compliance: 10/21/20	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accommodate the needs of a resident (dependent on staff) to utilize their call bell	F 558	What corrective action will be accomplished for those residents affected by the deficient practice?	10/21/20

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F 558	Continued From page 5 system for assistance. This deficient practice was identified for 1 of 25 residents reviewed; Resident #49, and was evidenced by the following: On 10/5/20 at 10:40 AM, the surveyor observed Resident #49 in bed with [redacted]. The alert resident greeted the surveyor, stated that they had [redacted] Resident #49 stated that they wanted to get out of bed, but the Certified Nursing Assistant (CNA) had not yet come to assist. The surveyor asked the resident if they were able to use the call bell to obtain assistance. The resident replied that they were unable to reach it and gestured toward the call system. The surveyor observed that the call bell was inaccessible to Resident #49 as it was wedged behind the bed that was pushed against the wall. The surveyor reviewed the resident's Admission Record that indicated Resident #49 was admitted to the facility with diagnoses that included but were not limited to [redacted]. A review of the [redacted] Part C of the Quarterly Minimum Data Set (MDS), an assessment tool, Brief interview for Mental Status (BIMS) documented a score of [redacted] indicating that the resident had [redacted] cognitive impairment. The [redacted] MDS also assessed Resident #49 as requiring extensive assistance from staff for transfers and that the resident was occasionally [redacted] and [redacted].	F 558	On 10/5/20, the surveyor observed Resident #49 call bell unable to reach. Call bell was wedged behind Resident #49's bed frame and would be inaccessible to the resident. CNA was in-serviced immediately on ensuring the call bell was always within the resident's reach. Call Bell clip was attached to the Call Bell cord to ensure it is within the resident's reach How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. An in-serviced was conducted on all Nursing employees on ensuring the call bell was always within the resident's reach. An audit was conducted on all resident's call bell placement. All call bell was within the resident's reach. No harm done on 10/5/20. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Assistant Director of Nursing/Designee	

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F 558	Continued From page 6 On 10/5/20 at 11:06 AM, the surveyor observed the CNA enter Resident #49's room. The CNA assisted the resident out of bed to a standing position and stated, [redacted]." The surveyor asked the CNA if she had provided incontinence care for the resident that morning. The CNA replied, "no, the resident will usually call when they need to be changed." The surveyor asked how the resident would typically call for assistance. CNA #1 replied that the resident "uses the call bell." The resident then stated, "I can't reach the call bell." The CNA did not acknowledge or respond to the resident's statement and assisted Resident #49 into the bathroom and provided morning care. On 10/5/20 at 12:33 PM, the surveyor and the CNA entered Resident #49's room to find that the call bell was still wedged behind Resident #49's bed frame and would be inaccessible to the resident. The CNA stated she did not check to ensure that Resident #49's call bell was within their reach at any time that morning, and further stated, "I just assumed she could reach it; I should have checked." On 10/9/20 at 2:15 PM, the surveyor discussed the above observations and concerns with the Administrator, Director of Nursing, and Regional Nurse. No further documentation was provided. N.J.A.C. 8:39-27.1 (a)	F 558	will in-service all Employees Call Bell placement to ensure they are within resident's reach. This in-service will also be done for all employees and new hire orientation of employees. Unit Managers and Nursing Supervisor will be monitoring all resident's call bell placement to ensure they are within resident's reach weekly x 4 weeks, then monthly x 6 months. Any concerns during audits will be addressed immediately to ensure compliance with standards of care. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Unit Manager/Designee will be conducting audits on Call Bell placement to ensure they are within resident's reach weekly x 4 weeks then monthly x 6 months unless any significant trends are identified. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meetings (Quality Assurance Performance Improvement). Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Monitoring will occur for 4 weeks and then monthly for 6 months unless any significant trends are identified.	

