STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

(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: 6/13/19 CENSUS:293 SAMPLE: 35 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=D	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 provider must give a copy of the grievance policy	F 585		7/9/19

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

Electronically Signed | 07/03/2019

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F 585	Continued From page 1	F 585		

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, and/or misappropriation of resident property, by

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F 585	Continued From page 2 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 observation, interview and record review, it was determined the facility failed to follow their facility policy for filing a formal grievance. This was observed for 1 of 1 residents (Resident#250) identified for a family member's concern. This deficient practice was evidenced by the following: On 06/09/19 at 11:17 AM, during the initial tour of the facility, the surveyor received a family	F 585	F 585 SS=D HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The grievance was initiated immediately after surveyor notification. Residents #250 had no negative effects from this practice. The social worker responsible	

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F 585	Continued From page 3 member's concern regarding Resident #250 during a representative interview. The family member of Resident #250 sent an email to the Social Worker (SW) on 5/28/19, about a care issue that occurred on 5/26/19. The family member stated [redacted] received an email response on 5/28/19 from the SW, which stated, "We will address!" There was no further communication between the family member and the facility. A review of the resident's medical record indicated medical diagnoses of [redacted]. The Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], indicated a BIMS Score of [redacted] which indicated severe cognitive impairment. The resident required one person assistance with bed mobility, dressing, toilet use and personal hygiene and was always [redacted]. On 06/10/19 at 10:21 AM, during an interview about the formal grievance process used by the facility, the Director of Social Work (DSW) stated that a formal grievance is filed by the SW assigned to the resident and emailed to the Administrator and the Director of Nursing (DON). The facility would then investigate the grievance and if a concern was identified, appropriate action would be taken. All concerns should have a resolution within a week. On 6/12/19 at 10:10 AM, when asked, the DSW could not find a formal grievance filed by Resident #250's family member and sent on 5/28/19 regarding a care issue on 5/26/19. On 06/12/19 at 10:45 AM, the surveyor	F 585	for not completing and following up on the grievance process received a 1:1 in-service on the facility grievance policy and process. Care Conference was held with resident #250's responsible party to ensure all concerns were addressed and rectified. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No other residents were identified as affected by this practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Director of Social Services department will meet with all facility Social Workers on a daily basis for next 30 days to review any open grievances or concerns. All email correspondence related to any concern or grievances will be CC to the Director of Social Services. Reeducation to all the social workers will be provided on the policy for grievance follow up. The Social Services Director will complete monthly audit for the next two quarters regarding follow up on all grievances. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO	

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F 585	Continued From page 4 conducted an interview with the SW assigned to the second floor and the Registered Nurse (RN)-acting unit supervisor. The surveyor asked if any emails or grievances were sent to the SW on 5/28/19 concerning Resident #250, they both replied, "Not to my knowledge." After the surveyor informed the SW and RN about the concern identified by the resident's family, the SW returned at 1:15 PM with copies of an incomplete grievance investigation. On 06/13/19 at 09:15 AM, the surveyor interviewed the SW and asked if she had followed the facility's policy for formal grievances. The SW stated, "It was my error in this case. I did forward the email from Resident #250's family member to the Unit Manager (UM) at the time (who has since resigned from the facility). It was my mistake, I didn't initiate a formal grievance and I should have. This email got lost in the shuffle because I get so many emails." The SW further stated, "I did not discuss this with my boss (the DSW) and I did not follow up with the nurse manager. I sent an email to Resident #250's family member that said it will be addressed, but I did not follow up with a resolution to the grievance." On 06/13/19 at 9:25 AM, the surveyor interviewed the DON concerning the formal grievance process for Resident #250. The DON stated, "I was not aware of this grievance." When asked if this formal grievance was investigated, the DON stated, "No, it did not happen in this instance because we didn't know about it." On 06/13/19 at 10:25 AM, the administrator was interviewed about the formal grievance for	F 585	ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Social Services Director will forward the findings to the QAPI committee on a quarterly basis for the next two quarters to assure compliance. TIME FRAME: 7/9/19	

