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	315147	A. BUILDING _____ B. WING _____	10/18/2019

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F 000	INITIAL COMMENTS STANDARD SURVEY: 10/18/19 CENSUS: 130 SAMPLE SIZE: 30 + 20 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 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the	F 585		11/22/19

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

Electronically Signed | 11/06/2019

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provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,

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F 585	Continued From page 2 and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure that residents had a method for filing a grievance anonymously. This deficient practice was identified for 6 or 6 residents who attended the Resident Council group meeting, (Resident #60, #66, #87, #104, #107, and #281). The evidence was as follows: On 10/15/19 at 10:42 AM, the surveyor conducted the Resident Council group meeting with six (6)	F 585	I. CORRECTIVE ACTION Suggestion boxes were placed on all units, posters with a hotline number to call and file a grievance anonymously were placed on all the units. Residents were informed how to file anonymous grievances on all the units, it was reiterated again at resident council.	

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F 585	Continued From page 3 residents that the facility identified as alert and oriented. The surveyor asked the residents the methods for filing a grievance if they were to have a concern. The residents stated that they felt comfortable speaking to the Director of Nursing (DON), a nurse on duty, or a nursing supervisor. The surveyor asked the residents if they were able to file a grievance anonymously, if they chose? Six out of the six residents stated that the facility did not have a system in place for them to file a grievance anonymously, and they stated they thought that it would be a good idea if the facility allowed for them to do that. On 10/15/19 at 12:09 PM, the surveyor conducted an interview with the Social Worker (SW) who stated that if the residents wanted to file a grievance, they could let the nurses or any department head in the facility know and the staff member would fill out a grievance form for the resident. The SW stated that the appropriate department would follow up and resolve the resident's concern as best as possible. The SW further stated that the facility had no formal method in which the residents could file a grievance anonymously. On 10/15/19 at 12:36 PM, the surveyor interviewed the DON who stated that if the residents wanted to file a grievance, they could go to any staff member to fill out the grievance form for them. The DON stated that the resident's concern would be addressed by the facility. The surveyor asked the DON if the residents had a method to file a grievance anonymously. The DON stated, "Currently, no." On 10/16/19 at 10:41 AM, the surveyor conducted an interview with the Licensed Nursing Home	F 585	II. IDENTIFY OTHER INSTANCES All residents have the potential to be affected. III. SYSTEMIC CHANGE Facility policy was updated to instruct how to file grievances anonymously. Care & Concern form updated with an option to file anonymously. Residents were informed of how to file anonymous grievances on all the units, it was reiterated again at resident council. IV. MONITOR CORRECTIVE ACTION At monthly resident council meetings Director of Activities will ask residents if they know how to file a grievance anonymously. Director of Activities will report findings at quarterly QA Meeting.	

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Administrator (LNHA) who stated that the facility had anonymous forms located on every unit, but the residents had to ask the nurse for the form. The LNHA then acknowledged that the system was not anonymous if the residents had to ask the nurse for the form. The LNHA further stated that it was an "oversight" by him, but he now ordered a suggestion box for the residents to place their grievances anonymously and the facility also had a hotline number the residents could call which was he now posted on all the units in the facility today. The LNHA stated that the grievance policy was a work in progress and would be updated.

A review of the facility's undated Care & Concern Form provided by the SW did not reflect an area for the resident to document that they were filing the grievance anonymously. The Care & Concern Form included a section for the resident's name to be filled out and the person reporting the problem.

A review of the facility's Resident Grievance Policy & Procedure dated 9/19 provided by the LNHA reflected, "Grievances can be filed orally (i.e. spoken) or in writing, and can be filed anonymously. (All information in regards to grievances will remain confidential.)" The facility's Grievance Policy and Procedure further reflected, "Resident Grievance Procedure: The resident or his representative should be directed to express his grievance to the charge nurse on the resident's floor. If the nurse is unable to resolve the grievance, he/she will complete a Care & Concern Form and submit to the Director of Social Service who will proceed the complaint and initiate and investigation. (The Nurse should also relay this complaint to Director of Nursing or

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F 585	Continued From page 5 Director of Social Services or alternatively to the Supervisor to relay further.) Resident can complete Care & Concern Form anonymously and place in Social Service mailbox." NJAC 8:39-4.1(a)	F 585		
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 accurately assess residents for the risk of falls in accordance with professional standards of nursing practice. This deficient practice was identified for 2 of 2 residents reviewed for falls, (Resident #89 and #125). Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through 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."	F 658	I. CORRECTIVE ACTION New fall risk assessments, with accurate information about fall history, were completed for Residents 125 and 89 on [redacted] MDS for resident 125 was modified on [redacted] with accurate fall information. II. IDENTIFY OTHER INSTANCES All residents have the potential to be affected. III. SYSTEMIC CHANGE An audit was conducted of most recent fall risk assessments for all current residents to ensure accuracy. Nursing staff were re-educated about fall risk	11/22/19

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F 658	Continued From page 6 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: 1. On 10/9/19 at 10:23 AM, the surveyor observed Resident #125 ambulating with a rolling walker in the hallway with the Restorative Certified Nursing Aide (R/CNA). The R/CNA informed the surveyor that the resident did not [redacted]. The surveyor reviewed the medical record for Resident #125. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included [redacted]. A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had one fall	F 658	assessment policy, including timing and accuracy of assessments. MDS Coordinator who completed inaccurate MDS for Resident # 125 is no longer employed at New Grove Manor. No issues with MDS assessment accuracy have been identified with current MDS department, however education about MDS accuracy was provided to MDS department. IV. MONITOR CORRECTIVE ACTION DON/Designee will audit 2 resident charts per week x 8 weeks for accuracy and timeliness of fall risk assessments. Results will be reported at quarterly QA meeting. Regional DON will audit 2 MDS assessments per month x 3 months Results will be reported at quarterly QA meeting.	

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with injury since admission to the facility.

A review of the Resident's Fall Risk Evaluation reflected that the last fall risk evaluation was dated [redacted] which indicated the resident had three or more falls in the past three months. The assessment sheet was completed but undated for three subsequent fall risk evaluations, and the assessments reflected that the resident had three or more falls in the past three months for each of the undated subsequent evaluations. The resident's total score for all four of the evaluations was [redacted]. A score of 10 or above represented "high risk" for falls. The assessments were signed by an ADON who was no longer employed by the facility.

A review of the resident's individualized comprehensive care plan initiated on [redacted] and revised on [redacted] indicated that the resident had a potential for falls related to weakness and impaired mobility, impaired cognition, and history of falls in the community. There was no evidence within the care plan that the resident had an actual fall.

On 10/11/19 at 9:05 AM, the surveyor interviewed the Certified Nursing Aide (CNA) who stated that the resident was very active and had a tendency to ambulate to the bathroom on his/her own. The resident has been educated multiple times to use the call bell for assistance. The CNA stated that the resident had never fallen during her shift, but she did not know if the resident fell during any other shifts.

At 10:50 AM the surveyor interview the Licensed Practical Nurse (LPN), who stated that she was a "floating" nurse which meant that she had no

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permanent assignment and worked on multiple floors. The LPN confirmed that she was assigned to Resident #125 for the day. The LPN stated that the resident was on fall precautions which meant that the facility needed to ensure the resident maintained a clutter free environment. The LPN was unsure if the resident had any falls. The LPN stated that the Licensed Practical Nurse/Unit Manager (UM) completed the Fall Risk Evaluations.

At 10:59 AM, the surveyor interviewed the LPN/UM who stated that Resident #125 mainly self-propelled in the wheelchair, but ambulated with a rolling walker with the R/CNA. The LPN/UM stated that the resident was on fall precautions related to his/her age and unsteadiness of gait, and to the best of her knowledge, the resident had no falls. The LPN/UM stated that the unit managers complete the Fall Risk Evaluation quarterly. The LPN/UM was unable to tell the surveyor where the resident's Fall Risk Evaluation sheet was for this past quarter. She could not speak to the Fall Risk Evaluation done on the resident's chart with four evaluations done and the former ADON's signature.

At 11:22 AM, the Director of Nursing (DON) informed the surveyor that the Fall Risk Evaluation sheet would get completed by the admitting nurse upon the initial assessment, and then was completed quarterly by the UM or charge nurse. The surveyor requested to review all fall investigations that may have been completed for Resident #125.

At 11:59 AM, the DON in the presence of the new Assistant Director of Nursing (ADON) informed

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the surveyor that the last fall the resident had in the facility was in [redacted] which resulted in no injury. The surveyor reviewed the resident's Fall Risk Evaluation with the DON. The DON confirmed that the assessment should be completed quarterly, and could not speak to why the last dated assessment was dated [redacted] or why the additional three undated assessments reflected that the resident had three or more falls in the past three months. The DON confirmed the resident did not have three or more falls in the last 3 months, and confirmed that was not an accurate assessment. He was unable to provide the surveyor evidence that a Fall Risk Evaluation had been done this past quarter.

On 10/16/19 at 12:58 PM, the MDS Coordinator informed the surveyor that she was new to the facility. The MDS Coordinator stated that the Licensed Nursing Home Administrator (LNHA) had contacted her regarding the last quarterly MDS dated [redacted], which was completed by the previous MDS Coordinator. The MDS Coordinator stated that she was unable to determine where the information regarding the fall with injury came from since the resident did not have a fall with injury in the facility.

On 10/18/19 at 11:59 AM, in the presence of the survey team, the LNHA confirmed that the resident had no falls with injury in the facility, and that the assessments were not accurate.

At that time, the DON stated that the Fall Risk Evaluation sheet was not completed and was an "oversight" by nursing.

A review of the facility's Fall Prevention policy dated as reviewed 8/2019 included that all

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residents will have a fall risk assessment done on a quarterly basis coinciding with the MDS 3.0 schedule.

2. On 10/10/19 at 11:24 AM, the surveyor observed Resident #89 sitting in a high-back wheelchair in his/her room. The resident had a large neck pillow behind the neck and was watching television. The resident was awake and the surveyor attempted to interview the resident but the resident was nonverbal.

The surveyor reviewed the medical record for Resident #89.

A review of the Admission Record face sheet reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included [redacted].

A review of the Fall Risk Evaluation dated [redacted] indicated that the resident had one to two falls in the past three months. The assessment evaluations totaled [redacted] for both those dates. A total score of 10 or above represented "high risk" for falls.

A review of the resident's individualized person-centered care plan initiated [redacted] and revised [redacted] indicated that the resident was at risk for falls related to [redacted] and a history of falling. The care

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plan did not indicate that the resident had an actual fall.

A review of the most recent quarterly MDS dated [redacted], indicated that the resident had no falls since admission.

On 10/16/19 at 10:16 AM, the surveyor interviewed the CNA who stated that Resident #89 had not been at the facility that long. The CNA stated that the resident can understand and that he/she can make[redacted], [redacted] appropriately to communicate, and would get out of bed every day into a wheelchair. The CNA stated that the resident had not fallen since being at the facility.

At 10:18 AM, the surveyor interviewed the Registered Nurse/ Unit Manager (RN/UM) who stated that the resident had transferred to this unit from another floor back in [redacted]. The resident has had no falls on this unit.

At 10:27 AM, the surveyor interviewed the third floor LPN/UM who confirmed Resident #89 used to be on this floor. The LPN/UM stated that she could not recall if the resident had fallen, and she would need to look into it.

At 11:04 AM, the surveyor reviewed Resident #89's Fall Risk Evaluation with the RN/UM who stated that the Fall Risk Evaluation was triggered on [redacted]. The RN/UM stated that you would need to look at the Nurse's Notes from June. Those notes were no longer in the resident's medical record on the floor.

At 11:14 AM, the DON confirmed that Resident #89 had no accidents or incident reports

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conducted by the facility, indicating the resident did not have a fall at the facility.

The surveyor reviewed the Nurse's Notes dated [redacted], which indicated at 8:40 PM the resident's [redacted] reported that the resident's [redacted] was "hanging off the bed touching the floor." The Supervisor was made aware and no visible injuries observed. The resident denied pain, and the doctor was notified. There were no new physician's orders.

On 10/17/19 at 10:35 AM, the surveyor conducted a phone interview with the resident's family member. The [redacted] stated that he/she came to the facility every day to visit the resident, and the resident had never fallen at this facility.

At 10:38 AM, the surveyor attempted a phone interview with the LPN who wrote the Nurse's Note on [redacted], but the LPN did not answer or return the surveyor's call.

At 10:40 AM, the surveyor asked the DON for clarification of the Nurse's Note dated [redacted]. The DON stated that the RN Supervisor was there, so she could explain the situation.

At that time, the RN Supervisor informed the surveyor and the DON that the family member had reported the resident's [redacted] was out of bed. The RN Supervisor stated that she informed the LPN that since the resident's [redacted] touched the floor, it would be considered a fall so an investigation would need to be completed. The RN Supervisor stated that an investigation was completed at that time. The DON stated to the RN Supervisor and surveyor that there were no investigations completed for this resident. The

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F 658	Continued From page 13 DON confirmed that a [redacted] that came in contact with the floor was not considered a fall. On 10/18/19 at 12:03 PM, the DON stated in the presence of the survey team that he had spoken with the resident's [redacted] who confirmed that the resident had no falls at the facility. The DON confirmed the resident did not have any falls at the facility, and that the Fall Risk Evaluations were not accurately conducted by the signing Registered Nurse in accordance with professional standards of nursing practice. NJAC 8:39-11.2(b)	F 658		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was identified that the facility failed to provide a resident with meaningful activities that reflected the resident's preferences for [redacted] and [redacted]. This deficient practice was identified for 1 of 7 residents reviewed for	F 679	I. CORRECTIVE ACTION Resident # 88's TV was repaired, radio was purchased and placed on resident's bedside table. II. IDENTIFY OTHER INSTANCES	11/22/19

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F 679	Continued From page 14 activities, (Resident #88), and was evidenced by the following: On 10/10/19 at 11:26 AM, the surveyor observed Resident #88 lying in bed on his/her right side. The resident's bed was placed up against the wall, and the position of the bed was arranged in a way in which the resident was facing the pulled privacy curtain. The surveyor observed a bulletin board on the wall behind the head of the resident's bed, out of the line of sight for the resident. The bulletin board had an activity calendar and a communication booklet posted on it, both of which were out of reach. The surveyor observed a radio on the resident's nightstand underneath the bulletin board. The radio was off. A television was hanging on the wall in the resident's room and positioned on the wall along the right side of the resident's bed. The TV was off. The surveyor heard the resident humming a song to him/her-self. On 10/11/19 at 9:05 AM, the surveyor observed the resident in his/her room positioned upright in bed with a breakfast tray. The resident's privacy curtain was open, and the resident was facing the roommate. The surveyor observed that resident was not eating the breakfast. The surveyor asked the resident if he/she was hungry and the resident shook his/her head no. The resident's television and radio were both off. On 10/15/19 at 9:44 AM, the surveyor observed the resident lying in bed positioned on his/her right side. The TV and radio were off. The privacy curtain was drawn shut and the surveyor overheard the roommate's television on in the background.	F 679	All residents that do not attend group activities have the potential to be at risk. III. SYSTEMIC CHANGE “Resident Activity Attendance” form was updated to reflect time and duration of one-to-one recreational stimulation, and to indicate whether resident’s preferred recreational equipment was available and functioning at the time of the visit. A facility wide audit was conducted to identify residents on a one-to-one room visit schedule, and whether residents’ preferences are being met. IV. MONITOR CORRECTIVE ACTION Director of Activities will observe 2 “one-to-one room visit” weekly for one month to ensure residents preferences are being met. Director of Activities will report findings at quarterly QA Meetings.	