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F 558	Continued From page 7	F 558	Date of Compliance: 10/21/20	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by:	F 583		10/21/20

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F 583	Continued From page 8 Based on observation, interview, and record review, it was determined that the facility failed to respect the resident's right to mail delivery privacy. This deficient practice was identified for 1 of 25 residents reviewed; Resident #58, and was evidenced by the following. On 10/5/20 at 11:47 AM, the surveyor observed Resident #58 lying in bed. Resident #58 greeted the surveyor, and after obtaining the resident's permission, agreed to be interviewed. At that time, Resident #58 told the surveyor that the facility Social Worker (SW) delivered a letter that was opened on 10/2/20. The resident explained that it was a letter from a [redacted] Resident #58 further stated that it was upsetting that "someone would have the nerve" to open mail addressed to the resident. The resident showed the surveyor the letter that was clearly addressed to Resident #58. The surveyor reviewed the Admission Record that indicated Resident #58 was admitted to the facility with diagnoses that included [redacted] The surveyor reviewed the Annual Minimum Data Set (MDS), an assessment tool that reflected a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that Resident #58 was cognitively intact. On 10/6/20 at 1:15 PM, the surveyor interviewed Resident #58, who stated that they had spoken to the Business Office Manager (BOM) yesterday in the late afternoon. The BOM informed the	F 583	What corrective action will be accomplished for those residents affected by the deficient practice? Resident #58 received an opened mail on 10/2/20 by the Business Office Manager (BOM) addressed to the resident of a personal nature. The BOM was in-serviced and educated on resident's right to receive mail addressed to them unopened. The BOM apologized to Resident #58 on 10/6/20 for opening the mail and not acknowledging it immediately. How will the facility identify other residents having the potential to be affected by the same deficient practice? All resident has the potential to be at risk related to the citation. Inservice and education was provided immediately to the BOM on opening mail addressed to residents. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Administrator/Designee will in-serviced Receptionist and Recreation who is involved with sorting and delivering mail to review the address of the envelope and ensure mail is placed in appropriate mailbox for delivery.	

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F 583	Continued From page 9 resident that she had opened the letter by mistake. The resident mentioned that the letter came inside another large envelope addressed to him/her. The resident showed the envelope to the BOM, which was addressed to the resident, stamped and postmarked September 30, 2020. The resident stated that the BOM then apologized for opening the resident's mail. On 10/7/20 at 11:10 AM, the surveyor asked the administrator to meet with the BOM. The administrator replied that the BOM would be in the following day and that she was aware of the "issue." On 10/8/20 at 11:01 AM, the surveyor met with the BOM. During the interview, the BOM stated that the resident's open letter came inside another envelope and that she thought it was addressed to her and mistakenly opened it. The BOM further noted that in the late afternoon on 10/2/20, she was running late and asked the SW to hand-deliver the opened piece of mail to Resident #58, without any explanation as to why the letter was opened. The BOM acknowledged that on 10/2/20, she should have delivered the letter to Resident #58 with an explanation as to why the letter was mistakenly opened. On 10/8/20 at 11:35 AM, the surveyor met with the SW, who explained that the activities staff generally deliver mail to residents. On Friday, 10/2/20, the BOM asked her to do her a favor and hand-deliver the envelope to Resident #58. The SW further stated that the BOM did not tell her that she had mistakenly opened the resident's letter nor informed her to speak to Resident #58 about it.	F 583	How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Administrator/Designee will audit the mail placed in the BOM's mailbox, belongs to the BOM and not to the resident weekly x 4 weeks then monthly x 6 months unless any significant trends are identified. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meetings (Quality Assurance Performance Improvement). Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Monitoring will occur for 4 weeks and then monthly for 6 months unless any significant trends are identified. Date of Compliance: 10/21/20	

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F 583	Continued From page 10	F 583		

On 10/8/20 at 11:56 AM, the surveyor met with the Administrator, who stated that she was not certain how she first became aware of the open mail being delivered, and noted that she thought the resident called her Monday, 10/5/20. The Administrator further stated that the resident informed her that she didn't understand what the letter was about in the phone call.

