STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING _____ B. WING _____	08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARDELL GARDENS AT TINTON FALLS	524 WARDELL ROAD TINTON FALLS, NJ 07753

(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: 8/21/19 CENSUS: 62 SAMPLE SIZE: 17+3 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 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625		9/23/19

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

Electronically Signed | 09/09/2019

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F 625	Continued From page 1 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to notify, in writing, the resident or the resident's representative of the facility's bed hold policy for resident's transfer to the hospital for 2 of 2 residents (Resident #64 and #43) reviewed for hospitalization. This deficient practice was evidenced by the following: 1. Review of Resident #64's discharge Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted] The MDS also reflected the resident had diagnoses that included [redacted] Review of a progress note, dated [redacted] at 3:45 PM, reflected that Resident #64 was sent to the hospital and admitted with a diagnosis of [redacted] An additional progress note, dated 4/12/19 on the 3-11 shift, revealed the resident was re-admitted to the facility on that date. There was no documentation in the medical record that the resident or the resident's representative was provided written notice regarding the facility's bed hold policy. On 8/21/19 at 9:43 AM, in the presence of the survey team, the Administrator was unable to provide a copy of the bed hold policy notification letter for Resident #64 and stated, "We didn't	F 625	F625 -S/S B NOTICE OF BEDHOLD POLICY BEFORE/UPON TRANSFER 1. Resident #64 and #43 were affected by this deficient practice. Both of these residents were re-admitted to the facility. 2. All patients have the potential to be affected by this deficient practice. A notice of bed hold letter was immediately created to be given to residents or resident representative when transferred to the hospital. 3. Regional Director Nursing re-educated the NHA on the regulation. The NHA re-educated the Director of Admissions and Social Worker to provide a resident or resident representative written information before being transferred to the hospital of the duration of the bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility, including the reserve bed payment policy in the state plan. 4. The Social Worker will audit all residents that are transferred to a hospital to ensure the resident or resident representative were properly notified in writing of our bed-hold policy. Audits will be completed weekly x 3 months. Licensed Social Worker will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director.	

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F 625	Continued From page 2 send the bed hold letter." 2. According to the Admission record, Resident #43 was re-admitted to the facility from the hospital on [redacted] with diagnoses which included, [redacted]. Review of a progress note, dated [redacted] at 10:30 PM, revealed Resident #43 was admitted to the hospital for [redacted] Review of Resident #43 Care Plan, dated [redacted], revealed a BIMS of [redacted] Review of Resident #43's medical record did not reveal documentation that the resident or the resident's representative was provided written notice regarding the facility's bed hold policy. During an interview with the surveyor on 8/20/19 at 10:26 AM, the Administrator stated he "did not know about a letter informing of the 10 day bed hold and returns" and was unable to provide a copy. NJAC 8:39-4.1 (a) (31)(i-iv)	F 625		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		9/23/19

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F 695	Continued From page 3 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. 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 a resident received [redacted] as ordered for 1 of 2 residents (Resident #2) reviewed for [redacted]. This deficient practice was evidenced by the following: According to the Admission Record, Resident #2 was admitted to the facility on [redacted] and had a diagnosis of [redacted]. Review of the Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected a Brief Interview for Mental Status (BIMS) score of [redacted]. Review of a physician order, dated 7/17/19, revealed an order for [redacted]. On 8/12/19 at 11:36 AM, the surveyor observed Resident #2's room. The resident was not in the room, but the [redacted] was on and set to [redacted]. The [redacted] aide entered the room,	F 695	F695 □S/S D Respiratory / Tracheostomy Care and Suctioning 1. Resident #2, was affected by this deficient practice. The physician orders and treatment administration record was reviewed and the order was revised to indicate the correct [redacted]. The Resident□s was also [redacted] and [redacted] the current order. Residents care plan was also updated to [redacted]. The CNA caring for the patient was instructed to notify the nurse when switching patient from [redacted]. 2. 4 Residents have the potential to be affected by this deficient practice. All 4 Residents physician orders were compared to the Medication administration record for proper transcription and the [redacted] was also audited to ensure the current order is being administered, and the care plan to ensure it was updated and care planned. 3. The DON re-educated all staff Nurses on the policy and procedure for administering [redacted]. The DON also re-educated the Nurse□s Aides on informing the Nurse when they need to transfer a Resident from bed to	

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F 695	Continued From page 4 unplugged the [redacted], brought it to the dayroom, and connected the [redacted] to the resident. On 8/13/19 at 8:46 AM, the surveyor observed Resident #2 lying in bed asleep [redacted] that was [redacted] On 8/14/19 at 9:21 AM, the surveyor observed Resident #2 lying in bed awake. The resident was [redacted] on the [redacted] The [redacted] was [redacted] When asked about the [redacted] the resident put the [redacted] On 8/15/19 at 9:15 AM, the surveyor observed Resident #2 lying in bed awake [redacted] that was [redacted] On 8/16/19 at 8:29 AM, the surveyor observed Resident #2 lying in bed awake. The resident was not receiving [redacted] as the [redacted] was noted laying on the resident's bed. The [redacted] was on and [redacted]. At 9:39 AM, the resident's Registered Nurse (RN #1) obtained a [redacted] The RN acknowledged that the resident was not [redacted] The surveyor and RN #1 then reviewed the resident's physician's orders and the RN stated, "[Resident #2] is supposed to be on [redacted]." On 8/20/19 at 9:07 AM, the surveyor, in the presence of RN #1, observed Resident #2 lying in	F 695	wheelchair to change the [redacted] over from [redacted]. 4. The DON will audit the Resident population on [redacted] to ensure that the correct and current physician order is transcribed and being administered as ordered and the care plans are updated. Audits will be completed 5 times a week x 2 weeks then weekly x 3 months. The DON will report results during the monthly QAPI meeting. The QAPI is attended by the NHA, DON and Medical Director.	