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On 10/15/19 at 11:55 AM, the surveyor observed the resident lying in bed and positioned on his/her left side. The resident was facing the wall and fidgeting by folding the bed sheet with his/her hands. There was no music and no television on in the resident's room.

Additional observations were made by the surveyor on 10/9/19 at 9:39 AM, on 10/10/19 at 9:14 AM, on and 10/11/19 at 11:56 AM in which the resident was lying in bed in his/her room with the TV and radio off.

The surveyor reviewed the medical record for Resident #88.

A review of the resident's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] and re-admitted on [redacted] with diagnoses which included [redacted].

A review of the resident's significant change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that a brief interview for mental status (BIMS) could not be obtained, so staff assessed the resident's cognition level. The staff assessment reflected that the resident had a [redacted] with a [redacted]. [redacted] of the MDS for Preferences for Customary Routines and Activities completed by staff reflected that the resident's [redacted] was involved in care decisions, the resident liked to listen to music, and it was important for the resident to participate in his/her favorite activities.

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A review of the Resident Activity Assessment dated [redacted] reflected that the resident's past interest included music, spiritual/religious activities, and watching television.

A review of the resident's individualized, comprehensive care plan revised on [redacted] reflected a focus area that the resident was dependent on staff for activities and had [redacted] related to being [redacted]. The focus area further reflected that the resident was at risk for [redacted]. The goal indicated that the resident would participate in at least 15 minutes of [redacted] activities daily and enjoyed being read to and watching television. There was one intervention on the care plan which reflected staff would initiate [redacted] visits with the resident to build trust and rapport. It did not specify when those visits would take place.

A review of the resident's most recent quarterly activity progress note dated [redacted] reflected the resident continued to relax in his/her room with daily visits from the nursing staff. The activity progress note further reflected that the activity staff provided the resident with daily room visits, but the note did not specify what activity and/or interaction was provided with the resident and his/her response to the activity. In addition, it did not specify how long the room visits were.

A review of the August 2019, September 2019, and October 2019 Resident Activity Attendance form reflected that the resident was provided with [redacted] room visits five days a week. The targeted activities for the resident were music playing, reading literature, and conversing.

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F 679	Continued From page 17 On 10/16/19 at 10:00 AM the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was alert to self and could recognize familiar faces. The CNA stated the resident could [redacted] The CNA stated that the resident used to get up out of bed but didn't get out anymore. The CNA further stated that that the resident's preferences included talking to his/her family member on the phone, spirituality, listening to the radio sometimes, and watching television. The CNA stated that the television in the resident's room was broken and she didn't know what was going on with it, but the maintenance department was aware and trying to fix it. The CNA was unable to tell the surveyor how long the resident's TV had been broken. On 10/17/19 at 9:14 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident was [redacted], could make his/her [redacted] to staff, and never got up [redacted]. The LPN further stated that the resident was an extensive assist with activities of daily living, liked to speak with his/her family member on the phone, watch television, and listen to music. The LPN stated that the resident would sometimes ask the LPN if he/she could fold a piece of paper. The LPN told the surveyor that she would position the resident in bed so he/she could watch the television. The surveyor asked the LPN if the TV worked, and in response the surveyor and the LPN went into the resident's room to try and turn on the television. A maintenance staff member overheard the surveyor ask the LPN about turning on the television in the resident's room and stated that the "box" to the television was not working so it	F 679		

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could not be turned on. The LPN stated, "Oh well then. I guess it ain't working."

On 10/17/19 at 9:27 AM, the surveyor interviewed the Recreational Aide (RA) who stated that [redacted] was not the resident's [redacted], but the resident could communicate simple-needs to staff in [redacted]. The RA further stated that she would try and get the resident to attend group activities, but the resident would refuse. The RA stated that she made private visits to the resident's room twice daily and during these visits the resident liked physical touch, so she would hold the resident's hand. The RA further stated that the resident's favorite activities were listening to [redacted] music and watching television. The RA was not aware that the resident's television was not working and stated that it could not have been broken for too long because she knew the television was working before her vacation a few weeks ago. The RA stated that if the television wasn't working, she would let her supervisor know so they could get the maintenance department to fix it.

On 10/17/19 at 9:57 AM, the surveyor interviewed the Director of Maintenance (DOM) who stated that he was unaware the television in the resident's room was not working. The DOM further stated that if the television wasn't working, he would get one of his staff members to fix it. The DOM told the surveyor that if his staff was unable to fix the television the Director of Recreation (DOR) would then be notified to get a new box through the cable company.

On 10/17/19 at 10:14 AM the surveyor interviewed the DOR who stated she was not made aware the resident's television was not

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working.

On 10/17/19 at 10:19 AM, the surveyor conducted an interview with the maintenance staff member who stated that a CNA had told him on Monday, October 14th that the resident's television was not working. The maintenance staff member could not speak as to why the television was not fixed that day and why the DOR was not made aware the television was not working.

On 10/18/19 at 11:43 AM, the surveyor interviewed the LNHA who stated that they turned the bed around in the resident's room so the resident was facing the television. The LNHA stated that the radio on the resident's night stand did not belong to Resident #88. He did not know who the radio belonged to. He added that the RA played music for the resident on her personal phone. The surveyor asked the LNHA why the resident did not have their own radio if the resident enjoyed music and why it was on the resident's personal nightstand if it belonged to another resident. The LNHA could not provide the surveyor with an answer. The LNHA further stated that there was a break in communication for fixing the television for the resident. The LNHA stated that the RA provided [redacted] visits for the resident two - three times a day. The surveyor asked the LNHA what other engagement the resident had for the remaining hours in the day if he/she had no radio and his/her television was broken. The LNHA could not provide a response.

A review of a hand-written statement by the Recreation Aide (RA) provided by the Licensed Nursing Home Administrator (LNHA) dated [redacted] reflected that the RA provided the

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F 679	Continued From page 20 resident with room visits at least twice daily. The statement from the RA reflected that she played [redacted] music from [redacted] personal cell phone for the resident. A review of the undated Individual Activities (One to One Program) policy and procedure included, "When residents are not able or are unwilling to participate in group activities a one to one program has been adopted to provide companionship and assist residents to maintain their quality of life within their environment. Residents who are [redacted] will receive [redacted] to provide tactile stimulation and other therapeutic activities to continually provide a variegated means of stimulation."	F 679		
F 684 SS=E	NJAC 8:39-7.3(a) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to: a.) implement a physician's order for a daily limit [redacted], b.) ensure [redacted] were administered in a	F 684	[redacted] order for Resident # 78 was carried out on [redacted] Unable to retroactively correct concerns with resident #41, #51, & #88.	11/22/19

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F 684	Continued From page 21 timely manner for residents with [redacted] infections. This deficient practice was identified for 1 of 1 residents reviewed on [redacted] (Resident #78) and 3 of 3 residents reviewed for [redacted] infections (Resident #41, #51, and #88). This deficient practice was evidenced by the following: 1. On 10/11/19 at 9:33 AM, the surveyor attempted to observe Resident #51, but the resident's room was vacant. At that time the Registered Nurse/Unit Manager (RN/UM) stated to the surveyor that the resident had been hospitalized for a [redacted]. The surveyor reviewed the medical record for Resident #51. A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident was originally admitted to the facility on [redacted] and had diagnoses which included [redacted] and [redacted]. The MDS further reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating a [redacted] cognition. The assessment further reflected the resident was occasionally incontinent of [redacted]. A review of an individualized care plan initiated on [redacted] included that the resident had a history of a [redacted]. The goal specified that the resident will be free from new onset of a [redacted] by the end of the review date. Interventions included to encourage adequate fluid with meals,	F 684	II. IDENTIFY OTHER INSTANCES All residents have the potential to be affected. III. SYSTEMIC CHANGE Nurses were in serviced regarding utilization of on-call physician service for any resident care issues that arise during non-business hours. Nurses were in-serviced to document in the clinical record about any change in condition, care-related issue, medication issue, and any communication with physicians and / or clinical providers. Nurses were in-serviced to ensure the “Dietary Communication Form” is communicated with the kitchen timely. Nurses were in serviced regarding utilization of the backup Medication box. A list of the medications available in the Backup Medication Box was posted at each nurses’ station for easy reference. NP participates in clinical rounds with the DON/ADON to ensure any change in condition, care-related issue, medication issue, etc., has been communicated. Evening Supervisor will check each unit daily for abnormal lab results, in addition to any changes in condition, and ensure that these are communicated immediately to physician on-call service.	

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F 684	Continued From page 22 medications, snacks and keep fluids within reach. It also specified to "Monitor/document/report" to the Attending Physician as needed for signs and symptoms of [redacted] and obtain and monitor lab/diagnostic work as ordered. The intervention specified to "report results to MD [Medical Doctor] and follow up as indicated." A review of a Nurse Practitioner (NP) progress note dated [redacted] reflected that the resident was status-post fall and had a work-up done in the emergency room and returned to the facility without the test results. The NP documented that the resident "seems more confused." included recommendations to check labs, obtain a [redacted], and obtain a [redacted] A review of a Nurse's Notes dated [redacted] timed 6:50 AM reflected that the resident's " [redacted] A review of the [redacted] report with a collection date of [redacted] at 6:00 AM and a print date of [redacted] at 9:40 AM, reflected that the resident had greater than [redacted] The results were signed as reviewed by the prescriber, but not dated. A review of the subsequent NP Progress Note dated [redacted] reflected that the resident denied pain, shortness of breath and nausea. The sections in the assessment for [redacted] were blank, and did not address the [redacted] report. A review of the NP Progress Note dated [redacted]	F 684	IV. MONITOR CORRECTIVE ACTION Unit Managers will conduct daily audit of charts of all residents followed on 24-hour report, to ensure communication & documentation has been completed. DON/Designee will audit 2 resident charts per week x 8 weeks for accuracy of documentation and timeliness of physician communication. Results will be reported at quarterly QA meeting.	

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reflected that the resident denied [redacted]. The assessment indicated that the [redacted] was [redacted]. The plan reflected that it was "[redacted]

A review of the Physician's Order's sheet dated [redacted] reflected to repeat the [redacted], and may [redacted]."

A review of the Nurse's Notes dated [redacted] at 1:00 (AM/PM not specified) reflected that the resident had another order to repeat the [redacted] and may [redacted].

The next nurse's note dated two days later on [redacted] reflected, "Stable. [redacted] collected via [redacted]. Hygiene care rendered. Fluids given. Tolerated." There was no documented evidence as to why the [redacted] was not collected on [redacted]

A review of the [redacted] report with a collection date of [redacted] at 3:01 PM and printed on [redacted] at 11:10 AM, reflected that the resident's [redacted] and had [redacted]

A review of a Nurse's Notes dated [redacted] at 2:00 PM did not address the [redacted] and/or notification of the physician in regards to the report.

A review of the NP Progress Note dated [redacted] reflected that although the initial [redacted] done on

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[redacted] may have been [redacted] and the repeated [redacted] done [redacted] collected on [redacted] was in chart and ready for review. The NP indicated that the resident denied [redacted] and fevers but had [redacted] on exam. The note further reflected that the [redacted] for many [redacted] The NP's plan indicated to administer an [redacted] twice a day (BID) for [redacted].

The surveyor noted a Physician's Orders sheet dated [redacted] containing the order to check vital signs every shift for three days, increase [redacted] to [redacted] every shift for [redacted] days, start a [redacted] days, and administer the [redacted] by mouth twice a day for [redacted] days for [redacted].

A review of the Nurse's Notes dated [redacted] timed 2 PM reflected that the NP ordered Macrobid suspension for the [redacted].

A review of the Medication Administration Record (MAR) for September 2019 reflected the corresponding physician's order (PO) dated [redacted] to administer the [redacted] by mouth BID for [redacted]. The order was plotted for the medication to be administered at 9 AM and 9 PM. Further review of the MAR reflected the [redacted] dose was to be administered at [redacted] but there was a "D/C" [discontinue] next to the order in the MAR, and no evidence that the [redacted] was ever administered.

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A review of the Nurse's Notes on [redacted] and [redacted] did not address why the [redacted] wasn't administered in accordance with the PO. There was no documented evidence that the MD or NP was notified regarding the [redacted] and/or the availability of the [redacted].

A review of a follow-up PO dated [redacted] reflected to to discontinue the [redacted] was "(Not in stock)." The order specified a new concentration of the [redacted] by mouth BID for [redacted] days for [redacted].

A review of the MAR for September 2019 contained a PO dated [redacted] to administer [redacted] by mouth twice a day for [redacted] for [redacted]. The MAR had the medication scheduled to be administered at 9 AM and 9 PM. According to the MAR the first dose was administered on [redacted] at 9 AM and was signed as administered twice a day for [redacted]. The MAR indicated the resident completed the regime of [redacted] at 9 PM.

On 10/15/19 at 10:51 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN). The surveyor asked what were the reasons why a [redacted] would be ordered by a physician. The LPN stated that if the [redacted] looked [redacted], or the resident experienced [redacted] and/or if a fever developed could all be signs of a [redacted] brewing and a [redacted] might be ordered by the MD. The surveyor asked who would perform the [redacted] collection for a [redacted], and the LPN stated that if it was a routine order for an annual History and Physical that the night

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shift would perform the collection, but if the resident was showing signs and symptoms of a [redacted], then it would be done as soon as possible on her shift and she would collect the sample. The LPN added that one way to obtain the sample would be to [redacted] the resident but that method would require a physician's order. The LPN added that "We get the lab reports and we immediately call it in and get orders" [from the MD or NP]. The LPN confirmed that it would be documented in the resident's medical record regarding notification of the MD or NP. The LPN could not speak to why the [redacted] wasn't collected on [redacted] in accordance with the physician order and why it took two days to obtain the [redacted]. The surveyor further inquired regarding the availability of the [redacted]. The LPN stated that she thinks there was an issue with the way the order was written because the originally ordered concentration of [redacted] wasn't available. The LPN confirmed that the resident did not receive any [redacted] from [redacted] (when the [redacted] report was printed) until [redacted] at 9 AM when the resident received the first dose. She did not know if there was documentation in the resident's medical record as to why the [redacted] was not given or if there was any communication with the MD or NP. She stated that the nurse's are responsible for documenting those issues. The LPN stated to the surveyor that the resident was readmitted from the hospital over the [redacted].