On 10/8/20 at 12:30 PM, Resident #58 informed the surveyor that the phone call to the Administrator was made on Monday 10/5/20 in the morning before the resident had informed the surveyor about the opened letter. Resident #58 further stated that he/she told the administrator that receiving the opened private letter on Friday 10/2/20, made the resident very upset. The resident said that the Administrator suggested speaking to the SW about it.

On 10/9/20 at 2:15 PM, the surveyor discussed the above observations and concerns with the Administrator, Director of Nursing (DON), and Regional Nurse.

On 10/15/20 at 11:46 AM, the surveyor and Team Coordinator met with the Administrator and DON at the facility's request. The Administrator stated that she now remembered that the resident had called her Monday morning before 9:30 AM. She noted that she did not recall the resident mentioning the mail being opened. The Administrator stated that she asked both the SW and BOM to go to Resident #58's room to discuss the nature of the letter. The surveyor asked the Administrator why she had sent both the BOM and SW to Resident #58's room if she wasn't aware of the concern. The administrator did not answer that question. The administrator

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F 583	Continued From page 11 then stated, "maybe the [BOM] should have waited until Monday and delivered the opened letter herself." The surveyor requested the facility Policy and Procedure for mail delivery to residents. The facility provided no further information. N.J.A.C. 8:39-4.1 (a) 16, 19	F 583		
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 record review, it was determined that the facility failed to maintain professional standards of nursing practice by not following a physician's order for 2 of 28 residents reviewed; Resident #6 and #49. This deficient practice was evidenced by the following: 1. On 10/9/20 at 10:20 AM, the surveyor observed Resident #6 seated on the bed in the resident's room. The resident smiled and responded to the surveyor's greeting in [redacted]. On 10/9/20 at 11:00 AM, the surveyor reviewed the records for Resident #6 who was admitted to the facility on [redacted] and readmitted on [redacted] with diagnosis that included but were no limited to [redacted]	F 658	What corrective action will be accomplished for those residents affected by the deficient practice? On 10/9/20, the surveyor reviewed the September and October Electronic Medication Administration Record (EMAR) for Resident #6, the nurse administered [redacted] mg to Resident #6, on numerous occasions when the [redacted] was [redacted]. On 10/14/20, the surveyor reviewed the September and October Electronic Medication Administration Record (EMAR) for Resident #49, nurses did not hold the [redacted] mg on numerous occasions when the [redacted] was [redacted] Nurses involved was in-serviced on	10/21/20

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F 658	Continued From page 12 [redacted] On 10/13/20 at 11 AM, the surveyor reviewed the September and October 2020 Electronic Medication Administration Record (EMAR) for Resident #6, which revealed an order dated [redacted] and discontinued on [redacted] for [redacted] mg daily before meals for [redacted] hold if greater than [redacted]. This Physician's order was documented to be administered at 7:00 AM, 11:30 AM, and 5:00 PM. A review of the October 2020 EMAR, revealed a [redacted] Physician order change to [redacted] mg two times a day every Monday, Wednesday, and Friday for [redacted] greater than [redacted] before meals. The surveyor reviewed the September and October 2020 EMAR that revealed documentation that the nurses administered the [redacted] mg to Resident #6, on numerous occasions when the SBP was greater than 130. The [redacted] was administered to Resident #6 on 9/4 at 11:30 AM with the SBP at [redacted], 9/10 at 5:00 PM with the SBP at [redacted], 9/16 at 11:30 AM with the SBP at [redacted], 9/27 at 7:00 AM with the SBP at [redacted] 10/2 at 11:30 AM with the SBP at [redacted], 10/3 at 5:00 PM with the SBP at [redacted] 10/7 at 11:30 AM with the SBP at [redacted] and 10/9 at 11:30 AM with the SBP at [redacted]; There were no adverse consequences noted after receiving the medication against parameters. On 10/14/20 at 12:00 PM, the surveyor interviewed a Medication Nurse responsible for administering [redacted] to Resident #6, who stated that [redacted] is administered to Resident	F 658	[redacted] medication parameters based on physician's order. How will the facility identify other residents having the potential to be affected by the same deficient practice? All medication with parameters has the potential to be at risk related to this citation. An audit was conducted on all residents with [redacted] medication parameters based on physician's order. All nurses are in compliance with the parameters. No harm noted on 10/9/20. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Assistant Director of Nursing/Designee will in-service all Nurses on following Midodrine medication parameters based on physician's order. This in-service will also be done for all new hire orientation of nursing employees. Unit Managers and Nursing Supervisors will be monitoring all resident's on Midodrine medication with parameters weekly x 4 weeks, then monthly x 6 months. Any concerns during audits will be addressed immediately to ensure compliance with standards of care. A handout will be provided to all nursing	

