STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315517	A. BUILDING _____ B. WING _____	09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION MOORESTOWN	212 MARTER AVENUE MOORESTOWN, NJ 08057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 9/24/19 CENSUS: 105 SAMPLE SIZE: 24 +19= 43 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that [redacted] prevention interventions were implemented to address the risk of development of a [redacted] for a resident that was identified as being at risk for [redacted] development. This deficient practice was identified for Resident	F 686	1. Patient (Resident #108) has been safely discharged from the center to home. 2. All patients have the potential to be impacted by this deficient practice. Current patients will be reviewed to ensure [redacted] interventions are implemented to address the risk of	11/19/19

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

Electronically Signed | 10/27/2019

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F 686	Continued From page 1 #108, 1 of 2 residents reviewed for [redacted] and was evidenced by the following: On 09/18/19 at 8:28 AM, during the initial tour, the surveyor observed Resident #108, who was awake, alert and lying supine (on back facing upward) in bed with the head of the bed slightly elevated. Concurrently, the surveyor observed the Registered Nurse, Minimum Data Set Coordinator (RN/MDS) and Assistant Director of Nursing (ADON) enter the resident's room. They stated they were going to boost the resident up in bed. The ADON stated, upon lifting the resident up in bed, "these need to come out." The ADON was observed removing towels and a sheet, that appeared wet, from underneath the resident. The resident stated, "they told me it was a good cushion for my [redacted]." The resident was not observed lying on a [redacted]. At 8:51 AM, the surveyor returned and continued the interview with Resident #108. The surveyor observed Resident #108 lying supine in bed with head of bed slightly elevated. The resident stated that he/she had [redacted]" on the base of his/her [redacted] and that he/she did not have any [redacted]," or any issues with his/her skin before coming to the facility. The resident further stated that he/she spent many weeks in another facility and had no problems with his/her skin and that since he/she came to the facility that he/she got [redacted]" from being left lying in a [redacted] brief and due to frequent [redacted]. The resident continued to state that he/she had a [redacted] that was removed at 18 years of age and that there was also a "[redacted]" in the area of his/her [redacted]. The resident stated that he/she thought the [redacted] was not getting "wiped" clean by the CNAs. Resident #108 further stated that he/she kept	F 686	developing a [redacted]. 3. Nurse Practice Educator/designee will re-educate Nursing Staff on Skin Integrity Management Policy and the development and implementation of care plan interventions to address residents risk of developing [redacted]. Clinical Directors/designees will complete weekly random audits for residents at risk for [redacted] development to ensure interventions have been implemented. 4. Center Nurse Executive/designee will review reports monthly, for the next 3 months, for compliance and trending. Reports will be submitted to QAPI Committee to evaluate the need for further audits and/or action monthly for 3 months.	

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F 686	Continued From page 2	F 686		

telling the CNAs that his/her backside was [redacted] and that they (CNAs) "told me it was [redacted] and that it was okay."

On 09/19/19 at 8:33 AM, the surveyor observed Resident #108 lying supine in bed with the head of the bed slightly elevated. No [redacted] was observed. The surveyor interviewed the resident regarding the towels and sheet that was observed being removed from underneath the resident on [redacted]. The resident stated, "yesterday, the CNA put the towels under me because of my [redacted]."

According to the Admission Record, the resident was admitted to the facility on [redacted] with diagnoses that included [redacted] of [redacted] A Physician follow-up note, dated [redacted], revealed the resident was assessed as having a [redacted] and [redacted]

According to the Admission Minimum Data Set (MDS), an assessment tool used to facilitate care dated [redacted], the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident was [redacted] intact. The MDS also revealed that the resident needed maximal assistance to roll [redacted], was dependent on staff for toileting, was non-ambulatory, was at risk for developing [redacted], did not have any unhealed [redacted], was frequently [redacted] and that a trial toileting program has not been attempted.

Review of a Nursing Admission Documentation

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F 686	Continued From page 3 Note (NADN), dated 08/12/19 at 5:04 PM, revealed Resident #108 was admitted without a [redacted] and that the resident scored 10 on the [redacted] Score (an assessment tool used to assess a resident's risk of developing [redacted]. A score of [redacted] indicated the resident was at [redacted] for developing [redacted]. An ADL (Activity of Daily Living) summary revealed the resident was totally dependent on staff for bed mobility, personal hygiene/dressing and required extensive assistance for toileting. The [redacted] system reviewed and [redacted] toileting program section was blank. Review of an [redacted] l Therapy Encounter Note [redacted], dated [redacted] revealed precautions for skin integrity. The note also included that the resident was dependent for bed mobility and skilled interventions that included "promotion of postural alignment and control and patient/caregiver education in bed positioning strategies to focus on facilitation of [redacted] distribution, facilitation of [redacted] and [redacted] Review of an [redacted] Note, dated [redacted], revealed precautions for skin integrity and skilled interventions that included, "patient/caregiver education in bed positioning strategies focusing on optimal skin integrity and [redacted] reduction." Review of the Care Plan (CP) revealed a "Focus" area, initiated [redacted] which revealed that Resident #108 was dependent (on staff) for bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to limited mobility. The goal was to anticipate and meet the resident's ADL (activities of daily living) needs. Interventions	F 686		