On 10/15/19 at 11:10 AM, the surveyor observed Resident #51 in bed with his/her eyes open. The surveyor knocked and requested entrance to the room, and the resident nodded yes. The

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surveyor asked the resident their name and the resident just stared at the wall, and did not respond to the surveyor. The surveyor asked how he/she was doing and the resident nodded his/her head, yes. The surveyor asked the resident if he/she had been at the hospital and the resident did not respond to the surveyor. The surveyor was unable to complete any further interviewing questions with the resident.

At 11:35 AM, the surveyor interviewed the RN/UM and reviewed the resident's chart together. The RN/UM stated she would need to get back to the surveyor with the information.

On 10/15/19 at 11:43 AM, the surveyor interviewed the NP in the presence of another surveyor. The NP stated that she had seen the resident initially on [redacted] for a fall and requested a [redacted], among other orders. The NP stated that she did not get the results until [redacted] and believed at that time that the result had been contaminated based on the [redacted] in [redacted]. She stated Resident #51 did not have symptoms of a [redacted] at that time which was why she ordered a repeat [redacted] and to collect it using a [redacted] to avoid specimen contamination. The NP could not speak to why the [redacted] wasn't collected until [redacted]. She stated that she believed the [redacted] usually took five days to grow. The NP added that she saw the results from the [redacted] t [redacted] and this time the resident had [redacted]. At this point she felt it was necessary to treat the resident with an [redacted]. The surveyor asked why she chose to order a [redacted] as the formulation of choice, and the NP stated because the resident was on a [redacted] diet and thought it

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would be easier to swallow. She stated that the pharmacy had contacted her on [redacted] that the [redacted] concentration she originally ordered wasn't available on the formulary and she had to re-write the order.

On 10/18/19 at 11:01 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Regional Director of Nursing (R/DON) in the presence of the survey team. The LNHA stated that in regards to the delay in obtaining a urine specimen and treating the [redacted] the LNHA stated that the resident was symptomatic with [redacted] and a [redacted] with the [redacted] result, and the NP had documented the results. The surveyor inquired about the process of when [redacted] was to be collected and when an [redacted] was to be started if there was a physician's order, and the LNHA stated that we initiated a Quality Assurance Performance Improvement (QAPI) on this. The surveyor inquired again about the process that nurses are supposed to follow, and the R/DON stated, "We recognize there was a delay, and that there should have been communication" between the nurses and the NP or MD to get an alternate order. The LNHA was unable to speak to and/or provide documented evidence as to why the [redacted] was not collected from [redacted] until [redacted], and subsequently did not receive the first dose of [redacted] until [redacted] at 9 AM. The LNHA was unable to provide documented evidence from nursing that the NP or MD was notified regarding the availability of the [redacted].

2. On 10/11/19 at 8:30 AM, the surveyor

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observed Resident #41 in bed awake watching TV. The surveyor observed a [redacted] bag secured to the resident's bed frame with an [redacted] The surveyor observed that there was clear [redacted] in the [redacted].

On 10/15/19 at 9:32 AM, the surveyor observed Resident #41 in bed and the resident agreed to be interviewed. The surveyor observed the [redacted] to be [redacted] with some [redacted] in the [redacted]. The surveyor asked if he/she had a [redacted] and/or had received [redacted] recently for a [redacted] and the resident denied having any infection. The surveyor inquired if he/she had any [redacted] or [redacted] as a result of the [redacted] and the resident denied any complaints, and/or signs and symptoms associated with a [redacted]. The surveyor asked the resident if nursing staff exchange the [redacted] at any particular times, and the resident stated "staff switch it out every once in a while." The resident could not tell the surveyor specifically when and/or under what circumstances it would get changed.

The surveyor reviewed the medical record for Resident #41.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was originally admitted to the facility on [redacted] and re-admitted on [redacted]

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A review of the most recent quarterly MDS dated [redacted] reflected that Resident #41 had a BIMS score of [redacted], indicating that the resident had [redacted] impaired cognition. It further reflected that the resident was always incontinent.

A review of the resident's individualized, comprehensive care plan initiated on [redacted] reflected that the resident had a [redacted] and the presence of an [redacted] r. The goal indicated that the resident will resolve symptoms of [redacted] through the review date. Interventions included to observe the resident for fever, chills, [redacted] "Administer medications as ordered[redacted] .."

A review of the Physician's Orders sheet reflected a telephone physician order dated [redacted] to "Send [redacted] STAT (immediately)" for a diagnosis of [redacted] There was no documented evidence within the physician order sheets that the order to obtain a [redacted] culture had been held, discontinued, and/or re-ordered.

A review of the [redacted] report dated as collected 14 days after the physician's order on [redacted] at 1:32 PM, and printed [redacted] at 11:10 AM, reflected a [redacted] The report was signed by the NP and specified "see orders."

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F 684	Continued From page 31 A review of the Nurse's Notes dated [redacted] did not address the [redacted] that was collected at 11:10 AM that day and sent to the lab. In addition the Nurse's Notes dated [redacted], contained no documented evidence that the NP or MD was notified of the [redacted] results when they were printed and available for review. There were no Nurse's Notes for [redacted] in the resident's medical record. A review of the NP Progress Note dated [redacted] reflected that Resident #41 was seen by [redacted] the resident denied any symptoms including [redacted]. The note indicated that the resident had an [redacted] with [redacted] noted. The note included that according to the [redacted]), the facility was to repeat a [redacted] in addition to other labs. There was no documented evidence that the [redacted] obtained on [redacted] and printed on [redacted] had been reviewed. On 10/15/19 at 10:51 AM, the surveyor interviewed the resident's assigned LPN. The surveyor asked who performed the [redacted] collection for a [redacted], and the LPN stated that if it was a routine order for an annual History and Physical that the night shift would perform the collection, but if the resident was showing signs and symptoms of a [redacted] then it would be done as soon as possible on her shift and she would collect the sample. The surveyor asked how the sample gets collected for a resident with an [redacted]. The LPN confirmed she had collected a [redacted] from an [redacted] by disconnecting the [redacted] from the [redacted], collecting the	F 684		

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urine in a sterile specimen cup, and then re-connecting the [redacted] to the [redacted]. The LPN stated that it should be documented how the specimen gets collected. The LPN further stated that when the [redacted] report comes in that, "We get the lab reports and we immediately call it in and get orders" [from the MD or NP]. The LPN confirmed that it would be documented in the resident's medical record regarding notification of the MD or NP. The surveyor asked if the resident had any other [redacted] reports returned other than the one collected on [redacted], and the LPN indicated any reports would be in Resident #41's chart.

The surveyor continued to review the resident's chart on 10/17/19, and noted the following:

A review of the NP Progress Note dated [redacted] reflected the reason for the visit was [redacted]." The note included that the resident has a history of [redacted] use, [redacted] and was seen by the [redacted]. A [redacted] had been ordered and the results were ready for review. The note indicated that the resident had no complaints and no [redacted]. The [redacted] in the [redacted] was [redacted] with [redacted]. The Assessment/Plan included that the resident had a [redacted] and the plan included to start the [redacted] mg BID for [redacted] days for [redacted]

A review of the subsequent Nurse's Note written on [redacted] at 1:00 (AM/PM not specified) reflected the NP's new orders which included to increase [redacted] for seven (7) days and start the [redacted] mg by mouth every [redacted] hours for [redacted] days for [redacted] There was no evidence within the nurse's notes that the

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nursing staff were documenting an assessment of the [redacted] from [redacted].

A review of the Physician's Orders sheet reflected the physician order dated [redacted] which included to start the [redacted] mg by mouth every [redacted] hours for [redacted] days for [redacted].

A review of the MAR for October 2019 included the corresponding physician order dated [redacted] to start the [redacted] mg by mouth every [redacted] hours for [redacted] days for [redacted]. The medication was scheduled to be administered at 9 AM and 9 PM accordingly. No stop date was included on the MAR. The MAR indicated that the first dose was administered on [redacted] at 9 AM. There was no evidence within the MAR that a first dose was started on [redacted], the order date.

On 10/17/19 at 9:50 AM, the surveyor interviewed the RN/UM who stated that the NP ordered the [redacted] for the resident because of [redacted] in the [redacted]. She confirmed the dose was ordered yesterday [redacted] She could not speak to when the first dose was started, or answer further as to why the [redacted] was ordered for the resident. She indicated that the NP would be able to better answer the surveyor's questions.

On 10/17/19 at 10:00 AM, the surveyor interviewed the LPN who stated that she gave the first dose of the [redacted] this morning at 9 AM. She confirmed the [redacted] was ordered [redacted] on [redacted]. The surveyor inquired about the resident's symptoms and she stated that the surveyor should ask the RN/UM about

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the resident's symptoms. The LPN confirmed that she would look for signs and symptoms of a [redacted], but the RN/UM and NP handle the assessments, and they would be able to better answer the surveyor's questions.

On 10/17/19 at 11:18 AM, the surveyor and the Assistant Director of Nursing (ADON) with the Nursing Supervisor reviewed the back-up supply box in the supervisor's office. The surveyor observed that there was a back-up supply of the [redacted] mg on hand. The ADON and surveyor counted a total of four tablets of [redacted] mg available in the back-up supply box. There was no evidence of a declining inventory sheet for the [redacted] mg in the book at the time of this review. The Nursing Supervisor stated that "sometimes the nurses forget to write in the declining inventory sheets" and that she thought the nurse had given a dose to Resident #41 last night. The ADON stated that she would have to find the inventory sheet.

At 11:40 AM, the ADON provided the surveyor a copy of a Unit Dose Back-Up Record for [redacted], which reflected that the facility had [redacted] mg tablets in a back-up supply box. The declining inventory form reflected that the there were four (4) tablets available in the back-up supply since 4/15/19, and that no tablets had been signed out as removed and administered to Resident #41 on 10/16/19. The ADON confirmed that the resident did not receive the ordered [redacted] from the facility's back up box based upon the declining inventory log and the number of tablets remaining.

On 10/18/19 at 11:20 AM, the surveyor interviewed the LNHA, DON and the Regional

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Director of Nursing in the presence of the survey team. The surveyor inquired about the process the facility follows. The DON responded that the antibiotic should be administered "as soon as possible preferably the same day if it's on back-up" supply. The DON confirmed [redacted] was available in back up supply and each floor has a list of medications that are available on back-up. The LNHA and DON were unable to provide documented evidence that a dose had been administered to Resident #41 on 10/16/19.

On 10/18/19 at 12:24 PM, the surveyor interviewed the NP. The NP stated she sees resident's on an acute-need basis, and that she gets asked to see residents when there is a specific need to see them. She stated that she communicates with the primary care provider as needed and that she will document in the resident's medical record her rationale for starting an [redacted]. The NP stated that Resident #41 was seen by a [redacted] who ordered the [redacted]. The NP told the surveyor Resident #41 had "[redacted]" and a [redacted] with [redacted] so she started the resident on an [redacted] She stated that she did not communicate with the [redacted] regarding the results or starting of the [redacted]. The surveyor asked if she gets called when there is a positive [redacted] result, and she stated that "it comes in my book as an acute reason to see the resident" and that she then sees the resident as soon as possible thereafter. She stated that the resident should have started the [redacted] as soon as possible and that if it is in back-up, it should be administered the same day it was ordered.

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3. On 10/9/19 at 9:39 AM, the surveyor observed Resident #88 lying in bed in his/her room. The surveyor observed that the resident had an [redacted]). The [redacted] in the [redacted] of the [redacted] was [redacted] with [redacted]. The surveyor asked the resident his/her name. The resident communicated his/her name to the surveyor, made a groaning sound, and then spoke unintelligible words.

The surveyor reviewed the medical record for Resident #88.

A review of the resident's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] and re-admitted on [redacted] and had diagnoses which included but were not limited to [redacted].

A review of the resident's most recent significant change MDS dated [redacted] reflected that a brief interview for mental status (BIMS) could not be obtained so staff assessed the resident's cognition and determined the resident had a [redacted].

A review of the resident's individualized, comprehensive care plan revised on [redacted] reflected that the resident had a focus area for an [redacted] in place to enhance

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[redacted]. The goal reflected that the resident would not show signs and symptoms of a [redacted] through the next review date. The interventions included to monitor, record, and report to physician signs and symptoms of a [redacted] such as [redacted], increased [redacted] and [redacted]

A review of the July 2019 Physician's Order sheet (POS) reflected a PO dated [redacted] to repeat a UA/C&S for the resident.

A review of the [redacted] report with a collection date of [redacted] at 7:00 AM and printed on [redacted] at 11:42 AM, reflected that the resident's [redacted] and had [redacted] than [redacted].

A review of the Nurse's Notes dated [redacted] reflected that the resident's [redacted] had been collected and was placed in the refrigerator and waiting to be collected by the laboratory technician. The surveyor reviewed the Nurse's Notes from [redacted] and found these notes did not address a [redacted] or the notification of the physician regarding the report findings.

A review of the August 2019 POS reflected a PO dated [redacted] to send the resident to the hospital for recurrent [redacted] despite by mouth and intravenous [redacted] medications.

A further review of the Nurse's Notes dated [redacted] at 3:50 PM reflected that the NP reviewed the positive [redacted] and had the resident transferred to the hospital. A review of a Nurse's Note dated [redacted] at 12:25 AM reflected that the

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F 684	Continued From page 38 resident was admitted to the hospital with a [redacted]. A further review of the August 2019 POS reflected that the resident was re-admitted to the facility on [redacted] and required intravenous [redacted] treatment for a [redacted]. A review of the September 2019 POS reflected a PO dated [redacted] to collect a [redacted] from the resident. A review of the [redacted] report with a collection date of [redacted] at 1:17 PM and printed on [redacted] at 3:10 PM, reflected that the resident's [redacted] was [redacted] and had [redacted]. A review of the Nurse's Notes dated [redacted] reflected that a urine specimen was collected and placed in the [redacted] refrigerator. A further review of the Nurse's Notes from [redacted] to [redacted] did not address a [redacted] or the notification of the physician or their designee regarding the results of the report. A further review of the September 2019 POS reflected a PO dated [redacted] for an [redacted] for the treatment of the [redacted]. The surveyor continued to review the Nurse's Notes which reflected that on [redacted] the NP gave the orders for the [redacted] treatment for the [redacted]. On 10/16/19 at 11:27 AM, the surveyor interviewed the LPN who stated that signs and	F 684		

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symptoms of a [redacted] would be increased confusion, and observations of [redacted] in the [redacted] with [redacted] in it. The LPN stated that as soon as she received a lab result for a resident that was positive for a [redacted] she would notify the physician right away, and that it should be documented in the resident's chart.