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F 658	Continued From page 13 #6 if the SBP is less than [redacted] and held when the SBP is more than [redacted] 2. On 10/9/20 at 12:30 PM, the surveyor observed Resident #49 seated in a wheelchair, [redacted], eating lunch in the common area. The resident was approachable, responding quietly to the surveyor. On 10/14/20, the surveyor reviewed the records belonging to Resident #49, who was admitted to the facility on [redacted] and readmitted on [redacted] with a diagnosis that included but were not limited to [redacted] On 10/14/20, the surveyor reviewed Resident #49's October EMAR, which revealed an order dated [redacted] for [redacted] MG orally once daily for [redacted] for SBP Greater than [redacted]. This Physician's order was documented to be administered at 9:00 AM. The surveyor reviewed the October 2020 EMAR that revealed documentation that the nurses held administration of the [redacted] mg to Resident #49 on numerous occasions when the SBP was less than [redacted]. The [redacted] was held and not administered to Resident #49 on 10/3 at 9:00 AM with the SBP at [redacted] and 10/14 at 9:00 AM with the SBP at [redacted]. There were no adverse consequences noted after receiving the medication against parameters. On 10/13/20 at 2:20 PM and again on 10/14/20 at 2:30 PM, the irregularity associated the administration of [redacted] to Resident #6 and	F 658	employees on Residents currently on [redacted] medication as a reminder to check the medication and parameters before giving the medication to ensure compliance with standards of care. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Unit Managers/Designee will be conducting audits on all residents on [redacted] medication to ensure nurses are following the parameters based on physician's order weekly x 4 weeks then monthly x 6 months unless any significant trends are identified. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meetings (Quality Assurance Performance Improvement). Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Monitoring will occur for 4 weeks and then monthly for 6 months unless any significant trends are identified. Date of Compliance: 10/21/20	

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F 658	Continued From page 14 Resident #49 was discussed with the facility Director of Nursing (DON) and the Administrator. The (DON) and the Administrator could not provide any further information as to why the parameters set by the Physician's order were not accurately followed by the facility nursing staff.	F 658		
F 677 SS=D	NJAC 8:39-27.1(a) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide the necessary services to maintain adequate grooming for a resident who was dependent on the staff for activities of daily living. This deficient practice was observed for 1 of 25 residents reviewed; Resident #32, and was evidenced by the following: On 10/01/20 at 1:07 PM, the surveyor observed Resident #32 lying in bed. Resident #32's was observed having [redacted], long beard. The resident told the surveyor that they had asked the Unit Manager (UM) for a shave over a week ago. Resident #32 stated that the UM informed the resident that he had someone who would do it, but the UM never followed through. The surveyor reviewed the Admission Record	F 677	What corrective action will be accomplished for those residents affected by the deficient practice? On 10/1/20, resident #32 was observed with [redacted] Resident #32 was immediately shaved by the Unit Manager. CNA was in-serviced immediately on grooming care. How will the facility identify other residents having the potential to be affected by the same deficient practice? All dependent residents have the right to be provided with necessary services to maintain adequate grooming.	10/21/20