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initiated included to provide the resident with a total assist of two staff for bed mobility and transfers via Hoyer (a mechanical lift device). The CP further revealed that upon admission, [redacted], the resident was dependent on two staff for bed mobility. The CP did not have specific, quantifiable or measurable interventions noted for repositioning the resident. There was no CP intervention for the resident's frequent urinary incontinence; although, on [redacted], the CP revealed that the resident was at risk for skin breakdown related to decreased activity and incontinence. The CP did not reveal bed positioning strategies as documented in the [redacted] Note and to maintain optimal skin integrity,

Review of the CP revealed a "Focus" area, initiated[redacted], which indicated that Resident #108 was at risk for skin breakdown due to decreased activity. The goal was "to remain free of[redacted] and/or[redacted] X 90 days." Interventions initiated at that time included, "apply barrier cream with each cleansing," "pat (do not rub) skin when drying," and "provide preventative skin care i.e. lotions, barrier creams as ordered."

Review of a Physician Progress Note, dated [redacted] revealed the resident leaned to the right and required full assistance for repositioning. The Physician recommendations for skin included an [redacted], and educating the resident and family on turning the resident.

Review of the CP revealed an intervention for [redacted] surface to bed" which was initiated on [redacted] and not on [redacted] when recommended by the physician.

Review of a Nursing Progress Note (NPN), dated

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F 686	Continued From page 5 [redacted] at 11:41 AM, revealed a Certified Nurse Aide (CNA) had provided peri-care for Resident #108 and notified the nurse that the resident was complaining of a [redacted] to the [redacted] (area below the [redacted] and above the [redacted] During that observation the nurse observed an opening [redacted] to Resident #108's [redacted]. A review of a Physician's Order Summary (POS) Report revealed a treatment order, dated [redacted] for the [redacted] clean[redacted], apply [redacted] and cover with dry sterile dressing (DSD) every night shift for [redacted] treatment. Review of the Progress Note, signed by a Registered Nurse (RN), dated [redacted] at 9:33 AM, revealed the facility in-house acquired [redacted] was identified as [redacted]). The note also revealed that the resident refused an [redacted] and education was provided on the benefits of high [redacted]. There was no alternative intervention, nor additional interventions added to the CP after the resident's refusal of the [redacted] Review of a Nursing Documentation Note (NDN), dated [redacted] at 3:59 PM, completed by a Licensed Practical Nurse (LPN), revealed "No skin injury [redacted] noted. Review of the September 2019 Treatment Administration Record (TAR) revealed there was no corresponding documentation regarding the turning and repositioning and checking the resident's skin every two hours. Review of a [redacted] Visit note, dated [redacted] at 8:07 PM, completed by the Advanced Practice	F 686		

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Nurse (APN), revealed a [redacted] that measured [redacted] in [redacted] (drainage). The APN [redacted] visit recommendations revealed to limit seating to two hours at a time. There was no change in the treatment order, nor was there a physician order corresponding with the recommendations made by the APN to limit seating to two hours at a time. The APN visit further revealed that the plan of care was discussed with the nursing staff.

Review of a [redacted] Visit note, dated [redacted] at 00:00, completed by the APN for follow up a a [redacted], revealed that the resident stated "she cannot tolerate" the [redacted] but would like to try an [redacted] The visit further revealed the APN discussed this with the resident and the Unit Manager who "will" follow up. The visit further revealed the APN now classified the [redacted] as an [redacted] involving [redacted] or [redacted]) that measured [redacted]. A picture of the [redacted], dated [redacted] revealed "a [redacted] The APN visit further revealed to D/C (discontinue) [redacted] to the [redacted] and apply [redacted] and [redacted] to [redacted] daily and cover with a dry dressing and border gauze and limit seating to two hours at a time.