On 10/16/19 at 11:34 AM, the surveyor interviewed the NP who stated that if a resident was positive for a [redacted], the physician should be notified of the results without delay.

ON 10/16/19 at 11:34 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that signs and symptoms of a [redacted] would be an elevated temperature and possibly [redacted] The RN/UM stated that if a [redacted] was suspected it should be monitored and documented in the resident's medical record. The RN/UM further stated that as soon as the laboratory test results came back [redacted] a [redacted] the physician should be notified. The RN/UM stated that if the physician's did not call back right away, she would have to notify the Medical Director, Director of Nursing, or Nursing Supervisor.

On 10/18/19 at 11:03 AM, the Regional/DON (R/DON) stated that since surveyor inquiry, the facility initiated a quality assurance improvement project and the nurses were being educated on notification of the physician right away.

On 10/18/19 at 11:12 AM, the R/DON further stated that there was a breakdown in the nursing staff in how quickly they were communicating information to the physician, and a breakdown on

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F 684	Continued From page 40 documentation of physician notification. The R/DON further stated all the nurses still needed to be educated on communication and documentation to the physician. The LNHA was unable to provide documented evidence that the physician had been notified in a timely manner of the [redacted] results. A review of the undated Physician Communication policy and procedure included it was the policy of the facility, "to ensure that physician is notified of any change in condition or care related issues.", "1. The physician will help identify individuals with a significant risk for having acute changes of condition during their stay. 2. In addition, the nurse shall assess and document/report the following baseline information: h. Recent labs." 4. On 10/9/19 at 10:25 AM, the surveyor observed Resident #78 in his/her room. At that time, the resident agreed to be interviewed. The resident stated that he/she went out to the [redacted] center on [redacted], [redacted], and [redacted] around 4 AM and returned to the facility by 10 AM. The surveyor observed a container of water on the resident's nightstand. On 10/10/19 at 12:44 PM, the surveyor observed Resident #78 in their room eating lunch. The surveyor reviewed the resident's meal ticket for accuracy. The resident stated he/she was unaware if there was a limit as to the amount of [redacted]. The resident added that he/she has spoken to the dietician several times. The meal ticket did not specify evidence of a fluid restriction.	F 684		

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F 684	Continued From page 41 The surveyor reviewed the medical record for Resident #78. A review of the Admission Record face sheet reflected that the resident was admitted to the facility on [redacted] and was readmitted on [redacted] with diagnoses which included [redacted]). A review of the most recent quarterly MDS dated [redacted] reflected the resident had a BIMS score of [redacted] indicating that the resident had an [redacted] cognition. A review of the resident's Physician's Orders form revealed a PO dated [redacted] for "[redacted] every day." A review of the Nurse's Notes dated [redacted] and timed at 9 AM indicated that the resident was seen by the NP and a new order for [redacted] restriction was to be reviewed by the dietician, and that all orders were documented and carried out. The surveyor attempted to review subsequent dietary notes, but there were no documented notes from the Registered Dietician (RD) in the resident's medical record addressing the [redacted] restriction. A review of the resident's MAR for September and October 2019 did not reflect evidence that the resident was on [redacted] restriction. A review of the resident's individualized,	F 684		

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Comprehensive Care Plan (ICCP) dated as revised [redacted] indicated that the intervention for the resident's dietary requirements based on medical conditions and nutritional needs was to utilize the "Meal Tracker." In addition, the ICCP dated as revised [redacted] had indicated that the resident had a potential for [redacted] and [redacted] secondary to [redacted] and [redacted]. The ICCP did not indicate that the resident was on a [redacted] restricted diet.

On 10/16/19 at 10:40 AM, the surveyor with the Licensed Practical Nurse/Unit Manager (UM) reviewed the PO dated [redacted] for the [redacted] restriction. The UM could not speak to whether the resident was on a [redacted] restricted diet and/or supposed to be on one, and stated that she would have to review the resident's chart.

At that time, the surveyor with the UM reviewed the resident's [redacted] communication book with a sheet dated [redacted], which had not been completed by the [redacted] center. The UM stated that she was calling the [redacted] center to obtain the information. The UM added that the [redacted] communication sheets from [redacted] to [redacted] did not reflect a recommendation for a [redacted] restriction for the resident. The UM added that the fluid restriction order dated [redacted] was written by the NP.

On 10/16/19 at 10:06 AM, the surveyor interviewed the Registered Dietician (RD) who stated that she was familiar with Resident #78 and had met with him/her several times because the resident had allergies and specific food preferences. The RD stated that the resident was not on [redacted] restriction.

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F 684	Continued From page 43 On 10/16/19 at 11:06 AM, the surveyor and the RD reviewed the resident's breakfast meal ticket dated 10/16/19. The RD stated that the resident's meal ticket specified a renal diet and did not specify a [redacted] restriction. The RD explained that the "Meal Tracker" system would identify a resident's meal ticket as [redacted] restricted and the amount of [redacted] restriction. The RD further explained that the usual process was that she would receive a "Dietary Communication" form if a resident had a [redacted] restriction order, and she would have written a dietary progress note regarding the [redacted] restriction. The RD added that she usually received a recommendation from the RD at the [redacted] center regarding a [redacted] restriction and then she would communicate that with the physician or NP. The RD then stated that she would have to review the resident's chart. On 10/16/19 at 11:19 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that she had reviewed the resident's chart with the UM regarding the [redacted] restriction order. The ADON stated that the NP ordered the [redacted] restriction based on a weight gain, and the ADON showed the surveyor a progress note completed by the NP. The ADON added that there was a [redacted] "Dietary Alert Sheet" that was sent to the kitchen on [redacted] and the nurses were waiting for the "breakdown" of [redacted], meaning how much [redacted] was allowed from dietary during meal times and nursing per day. On 10/16/19 at 12:58 PM, the survey team met with the facility administration team, including the LNHA and DON. The surveyor requested a copy of the [redacted] communication sheets for Resident #78.	F 684		

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F 684	Continued From page 44 On 10/16/19 at 1:40 PM, in the presence of another surveyor, the interviewed the RD who stated that she was unaware that the NP had written a PO for [redacted] restriction on [redacted] until after surveyor inquiry. The RD stated that a breakdown for [redacted] restriction could be done at any time by the dietary department and did not have to wait for an RD to review the PO to start the [redacted] restriction. The RD stated that the dietary department had not yet received the dietary alert form. The RD stated that she would have to review the chart as to why the [redacted] restriction was ordered. On 10/16/19 at 2:24 PM, in the presence of another surveyor, the surveyor interviewed the RD who explained that after review of the resident's chart the NP indicated a weight gain as the reason for the order for the [redacted] restriction but the weight gain had been an improvement and was desirable due to the increased [redacted] the resident was receiving. The RD stated that her quarterly "Medical Nutritional Therapy" assessment dated [redacted] indicated that she spoke with the resident and had recommended to increase the resident's [redacted] and a [redacted] was ordered. The RD further explained that the resident had lab results dated [redacted] from the hospital [redacted] center, and she had not assessed that a [redacted] restriction was necessary. In addition, the RD added that the [redacted] center had not recommended [redacted] restriction was necessary as to date and would have to review with the physician the need for a [redacted] restriction. On 10/17/19 at 9:18 AM, the surveyor interviewed the LPN on the medication cart on the [redacted]	F 684		

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who stated that if a resident was on a [redacted] restriction then the MAR would reflect the [redacted] restriction breakdown in the MAR.

At that time, the LPN referred to the UM who stated that the MAR did not reflect evidence that the resident was on a [redacted] restriction since [redacted]. The UM added that there was a clarifying order dated [redacted] with the breakdown of [redacted] The UM confirmed there were no other orders within the physician order sheets that reflected to discontinue or hold the [redacted] restriction. The UM confirmed the order for the [redacted] restriction dated [redacted] had been an active order.

On 10/18/19 at 10:54 AM, the survey team met with the facility administration, including the LNHA, DON and the Regional RD. The Regional RD stated that a review of the surveyor's inquiry was completed as to why the NP ordered a [redacted] restricted diet, and the review revealed that the [redacted] restriction was no longer necessary. The Regional RD stated that a PO for [redacted] restriction can be instituted by the dietary department and would not have to wait until a RD reviewed for the breakdown of the [redacted] amount. The surveyor inquired how the NP came to the determination of [redacted] restriction and the Regional RD stated that she would have to ask the NP that question, and acknowledged that the NP notes did not reflect evidence of how she came to that specific number, and/or her rationale for the [redacted] restriction. The LNHA was unable to provide documented evidence of a dietary progress note addressing the [redacted] restriction order from [redacted] until surveyor inquiry. The Regional RD confirmed the resident did not have dependent [redacted]), and/or signs and

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symptoms of [redacted]. The Regional RD stated that the resident had no negative outcome.

On 10/18/19 at 12:24 PM in the presence of another surveyor, the surveyor interviewed the NP who stated that she was prompted to assess Resident #78 on [redacted] because of a [redacted] and [redacted]. The NP stated that after her assessment she ordered [redacted] restriction based on a weight gain from admission to a current weight and [redacted]. The NP added that she came to number [redacted] because that was a typical volume of [redacted] restricted for any [redacted] resident at this facility, and that's how she determined that number. She indicated that it wasn't based on a calculation for the resident. The NP added that when she writes an order, the expectation was that the order would be implemented accordingly.

On 10/18/19 at 1:30 PM, the survey team met with the facility administrative team which included the LNHA, DON, Regional DON and Regional RD. The Administrator and Regional DON stated that the [redacted] communication sheets were not able to be copied because they could not be located at that time. The Regional DON stated that "We recognize the breakdown in communication regarding the [redacted] restriction" order.

A review of the facility policy dated as reviewed 1/2019 for [redacted] Restriction" included that a [redacted] restriction will be implemented only as part of a therapeutic diet prescription and the nurse will notify the dietary department in the Diet Requisition Form. In addition, nursing was responsible for tracking and documenting the total volume. The policy had not identified the Diet

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F 684	Continued From page 47 Requisition Form.	F 684		
F 690 SS=E	NJAC 8:39-27.1(a) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		11/22/19

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F 690	Continued From page 48 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) provide incontinence care in a manner to prevent [redacted] infections, b.) appropriately store an [redacted] to prevent the spread of infection, and c.) remove and replace [redacted] for residents who were treated for [redacted] in accordance with nationally accepted guidelines for infection control and prevention. This deficient practice was identified for 3 of 4 residents reviewed for [redacted] management (Resident #41, #88, and #90), and was evidenced by the following: 1. On 10/15/19 at 9:14 AM, the surveyor observed Resident #90 in bed with the head of bed elevated at 90 degrees. The resident was finishing eating breakfast with an adaptive spoon. The resident stated that he/she was going to get morning care soon. The resident denied any skin breakdown and/or [redacted] infections in the past. On 10/15/19, the surveyor observed the Certified Nursing Aide (CNA) provide morning care to Resident #90 while the resident was in bed. The surveyor observed the following: At 9:36 AM, while at the resident's sink with the water running, the CNA pressed the soap dispenser three times and immediately placed her hands under the running water. There was no friction with the soap outside of the running water.	F 690	I. CORRECTIVE ACTION 1. Hand hygiene and incontinence care competency completed with CNA assigned to resident #90. 2. Resident #41's [redacted] was changed on [redacted] 3. Resident #88's [redacted] were secured to the bedframe to prevent contact with floor. [redacted] was replaced. II. IDENTIFY OTHER INSTANCES All residents with indwelling urinary catheter have the potential to be at risk. All residents who receive incontinence care have the potential to be at risk. III. SYSTEMIC CHANGE Incontinence care policy / procedure was updated to specify that water should be changed after cleaning the body and before providing incontinence care. Incontinence care competency will be added to orientation and annual education for all CNAs. Staff re-educated to prevent [redacted], and [redacted] from contacting the floor. Staff were re-educated on the [redacted] policy to change a [redacted] based on clinical indication such as infection, obstruction,	

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F 690	Continued From page 49 The surveyor did not observe any soap suds on the CNA's hands or in the sink. The CNA turned the water off with a dry towel. The surveyor timed the handwashing procedure of the CNA, and she washed her hands for seven (7) seconds. At 9:40 AM the CNA prepared the bedside table. Without disinfecting the table, she unfolded two (2) single-use incontinence cloths the size of a dinner napkin and placed them directly on the bedside table. She donned a pair of gloves and filled a resident-designated pink basin halfway with warm water in preparation for morning care. She dispensed aloe soft soap in the water and the water was foamed. At 9:49 AM, the surveyor observed the CNA prepare a new incontinence brief on the foot of the bed and the CNA began to open drawers in the resident's room stating that the resident was "out of everything." The surveyor inquired what the resident was out of, and she stated that there was no [redacted] cream (a moisture barrier cream to prevent skin irritation and breakdown) in the resident's room. The CNA continued to prepare the resident for morning care without the moisture barrier cream. At 9:50 AM, the surveyor observed the CNA using a large terrycloth bath towel and wet one end of the towel into the basin of water and cleansed the resident's face and behind the ears and dried it with the dry side of the towel. She then dipped the wet end of the towel back into the water and cleansed under the resident's arms and trunk, and dried it. Wetting the towel again, she rang it out into the basin and cleansed the resident's legs, feet and around the toes and dried the area.	F 690	or when the closed system is compromised. A letter was sent to all Attending Physicians regarding same policy. IV. MONITOR CORRECTIVE ACTION 2 times per month, for 2 months ADON/designee will observe incontinence care. Once a week x 4 weeks, ADON/designee will check one room of a resident with an [redacted] catheter to ensure appropriate storage of [redacted] and [redacted] bag. Once a week x 4 weeks, DON/designee will audit 2 TARs of residents with [redacted] to ensure physician orders for foley changes comply with facility policy / national guidelines. Results of all audits will be reported at quarterly QA meeting.	

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At 9:54 AM, the surveyor observed the CNA take one of the single-use incontinence cloths that was directly on the bedside table and wet it in the same water used to clean the resident's body. She proceeded to cleanse the resident's peri-area with the cloth and discarded it. She used the second cloth to wet that in water and clean a second time and discarded it. She then assisted the resident to turn, and the surveyor observed that the resident had a small, soft bowel movement in the incontinence brief. The CNA cleansed the area using the terrycloth towel and drying it. She put the towel with bowel movement in a clear plastic bag. The resident's skin to the area appeared pink and intact.

From 9:57 AM to 10:02 AM, the CNA applied a new incontinence brief while wearing the same gloves. She did not change her gloves. The CNA fastened the incontinence brief without obtaining and applying a moisture barrier cream. She told the resident that she would apply the moisture barrier cream during her next incontinence change with the resident. The resident stated to the CNA that he/she was "going out today" and the CNA assisted the resident with applying a pair of pants.