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F 677	Continued From page 15 that indicated Resident #32 was admitted to the facility with diagnoses which included: [redacted] The surveyor reviewed the Quarterly Minimum Data Set (MDS), an assessment tool that reflected Resident #32 had a Brief Interview for Mental Status (BIMS) of [redacted] indicating the resident had a [redacted] cognitive impairment. The MDS further assessed that Resident #32 required extensive staff assistance for personal hygiene, including combing hair, brushing teeth, and shaving. On 10/6/20 at 11:41 AM, the surveyor observed the resident still with [redacted] hair and in need of grooming. The resident informed the surveyor that there were several requests to several staff members to be shaved and to have their haircut. Resident #32 added that staff had not made any attempt to shave or have the resident's hair cut. On 10/7/20 at 11:40 AM, the surveyor observed that Resident #32's hair was cut, and facial hair was groomed but still had facial whiskers. The resident informed the surveyor that they wanted a close shave but that the staff member told the resident that she did not have a razor. On 10/7/20 at 11:44 AM, the Unit Manager (UM) stated that he had no recollection of Resident #32 asking for a shave/haircut. The UM said that it was the Certified Nursing Assistant's (CNA) responsibility to shave residents. The UM further stated that he had noticed that Resident #32 was very "[redacted] yesterday, and he told the CNA on the 3-11 PM shift to shave the resident. The UM	F 677	An audit was conducted on all resident's grooming care. No harm done noted on 10/1/20. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Assistant Director of Nursing/Designee will in-service all CNA grooming care and will be documented electronically in Point of Care as scheduled. This in-service will also be done for all new hire orientation of CNA employees. Unit Managers and Nursing Supervisors will be monitoring all resident's grooming schedule and ensure it is timely done and completed weekly x 4 weeks, then monthly x 6 months. Any concerns during audits will be addressed immediately to ensure compliance with standards of care. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Unit Managers/Designee will be conducting audits on all resident's grooming schedule and ensure it is timely done and completed weekly x 4 weeks then monthly x 6 months unless any significant trends are identified. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meetings (Quality Assurance	

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F 677	Continued From page 16 stated that male residents should be shaved regularly if it is their preference and was unsure why the resident had not been shaved. On 10/7/20 at 11:55 AM, during an interview with the Assistant Director Of Nursing (ADON), she stated that she had noticed yesterday that Resident #32's facial hair was "[redacted] so she cut only the [redacted] off as she was concerned about using a razor on the resident's face. The ADON further stated that someone should have noticed, as she had, that the resident needed a shave. On 10/7/20 at 12:18 PM, the surveyor observed the UM shaving resident #32. The surveyor asked the resident if [redacted] wore a [redacted] before coming to the facility. The Resident replied, [redacted] On 10/7/20 at 1:40 PM, during an interview, the CNA routinely assigned to Resident #32's care stated that she usually shaved her residents every 2-3 days unless they refused. The surveyor asked the CNA when she last shaved Resident #32. The CNA replied, [redacted] refuses; you want to go in now and see that he refuses?" At that time, the surveyor accompanied the CNA into the resident's room. The CNA said to the resident, "don't you refuse to be shaved?" The resident replied, "[redacted]." The surveyor observed the resident was smiling [redacted] rubbed [redacted] face. The CNA turned and walked out of the room. The surveyor viewed the resident's admission	F 677	Performance Improvement). Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Monitoring will occur for 4 weeks and then monthly for 6 months unless any significant trends are identified. Date of Compliance: 10/21/20	

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F 677	Continued From page 17 picture with an admission date of [redacted] and observed that the resident had [redacted]. The surveyor reviewed the CNA assignment/tablet, which reflected the resident had a self-care performance deficit and required staff assistance for personal hygiene. On 10/9/20 at 2:15 PM, the surveyor discussed the above observations and concerns with the Administrator, DON, and Regional Nurse. No further information was provided by the facility.	F 677		
F 880 SS=D	NJAC 8:39-27.1 (a) 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	F 880		10/21/20

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F 880	Continued From page 18	F 880		

facility assessment conducted according to §483.70(e) and following accepted national standards;