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F 585	Continued From page 5 Resident #250 and stated, "I did not know about it." On 06/13/19 at 10:38 AM, the surveyor reviewed the formal grievance policy for the facility titled, "Social Services Policy and Procedure for Resident Grievances." The facility policy reflected, "#3 Once the SW receives notice of a grievance, she will record it on a Service Comment Form and forward to it to the Administrator/GO and other applicable employees when appropriate," and "#5 With oversight from the Administrator/GO, this employee will thoroughly investigate the grievance." The policy further reflected, "After reviewing the information and facts gathered during the investigation, the employee responsible for answering the grievance will put a report in writing and submit it to the Administrator/GO."	F 585		
F 658 SS=D	NJAC 8:39-13.2(c) 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 observations, interviews and review of the medical and Electronic Medical Records (EMR), as well as review of other pertinent facility documentation, it was determined that the facility nursing staff failed to document on the Medication Administration Record (MAR) to	F 658	F 658 SS=D HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN	7/9/19

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F 658	Continued From page 6 indicate that the medications were administered according to the Physician's Order (PO). This deficient practice was observed for 1 of 5 residents, (Resident #43) reviewed for unnecessary medications. This deficient practice was evidenced by the following: According to the "Admission Record", Resident #43 was admitted to the facility on [redacted] and readmitted on 03/13/2019, with diagnoses including but not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool, dated [redacted] Resident #43 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that Resident #43 is cognitively intact. The MDS documentation included that Resident #43 received [redacted] daily. A review of both the Physician's Order Sheets (POS) and MAR's for Resident #43 dated [redacted] and June 2019, respectively, revealed the following physician order: [redacted] Check [redacted] daily at 1630 [4:30 PM]. Call MD if result is less than [redacted] On 6/11/19 at 9:37 AM, the surveyor observed the resident self wheeling into the [redacted] activity room. The surveyor questioned Resident #43 whether he/she received [redacted] for their	F 658	AFFECTED BY THE PRACTICE: Resident # 43 was assessed and medical record was reviewed by the attending physician. Resident #43 had no negative outcomes. Resident #43 continues to have their [redacted] monitored at 4:30pm on a daily basis since 6/01/2019 as ordered by the physician. [redacted] results were reviewed with the attending physician and no new order were given. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Residents with orders to monitor [redacted] had the potential to be affected by this practice. An audit was conducted of all residents with orders for monitoring [redacted] No other residents were affected by this practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Licensed nurses will be reeducated regarding monitoring [redacted] as ordered by the attending physician. An audit will be conducted by the Unit Manager or Designee of each unit on a weekly basis for the next two quarters to ensure compliance. Any discrepancies will be rectified immediately to assure compliance.	

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F 658	Continued From page 7 [redacted]. The resident stated, "They check it once a day now." When questioned if the [redacted] is checked everyday, the resident stated, "Yes, it changed many times since I've been here." On 6/12/19 at 11:11 AM, the surveyor obtained the MAR's for the following months: March, April, May and June of 2019. The surveyor observed the April 2019 [redacted] Routine Medication" sheet. The sheet revealed that Resident #43 did not receive a [redacted] check, as ordered, for the following dates: 4/3/19 to 4/10/19; 4/12/19 to 4/20/19; 4/24/19, 4/25/19 and 4/30/19. The surveyor reviewed the May 2019, '[redacted] Routine Medication" sheet. The surveyor observed that Resident #43 did not have their [redacted] checked, as ordered on the following dates: 5/11/2019, 5/12/2019, 5/15/19, 5/23/2019, 5/25/2019 and 5/29/2019. On 6/13/19 at 11:17 AM the surveyors interviewed the Director of Nursing (DON). When asked if the nurse's failed to obtain the [redacted] for Resident #43 in April and May as ordered, the DON stated, "Yes." On 6/13/19 at 12:09 PM, the surveyor interviewed the [redacted] Unit Manager (UM). The surveyor provided a copy of the [redacted] Routine Medication" sheet, dated April 2019 for the UM to observe. The surveyor interviewed the UM and asked if Resident #43 should have had their [redacted] checked daily at 1630 [4:30 PM]. The UM stated, "If I'm reading it, I would check it daily because it's a daily order and it is on a routine medication sheet."	F 658	HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Director of Nursing or Designee will report the findings to the Quality Assurance Committee on a quarterly basis for the next two quarters to assure compliance. TIME FRAME: Completed by 7/09/2019	