On 10/15/19 at 10:08 AM, the surveyor interviewed the CNA who stated that that the unit gets one pack of single-use incontinence cloths to be dispensed for the entire unit and there are three CNA's on the unit. The surveyor asked about if she had to change the water or her gloves at any point in providing incontinence care and she stated that she did not have to change the water because incontinence care was done last in the sequence of the bed bath. The CNA stated she might have to change her gloves. She

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acknowledged she did not apply the moisture barrier cream because it was not available in the resident's room. The surveyor asked her to show the surveyor the pack of single-use incontinence cloths, and she went to her cart and there were four (4) cloths left on her cart. The surveyor asked the CNA if she could take one of the cloths. The surveyor asked if the CNA if she had more residents left on her assignment for incontinence care and she stated that she had had nine residents on her assignment today and three resident's left for morning care. She stated that she uses two or three cloths per resident with incontinence care. She acknowledged that she did not have enough cloths to finish incontinence care for her residents and stated that she could ask the supervisor for more cloths. She then reached for the washcloth in the surveyor's hand that had been handled, and requested for it back because she was running low. The surveyor suggested that she obtain new ones and not one that was already handled. The surveyor asked if she runs low on the washcloths frequently, and she denied that she runs low on them or has to ask anyone for more. She could not speak to how she almost ran out of her designated supply with three resident's left who were dependent for incontinence care.

At 10:30 AM, the surveyor and the Unit Clerk went to the central supply together. The Unit Clerk stated that she supplies each unit with a bag of items that a designated CNA picks up at the start of the shift. The Unit Clerk stated that she supplies each unit with one pack of single-use incontinence care "washcloths" and that there are 50 cloths per pack. The surveyor asked if 50 cloths per unit were enough for each floor for an 8 hour shift, and she stated that she

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didn't know, but that the staff could ask her or the nurse for more and she would go to the supply room to get more. The surveyor observed seven (7) full boxes of washcloths with 16 packs of 50 washcloths per box in the central supply. There was one opened box of washcloths with 14 packs of washcloths. The Unit Clerk stated that the units had not asked her to bring up more washcloths on a regular basis, so it seemed as though one pack per floor on a regular day to day was sufficient.

The surveyor reviewed the medical record for Resident #90.

A review of the resident's annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted]. The MDS reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] indicating an intact cognition level. The assessment further reflected that the resident required a one-person physical assist with personal hygiene and was totally dependent. The assessment included that the resident was always incontinent of bladder and bowel.

A review of the resident's individualized, comprehensive care plan revised [redacted] included that the resident had a potential for skin impairment related to incontinence, weakness and impaired mobility. The goal specified that the resident will be free from new onset skin impairment by the end of the review date. Interventions included that the resident would "receive incontinence care as [he/she] requires

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with barrier cream to be applied to perianal area with well fitted briefs to assist with skin breakdown prevention."

A review of the CNA Resident Care Guideline for Resident #90 included that the resident was incontinent of bowel and bladder and required an assistance of one person staff for toileting.

On 10/16/19 at 11:00 AM, the Director of Nursing (DON) provided the surveyor a copy of Managing Urinary Incontinence policy reviewed 8/2019. The policy included that "Hygiene and skin care is strictly observed for patients with urinary incontinence to avoid occurrence of complications such as skin problems, bed sore, skin and urinary infection." The procedure included that wet incontinence pads "must be changed promptly, the skin cleansed, and a moisture barrier applied to protect the skin." The procedure did not address if or when water should be changed.

A review of the undated Urinary / Perineal Care policy included, "fill the bath basin with clean warm water, position the [resident] on their back put a protective cover over the bed linen, wash the [perineal area] from the front to the back starting at the groin area and then going to the inside of the thighs, rinse the cloth or use a new washcloth...turn the person on [his/her] side, wash rise and dry rectal area."

On 10/16/19 at 11:34 AM, the surveyor asked the DON for evidence of a competency on incontinence care of the CNA.

On 10/17/19 at 3:00 PM, the surveyor interviewed the DON and the Licensed Nursing Home

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Administrator (LNHA) who were unable to provide evidence of the incontinence care competency for the CNA.

On 10/18/19 at 11:58 AM, the surveyor interviewed the DON, in the presence of the LNHA and the survey team. The DON was unable to provide documented evidence of a competency for incontinence care from the CNA. The DON stated that the procedure for incontinence care was that after cleaning the body, the water in the basin should be dumped and new soap and water applied. The LNHA provided the survey team with purchase orders of the wash cloths and competencies and audits on hand hygiene in which staff who were audited from each department had passed their handwashing competency.

2. On 10/11/19 at 8:30 AM, the surveyor observed Resident #41 in bed awake watching TV. The surveyor observed a [redacted] bag secured to the resident's bed frame with an [redacted] bag inside the [redacted] bag. The surveyor observed that there was clear [redacted] in the [redacted]

On 10/15/19 at 9:32 AM, the surveyor observed Resident #41 in bed and the resident agreed to be interviewed. The surveyor observed the [redacted] to be [redacted] with some [redacted] in the [redacted]. The surveyor asked if he/she had a [redacted] and/or had received [redacted] recently for a [redacted] and the resident denied having any infection. The surveyor inquired if he/she had any [redacted] or [redacted] as a result of the [redacted] and the resident

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denied any complaints, and/or signs and symptoms associated with a [redacted]. The surveyor asked the resident if nursing staff exchange the [redacted] at any particular times, and the resident stated "staff switch it out every once in a while", but the resident could not be specific about the timeframes or circumstances for the [redacted] changing. .

The surveyor reviewed the medical record for Resident #41.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was originally admitted to the facility on [redacted] and re-admitted on [redacted] with diagnoses which included [redacted]

A review of the most recent quarterly MDS dated [redacted] reflected that the resident had a BIMS score of [redacted] indicating that the resident had a [redacted] impaired cognition. It further reflected that the resident was always incontinent.

A review of the resident's individualized, comprehensive care plan initiated on [redacted] reflected that the resident had a history of [redacted] and the presence of an [redacted] The goal indicated that the resident will resolve symptoms of [redacted] through the review date. Interventions included to observe the resident for fever, chills, [redacted], and perform vital signs and inform the Medical Doctor as required.

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A review of the Physician's Orders Form for October 2019 reflected undated physician's orders to change the indwelling [redacted] monthly on the 11 PM to 7 AM shift, change the [redacted] every two weeks on the 3 PM to 11 PM shift, and perform indwelling catheter care every shift.

A review of the Treatment Administration Record (TAR) for August 2019 reflected a physician's order (PO) with an unclear date to change the [redacted] once a month on the 30th of the month during the 11 PM to 7 AM shift. The TAR was signed to reflect a new [redacted] was inserted on [redacted].

A review of the [redacted] report dated as collected on [redacted] at 5:20 AM reflected the resident had a [redacted]. The report reflected there were few [redacted] and an [redacted]). The [redacted] report reflected there was [redacted]. The print date for the [redacted] report was [redacted] at 5:40 PM and it was re-printed on [redacted] at 1:40 AM. The report was signed by the NP.

A review of the Physician's Orders sheet dated [redacted] reflected orders for Intravenous [redacted] every 6 hours for [redacted] days and [redacted] days due to [redacted]. The orders included to administer [redacted]. There was no evidence within the

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Physician's Orders sheet that indicated to remove/replace the [redacted]

A review of the Medication Administration Record (MAR) for September 2019 reflected that the resident received the [redacted] from [redacted] through [redacted].

A review of the TAR for September 2019 did not reflect evidence that the resident's [redacted] was removed when the resident was identified to have [redacted]. The [redacted] was not removed/changed until its next routinely scheduled change on the 30th of the month, [redacted]. The PO to change the [redacted] every 30 days on the 11 PM to 7 AM shift was dated [redacted]

On 10/15/19 at 10:51 AM, the surveyor interviewed Resident #41's assigned LPN. The surveyor asked the LPN about how to care for an [redacted]. The LPN stated that it gets hung [redacted] the [redacted] of the [redacted] in a [redacted]. The surveyor inquired what the signs and symptoms of a [redacted] when the resident has a catheter. The LPN stated that some signs and symptoms of a [redacted] l included a [redacted], fevers, a change in [redacted] She stated that if she saw those symptoms the NP would order a [redacted] and [redacted]. When the culture report comes back, "We get the lab reports and we immediately call it in and get orders" from the Nurse Practitioner or MD. The LPN confirmed that it would be documented in the resident's medical record regarding notification of the MD or NP. The surveyor asked if a resident started an [redacted] and the resident had an [redacted], would the old

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[redacted] would be removed and a new one placed? The LPN stated only if there was a physician's order. She stated that the [redacted] get replaced every month, and it wasn't necessarily a routine practice they followed to remove a [redacted] if the resident developed an infection.

The surveyor asked if Resident #41's [redacted] was removed on or around [redacted], and the LPN confirmed there was no documented evidence in the TAR or nursing notes that it had been done until [redacted] during the next routine change. The LPN confirmed there was no physician's order to replace it during that time on the resident's chart. At that time, the Registered Nurse/Unit Manager (RN/UM) began looking through the resident's chart to see if a there was a [redacted] when the resident developed a [redacted]. The RN/UM was unable to show the surveyor evidence from the resident's medical record. She confirmed there was no physician order to replace it.

On 10/15/19 at 11:49 AM, the surveyor interviewed the NP in the presence of another surveyor. The NP stated that a [redacted] is requested for specific reasons, such as to rule out a [redacted] The NP stated that the resident had recently had a diagnosis of [redacted]. The surveyor asked what process she follows when the resident exhibits signs and symptoms of [redacted] and has an [redacted] The NP stated that the facility had a protocol in which all [redacted] were exchanged routinely on a monthly basis and that the nurses change the [redacted] The surveyor inquired about the practice of routine [redacted] exchanges and she stated that this was the protocol the facility adopted at some point and could not speak to nationally accepted

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infection control guidelines, including the Centers for Disease Control and Prevention (CDC). She stated that nurses had to have a physician order in order to change an [redacted]. The surveyor asked if she would order to remove the [redacted] if the resident had an infection, and she stated that she usually had orders to remove it after the [redacted] are done. The NP stated that she could not recall if this was done for Resident #41 and/or what the facility's protocol was for how [redacted] are handled if the resident developed a [redacted] a [redacted]. She stated she would have to look further into the resident's chart.

The surveyor continued to review the resident's medical record on 10/17/19.

A review of the NP Progress Note dated [redacted] reflected the reason for the visit was [redacted] The note included that the resident has a history of [redacted], [redacted], and was seen by the [redacted] and a [redacted] and [redacted] was ordered-results were ready for review. The note indicated that the resident had no complaints and no [redacted]. The [redacted] in the [redacted] was [redacted]. The Assessment/Plan included that the resident had a [redacted] and the plan included to start [redacted] mg BID for [redacted] days for [redacted]. The note indicated that the [redacted] should be replaced 24 hours after the the [redacted] was started.

A review of the subsequent Nurse's Note written on [redacted] at 1:00 (AM/PM not specified) reflected the NP's new orders which included to start the [redacted] mg by

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the DON in the presence of the LNHA and the survey team. The DON stated that if someone with an [redacted] develops a [redacted], the standard of practice at the facility was to remove the [redacted] hours after completion of the [redacted]. The surveyor inquired about what nationally accepted guideline for infection control they adopted that practice from, and the DON stated that he reviewed the CDC guidelines stating, "I did my research last night and couldn't come up with anything" as to where the facility's practice was taken from. He stated he would have to look into the resident's chart to see if the catheter was replaced in September when the resident had a [redacted].

On 10/18/19 at 11:20 AM, the surveyor interviewed the LNHA, DON and the Regional Director of Nursing in the presence of the survey team. The LNHA stated the facility was going to initiate a quality assurance performance improvement project in response to the surveyor's inquiry on [redacted]. The LNHA was unable to provide a policy that addressed a facility protocol or procedure for [redacted] The DON/Infection Preventionist acknowledged that the CDC recommended that [redacted] not get replaced on regularly scheduled intervals, but stated it was "just a recommendation." The surveyor inquired about what process they follow if the facility chose to not follow a nationally accepted guideline for infection control such as the CDC recommendations, and the administration was unable to provide the survey team an answer to their process.

On 10/18/19 at 12:24 PM, the surveyor interviewed the NP. The NP stated she sees

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resident's on an acute-need basis, and that she is asked to see residents when there is a specific need to see them. She stated that she communicates with the primary care provider as needed and that she will document in the resident's medical record her rationale for starting an [redacted]. She stated that she liked liked to have an [redacted] in the resident's system for [redacted] hours before [redacted]. This conflicted with her initial interview on 10/15/19 at 11:49 AM. She stated that it made sense to have an [redacted] in the resident's system for 24 hours first, because if a [redacted] was being inserted before the [redacted] started than the [redacted] might get infected, because its being introduced to infected [redacted]. She stated that she would not remove the source of the infection (i.e. the [redacted]) until the resident completed [redacted] NP to provide nationally accepted guidelines such as from the CDC that addressed it. She stated that she looked into it because the survey team had inquired, and that she found that the CDC specified that the [redacted] should come out if the resident had an [redacted] but that it did not specify "when" the [redacted] had to be removed. She confirmed that was why she chose [redacted] hours to remove the [redacted] when the resident developed the new [redacted]. She was unable to provide documented evidence that the [redacted] was removed from when the resident was treated for a [redacted] on [redacted].

A review of the facility's undated [redacted] Care policy and procedure included that the objective of the policy was to minimize the risk of [redacted] and its related problems. The procedure included that the [redacted] should be [redacted] regularly as per MD

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order" and "Observe for unusual presentation which should be reported to physician." The policy did not speak to protocols to follow in the event the resident developed a [redacted].

3. On 10/9/19 at 9:39 AM, the surveyor observed Resident #88 lying in bed in his/her room. The surveyor observed that the resident had an [redacted]. The [redacted] was [redacted] with [redacted]. The surveyor observed that the [redacted] of the [redacted] was in direct contact with the bottom metal bar of the resident's overbed table which was black in color and was visibly soiled with brown stains and a dusty, dirt-like debris covering the surface. In addition, the [redacted] was in a dark [redacted]. The outside of [redacted] was observed to be in direct contact with the floor and was faded in color and stained brown where it was touching the floor of the resident's bedroom. The surveyor asked the resident his/her name. The resident replied appropriately, but then made a groaning sound, speaking unintelligible words.

On 10/10/19 at 11:26 AM, the surveyor observed the resident lying in bed positioned on his/her right side. The surveyor observed the [redacted] had [redacted] with [redacted] in it. The [redacted] was directly touching a safety floor mat placed beside the resident's bed. The floor mat was dark blue in color and observed to be visibly soiled throughout the surface.