Review of a [redacted] assessment, dated [redacted], revealed that as of [redacted], the 8 days old in-house [redacted] was [redacted] and [redacted]. There were no

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F 686	Continued From page 7 additional interventions added to the CP to prevent additional wound deterioration. Review of the POS, dated [redacted] at 12:31 PM, revealed that there was no indication or documentation that the [redacted] was discontinued and the [redacted] was ordered in accordance with the APN recommendations on [redacted] Further, the TAR, printed on [redacted] at 12:42 PM, revealed the [redacted] treatment was administered on [redacted] and [redacted] and remained on the TAR as active. There was no documentation to support the APN recommendation to limit the resident's seating to two hours at a time nor, support the trial of an [redacted]. There was no evidence of changes in the CP interventions noted on [redacted] 9 when the [redacted] was identified as progressing to a [redacted] by the APN. On 09/19/19 at 11:11 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1 regarding if the resident gets out of the bed and if the resident was on a turning and repositioning schedule. LPN #1 stated that the resident can get out of the bed and go into a wheelchair. LPN #1 further stated that the resident is not on a turning schedule because if the resident was on a turning schedule that "it would be on the sheet." LPN #1 proceeded to show the surveyor the LPN's Report Sheet, dated [redacted] As an example, LPN #1 showed the surveyor another resident's notes that clearly indicated, and was highlighted, to turn the resident every two hours. LPN #1 stated if Resident #108 was supposed to be turned every two hours, it would appear under the resident's name on the Report Sheet.	F 686		

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F 686	Continued From page 8 On 09/19/19 at 2:12 PM, the surveyor interviewed the CNA assigned to Resident #108. The CNA showed the surveyor a hand-held computer and stated that if the resident was on a turning schedule then it should be on her hand-held computer, which had the CNA Kardex (resident care instruction) section in it. The CNA was unable to locate the turning schedule for Resident #108 in the Kardex and stated "they took it off, it is not here." The surveyor reviewed the Skin Care interventions on the CNA Kardex, dated 09/19/19. The interventions revealed, observe skin condition daily with ADL care and report abnormalities, pat (do not rub) skin when drying, preventative skin care lotions/cream-type and site to be applied to [redacted] and [redacted] and during incontinence and preventative skin care, [redacted] while in bed with pillow. The CNA further stated that the resident could not turn him/herself and the resident was not on an [redacted] and stated that she knew that because "I just changed the resident's sheets." Review of a nursing Skin [redacted] Evaluation (SWE), dated [redacted] at 7:54 AM, revealed the [redacted] had progressed to a [redacted]) on [redacted]. The SWE further revealed, under additional care, a cushion and turning/repositioning program. Notes: revealed treatment changed from [redacted], gauze and bordered gauze. Review of the handwritten two-hour repositioning sheets, dated 08/16/19, 08/17/19, 08/18/19, 08/19/19, 08/20/19, and 08/21/19, revealed that the resident refused to be repositioned: 08/17/19-four times, 08/18/19-two times,	F 686		

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08/19/19-two times, and 08/21/19-one time. The sheets were not completed after 08/21/19.

On 09/24/19 at 9:05 AM, the surveyor interviewed the Center Nurse Executive (CNE), in the presence of the survey team, Administrator and Corporate Clinical Director. The CNE stated the providers were aware that the resident refused to be turned at times and no new interventions were implemented to prevent further skin breakdown. She continued to state there was no order for the turning schedule other than the care plan. She further stated that the manual (handwritten) sheets would have been used to document the resident's turning schedule and there was no information in the electronic medical record that would document the two hour turning schedule or the refusals. She did not provide an explanation as to why the two-hour turning schedule sheets were not completed after [redacted] She confirmed that once it was known that the resident was refusing to be turned, there were no additional preventative interventions implemented and confirmed the facility [redacted] advanced to a [redacted] and the staff documented the resident's refusal of an [redacted].

On 9/24/19 at 11:04 AM, the surveyor, in the presence of the survey team, interviewed the CNE regarding the further progression of Resident #108's [redacted]. The CNE stated that the facility had initiated an investigation to determine how Resident #108's [redacted] progressed to a [redacted]

Review of the facility Skin Integrity Management Policy, revised on [redacted], revealed, "Staff continually observes and monitors patients for changes and implements revisions to the plan of

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F 686	Continued From page 10 care as needed." NJAC 8:39-27.1(e)	F 686		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it was determined that the facility failed to provide palatable foods at appetizing temperatures. This deficient practice was identified for 3 of 5 residents reviewed for food (Residents #58, #162, #215) and was evidenced by the following: On 09/17/19 at 10:20 AM, the surveyor interviewed Resident #58. The resident was alert and oriented and observed sitting on the edge of the resident's bed. The resident stated the toast today was "hard as a rock." At 10:27 AM, the surveyor interviewed Resident #162. The resident was alert and oriented and observed sitting in a chair in the resident's room. The resident stated "sometimes the food is cold at dinner and lunch is either warm or luke warm."	F 804	1. Patients (Resident #58, #162, and #215) were discharged. 2. Current patients have the potential to be impacted by these deficient practices as all food provided to patients is prepared on-site. 3. Current Dining Services staff will be re-educated by Food Service Director on the following policies: Meal Service, Meal Times and Delivery, Food Handling, Production Tools, Thermometer Usage, Consistency Alteration and Therapeutic Menus. Nurse Practice Educator/designee will re-educate nursing staff on Meal Delivery Policy. 4. Dietician/designee will conduct random weekly audits of kitchen tray line and point of service on [redacted] units to	11/19/19