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F 658	Continued From page 8 NJAC 8:39-27.1(a)	F 658		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to handle potentially hazardous food and maintain kitchen sanitation in a safe and consistent manner in order to prevent food borne illness. This deficient practice was evidenced by the following: On 6/9/19 from 8:14 to 9:11 AM, the surveyor, accompanied by the Dietary Supervisor (DS), observed the following in the kitchen:	F 812	F-812 SS= E 1)Dietary aide was observed with exposed hair not fully restrained under hair net. Dietary aide was observed wearing a headband with hair fully exposed. Step 1 WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE	7/9/19

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F 812	Continued From page 9 1. The surveyor observed a Dietary Aide (DA) with a ponytail extending below the lower back in length. The DA had a hairnet that only partially covered her hair to just above the neck. The ponytails full length from the neck to the lower back was left exposed. The surveyor observed an additional DA wheel a utility cart into the kitchen and proceed into the dishwashing area. The DA was observed wearing a headband. The DA did not have a hairnet and the hair was fully exposed. 2. The surveyor observed a DA washing dirty dishes at the three compartment sink at 8:29 AM. The surveyor questioned the DA whether the sanitization log was filled out prior to initiating dish washing. The DA stated, "Before washing dishes, I test the sanitizer level." When the surveyor requested to see a copy of the sanitization log, the DA was unable to provide the surveyor with a copy of the log and proceeded to continue to wash dishes. The surveyor questioned the DA again, if he tested for sanitizer level prior to initiating dishwashing. The DA then stated, "No." The surveyor interviewed the DS whether the sanitizer level should be checked prior to manually washing dishes at the three compartment sink. The DS stated, "yes, the sanitizer should be tested prior to initiating dishwashing." The DS then proceeded to check the sanitizer level utilizing QAC QR Test Strips. The first observation revealed a sanitizer level of approximately 100 parts per million (ppm). The minimum standard for the Quat sanitizer, according to the facility's sanitization log is 200ppm. The DS instructed the DA to empty the sanitizing sink and refill the sink in the presence of the surveyor. At 08:55 AM,	F 812	DEFICIENT PRACTICE All dietary personnel were in-serviced on proper wearing of hair nets. Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN All residents have the potential to be affected. No negative outcome reported. Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR The daily opening checklist will consist of management checking all employees for proper wearing of hair nets. All employee job flows will consist of usage of hair net restraints upon starting their shift. Management team will then monitor proper hair net restraints throughout the day from opening until closing the department to assure compliance using hair nets. Step 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED	

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F 812	Continued From page 10 the sanitization sink was filled and the surveyor observed DS test the sanitizer at 200ppm utilizing the QAC QR Test Strip. The DA was then instructed by the DS to rewash all previously cleaned dishes with the correct sanitizer level in the presence of the surveyor. The surveyor observed all previously washed dishes at 100ppm rewashed at the acceptable standard of 200ppm. 3. On a middle shelf in the refrigerator section of the Snack Refrigerator/Freezer, a metal pan containing hard boiled eggs had no dates. The DS stated, "that should be dated, yes." The DS threw the eggs in the trash. 4. In the dry storage area, the surveyor observed a can of whole potatoes with a dented seam on a multi-tiered storage rack. The DS removed the can to the designated dented can area. On an upper shelf , an opened container of thyme had no dates. The DS stated, "that should be dated with an open date." The DS threw the thyme into the trash. 5. On a middle shelf of the Beverage Refrigerator, a small styrofoam container covered with a white plastic lid contained vinegar and cucumbers, per the label. The lid was dated "6-1" and had a use by date of "6-3." The DS removed from the refrigerator and stated, "I'm gonna throw it out, it's expired." On 6/12/19 from 10:57 AM to 12:41 PM, the surveyor, accompanied by the Food and Nutrition Director (FND), observed the following in the kitchen: 1. On a lower shelf in the Walk-In Refrigerator,	F 812	AND WILL NOT REOCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE FSD will report the findings from the daily opening check list. Any identified hair net infractions from monitoring the daily opening check list shall be reported to the administrator monthly for six months. FSD will report trends to the quality assurance quarterly meeting the next two quarters to ensure compliance. 2)The pot sink sanitizer was not checked using the QAC QR test strips before pot washing to ensure proper sanitation of pots. Sanitation levels were not acceptable reading 100 ppm. Step 1 WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE All dietary pot washing personnel was in-serviced on proper testing of sanitation using the QAC QR test strip before pot washing. Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RSIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 11 an opened 1 gallon, glass jar of cherry peppers was labeled "opened" 5/14/19 and was labeled "use by" 6-1-19. The surveyor questioned the FND whether this product was expired and should it still be in refrigerated storage for use. The FND stated, "I'm gonna leave this here because I know my cook will remove it later." The surveyor then asked if the product was past its "use by" date of 6-1, as the current day was now June 12th, 11 days past the 6-1 "use by" date. The FND then stated, "It should have been thrown away and I am going to throw it away right now." The FND threw the jar of cherry peppers in the trash in the presence of the surveyor. 2. On a middle shelf of the Walk-In Refrigerator, a 1/3 pan contained chunks of deli turkey and swiss cheese wrapped in plastic wrap. The pan was labeled "prep" 6/10 and "use by" 6/11. The FND stated, "I'm tossing it. I'm gonna tell my cook that he labeled it wrong. It should have been good for 7 days but I have to throw it away because it is dated for use by the eleventh." 3. The surveyor observed a kitchen staff member (cook) wheeling a cart through the food preparation area. The cook was noted to have lengthy facial hair. The cook did not have a beard guard. The surveyor questioned the FND, who was standing next to the surveyor, whether the cook should have a beard guard. The FND stated, "yes" and instructed the cook to don a beard guard. Cook then promptly donned beard guard in surveyor and FND presence. 4. The surveyor observed an opened box of plastic wrap on a shelf below the steam table. The plastic wrap lid was open and the plastic	F 812	Residents residing in the facility were not affected, all pots were re-washed, rinsed and sanitized @ 200 ppm. Then air dried before storage. Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Management team will monitor all pot washing personnel before pot washing begins to ensure proper sanitation levels are correct using a pot washing sanitation monitoring form. Step 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE FSD will report the findings from the daily closing check list. Any identified sanitation infractions from monitoring the daily pot washing shall be reported to the administrator monthly for six months. FSD will report trends to the quality assurance quarterly meting for the next two quarters to ensure compliance.	