On 10/11/19 at 9:05 AM and on 10/15/19 at 9:44 AM, the surveyor made additional observations

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where the resident's [redacted] was in direct contact with the floor in the resident's room.

The surveyor reviewed the medical record for Resident #88.

A review of the resident's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] and re-admitted on [redacted] and had diagnoses which included but were not limited to [redacted]

A review of the resident's most recent significant change MDS dated [redacted], reflected that a BIMS score could not be obtained so staff assessed the resident's cognition status. The staff assessed the resident as having a [redacted] The MDS included that the resident had an [redacted].

A reviewed the July 2019 Physician Order form reflected a physician's order (PO) dated [redacted] for a [redacted] and [redacted] to be performed on [redacted].

A review of the [redacted] report with a collection date of [redacted] at 5:00 AM and printed on [redacted] at 6:47 PM, reflected that the resident's [redacted] was [redacted] and had [redacted] use).

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F 690	Continued From page 65 A further review of the July 2019 POS reflected a PO dated [redacted] for the [redacted] medication, [redacted] every day for [redacted] days for a [redacted]. The July 2019 POS did not reflect evidence of a PO for the removal/replacement of the resident's [redacted] in response to the resident's [redacted]. Further, the surveyor reviewed the September 2019 POS which reflected a PO dated [redacted] to collect a [redacted] on the resident. A review of the [redacted] report with a collection date of [redacted] at 1:17 PM and printed on [redacted] at 3:10 PM, reflected that the resident's [redacted]. A further review of the September 2019 POS reflected a PO dated [redacted] for the [redacted] every eight hours for [redacted] days for [redacted]. The September 2019 POS did not reflect a PO for the removal/replacement of the resident's [redacted] in relation to the [redacted] culture. A review of the October 2019 POS reflected an undated PO to change the [redacted] every two weeks on 3 PM - 11 PM shift, provide [redacted] care every shift, and to change the [redacted] monthly on the 11 PM - 7 AM shift. A review of the resident's individualized	F 690		

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Comprehensive Care Plan revised on [redacted] reflected that the resident had a focus area for an [redacted] enhance [redacted]. The goal specified that the resident would not show signs and symptoms of a [redacted] infection through the next review date. The interventions included to monitor, record, and report to physician signs and symptoms of a [redacted] such as [redacted], [redacted], [redacted], increased temperature, and [redacted] in [redacted]. The interventions further reflected to change the [redacted] as ordered and needed, and to position the [redacted] and [redacted] below the [redacted] of the [redacted] with a [redacted] when the resident was out of bed and in a chair.

On 10/16/19 at 10:00 AM, the surveyor interviewed the resident's assigned CNA who stated that the resident never got up out of bed, so she never changed the resident's [redacted] to a [redacted]. The CNA told the surveyor that her job in relation to [redacted] care was to empty the [redacted] from the [redacted] and tell the nurse how much [redacted] was emptied from the [redacted]. The CNA further stated that the resident's [redacted] was never to touch the floor. However, the CNA stated that was "a problem" with the resident because his/her bed needed to be low because the resident was a fall risk. The CNA stated that she could lift the bed up a little higher so the tubing would not be touching the floor.

On 10/16/19 at 11:27 AM, the surveyor interviewed the Licensed Practical Nurse (LPN)

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who stated that signs and symptoms of an [redacted] included increased confusion, and [redacted]. The LPN further stated that the [redacted] should always be stored below the [redacted], should not be [redacted], and should never be touching the floor. The LPN stated that an [redacted] would be changed according to a physician's order. The LPN stated that the facility had physician orders to change resident's [redacted] monthly. The LPN stated that the [redacted] would be changed every two weeks in accordance with the physician's order.

On 10/16/19 at 11:34 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that an [redacted] should be stored in a clean [redacted] bag and the [redacted] of the [redacted] should never touch the floor. The RN/UM further stated that the [redacted] changes were only done if there was a physician's order, and that the they get changed out on a routine monthly basis.

On 10/17/19 at 2:32 PM, the surveyor interviewed the Infection Preventionist/Director of Nursing (DON)who stated that he was told by the NP that if someone had an [redacted] in conjunction with a [redacted] was a standard of practice to change the [redacted] hours after starting the resident on an [redacted]. The DON stated that the facility had just adopted that [redacted] hour removal protocol after surveyor inquiry. He further added that he had researched the Centers for Disease Control and Prevention (CDC) guidelines on [redacted] and couldn't find the information he was

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F 690	Continued From page 68 looking for. On 10/18/19 at 11:00 AM, the LNHA stated that all staff were in-serviced about [redacted] and how it should never be in direct contact with the floor. The LNHA provided the surveyor with a copy of the in-service record which was done after surveyor inquiry. On 10/18/19 at 11:22 AM, the surveyor conducted a follow-up interview with the DON who stated that when he looked up information in relation to [redacted] changes and removal on the CDC website, the CDC specified to remove the [redacted] if a resident were to develop a [redacted]. The DON further stated that he could not find information on the time frame for removal of the [redacted]. He stated, "based on his knowledge of infection control practices the CDC recommended that the [redacted] should be removed, but we have a time frame of 30 days for it to be removed." He acknowledged that the 30 day time frame was the facility's routine practice even if the resident was not exhibiting signs and symptoms of infection. On 10/18/19 at 11:23 AM, the Regional DON stated that the facility had physician orders for [redacted] to be removed every 30 days. The surveyor asked the R/DON what should be done with the [redacted] if the resident develops [redacted]. The R/DON stated that they would review the facility's policy to see what would be appropriate and would revise it accordingly. On 10/18/19 at 12:25 PM, the surveyor conducted and interview with the NP in the presence of the survey team. The NP stated that she liked to get	F 690		

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at least one dose of [redacted] into the resident before changing the resident's [redacted] r. She acknowledged she had not been following that practice prior to surveyor inquiry. The NP stated that her conclusion of changing the [redacted] in relation to a [redacted] was based on her own logic. The NP then asked the survey team what the CDC guidelines were because she just wasn't going to change an [redacted] r for no reason. The NP further stated that she believed the facility had a policy that if a resident had an [redacted] it would be changed every 30 days. The NP stated that she would not write an order to change an [redacted] unless she assessed the resident and there was a clinical reason to do so. She acknowledged there was no physician order to remove/replace the [redacted] at any point, except for the routine 30 day intervals, when the resident developed a [redacted] and started [redacted] on [redacted] and [redacted].

A review of the Staff Education Sheet topic on Infection Control Practices [redacted] dated [redacted] (after surveyor inquiry) and provided by the LNHA reflected that the staff should check the [redacted] function and that the staff should make sure that the [redacted] did not touch the floor.

A review of the [redacted] Care policy and procedure dated 8/2019 included that the purpose of the policy and procedure was to prevent [redacted]. It further included , "2.b. Be sure the [redacted] and [redacted] are kept off the floor." And when changing [redacted] "1. Changing [redacted] at routine, fixed intervals is not recommended.

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F 690	Continued From page 70 Rather, it is suggested to change [redacted] and [redacted] based on clinical indications such as infection, [redacted], or when the [redacted] is compromised." According to the CDC's 2009 Guideline for Prevention of [redacted] Infection, "If breaks in aseptic technique, [redacted], or [redacted] occur, replace the [redacted] and [redacted] using aseptic technique and sterile equipment. 2. Consider using [redacted] with preconnected, sealed [redacted]. B. Maintain unobstructed [redacted] flow. 1. Keep the [redacted] and collecting [redacted] free from [redacted]. 2. Keep the [redacted] below the [redacted] of the [redacted]r at all times. Do not rest the [redacted] on the floor. 3. Empty the collecting [redacted] regularly using a separate, clean collecting container for each patient; avoid splashing, and prevent contact of the drainage spigot with the nonsterile collecting container... Changing [redacted] or [redacted]bags at routine, fixed intervals is not recommended. Rather, it is suggested to change [redacted] and [redacted] based on clinical indications such as infection, [redacted], or when the [redacted] is compromised." On 10/18/19 at 1:00 PM, the LNHA and DON were unable to provide the facility's procedure if choosing not to follow a nationally accepted infection prevention and control guideline, such as the CDC. NJAC 8:39-27.1(a)	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		11/22/19

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F 692	Continued From page 71 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) address and implement appropriate interventions for a resident with a significant weight gain, b.) notify the resident's primary care physician of the resident's significant weight gain, and c.) provide an accurate assessment with an updated care plan regarding the significant weight gain. This deficient practice was identified for 1 of 4 residents reviewed for nutrition (Resident #77), and was evidenced by the following: On 10/11/19 at 9:14 AM, the surveyor observed Resident #77 standing over his/her breakfast tray	F 692	I. CORRECTIVE ACTION: MDS assessment for resident #77 dated [redacted] was corrected to reflect accurate weight of [redacted]. The PCP was notified of resident #77□s significant weight gain; low fat modifications to the Regular diet were initiated including Skim milk and reducing concentrated sweets. The care plan for resident #77 was updated to reflect a goal of weight stability and low-fat diet modifications.	

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F 692	Continued From page 72 in his/her room. The resident appeared well nourished. The surveyor observed that the resident had consumed 100% of the breakfast meal. The surveyor further observed an empty eight-ounce (oz) carton of whole milk on the resident's breakfast tray. The resident opened and started to drink a four-ounce cup of orange juice in front of the surveyor. The surveyor reviewed the meal ticket that was on the resident's breakfast tray. The meal ticket reflected that the resident was on a regular diet and for breakfast received a three-quarter's cup of oatmeal, one square piece of coffee cake, one non-dairy creamer, eight-ounces of whole milk, one cup of coffee, and four-ounces of orange juice. On 10/11/19 at 12:30 PM, the surveyor observed the resident eating lunch in his/her room. The resident had just started to eat. The surveyor observed various foods, including a side of pudding and an eight-ounce carton of whole milk. The surveyor reviewed the meal ticket on the resident's lunch tray. The meal ticket reflected that the resident was on a regular diet and for lunch received three-ounces of battered pollock fish fillet, one dinner roll, one side of margarine, a half of a cup of banana pudding, one-ounce tartar sauce, one cup of coffee, and one non-dairy creamer. The ticket did not reflect the eight-ounce carton of whole milk observed on the meal tray. The surveyor reviewed the medical record for Resident #77. A review of the resident's Admission Record face sheet (an admission summary) reflected that the	F 692	II. IDENTIFY OTHER INSTANCES: All residents with significant weight change may be at risk. III. SYSTEMIC CHANGE: All dietary care plans were reviewed and modified to reflect measurable and desired goals. Appropriate corresponding interventions that were consistent with the dietary assessment were ensured as well. The RD will be responsible for completion and accuracy of [redacted] on the MDS, and implementing and updating dietary care plans. Monthly weight meetings involving IDCP will continue to be held to address all residents with significant weight gain/losses. IV. MONITOR CORRECTIVE ACTION: Monthly x 3 months, the Regional RD will audit charts of 2 residents who experienced a significant weight change, to ensure patient-specific and clinically sound interventions were put in place and reflected on the care plan. Findings will be reported at quarterly QA Meeting.	

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F 692	Continued From page 73 resident was admitted to the facility on [redacted] and had diagnoses which included but were not limited to [redacted], and persona[redacted]. A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted] impaired cognition. A review of the resident's admitting nutritional assessment dated [redacted] reflected that the resident's height was [redacted] and weighed [redacted]. This reflected a Body Mass Index (BMI) (a method used to screen for weight categories) of approximately 24.1 (a healthy weight). A review of the resident's October 2019 Physician's Order sheet reflected an undated physician's order for a regular diet with a regular consistency. A review of the resident's weight sheet reflected that in February 2019 the resident's weight was [redacted]. The weight sheet further reflected that the resident's weight in August 2019 was [redacted]. This reflected a [redacted] % significant weight gain over a 180-day (six month) period. A further review of the resident's quarterly MDS date[redacted] reflected that in [redacted] Swallowing and Nutritional Status the resident's weight was recorded as [redacted]. This did not correspond with the August 2019 weight of [redacted]	F 692		

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lbs as was recorded in the resident's weight sheet.

A review of the resident's Dietary Progress Notes dated [redacted] reflected that the resident had an [redacted] % weight increase over the last 180 days. The note further reflected that the resident was on a regular diet, had a good appetite, and the resident's weight had consistently trended up since admission. The note included that the resident's BMI was now in the [redacted] range and the resident was unable to be educated due to a cognitive impairment. The note specified that the Registered Dietician (RD) would continue to monitor the resident's weight and adjust the plan of care if the weight continued to increase. There was no evidence of a goal weight for the resident and/or interventions to monitor and manage the resident's significant weight gain.

A review of the resident's individualized Comprehensive Care Plan revised on [redacted] reflected a focus area that the resident had a potential for nutritional problem related to a BMI of [redacted]. (This was not an accurate calculation of the resident's BMI at the time of [redacted]). The care plan reflected an inappropriate goal that the resident would maintain an adequate nutritional status as evidence by maintaining weight, showing no signs and symptoms of malnutrition, and consume at least 75 % of at least two of three meals daily through the review date. The goal did not include a measurable goal weight to maintain and/or an appropriate goal that addressed the resident's significant weight gain. The interventions included that the resident was to be weighed as ordered and a significant weight loss or gain was to be reported to the physician and for the RD to evaluate and make dietary

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recommendations as needed.

A review of the Nurse's Notes and dietary notes within the resident's medical record did not reflect evidence that the resident's Attending Physician or Nurse Practitioner (NP) was made aware of the resident's significant weight gain.

On 10/16/19 at 10:12 AM, the surveyor conducted an interview with the RD who stated she was new and was not the same RD who identified the significant weight gain. The surveyor inquired how she would assess and plan for a resident with a significant weight gain. The RD stated that if a cognitively impaired resident had an undesirable significant weight gain she would speak to nursing and have nursing monitor the resident's snack and meal intake. The RD further stated that an appropriate intervention for a resident with a significant weight gain would be to have nursing monitor the resident's caloric intake and start the resident on a controlled carbohydrate diet (CCD). The RD stated that whole milk would not be appropriate to give to a resident had experienced a significant weight gain, as that could potentially further weight gain.

On 10/16/19 at 11:51 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was alert to person and could recognize familiar faces. The CNA stated that the resident was a "very good eater" and would eat everything on his/her meal tray and anything that you gave to him/her. The CNA further stated that the resident had behaviors and could be re-directed and "lured" with coffee.

On 10/16/19 at 12:10 PM, the surveyor

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interviewed the resident's Licensed Practical Nurse (LPN) who stated that she did not think the resident was [redacted] enough to make decisions independently. The LPN stated that the resident was able to feed him/her-self independently. The LPN stated that the resident at times had behaviors and would react positively when staff offered food and snacks. The LPN further stated that the resident loved to eat and drink and loved sandwiches and coffee. The LPN stated that she was unsure if the resident had gained weight and would have to look in the resident's chart.