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F 804	Continued From page 11 At 12:51 PM, the surveyor interviewed Resident #215 during the lunch meal. The resident was alert and oriented and observed sitting upright in bed. The meal included a sloppy Joe sandwich. The resident stated the sandwich was dry even though he/she had requested extra gravy. On 09/19/19 at 11:41 AM, the surveyor observed the lunch tray meal preparation line in the kitchen. The surveyor randomly selected food items from the meal. The items included puree beef, puree carrots and mashed potato. Additionally, one-half of an egg salad sandwich was selected from the sandwich preparation unit which was adjacent to the lunch tray preparation line and was being used by staff. The sample food items were placed on the "[redacted]" unit food cart and the surveyor, and Dietary Director (DD) accompanied the tray to the unit. At 11:58 AM, the last tray was passed on the unit. The surveyor, used a calibrated thermometer to immediately check the food temperatures and the DD concurrently checked food temperatures with his thermometer. The DD stated the cold food should have a temperature of less than 40 degrees Fahrenheit (F) and the hot food should be no less than 145 degrees F at the point the resident received the food. The DD stated that the beef item was the puree hot version of the main entree which was roast beef and provolone sandwich. The following food temperatures were recorded: Puree Beef Surveyor: 116 degrees F DD: 115.8 degrees F	F 804	ensure proper food temperatures and consistency and palatability of pureed diet. Food Service Director will review reports monthly for compliance and trending. Reports will be submitted to QAPI Committee to evaluate the need for further audits and/or action monthly for 3 months.	

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Puree Carrots
Surveyor: 119 degrees F
DD: 118.6 degrees F

Mashed Potato
Surveyor: 123.8 degrees F
DD: 126.3 degrees F

Egg Salad
Surveyor: 56.2 degrees F
DD 59.5

Upon completion of the temperatures the DD stated that the hot food was too cold and the egg salad should not have been greater than 40 degrees F.

The surveyor observed that the puree beef had a grayish color and was spread out on the plate and the puree carrots had a shiny appearance and gel-like texture. The surveyor and DD tasted the puree beef and puree carrots. Both food items had a gritty feel when tasted, which is consistent with too much thickening agent used when the items were prepared. The DD confirmed the surveyors assessment of the puree beef and carrots. The DD stated there are recipes that are used for the puree food items.

At 12:17 PM, the surveyor and DD returned to the main kitchen. The DD stated the sandwich preparation unit was kept open during meal time and sandwiches were made on demand for residents. The lunch meal tray preparation line continued and the surveyor and DD concurrently checked the temperature of the egg salad which was located in the sandwich preparation unit. The surveyor recorded a temperature of 41 degrees F and the DD recorded a temperature of

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F 804	Continued From page 13	F 804		

43 degrees F. The DD stated the temperature of the egg salad should not have been higher than 40 degrees F.

On 09/20/19 at 8:37 AM, the surveyor interviewed the cook, in the presence of the DD, regarding the food temperature log for 09/19/19. The Service Line Checklist (Food Temperature Log), dated 09/19/19, did not have food temperatures logged for the lunch puree vegetable and beef items. The DD confirmed that no temperatures were recorded for the puree carrots or beef.

At 9:01 AM, the surveyor in the presence of the DD, interviewed the cook who prepared the puree meal on 09/19/19. The cook stated he cooked four puree meals that day. The cook further stated there were recipes for the puree food and the recipes for the puree hot roast beef, bread and puree sliced carrots were reviewed with the cook and DD. The puree hot roast beef, bread recipe indicated that the ingredients were a hot roast beef sandwich. The Week-At-A-glance, Rehab Summer 2019 Week 2 menu revealed a puree roast beef and provolone on bread sandwich was listed as the puree entree.

The surveyor did not taste any bread or cheese in the puree beef . The cook stated he did not puree bread, although it was on the menu and that he did not add the provolone cheese to the puree beef. The cook stated he has not pureed bread in a year and did not offer a reason why.