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F 812	Continued From page 12 wrap was exposed. The FND proceeded to close the lid on the plastic wrap and removed the plastic wrap from the shelf under the steam table. 5. The surveyor observed a DA in the process of performing handwashing. Upon completion of washing and rinsing their hands, the DA proceeded to turn off the faucet with their bare hands. The DA then proceeded to dry hands with a paper towel and proceeded to throw paper towel in the trash. 6. The surveyor observed a black personal backpack, a woman's purse, and a green jacket on a shelf below a food preparation counter. The jacket was observed in a pan that would be used for resident meal preparation. The surveyor made the FND aware of the personal items on the lower shelf. The FND stated, "These things do not belong here." The FND removed the personal items from the food preparation area. 7. In the cooks area, the surveyor observed an elevated rack with hooks above a food preparation counter. The rack is utilized to hang cleaned and sanitized kitchen utensils. The surveyor observed two black, personal back packs suspended from the metal hooks above the food preparation counter. The surveyor interviewed the FND how this area was utilized. The FND stated, "It is a food preparation area. We generally don't use that hanging rack, we just use it for spoons sometimes. But it's not used for that (hanging personal items/backpacks)." The FND instructed the staff to remove the backpacks and put them in the office. 8. A cleaned and sanitized stand-up mixer was	F 812	3)Boiled eggs in Snack refrigerator not dated. Step 1 WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE All dietary personnel were in-serviced on proper labeling & dating of all foods. Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RSIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN Residents residing in the facility were not affected, Boiled eggs were discarded. Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Management team will monitor all refrigeration units for proper labeling and dating of all foods throughout the day from opening until closing the department to assure compliance with labeling and dating. Step 4 HOW THE FACILITY WILL MONITOR	