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

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

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 19 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a) ensure that contracting agents who provided services to residents were familiar and adhered to infection practice guidelines according to the facility's policy, Contracting Agents Policy and Center for Disease Control (CDC) identified for 2 of 25 residents, (Resident's #227, #226) observed during lab procedures rendered by a Certified Phlebotomy Technician (trained professional that draws blood for medical testing) (CPT); and, b.) ensure that staff perform hand washing as per the facility's policy to prevent the spread of infection while rendering care for resident for 1 of 25 residents (Resident #49). This deficient practice was evidenced by the following: 1. On 10/5/20 at 9:13 AM, the surveyor observed the CPT, wearing gloves and facemask, completing the blood draw for Resident #227. Resident #227 was observed lying in bed. The CPT's plastic supply carrier with attached sharps container (hard plastic container used to safely dispose of blood-contaminated needles) was noted on the resident's overbed table. On 10/5/20 at 9:14 AM, the surveyor observed	F 880	What corrective action will be accomplished for those residents affected by the deficient practice? On 10/5/20, the surveyor observed a phlebotomist placing a plastic supply carrier with attached sharps container on Resident #227's overhead table and left the room without washing/sanitizing hands nor cleaning the plastic supply carrier with attached sharps container. Same phlebotomist was also observed entering Resident #226's room without washing/sanitizing hands and cleaning plastic supply carrier. An in-serviced was conducted immediately on the involved phlebotomist the Lab Carrier Supervisor. On 10/5/20, surveyor observed CNA#1 going in and out of Resident #49's room without washing/sanitizing hands. CNA was in-serviced immediately on Hand Hygiene and Policy. How will the facility identify other residents having the potential to be affected by the same deficient practice? All contracting agents who provide	

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F 880	Continued From page 20 the CPT removing her gloves and remaining in the room, conversing with Resident #227. On 10/5/20 at 9:25 AM, the surveyor observed the CPT exit Resident #227's room, carrying the supply carrier with sharps container attached and entering the room of Resident #226. The CPT did not wash or sanitizing her hands nor clean the supply carrier with the sharps container attached before exiting Resident #227's room or entering Resident #226's room. The CPT was then observed, placing the plastic supply carrier with sharps container attached on Resident #226's nightstand located near the resident's bed. On 10/5/20 at 9:28 AM, the surveyor observed as the CPT put on a new pair of surgical gloves without washing or sanitizing her hands. The surveyor interrupted the CPT and asked if she could step out of the resident's room to speak. The surveyor interviewed the CPT, who stated that she should wash her hands before and after each resident, putting on and removing gloves. The CPT also showed the surveyor disinfectant wipes, "Hype Wipe," stored in the plastic supply carrier with a sharps container. The CPT stated that the Hype Wipe should be used to wipe down the plastic supply carrier with a sharps container before leaving one resident and entering another resident's room. The CPT stated that she was in a rush and forgot to wash her hands or disinfect the plastic supply carrier with sharps container, "I'm supposed to do that. I did clean the carrier before I came into the facility." The CPT immediately left the facility and did not enter other units or have contact with any other residents. A review of Resident #227's Face Sheet	F 880	services to residents should adhere to facility's infection control policy with regards to hand hygiene before and after caring for a patient and sanitizing their equipment upon entering the facility, in between patients, and prior to exiting the facility. An audit was conducted on the contracting agents. There was no negative outcome noted on 10/5/20. All CNAs who enters the resident's room should adhere to facility's infection control policy with regards to hand hygiene before and after caring for a patient and as needed. An audit was conducted on the CNAs. There was negative outcome on 10/5/20. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Assistant Director of Nursing/Designee will in-service all contracting agents who provide services to residents to ensure they are performing hand hygiene properly prior to performing phlebotomy, post performing phlebotomy, and as needed. All contracting agents who provide services to residents will be in-serviced on sanitizing their equipment upon entering the facility, before and after rendering services to the patients, and prior to exiting the facility.	