Review of the recipe procedures for the puree hot roast beef, bread, revealed that the portions were transferred to a food processor, blended and if too thick, add a small amount of broth or hot water and if too thin, add a small amount of

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F 804	Continued From page 14 non-nutritive food thickener. Similarly, the sliced carrot recipe revealed that if the puree carrots were too thick to add a small amount of broth or hot water and if they are too thin, add a small amount of non-nutritive food thickener. Upon further interview, and when asked how much thickener should be added, the cook stated a small amount. The cook further stated that he did not taste the puree roast beef or carrots after he prepared them and he confirmed that he did not puree the bread or add provolone cheese as the menu required. The cook did not provide the surveyor with a reason that the bread was not pureed and the cheese was not added or why he did not taste the food to confirm that it was properly prepared. The sliced carrots puree recipe further revealed that the temperature for service was 145 degrees. The surveyor interviewed the facility Registered Dietitian (RD) regarding the amount of thickener that should be added when pureeing the food. The RD stated that a tablespoon would be a suggestion. She continued to state that she was unaware of any menu substitutions for 09/19/19 or if there were reasons that the cook did not prepare the puree bread. She further stated that the cooks should be following the menu and taking the temperatures of the food prior to serving the food to ensure the food is not in the danger zone.	F 804		
F 812 SS=F	NJAC 8:39-17.4(a)2 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		11/19/19

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F 812	Continued From page 15 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to maintain a.) equipment in a manner to minimize microbial growth and cross contamination, and b.) the proper rinse temperature for the dish machine. This deficient practice was evidenced by the following: On 09/17/19 at 8:57 AM, during the initial tour of the kitchen and accompanied by the Chef, the surveyor observed the dish machine in operation and the Dish Washer (DW) was observed pushing two small containers through the machine to be washed. The rinse temperature was 140 degrees Fahrenheit (F). The DW stated it is "stuck," referring to the gauge. At 9:04 AM, the Dietary Director (DD) joined the	F 812	1. No specific patients in the center who consumed food were impacted by this practice. a. Dish Machine booster fixed b. Can opener blade cleaned c. Blender cleaned and sanitized d. Shallow pans were re-washed, air dried and stored inverted e. Ladles were cleaned, air dried and stored in clean bins f. Meat slicer sanitized and re-covered 2. Current patients in the center who consume food have the potential to be affected by the same deficient practice as all food provided to the patients is prepared on-site. 3. Food Service Director/designee will re-educate staff on Policy Cleaning	

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F 812	Continued From page 16 tour. The DD director was interviewed regarding if the hot water booster was in operation, he stated it was on. The DD confirmed that the rinse temperature of the dish machine was not reaching proper temperature and he stated he will make a service call. The tour continued with the Chef and the following was observed: The can opener blade contained debris. The large blender that was identified as clean, was stored upright and was wet. A rack, identified as containing clean equipment, by the Chef, contained the following: 6-1/3 shallow pans were stacked together and were wet inside 1-1/3 shallow pan was wet with plastic stuck to the bottom interior of the pan 2 large shallow steam table pans were wet inside 2 large shallow steam table pans contained debris inside A large bin of ladles was exposed to air and debris was noted inside the container containing the ladles The meat slicer was covered and identified as clean by the Chef. Debris was observed on the blade and base of the slicer. At 9:20 AM, the surveyor and DD continued the tour and the DW was observed using the dish machine and running through a steam table pan. The rinse temperature was observed, as in previous observation, at 140 degrees F. The surveyor asked the DW what the rinse temperature should be and he stated 180 degrees F. At that time, the Food and Nutrition	F 812	Standards,4.1 Cleaning Schedule and 4.4 Machine Ware Washing and Sanitizing Procedure (high temp dish machine). 4. Dietician/designee will conduct random weekly audits of the dish machine temperatures to ensure proper rinse temperatures are maintained. Dietician/designee will conduct a monthly sanitation audit to ensure proper maintenance of kitchen equipment to minimize microbial growth and cross contamination. Food Service Director/designee will conduct a weekly sanitation audit to ensure proper maintenance of kitchen equipment to minimize microbial growth and cross contamination. Food Service Director will review reports monthly for compliance and trending. Reports will be submitted to QAPI Committee to evaluate the need for further audits and/or action monthly for 3 months.	

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Services, Machine Warewashing Sanitation Log was reviewed. The Final Rinse Temperature for the 09/16, Noon meal was "157" with the initial of the DM next to the temperature. The DW confirmed he took that temperature and stated he was unaware of the temperature not reaching 180 degrees F. At that time, the DD instructed the DW to stop using the dish machine and a service call was placed.

On 09/19/19 at 12:20 PM, the DD provided the surveyor with a copy of a service call for the dish machine, dated 09/17/19 at 9:56 AM. The comments indicated the "Booster heater was tripped. Took off panel and hit the reset button. Temp went up to 190 after reset button was pushed."

Review of the Food Handling Policy in the Food and Nutrition Services Policies and Procedures manual, revised 08/08/18, revealed that food thermometers are available to all employees who are responsible for checking the internal temperature and holding temperature of the foods.

Review of the Machine Warewashing and Sanitizing Policy in the Food and Nutrition Services Policies and Procedures manual, revised 03/16/14, revealed the final rinse temperature is a minimum of 180 degrees F. If temperatures fall below the standard for either wash or final rinse, the Director of Dining Services or Maintenance is notified immediately.