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F 812	Continued From page 13 observed uncovered during non-use. The surveyor questioned the DA if the mixer was cleaned and sanitized and whether the mixer was currently in use. The DA stated, "Yes. It is cleaned and sanitized. I am not using it. That should be covered. I will cover it right now." The surveyor observed the DA cover the stand-up mixer with a clear plastic bag. The surveyor reviewed the facility policy titled "Storage of Personal Items", the policy was not dated. The policy stated, "Employees should not bring personal belongings into work. Any personal items such as a coat, pocketbook, etc. should be left in the employee locker room. No personal items are to be stored in any food preparation areas." The surveyor reviewed the facility policy titled, "Regulatory Date Marking Regulatory Dating and Labeling", the policy had no dates. Under the heading "RTE (ready to eat) Foods" the policy stated, "To keep track of the product a date marking system must be used; RTE foods opened can be used no more than 7 days stored at 41 degrees or below, or by their expiration date, whichever comes first. After the 7 days or expiration date has been reached, this product must be discarded. For unopened items use expiration date." Under the heading TCS (Temperature Controlled for Safety Foods), the policy stated, "To keep track of the product "Date Marking" system must be used. TCS (Time, Temperature Controlled for Safety foods) food items that are opened can be used for no more than 7 days or by their expiration date, whichever comes first. These opened items must be stored at 41 degrees or below. After the 7 days or expiration date has been reached, the product	F 812	ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE FSD will report the findings from the daily opening and closing check list. Any identified labeling and dating infractions from monitoring the daily opening and closing check list shall be reported to the administrator monthly for six months. FSD will report trends to the quality assurance quarterly meeting for the next two quarters to ensure compliance. 4)Dented can of whole potatoes found in the dry store on service rack. Opened container of thyme not dated. Step 1 WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE All dietary personnel were in-serviced on the facility's dented cans policies. All dietary personnel were in-serviced on the facility's policy on dating items when opening them. Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE	

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F 812	Continued From page 14 must be discarded. For unopened TCS food items use the expiration date mentioned on the product." Additionally, under the "Leftover Foods" heading, the policy stated "To keep track of the leftover food, Date marking system must be used. (Recommend to-write "Use By Date" on the left over products). Leftover foods can be used no more than 3 days. Leftover food must be stored at 41 degrees or below. After 3 days, leftover product must be discarded. From the day of preparation until product is discarded, should not exceed 7 days." The surveyor observed the facility policy titled "Cleaning Dishes-Manual Dishwashing", copyright 2013 Becky Dorner & Associates, Inc. Under the "Procedure" section, the policy states at 4. "Place a few dishes at a time into the sink. Wash thoroughly with a clean cloth or sponge. Scrub items as needed using a scouring pad. Rinse in sink 2, and sanitize in sink 3 following the directions below." The policy stated at 6. "Check sanitation sink often using a test strip to assure the level of the sanitizing solution is appropriate." The policy further revealed the following instructions for Sink 3: Sanitize. "Sanitize dishes: 1. Measure the appropriate amount of sanitizing chemical into the appropriate amount of water (following the manufacturer's guidelines). 2. Test the sanitizing solution in the sink using the manufacturer's suggested test strips to assure appropriate level. 3. Place the dishes in the sanitizing sink. Allow to stand according to the manufacturer's guidelines for sanitizer (or see the chart below). According to the chart, "Quarternary Ammonium" must have a strength of "150 to 200 PPM". The surveyor reviewed the facility policy titled	F 812	SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN Residents residing in the facility were not affected, can of whole potatoes were placed in the dented can section in dry storeroom. Thyme was discarded immediately. Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Management and cook team will monitor dry food store room for dented cans and undated opened items throughout the day from opening until closing the department to ensure compliance. Step 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE FSD will report the findings from the daily opening and closing check list. Any identified opened undated items or dented can infractions from monitoring will be reported to the administrator	

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F 812	Continued From page 15 "Personal Hygiene Training", copyright 2013 Becky Dorner & Associates, Inc. Under the Procedure section, the policy revealed at 4. "Keep hair neat and clean. Wear a hair restraint when around exposed foods, in the kitchen or food service areas including dining areas. The policy also stated at 5. "Keep beards and mustaches closely cropped and neatly trimmed. When around exposed foods, keep beards restrained." The surveyor also observed the facility's "Uniform Policy", the policy was undated. The policy stated, "All employees will adhere to [Facility] Food & Nutrition policy on proper wearing of a uniform required to work in the department." The policy stated that the following employee positions require the following uniform: Dietary Aides: Hair net; Cooks: Hair net or an approved chef hat; Floor Supervisors: Hair net. NJAC 8:39-17.2(g)	F 812	monthly for six months. FSD will report trends to the quality assurance quarterly meeting for the next two quarters to ensure compliance. 5)Beverage refrigerator was found with an out dated cup of cucumbers and vinegar. Step 1 WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE All dietary personnel were in-serviced on expiration dates of food. Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RSIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN Residents residing in the facility were not affected, cup of cucumbers and vinegar were discarded. Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Management team will monitor all refrigeration units throughout the day	