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F 880	Continued From page 21 documented that the resident had diagnoses that included but were not limited t [redacted]. Resident #213's room was located in an [redacted] to rule out COVID-19 infection for facility newly admitted residents. Resident's remain on the Observation Quarantine Unit for 14 days until they are cleared of any COVID 19 infection or any other infectious disease state. A review of Resident #226's Face Sheet documented that the resident had diagnoses that included but was not limited to [redacted]. Resident #226's room was also located in the [redacted] to rule out COVID-19 infection for facility newly admitted residents. On 10/5/20 at 10:30 AM, the surveyor met with the facility Administrator and Director of Nursing, who stated that the CPT should be wiping down all the equipment entering the facility, between each resident and washing or sanitizing hands before and after putting on gloves. On 10/5/20 at 1:30 PM, the Administrator presented the policies related to infection control and phlebotomy care. The surveyor reviewed the vendor policy dated 3/30/20 "Cleaning your Phlebotomy Kit" and "Personal Protective Equipment" policies supplied to the facility by the vendor and presented to the surveyor by the facility Administrator. The policy stated, "Only bring with you the needed phlebotomy supplies into the	F 880	Assistant Director of Nursing/Designee will in-service all certified nursing assistants on hand hygiene, and perform hand hygiene competencies on 10 certified nursing assistants weekly x 4 weeks, and then on 10 certified nursing assistants monthly x 6 months How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Unit managers/Nursing Supervisor will be conducting an audit on contracting agents performing hand hygiene via a competency and sanitizing their equipment properly weekly x 4 weeks, and then monthly x 6 months. Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Unit managers/Nursing Supervisor will be conducting an audit on hand hygiene of 10 staff members weekly x 4 weeks and then 10 staff members monthly x 6 months. Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meetings (Quality Assurance Performance Improvement). Any concerns during audits will be addressed immediately to ensure compliance with	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22 room. Place needed supplies into plastic bag," Place paper towels on table and place equipment on the towels. Once drawn, place tubes into biohazard bag and then double bag it" and "Hands should be washed with soap and water or hand sanitizer when changing or removing gloves." 2. On 10/5/20 at 10:40 AM, the surveyor observed Resident #49 lying in bed [redacted]. The resident greeted the surveyor and stated that they had [redacted] Resident #49 explained that because of [redacted] Resident #49 also stated that they wanted to get out of bed, and were waiting for the Certified Nursing Assistant (CNA) to come in and assist them. The surveyor reviewed the resident's admission record, which indicated that Resident #49 was admitted to the facility with diagnoses [redacted] A review of the [redacted] Quarterly Minimum Data Set (MDS), an assessment tool, reflected a Brief interview for Mental Status (BIMS) score of [redacted] which indicated that the resident had a [redacted] cognitive impairment. The MDS further reflected that Resident #49 required extensive staff assistance for transfers and was occasionally [redacted]. On 10/5/20 at 11:06 AM, CNA #1 entered Resident 49's room and put on gloves without first washing her hands or using hand sanitizer. CNA #1 gathered supplies and stated she needed to go and get a basin. CNA #1 removed	F 880	standards of care. Monitoring will occur for 4 weeks and then monthly for 6 months unless any significant trends are identified. Date of Compliance: 10/21/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING _____ B. WING _____	10/14/2020

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F 880	Continued From page 23	F 880		

her gloves, and the surveyor accompanied her to the supply room where she obtained the basin and then went back into Resident #49's room. CNA #1 again put on a new set of gloves without first washing or sanitizing her hands. CNA #1 then transferred the resident from their bed to the wheelchair and assisted the resident with incontinence and hygienic care.

On 10/5/20 at 12:22 PM, the surveyor observed CNA #1 leave Resident #49's room without washing or sanitizing her hands.

On 10/14/20 at 1:31 PM, the surveyor reviewed the facility policy for Hand Hygiene dated 10/5/2020, which read:

* Employee should perform hand hygiene before and after all resident contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.

*Employee should perform hand hygiene by using ABHR with 60-95% alcohol or washing hands with soap and water and vigorously scrubbing with soap for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.

*Hand hygiene supplies should be available to all personnel in every care location.

NJAC 8:39-19.4 (a)