Review of the Cleaning Procedure from the Warewashing Manual, dated 12/01/15, revealed to place dishware on drain board, inverted to drain and air dry.

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F 812	Continued From page 18 NJAC 8:39 17.2.(g)	F 812		
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined the facility failed to follow their policy regarding outside food brought in for residents and maintained in the resident room refrigerator to ensure food is stored in a safe and sanitary manner. This deficient practice was evidenced by the following: On 09/18/19 at 11:27 AM, during the tour of the facility, the surveyor observed the bedside table of Resident #108, which contained an empty dirty glass. The resident stated the glass contained chocolate milk and "they don't ever clean it, that chocolate shake is old." The surveyor observed a refrigerator in the resident's room and with permission of the resident, observed the contents. The resident's refrigerator contained multiple spills and visible debris, four glasses of an unlabeled, undated beverage, what appeared to be an open to air stick of butter, and three additional unlabeled, unidentified and one uncovered food container. According to the resident's Admission Record, the	F 813	1. Patient (Resident #108) was not affected by this deficient practice. Refrigerator was cleaned and all unknown, unlabeled and food not stored properly was discarded after conferring with patient. Patient no longer remains in this center. 2. Current patients in the center have the potential to be affected by this deficient practice as each patient room has a refrigerator. Every patient refrigerator was checked for cleanliness and expired food. Housekeeping Supervisor educated housekeeping staff regarding checking each refrigerator daily to ensure all foods are labeled with patient name and date food was brought in and food will be held for 3 days following the date on the label, ensuring food is stored in a closed container, food does not appear unsafe for consumption or beyond expiration date and cleanliness of each patient refrigerator. All food appearing unsafe for consumption, food not in closed container and expired food, per policy, will be discarded by staff upon notification of	11/19/19

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F 813	Continued From page 19 resident was admitted to the facility on [redacted] with diagnoses that included [redacted] According to the Admission Minimum Data Set (MDS), an assessment tool used to facilitate care dated [redacted], the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident was cognitively [redacted] On 09/20/19 at 10:22 AM, the surveyor interviewed the Administrator regarding the existence of a policy for monitoring the food and cleanliness of the resident room refrigerators. The Administrator stated there is no policy for the room refrigerators and that Housekeeping cleans the refrigerators. He further stated, "I don't think they open the refrigerator door every time they go in." On 09/24/19 at 9:16 AM, the surveyor, in the presence of the survey team and Center Nurse Executive (CNE), interviewed the Administrator regarding the surveyor's observations of Resident #108's room refrigerator. The Administrator stated, "it is impossible to keep up on labeling and dating in the refrigerators for individual rooms." He further stated, "if food is expired and we see it, the food would be thrown out and the refrigerator would be cleaned." He also stated, "we are a short stay building and we have been doing it this way for six years and there has not been an issue. The housekeeper may have looked the day before." The Administrator did not provide information regarding a process for monitoring the foods stored in, or the cleanliness of the resident room refrigerators.	F 813	patient. 3. Housekeeping and Guest Services staff will be re-inserviced on Policy 4.13 Food Brought in for Patients/Residents. Daily Housekeeping work-flow sheets have been updated to reflect checking patient room refrigerators for compliance with Policy 4.13. All new patients and visitors will be provided with Center's Guidelines for Food Brought in for Individual Patients/Residents. Housekeeping Supervisor/designee will conduct weekly audits of 10% of all patient room refrigerators to ensure we are compliant will all aspects of Policy 4.13. Housekeeping Supervisor will submit weekly audit reports to the Assistant Director of Nursing for review. 4. Assistant Director of Nursing will review reports monthly for compliance and trending. Reports will be submitted to QAPI Committee to evaluate the need for further audits and/or action monthly for 3 months.	

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F 813	Continued From page 20 On 09/24/19 at 9:31 AM, the surveyor interviewed the Director of Housekeeping (DOH), in the presence of the survey team and Administrator. The DOH stated she was unaware of the condition of Resident #108's refrigerator per the surveyor's observation on 09/18/19. The DOH stated she observed the Resident #108's refrigerator this morning and the refrigerator was "stuffed with stuff." The DOH stated she was not aware of the condition of the resident's refrigerator being as dirty as it was, until this morning. She further stated that her staff is supposed to tell her if the refrigerators are dirty. On 09/24/19 at 11:49 AM, the surveyor was provided a copy of the Food Brought in for Patients/Resident's Policy, effective 11/28/18. The policy revealed food brought to patients/residents by family or visitors will be handled and stored in a safe and sanitary manner. "Food may be stored in refrigerators outside of the Food and Nutrition Services Department on the nursing unit or in personal refrigerators in resident rooms." "Food items that require refrigeration must be labeled with the patient's/resident's name and date the food was brought in." "Food items must be stored in a closed container to prevent contamination." "Foods considered unsafe for consumption or beyond the expiration date will be discarded by staff upon notification to patient/resident." "Food will be held in the refrigerator for three (3) days following date on label and will be discarded by staff upon notification to patient/resident." NJAC 8:39-17.2(g)	F 813		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		11/19/19