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F 812	Continued From page 16	F 812	from opening until closing the department to ensure compliance of expired foods. Step 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE FSD will report the findings from the daily opening and closing check list. Any identified expired food infractions of expired foods will be reported to the administrator monthly for six months. FSD will report trends to the quality assurance quarterly meeting for the next two quarters to ensure compliance. 6)In walk-in refrigerator a gallon glass jar of cherry peppers was out dated. Step 1 WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE All dietary personnel were in-serviced on expiration dates of food. Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RSIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE	

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F 812	Continued From page 17	F 812	SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN Residents residing in the facility were not affected, the jar of cherry poppers were discarded. Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Management team will monitor all refrigeration units throughout the day from opening until closing the department to ensure compliance of expired foods. Step 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE FSD will report the findings from the daily opening and closing check list. Any identified expiration of food infractions of expired foods will be reported to the administrator monthly for six months. "FSD will report trends to the quality assurance quarterly meeting for the next two quarters to ensure compliance.	

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F 812	Continued From page 18	F 812	7)In walk-in refrigerator a pan of deli turkey and swiss cheese was out dated. Step 1 WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE All dietary personnel were in-serviced on expiration dates of food. Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RSIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN Residents residing in the facility were not affected, the pan of deli turkey and swiss cheese were discarded. Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REACCUR Management team will monitor all refrigeration units throughout the day from opening until closing the department to assure compliance of expired foods. Step 4 HOW THE FACILITY WILL MONITOR	

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F 812	Continued From page 19	F 812	ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE FSD will report the findings from the daily opening and closing check list. Any identified expiration of food infractions of expired foods will be reported to the administrator monthly for six months. "FSD will report trends to the quality assurance quarterly meeting for the next two quarters to ensure compliance. 8)Cook was identified with no beard net. Step 1 WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE All dietary personnel were in-serviced on proper wearing of beard nets. Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RSIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN All residents have the potential to be affected. No negative outcome reported.	

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F 812	Continued From page 20	F 812	Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR The daily opening checklist will consist of management checking all employees for proper wearing of beard nets. All employee job flows will consist of usage of beard net restraints upon starting their shift. Management team will then monitor proper beard hair net restraints throughout the day from opening until closing the department to ensure compliance utilizing beard nets. Step 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE FSD will report the findings from the daily opening check list. Any identified beard hair net infractions from monitoring the daily opening check list shall be reported to the administrator monthly for six months. FSD will report trends to the quality assurance quarterly meeting for the next	

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F 812	Continued From page 21	F 812	two quarters to ensure compliance. 9)Opened lid to plastic wrap stored under steam table. Step 1 WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE All dietary personnel were in-serviced on proper usage of plastic wrap. Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RSIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN Residents residing in the facility were not affected, Plastic wrap lid was closed. Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR The daily opening checklist will consist of management checking all plastic wraps to ensure all lid are closed. Management team will then monitor proper plastic wrap throughout the day from opening until closing the department to assure compliance using plastic wrap.	

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F 812	Continued From page 22	F 812	Step 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE FSD will report the findings from the daily opening check list. Any identified plastic wrap infractions from monitoring the daily opening check list shall be reported to the administrator monthly for six months. FSD will report trends to the quality assurance quarterly meeting for the next two quarters to ensure compliance. 10)Improper hand washing. Step 1 WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE All dietary personnel were in-serviced on proper hand washing. Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RSIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE	

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F 812	Continued From page 23	F 812	TAKEN Residents residing in the facility were not affected, dietary aide re-washed their hands. Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Management team will then monitor proper employee hand washing throughout the day from opening until closing the department to assure compliance hand washing. Step 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE FSD will report the findings from the daily monitoring. Any identified handwashing infractions from monitoring will be reported to the administrator monthly for six months. FSD will report trends to the quality assurance quarterly meeting for the next two quarters to ensure compliance. 11)In the cook area, employees had	

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	315159	A. BUILDING _____ B. WING _____	06/13/2019

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F 812	Continued From page 24	F 812	personal belongings (back packs) hang from the storage rack. Step 1 WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE All dietary personnel were in-serviced on proper storage of personal belongs. Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RSIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN Residents residing in the facility were not affected, personal employee belongings were taken down and stored properly. Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR The daily opening checklist will consist of management checking all personal belongings to ensure all are not in the kitchen. Management team will then monitor employee belongings throughout the day from opening until closing the department	