On 10/18/19 at 11:47 AM, the surveyor interviewed the Regional Registered Dietician (R/RD) in the presence of the survey team who stated that over the past year and a half the resident had gradually gained weight due to excellent food intake. The R/RD stated that the previous RD had documented that the resident was not receptive to education and would yell when the RD went in the room to speak to him/her. The R/RD further stated that the goal for the resident was quality of life and that the plan was to continually monitor the resident to see if he/she gained more weight before additional interventions were put into place. The RD stated that she had not reviewed the residents MDS or the individualized care plan to see if the goals or the interventions were appropriate for the resident. The R/RD further stated that a goal weight should have been included as a measurable goal in the resident's individualized care plan. The Licensed Nursing Home Administrator (LNHA) was unable to provide documented evidence of appropriate assessment and interventions to prevent the resident from gaining additional weight until surveyor inquiry.

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F 692	Continued From page 77 A review of the facility's Weight Program Policy & Procedure revised on 7/19 included, "6.c. The Dietitian documents all significant weight gain and loss (5 % in 30 days, 7.5 % in 3 months; 10 % in 6 months). Dietician also documents on any resident with a trend of weight gain or loss and will initiate any nutritional interventions as needed. The Weight Program Policy & Procedure further reflected, "8. All significant weight changes will be referred to the IDC team for review. 9. Care Plan are updated, as needed." NJAC 8:39-27.2(a)	F 692		
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	F 761		11/22/19

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F 761	Continued From page 78 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 record review, it was determined that the facility failed to remove expired medications dating back to June 2019 from active inventory that were being stored in the facility back-up supply box. This deficient practice was identified for 1 of 3 medication storage areas reviewed (Nursing Supervisor's Office), and was evidenced by the following: On 10/10/19 at 09:45 AM, the surveyor with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) observed the facility back up supply of medications in the nursing supervisor's office. At that time, the surveyor, DON and ADON observed the following ten medications in the active inventory with their corresponding expiration dates: 1. [redacted]s (MG) -three (3) tablets expired on 6/29/19 and two (2) tablets expired on 7/2/19. 2. [redacted] (a medication to [redacted]) MG -two tablets expired on 7/24/19 and 3 tablets expired on 8/15/19. 3. [redacted] ([redacted] MG- four (4) tablets expired on 10/1/19. 4. [redacted] (a [redacted] the [redacted]) [redacted] - five (5) tablets expired on 8/1/19. 5. [redacted] used to [redacted] MG - five (5) tablets expired on 9/6/19.	F 761	I. CORRECTIVE ACTION All expired medications were removed. Medications requiring replacement were ordered and delivered to the facility. II. IDENTIFY OTHER INSTANCES All residents have the potential to be affected. III. SYSTEMIC CHANGE Facility pharmacy representative is to conduct checks monthly to ensure protocol has been followed and no expired medications are contained in the backup medication supply box DON/designee will conduct weekly check of backup medication supply box to ensure no expired medications are contained within. Expired medications, if found, will be removed and returned to pharmacy, and replaced by pharmacy. IV. MONITOR CORRECTIVE ACTION Findings from monthly & weekly checks of	

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F 761	Continued From page 79 6. [redacted] MG - five (5) tablets expired on 8/2/19. 7. [redacted] MG - two (2) tablets expired on 9/9/19. 8. [redacted]) (a medication to treat[redacted] MG -three (3) capsules expired on 7/31/19 and two (2) capsules on 9/28/19. 9. [redacted] (a [redacted])10 MG - five (5) tablets expired on 10/3/19. 10. [redacted] two (2) tablets expired on 8/30/19 and 9 tablets expired on 9/4/19. At that time, the DON stated that the expired medications should have been removed. The DON added that the representative from the pharmacy provider and the 11 PM to 7 AM Nursing Supervisor would check the expiration dates of the back-up supply box of medications. The DON could not speak to why there were expired medications in the back-up supply. On 10/10/19 at 09:50 AM, during the review of the back-up supply box, the surveyor with the DON reviewed the facility list of "Back Up Box Contents" which revealed a column indicating expiration dates for each medication listed. The DON stated that the expiration dates on the list were not all accurate, as they did not correspond with the expiration dates identified. On 10/11/19 at 11:33 AM, the surveyor conducted a phone interview with the Pharmacy Provider Representative (PPR) regarding the facility's back up supply of medications. The PPR stated that	F 761	medication backup box will be presented at quarterly QA meeting by the DON and Pharmacy representative. Corporate DON to conduct a check quarterly to ensure protocol has been followed and no expired medications are contained in the backup medication supply box. Findings will be reported at quarterly QA Meeting.	

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F 761	Continued From page 80 she does quarterly audits at the facility and removes any medications that will be expiring soon or have expired. The PPR added that she had done an audit on 5/29/19 and thought that she had removed any medications that were going to expire at the end of September 2019. The representative could not speak to how there were expired medications dating as far back as June 2019. The PPR also stated that she was running late in doing the quarterly audit and should have done an audit the end of September or beginning of October 2019. In addition, she stated that she had spoken with the DON in reference to the "Back Up Box Contents" list and thought the expiration dates on the list were not all up to date. The PPR could not speak to whether the facility had an in-house system to remove expired medications. On 10/18/19 at 11:50 AM, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) acknowledged the surveyor's findings regarding the expired medications in the facility's back-up box. The surveyor reviewed the facility policy dated April 2014 for "Medication Storage" which reflected that expired medications would be removed from medication storage areas. NJAC 8:39-29.4(g)(h)	F 761		
F 880 SS=E	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	F 880		11/22/19

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(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

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F 880	Continued From page 82 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure: a.) alcohol-based hand gel was easily accessible on 4 of 4 nursing units, b.) the timing and technique of hand hygiene was performed appropriately to prevent infection, c.) soiled laundry cart lids had a mechanism to avoid repeated hand touching, d.) housekeeping staff disinfected a bedside table to prevent infection, and e.) a [redacted] was not re-applied to a resident when it had been in direct contact with the floor. This deficient practice was identified on [redacted] nursing units (Floor [redacted] and 1 of 1 [redacted] area (Floor [redacted]) and 1 of 2 residents reviewed for [redacted] care (Resident #90).	F 880	I. CORRECTIVE ACTION 1. All non-alcohol based hand sanitizer was replaced with alcohol-based hand sanitizer immediately on 10/17/19. 2. Hand hygiene education and competencies were conducted with the employees who demonstrated deficient hand hygiene practices. 3. Pedal-controlled laundry bins were ordered on 10/18/19. 4. Housekeeping staff were re-educated on appropriate disinfectant use, cleaning practices, and dilution techniques. 5. [redacted] was replaced immediately for Resident #90.	

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F 880	Continued From page 83 The evidence was as follows: 1. On 10/9/19 at 10:15 AM, the surveyor dispensed a hand cleansing foam from a wall dispenser onto their hands. When the foam dried, there was a slightly sticky film left on the hands. At that time, the survey team observed each nursing floor had hand foam cleansing dispensers on the walls throughout each unit. The product inside the dispensers indicated "Alcohol Free Foaming First Aid Antiseptic Hand Cleanser." There was one active ingredient listed, [redacted] The survey team did not use the product for hand sanitation for the duration of the survey and observed the following: a.) On the [redacted] in the rehab area, there were two dispensers with the Alcohol-Free hand foam, with one in the gym and one in the [redacted] office. There was a sink with hand soap and only one accessible alcohol-based hand gel (ABHG) in the rehab area. b.) On [redacted] there were six Alcohol-Free hand foam dispensers affixed to the walls. The dispensers were located between rooms [redacted] and [redacted], one affixed to the wall to the left of the nursing station, one between the [redacted] room and [redacted] bathroom, one in the center of the main dining room between rooms [redacted] and room [redacted] and one attached to the right of the wall by room [redacted]. There was only one accessible bottle of ABHG with 65% alcohol on the floor, and it was located on top of the medication cart. On 10/11/19 at 12:07 PM, the surveyor observed the Nurse Practitioner (NP) utilize the Alcohol-Free hand foam affixed to the wall next to	F 880	II. IDENTIFY OTHER INSTANCES All residents have the potential to be affected. III. SYSTEMIC CHANGE Only alcohol-based hand sanitizer will be supplied to the facility. All facility staff were re-educated on hand hygiene technique; performance of hand hygiene between direct resident contact and after removal of gloves; and infection control practices during resident care, including appropriate handling of [redacted]. IV. MONITOR CORRECTIVE ACTION ADON/designee will perform one hand hygiene observation / competency per week, and will observe infection control technique during patient care 2 times per month, for 2 months. Results will be reported at quarterly QA meeting. Director of Environmental Services will observe infection control technique during cleaning of resident areas once per week x 4 weeks Results will be reported at quarterly QA meeting.	

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the nurses station, rub the solution into her hands and press the elevator button and entered the elevator.

c.) On [redacted] there were five Alcohol-Free hand foam dispensers affixed to the walls throughout the unit. There were only two accessible bottles of ABHG on the floor, and they were both on top of the medication cart. There was one round top container of alcohol-based hand wipes in the dining room.

On 10/16/19 at 10:33 AM, the surveyor interviewed the cultural Program Manager (CPM) regarding the dispensers affixed to the walls on the [redacted] unit. The CPM stated that the dispensers were used by staff as well as visitors to sanitize the hands.

On 10/16/19 at 11:17 AM, the surveyor observed a Nurse Practitioner (NP) dispense the Alcohol-Free hand foam on her hands from the dispenser on the wall near the nursing station on the [redacted] and proceeded to rub her hands with the foam. The NP then proceeded down the hallway and entered a resident's room.

On 10/16/19 at 11:21 AM, the surveyor interviewed the NP who stated that she used the wall dispensers to obtain hand sanitizer as a precaution to prevent spreading of infections. The NP stated that the wall dispensers were easily accessible and she frequently used them.

d.) On [redacted] there were six Alcohol-Free hand foam dispensers affixed to the walls throughout the unit. There was only one accessible bottle of ABHG on the floor and it was located on top of the medication cart.

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F 880	Continued From page 85 On 10/11/19 at 9:35 AM, the surveyor observed a Certified Nursing Aide (CNA) #1 in the [redacted] dayroom use the Alcohol-Free hand foam dispenser. The CNA rubbed the foam onto his hands, then used a paper towel to remove any access solution. On 10/11/19 at 9:41 AM, the surveyor observed CNA #1 use the Alcohol-Free hand foam on the [redacted] dayroom during activities. On 10/11/19 at 9:54 AM, the surveyor observed the Activity Aide in the [redacted] dayroom use the Alcohol-Free hand foam dispenser during an activity program. On 10/11/19 at 10:03 AM, the surveyor observed CNA #1 use the Alcohol-Free hand foam dispenser in the [redacted] dayroom during the activity program. The CNA #1 dispensed the foam onto his hands, rubbed his hands together, then used a paper towel to dry his hands. On 10/11/19 at 12:09 PM, the surveyor observed the Licensed Practical Nurse (LPN) apply the Alcohol-Free hand foam during lunch service in the [redacted] dining room. The LPN then went to assist in feeding an unsampled resident. On 10/11/19 at 12:13 PM, the surveyor observed CNA #1 apply the Alcohol-Free hand foam in the [redacted] dayroom prior to exiting the room. At 12:19 PM, the CNA #1 returned to the dayroom and applied the Alcohol-Free hand foam. On 10/16/19 at 9:33 AM, the surveyor interviewed the CNA #2 on [redacted] who stated that the dispensers on the walls were a hand sanitizer	F 880		

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adding that you would use it to clean your hands instead of using soap and water.

On 10/16/19 at 9:36 AM, the surveyor interviewed CNA #3 who stated that the dispensers on the wall contained a hand sanitizer and that it would be used to sanitize the hands when passing out lunch trays.

On 10/16/19 at 9:44 AM, the surveyor observed CNA #1 apply the Alcohol-Free hand foam in the [redacted] dayroom. The CNA #1 informed the surveyor that the dispensers contained hand sanitizer, which would be used to sanitize the hand. The CNA #1 stated that hand sanitizer was not the same as washing your hands, but since he was in the dayroom, he was unable to wash his hands, so he used sanitizer instead.

On 10/16/19 at 10:07 AM, the surveyor observed the Activities Aide coming out of an unsampled resident's room. The Activity Aide stated that she had just given the resident coffee. The surveyor asked the Activity Aide what the foam dispenser on the wall was for. The Activity Aide informed the surveyor that the dispenser contained hand sanitizer. The Activity Aide proceeded to demonstrate the use of hand sanitizer. The Activity Aide stated that she used the hand sanitizer when she exits a resident's room.

On 10/16/19 at 11:28 AM both the LPN and the LPN/Charge Nurse informed the surveyor that the dispensers on the wall were hand sanitizer. When the surveyor inquired if there was a difference between the hand sanitizer on the wall and the hand sanitizer on the medication cart, both nurses confirmed the product was the same, just a different form. The nurses both confirmed

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that the wall contained a foam hand sanitizing solution, while the medication cart contained a gel hand sanitizing solution. The LPN stated that sanitizing was used when handing out medications rather than washing your hands. The LPN/Charge Nurse stated that you would need to wash your hands after applying the hand sanitizer three times.

On 10/16/19 at 11:56 AM, the surveyor observed both the Activity Aide and CNA #3 apply the Alcohol-Free hand foam in the [redacted] dayroom.

e.) On Floor #5, there were six Alcohol Free hand foam dispensers affixed to the walls throughout the unit. There was one dispenser by the nurse's station, one by the activity calendar wall, one in the activity/dining room, one adjacent to room [redacted], one next to room [redacted] and one dispenser between room [redacted] and [redacted] There were only two accessible bottles of ABHG on the floor, and it was located on top of the medication cart.

On 10/9/19 at 12:09 PM, the surveyor observed the Restorative Certified Nursing Aide (R/CNA) apply the Alcohol-Free hand foam on [redacted] prior to assisting an unsampled resident ambulate down the hallway. At that time, the R/CNA stated to the surveyor that she uses the hand foam from the wall to cleanse the hands before walking with residents.

On 10/10/19 at 10:33 AM, the surveyor observed the Registered Nurse/Unit Manager (RN/UM) on [redacted] apply the Alcohol-Free hand foam from the wall dispenser and enter the nurse's station to an opened resident chart.

f.) There was also one dispenser of the

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Alcohol-Free hand foam in the facility's conference room and one on the [redacted] by the [redacted] elevators.