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F 880	Continued From page 21 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 22 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: This is a repeated deficiency from the last standard survey, dated 09/28/18, for example #2. Based on observation and interview, it was determined that the facility failed to follow appropriate infection control procedures to: 1.) apply gloves during [redacted] medication administration for Resident #218; 2.) clean and disinfect shared medical equipment prior to resident use observed during medication pass; and 3.) perform hand hygiene after handling dirty	F 880	1. Patient (Resident #108 and #218) were discharged from Center with no adverse effects. Licensed nurses involved received education specific to Medication Administration [redacted] Policy to prevent further occurrences, as well as, all Licensed Nursing Staff. Resident #43 and #86 were potentially affected by improper disinfection of equipment before and after use. Both were discharged from Center with no adverse effects. [redacted]	

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F 880	Continued From page 23 linen and then providing resident care. The deficient practice was observed for 2 of 5 residents (Residents #43 and #86) reviewed for medication administration and 1 of 24 residents reviewed for infection control (Resident #108) and was evidenced by the following: 1. On 09/20/19 at 8:43 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 administer medication to Resident #218 during the medication pass. The surveyor observed LPN #1 perform hand hygiene using an alcohol based hand sanitizer and then administer the [redacted] medication into Resident #218's nostrils. LPN #1 did not don gloves prior to administering the [redacted] medication. On 09/24/19 at 9:10 AM, the surveyor interviewed the Center Nurse Executive (CNE). The CNE stated it was policy for the nurse to don gloves when administering nasal medications. The CNE further stated the procedures for [redacted] medication administration starts out instructing for the nurse to don gloves. Review of the facility's "Medication Administration: Nasal" policy with the revision date of 01/02/14. The policy instructed under the "Administer medication" section to "put on gloves" when administering [redacted] medications. 2. On 09/20/19 at 8:49 AM, the surveyor observed LPN #2 take the [redacted]) of Resident #43. LPN #2 applied the [redacted] to the resident's [redacted], obtained the reading and removed the [redacted]. The surveyor observed that LPN #2 did not clean the [redacted] prior to or	F 880	cuff was disinfected using [redacted] wipes per policy. Center Nursing Staff were re-educated on Disinfection Policy. ABHS dispenser noted to be non-functioning. Battery was replaced immediately. CNA immediately educated on Hand Hygiene Policy. 2. Current patients have the potential to be impacted by these deficient practices. Nursing staff are providing care to residents following infection control practices related to [redacted] medication administration, hand hygiene and disinfecting of shared medical equipment. 3. Nurse Practice Educator/designee will provide re-education to nursing staff on infection control procedures for [redacted] Medication Administration, Disinfection Policy for shared Medical equipment and Hand Hygiene Policy. Clinical Directors/designees will conduct random weekly audits to ensure nursing staff are following Infection Control practices for [redacted] Medication Administration, Disinfection Policy for shared medical equipment and proper hand hygiene after soiled linen handling. Clinical Directors/Nurse Practice Educator/designee will submit audit repots to Center Nurse Executive/designee. 4. Center Nurse Executive/designee will review reports monthly for compliance and trending. Reports will be submitted to QAPI Committee to evaluate the need for further audits and/or action monthly for 3 months.	

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F 880	Continued From page 24 after applying the device on Resident #43. On 09/20/18 at 9:07 AM, the surveyor observed LPN #2 take the [redacted] of Resident #86. LPN #2 applied the [redacted] on the resident's [redacted], obtained the reading and removed the [redacted]. The surveyor observed LPN #2 did not clean the [redacted] prior to using it on Resident #86. The surveyor observed LPN #2 return to the medication cart, remove a wipe from a container with a blue top that was stored on the bottom shelf, and wipe the [redacted]. The surveyor observed the container with the blue top was labeled as "instant hand sanitizing wipes." On 09/20/19 at 9:12 AM, the surveyor interviewed LPN #2. LPN #2 stated he usually cleaned the [redacted] after every resident. LPN #2 further stated he had run out of the other wipes yesterday and that he used the wipes that was stored on the medication cart. On 09/20/19 at 11:10 AM, the surveyor interviewed the CNE. The CNE stated nurses were supposed to wipe down shared medical equipment before and after every resident use. The CNE further stated the [redacted] are cleaned with the wipes in the black top container (germicidal wipes). At which time, the CNE stated there was no shortage of the germicidal wipes at the facility. The CNE stated that hand sanitizing wipes were not used to disinfect shared medical equipment. When interviewed on 09/20/19 at 12:14 PM, the CNE confirmed that germicidal wipes were used to disinfect shared medical equipment such as [redacted] and the hand sanitizing	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315517	A. BUILDING _____ B. WING _____	09/24/2019

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F 880	Continued From page 25	F 880		

wipes were used on the hands.