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F 812	Continued From page 25	F 812	to assure compliance using personal belongings. Step 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE FSD will report the findings from the daily opening check list. Any identified personal infractions from monitoring personal belongings shall be reported to the administrator monthly for six months. FSD will report trends to the quality assurance quarterly meeting for the next two quarters to ensure compliance. 12)A cleaned and sanitized up-right mixer was not covered. Step 1 WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE All cook personnel were in-serviced on proper bagging of a cleaned and sanitized mixer. Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RSIDENTS HAVING THE	

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F 812	Continued From page 26	F 812	POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN No residents were affected. Mixer was immediately covered. Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Management team will then monitor all mixers throughout the day from opening until closing the department to assure compliance with clean, sanitized and bagged mixers. Step 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE FSD will report the findings from the daily opening closing check list. Any identified personal infractions from monitoring the daily opening check list shall be reported to the administrator monthly for six months. FSD will report trends to the quality	

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F 812	Continued From page 27	F 812	assurance quarterly meeting for the next two quarters to ensure compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, 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;	F 880		7/9/19

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F 880	Continued From page 28 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to minimize the potential spread of infection to residents during medication administration for 1 of 2 nurses observed during the medication pass on 1 of 6 units ([redacted]	F 880	F 880 SS=D HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE:	

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F 880	Continued From page 29 This deficient practice was evidenced by the following: On 6/12/19 at 8:34 AM, during the medication pass, the surveyor observed the Licensed Practical Nurse (LPN) place a [redacted] onto Resident #637's [redacted] and obtained a reading. The LPN did not clean the device after it was removed from the resident's [redacted]. On 6/12/19 at 8:54 AM, during the medication pass the surveyor observed the LPN place a portable [redacted] onto Resident #31's [redacted] The LPN was unable to obtain a reading on either of the resident's [redacted] after multiple attempts. The LPN then obtained an alternate [redacted] that was attached to an automated [redacted] machine and successfully obtained a [redacted] reading. The LPN put both [redacted] devices away without cleaning them. The LPN began to sign out the medications that were administered to Resident #31 and stated that the resident had not received a scheduled dose of [redacted]. The LPN then pushed the medication cart back down to the resident's room, applied gloves and administered [redacted] to the resident without first performing hand hygiene. At 9:19 AM, the surveyor interviewed the LPN who stated that he/she was required to clean the [redacted] after each use and had forgotten to clean the [redacted] with the red-top	F 880	Residents #637 and resident # 31 had no negative effects from this practice. The nurse responsible for obtaining [redacted] readings on resident #637 and administering [redacted] to resident #31 received 1:1 in-servicing on cleaning [redacted] after each use, hand washing and infection control practices related to administering [redacted] HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Residents assigned to the nurses who monitored [redacted] reading on resident # 637 and administered [redacted] to resident #31 had the potential to be affected. The facility educator and IPN completed observations regarding cleaning [redacted] and proper hand washing before and after administering [redacted]. No other residents were identified as affected by this practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Facility Educator or Designee will provide re-education to the licensed nursing staff on the policy for cleaning multi use equipment between each resident use and hand hygiene before	

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F 880	Continued From page 30 sanitizer wipes that were kept in the bottom drawer of the medication cart. The LPN further stated, that per facility policy hand hygiene was required before and after [redacted] administration and further stated that he/she had forgotten to do so. On 6/12/19 at 11:00 AM, the Director of Nursing (DON) provided the surveyor with a copy of the facility policy titled, "Hand Hygeine [sic.]" (Revised 12/2018) which revealed the following: "Wash hands before having direct contact with patient." On 6/13/19 at 11:16 AM, the DON provided the surveyor with the facility policy titled, "STANDARD PRECAUTIONS POLICY AND PROCEDURE [sic.]" "Policy: Handling of potentially contaminated equipment or surfaces in the resident environment." "Multiple use items (e.g. [redacted] ...) are properly cleaned/disinfected between each resident use utilizing disinfecting wipes." NJAC 8:39-19.4(a)	F 880	and after resident contact related to [redacted] The Infection preventionist or Designee will conduct infection prevention observation weekly for the next two quarters for licensed nurses who use [redacted] monitoring equipment and administer [redacted] to our residents to assure compliance with facility policies and practices. Any reported concerns will be rectified immediately. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Infection preventionist or Designee will report the findings to the QAPI committee on a quarterly basis for the next two quarters to assure compliance. TIME FRAME: 7/9/19	