A review of the facility's Infection Control Program / Infection Control Guidelines for All Nursing Procedures revised 7/2019 included, "Employees must washing their hands for (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents; b. When hands are visibly dirty or soiled with blood or other body fluids; ...d. When removing gloves; e. After handling items potentially contaminated with blood, body fluids, or secretions; f. Before eating and after using a restroom. " It further included tha t "In Most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents...g. After contact with a resident's intact skin; h. After handling used dressings, contaminated equipment, etc; i. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; and j. After removing gloves. "

The facility's Infection Control Program did not address the use of an Alcohol-Free hand foam with the active ingredient [redacted] the facility was actively using.

On 10/15/19 at 10:42 AM, the surveyor observed the housekeeping central supply room with a housekeeping staff member. There were 14 one-gallon jugs of soap in addition to several stored boxes. Stored on a rack were 17 full

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bottles of Alcohol-Free hand foam. The housekeeper stated that there were no boxes of them left, but that they get re-ordered very quickly. The housekeeping staff stated that the housekeeper has the role to make sure dispensers are filled on each unit and they replace it, if it was empty. The staff member could not speak to how long the facility had been using the Alcohol-Free hand foam.

On 10/16/19 at 11:40 AM, the surveyor requested Purchase Orders for any hand sanitizer products they had purchased from the Licensed Nursing Home Administrator (LNHA). The LNHA asked what type of hand sanitizer and the surveyor responded for any and "all hand sanitizer products purchased."

On 10/16/19 at 12:56 PM, The LNHA stated to the survey team in the presence of the Director of Nursing/Infection Preventionist (DON), and the Regional Director of Nursing (R/DON) that "I noticed when I came here there were no wall [hand sanitizer] dispensers, so we ordered them." He further stated that the facility did have the ABHG bottles around the units, but that there were no wall dispensers, which was why the ordered them. The LNHA provided the survey team with the purchase orders.

A review of the Purchase Order sheets created on 8/16/19 and delivered on 8/23/19 reflected a quantity of 50 "Sanitizer, 1000 ml [milliliter] DISPENSER White/Black" without a cost for the dispenser. It further included a purchase order and cost for 48 bottles of the Alcohol-Free "Sanitizer, 1000 ml, [brand redacted] Foam." A Note on the purchase order included, "Please include 50 black dispensers for starters." The

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purchase order was approved by the Regional Director of Operations (R/DO).

The surveyor reviewed the Infection Control Tracking for the last two quarters. There was no documented evidence of a spike in infections or a change of new microorganisms since the Alcohol-Free hand foam had been delivered to the facility on 8/23/19.

On 10/17/19 at 11:28 AM and 12:31 PM, the surveyor interviewed the R/DO who made the purchase orders for the Alcohol-Free hand foam, in the presence of the survey team. The R/DO stated that he was making the purchase orders for the facility as of 7/1/19. He stated that they noticed there were only gel [ABHG] pumps around the facility so, "we started adding dispensers." He stated that the facility used different vendors depending on prices, and that the facility and the team "did a lot of research" as to which product to buy. He stated they chose to buy a foam-dispensing product because it was better than a gel-based dispensing product, because for one reason, the gel was sticky and leaked a lot and affects the floor finish.. He added that the gel was still available on all the medication carts. He stated that the administration team determined the [brand redacted] product was the best choice.

On 10/17/19 at 12:41 PM in the presence of the survey team, the surveyor interviewed the DON/Infection Preventionist, the Assistant Director of Nursing (ADON) and the LNHA. The surveyor asked the DON/Infection Preventionist what products the facility used for hand hygiene. The DON stated the staff could use soap and water to wash the hands and an alcohol-based

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hand gel rubs. The surveyor asked if there were any other products that the facility used for hand hygiene, and the DON stated, "Nothing else that I can think of." The surveyor asked where they kept the ABHG products, and the DON stated that they were on the medication carts and the black wall dispensers on each of the units. The LNHA added that the Regional/DON and him had noticed that there were no dispensers and we got it going. The surveyor inquired if they were aware of what the active ingredient was in the wall dispensers, and the DON, ADON and LNHA stated they were not aware of the active ingredient in the product. The surveyor directed them to wall dispenser unit in the conference room and asked them to read the product. They all acknowledged the product read that it was "Alcohol-Free" hand foam and the active ingredient was not alcohol but [redacted] %." The DON stated that he didn't know that the facility was using an Alcohol-Free hand foam and that he was under the impression that the facility was to use an alcohol-based hand hygiene product. The DON, ADON and LNHA could not speak to how the decision was made to use an Alcohol-Free hand foam.

At 2:22 PM, the DON and the R/DO were interviewed by the surveyor in the presence of the survey team. The R/DO stated that he spoke to the manufacturer of the Alcohol-Free hand foam who told him they sell this exact product to hundreds of nursing homes, and that the facility was an FDA approved facility. The R/DO provided the surveyor a Safety Data Sheet issued 8/18/14 from the manufacturer. There was no evidence it was an alcohol-based product. The R/DO further provided a manufacturer "Microbiology Division Final Report" for the

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"Evaluation of the Antimicrobial Effectiveness of [Brand redacted], sponsored and conducted by the manufacturer dated 5/21/03. The surveyor asked what the Centers for Disease Control and Prevention (CDC) recommended for hand hygiene in healthcare facilities? The DON stated he would research it tonight. The R/DO asked what the problem was with using the Alcohol-Free hand foam, and the surveyor stated that the facility infection control program indicated that alcohol-based products were to be used, and did not speak to the use of alcohol-free products. The surveyor asked if he found any nationally accepted infection control standards for healthcare facilities such as from the CDC, for the use of alcohol-free products the surveyor would review the material.

On 10/18/19 at 10:57 AM, the survey team interviewed the LNHA, Assistant Administrator, DON, and the R/DON. The LNHA stated that the facility replaced
all the Alcohol-Free products with alcohol-based foam. He added that the CDC recommended to use alcohol-based, but that the "key word is 'recommend.'" The R/DON stated that the Alcohol-Free hand foam killed 99.9% of bacteria. The surveyor asked if they had any materials other than manufacturer documents and/or marketing documents, that address the use of the Alcohol-Free hand foam from the CDC or other nationally accepted infection prevention and control standard. The administration was unable to provide documents to the surveyor. The surveyor inquired what the facility's process was if they were not following a nationally accepted guideline or recommendation, and no one could speak to and/or answer the surveyor's question. They could not speak to their infection control

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program which did not address the use of Alcohol-Free hand foam.

2. On 10/11/19 at 9:09 AM, the surveyor observed Resident #36 in bed. The RN/UM entered the resident's room without performing hand hygiene and adjusted the resident's pillow and blanket. She then exited the resident's room and entered a room across the hallway and held hands with the unsampled resident in the room while speaking to him/her. The RN/UM then picked up papers from the floor, and took two clear plastic bags with resident personal belongings in them from a wheelchair temporarily stored in the hallway and entered a third resident room and closed the door. There was no evidence of hand hygiene between the three resident encounters.

On the same day at 9:14 AM, the surveyor observed a CNA enter the room of an unsampled resident on [redacted] The CNA observed that there was remnants of the resident's breakfast on the front of the resident's shirt. The CNA got a towel and cleared the resident's shirt and removed the breakfast tray from the resident's room. The CNA then entered the adjacent resident room adjusted a bedside table and picked up a tray. The CNA exited that room when a second CNA asked her for assistance in a third resident room. There was no hand hygiene between resident contact.

On 10/11/19 at 9:26 AM, the surveyor observed on Floor #5, an Activities Aide (AA) going from room to room. The surveyor observed the AA enter room [redacted], then into room [redacted] and stated, "they will get you up soon." She then went into room [redacted] and opened the resident's privacy

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curtain with her bare hands, and spoke to the resident in that room. The AA continued to go to into four more rooms touching a door frame, holding onto door nob of a resident room while talking to a resident who was inside, and adjusted another resident's bedside table and privacy curtain in the room. The AA did not perform hand hygiene when going room to room and adjusting high-touch surfaces within the resident's environment.

On 10/17/19 at 9:26 AM, the surveyor observed the Physical Therapist (PT) turn on the sink in the rehab gym put her hands under running water for four seconds and turned off faucet with her bare hands and got a dry towel and dried her hands. There was no evidence the PT used any soap. The surveyor then went to interview the PT regarding what she was doing at the sink. The PT stated that she just washed her hands. The surveyor asked her about her technique and the PT stated that she would demonstrate her hand washing technique to the surveyor. The PT turned on the faucet and applied soap and put her hands immediately under the running water without friction. She then stated to the surveyor "happy birthday to you" three times and stated you say "happy birthday three times like that." At that time, she got a paper towel, dried her hands and turned off the faucet. The full hand hygiene process took 10 seconds. The surveyor asked the PT what the importance was of saying "happy birthday" and the PT stated that they tell you that if you say happy birthday three times, that's how long you wash your hands. The surveyor asked if she scrubs her hands using friction before rinsing them and she stated "yes" but the all go under the water anyway. The PT stated that was always how she washed her hands.

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4. On 10/16/19 at 9:48 AM, the surveyor observed a Housekeeper clean a table in the [redacted] dayroom that had brown colored spots on it. The Housekeeper used a colorless solution in a spray bottle with a washable towel. The surveyor asked the Housekeeper what type of solution he was using, and the Housekeeper stated and showed the surveyor the label on the bottle which indicated the solution was a multi-surface cleaner.

On 10/17/19 at 10:36 AM, the surveyor observed another Housekeeper cleaning a bedside table in an unsampled resident room on [redacted] The Housekeeper was using a spray bottle with a purple liquid and labeled "Glass Cleaner and Protector." The Housekeeper used a terrycloth rag and started by wiping the base of the bedside table, including the metal frame and underneath the metal base. The Housekeeper than cleaned up the bedside table and finished by cleaning the top of the resident's bedside table with the same rag. He then positioned the bedside table back in front of the resident who was in bed. The surveyor asked to see the bottle of solution he was using, and he stated it was glass cleaner. The surveyor asked why he was using glass cleaner to clean a bedside table and the Housekeeper stated "because the bedside table has metal on it" and it adds "shine." The surveyor inquired if he used any other product on the bedside table and the Housekeeper confirmed he was using just that product.

On 10/17/19 at 10:45 AM, the surveyor interviewed the Maintenance/Housekeeping Director who stated that the purple solution was a multi-purpose cleaner and not a glass cleaner

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and protector. He stated that it must have been labeled incorrectly by the housekeeper. He showed the surveyor the multi-purpose cleaner and the glass cleaner and stated that the multi-purpose cleaner was purple, and the glass cleaner was blue. He stated if the Housekeeper was using a purple product he was using the correct cleaner to clean the surface, but acknowledged it should not have been labeled as a glass cleaner. He could not speak to why the Housekeeper would tell the surveyor that the glass cleaner was appropriate for cleaning the bedside table.

On 10/17/19 at 2:16 PM, the surveyor interviewed the Director of Operations in the presence of the survey team stated that the Housekeeper on [redacted] was using the correct multi-surface cleaner, but the concentrated bottle of multi-surface cleaner in the dispenser did not have enough concentrated chemical for the proper dilution in water. The product contained more water than chemical. He confirmed that the multi-surface cleaner was not properly diluted, which explained why the solution appeared colorless rather than purple.

On 10/18/19 at 10:55 AM, the LNHA in the presence of the survey team stated that he spoke with the Housekeeping Director who stated that the concentrated chemical solution in the dispenser is pre-dispensed, but does not have an alarm to signify that the chemical is low and that housekeeping staff were in-serviced on the proper dilution on cleaning products.

4. On 10/15/19 at 9:36 AM, the surveyor observed Resident #90 in bed wearing [redacted] at

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two liters per minute via a [redacted]. The CNA was preparing the resident for a bedbath. The CNA removed the [redacted] from the resident's [redacted] and placed it on the bed. At that time, the [redacted] snaked through the siderails and fell directly to the floor. The CNA left it on the floor throughout the duration of the morning care.

At approximately 10:07 AM, the surveyor observed the CNA pick up the [redacted] from the floor and apply it back into the resident's nares. The [redacted] was on and set at the [redacted].

At that time at approximately 10:07 AM, the CNA and another CNA (CNA #2) was assisting the resident up in bed. The surveyor observed CNA #2 perform hand hygiene at the sink in the resident's room. The CNA #2 turned on the faucet, applied soap and rubbed it together for three seconds, then rinsed the hands with water and dried them.

At 10:15 AM, the surveyor interviewed the CNA who acknowledged that she reapplied the [redacted] that had fallen to the floor. The CNA stated that she should have told the nurse and got a new one.

5. On 10/15/19 at 10:20 AM, the surveyor observed the CNA on [redacted] bag soiled linen into a soiled linen cart on the unit. The lid of the linen cart had a nob on it which had to be lifted to discard. The surveyor observed the CNA lift the lid with her used gloved hand and dispose of the linens.

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F 880	Continued From page 98 On 10/16/19 at 9:25 AM, the surveyor interviewed a CNA who stated that she did not usually work this floor but all the floors had the blue soiled linen carts with the hand held nob to open it. She stated there was no other way to open it but to use your hands. She stated that she would use wear gloves when opening it. She stated there was one cart on the floor that had a stepper for soiled linens but showed the surveyor that the stepper did not work and that staff had to use their hands to open that one too. The surveyor observed the following on [redacted] On 10/17/19 at 9:11 AM, the surveyor observed three soiled linen carts in use on the second floor. The linen carts all had a nob on the lid that had to be lifted with the hand to discard soiled linen. The surveyor observed the following on Floor #3: On 10/17/19 at 9:22 AM, the surveyor interviewed the CNA who stated that each CNA had their own soiled linen cart and that there were two (2) CNA's on the [redacted]. The CNA stated that she was placing the soiled linens in a trash bag and bringing the bag to her soiled linen cart with a hand held nob on the lid. At that time, the surveyor observed the CNA in a resident's room with gloves on place the soiled linen in a trash bag and took the bag to her soiled linen cart. The surveyor observed the CNA lift the top of the soiled linen cart with the gloves on and placed the trash bag inside. The surveyor interviewed the Director of Nursing/Infection Preventionist and the LNHA in	F 880		

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F 880	Continued From page 99 the presence of the survey team on 10/17/19 12:41 PM. The DON stated that soiled linens are to be separated from clean linens, and staff wear gloves and discard into the blue mesh carts. The DON acknowledged that the blue mesh soiled linen carts were not new and that staff had to use a hand-held nob to open it to discard. He acknowledged that the nob was a high touch soiled surface. The DON stated that he does Infection control rounds where he looks at how on linens are transported, and he also does random audits for hand hygiene. He stated that "we just completed a hand hygiene audit" in [redacted] and that "everyone was compliant" in each department. He could not speak to the surveyor's observations. He confirmed hand hygiene should be performed between direct resident contact and after removal of gloves. NJAC 8:39-19.1, 19.2, 19.4, 19.5	F 880		