Review of the facility's "IC201 Cleaning and Disinfecting" policy, dated reviewed 11/15/18, revealed the "Purpose" was "To prevent infectious spread from items or environment to patients and/or staff" and "To ensure reusable medical equipment is cleaned and disinfected appropriately." The policy further revealed that "multi-patient equipment must also be cleaned/disinfected after patient use."

3. On 09/18/19 at 9:05 AM, the surveyor observed the alcohol based hand sanitizer (ABHS) dispenser, located outside of the soiled linen room had a flashing red light. The surveyor attempted to use the alcohol based hand sanitizer (ABHS) from the dispenser and nothing was dispensed.

At 9:09 AM, the surveyor observed a Certified Nurse Aide (CNA) enter the soiled linen room holding a bag of soiled linen in her hand. The soiled linen room had a red biohazard sign affixed to outside of the door. The CNA was observed exiting the soiled linen room and then proceeding to Resident #108's room where she donned gloves and began to provide care for Resident #108. The CNA was not observed using ABHS or washing hands prior to donning gloves and providing care.

The surveyor interviewed the CNA regarding the surveyor's observations. The CNA confirmed that she took dirty linen into the soiled linen room. She confirmed that she did not wash her hands prior to care and stated "it was a rush thing" and I needed to get the resident up, regarding caring for Resident #108. When asked about the

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F 880	Continued From page 26	F 880		

blinking light on the hand sanitizer located outside of the soiled linen room, the CNA stated that she observed the hand sanitizer was empty, "I was off for two days and it was there before I left."

At 10:51 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) in front of the blinking ABHS dispenser. The ADON confirmed that the ABHS dispenser was not functioning. She further stated that it was not acceptable to drop off dirty linen in the soiled linen room and provide care without washing hands or using ABHS.

On 09/20/19 at 10:51 AM, the surveyor interviewed the Clinical Operations Manager regarding what should be done after staff exit the soiled linen room and prior to staff providing resident care. She stated the staff can either wash their hands or use ABHS prior to providing resident care.

Review of the facility's "Hand Hygiene" policy, dated reviewed 11/15/18, indicated to perform hand hygiene before and after patient care and after contact with the patient's environment.

NJAC 8:39-19.4(a)1

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	03009	A. BUILDING: _____ B. WING _____	09/24/2019

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H 000	Initials Comments The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H 000		
H3470	8:43E-10.11(c)(2) Other Rprtng Rqrmnts Unrltd to Pt Sfty Act Examples of reportable events in the nature of physical plant and operational interruptions, include, but are not limited to, the following: Loss or significant reduction of water, electrical power, or any other essential utilities necessary to the operation of the facility. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 09/23/19, in the presence of facility management, it was determined that the facility failed to report power outages to the Department of Health (DOH), in accordance with the Reportable Events Protocol. This deficient practice was evidenced by the following: A review of the facility's emergency generator log for the previous 12 months revealed that the facility lost primary electrical power and was operating under emergency generator power on two occasions as follows: 1. 12/21/18 for 3 hours and 2 minutes. 2. 06/16/19 for 4 hours and 10 minutes.	H3470	1. No patients were identified to have been directly impacted by this practice. 2. All patients had the potential to be affected by this deficient practice even though the center is 100% covered by its diesel emergency back-up generator. 3. Maintenance and Administrative staff in-serviced on N.J.A.C. Title 8 Chapter 43E General Licensure Procedures and Standards Applicable to All Licensed Facilities (8:43E-10.11(c)(2) Other Rptng Unrltd to PT Sfty Act. the necessity to report all events related to the emergency generator starting (unless being run in test or full load setting initiated by center staff) within 24 hours. Maintenance Director/designee will audit emergency	11/19/19

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

Electronically Signed | 10/27/19

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H3470	Continued From page 1 In an interview at 11:00 AM, the Licensed Nursing Home Administrator stated that he did not have access to the reporting system and there was no documentation that these power outages were reported to DOH. Post survey, on 09/27/19, the surveyor confirmed with the DOH's reportable event intake personnel that these power outages were not reported.	H3470	generator logs weekly to ensure we are in full compliance with the 8:43E-10.11(c)(2) Other Rprtng Unltd to PT Sfty Act and submit a report of audit finding to the Administrator. 4. Administrator/designee will review audit reports monthly for compliance and trending. Reports will be submitted to AQPI Committee to evaluate the need for further audits and/or action monthly for 3 months.	