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F 695	Continued From page 5 bed [redacted] that connected to an [redacted] that was [redacted]. When asked if the resident's [redacted] order had changed, RN #1 checked the order and verified that the resident should have been on [redacted] During an interview with the surveyor on 8/20/19 at 10:06 AM, the Director of Nursing (DON) stated that the nurses should be checking that [redacted] is being administered as ordered every shift. The DON further stated that [redacted] is a medication and should be carried out as one. A review of the facility's [redacted] policy, revised on 12/10/18, revealed, "Turn [redacted] on the prescribed amount," and "Check that [redacted] is being delivered as per physician's order." NJAC 8:39-27.1(a)	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that the facility failed to complete and/or obtain missing information on dialysis communication forms that coordinate care between the facility and the dialysis center for 1 of 1 residents	F 698	F698-S/S E Dialysis 1. Resident #26 was affected by this deficient practice. The Assigned Nurse reviewed the [redacted] communication binder and noted the missing / incomplete communication sheets and notified the	9/23/19

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F 698	Continued From page 6 (Resident #26) reviewed for [redacted]. This is a repeat deficiency from the last standard survey dated 10/19/18. This deficient practice was evidenced by the following: According to the Admission Record, Resident #26 was admitted to the facility on [redacted] with diagnoses which included, [redacted]). Review of Resident #26's Physician's Order Sheet (POS), dated August 2019, revealed an order, not dated, for [redacted] on Tuesdays, Thursdays and Saturdays. Review of Resident #26's Care Plan (CP), dated 12/11/17, revealed the resident needed [redacted] three times a week with a goal to receive pre and post [redacted] care with the flow of information facilitated between the off site [redacted] service and the facility. Review of the [redacted] Communications" forms, contained in a 3-ring binder, revealed the following information had been missing or incomplete from the [redacted] center report: 5/2/19: pre-weight, Seen by Dr., New Orders; Any Meds given at Center; Dressing Change with Shunt Site Condition; Labs Drawn and Any problems during dialysis. 5/9/19: resident's name; Seen by Dr., New Orders; Any Meds given at Center; Dressing Change with Shunt Site Condition; Labs Drawn; Any problems during dialysis and the Licensed	F 698	[redacted] center, who faxed over the complete documentation. The communication forms were reviewed for any interventions or changes and filed accordingly in the binder. 2. There were no other Residents affected by this deficient practice. 3. The DON re-educated the Nurses on the policy and procedure and workflow for communication between the facility and the [redacted] center. 4. The DON will audit the [redacted] binder weekly x3 months. DON will report results during the monthly QAPI meeting. The QAPI is attended by the NHA, DON and Medical Director.	

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F 698	Continued From page 7 Nurse's signature. 5/14/19: date; resident's name; Any Meds given at Center; Dressing Change with [redacted] Condition; Labs Drawn and Any problems during dialysis. 5/21/19: resident's name; Any Meds given at Center; Dressing Change with [redacted] Condition; Labs Drawn and Any problems during dialysis. 5/28/19: Any Meds given at Center and Dressing Change with [redacted] Condition. 5/30/19: date, resident's name; Seen by Dr., New Orders; Any Meds given at Center; Dressing Change with [redacted] ite Condition; Labs Drawn and Any problems during [redacted]. 6/1/19: resident's name; Dressing Change with [redacted] Condition; Labs Drawn and Any problems during dialysis. 6/4/19: Seen by Dr., New Orders; Any Meds given at Center; Dressing Change with [redacted] Condition; Labs Drawn; Any problems during dialysis and the Licensed Nurse's signature. 6/6/19: Seen by Dr., New Orders; Any Meds given at Center; Dressing Change with [redacted] Condition; Labs Drawn; Any problems during dialysis and the Licensed Nurse's signature. 6/11/19: [redacted] Condition; Labs Drawn and Licensed Nurse's signature. 6/15/19: date; resident's name; Any Meds given at Center; Dressing Change with [redacted] Condition; Labs Drawn; Any problems during dialysis and Licensed Nurse's signature. 6/27/19[redacted] Communication sheet was not found. The facility obtained a copy of the [redacted] report and presented it to the surveyor on 8/20/19. 6/29/19: resident's name; Dressing Change with [redacted] Condition; Labs Drawn and Any	F 698		

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F 698	Continued From page 8 problems during [redacted]. 7/4/19: Dressing Change with [redacted] Condition; Labs Drawn and Any problems during dialysis. 7/13/19: Dressing Change with [redacted] Condition; Labs Drawn and Any problems during dialysis. 7/27/19: Dressing Change with [redacted] Condition; Labs Drawn and Any problems during dialysis. 8/1/19: resident's name and [redacted] Condition. 8/8/19: Seen by Dr. and New Orders. Review of the "[redacted] Communications," forms contained in a 3-ring binder, revealed the following information had been missing or incomplete from the Facility section: 7/4/19: Licensed Nurse's Signature. 8/1/19: Licensed Nurse's Signature. 8/8/19: Licensed Nurse's Signature. Review of the Nurse's Progress Notes, dated from 5/1/19 through 8/14/19, revealed no documentation that the facility contacted the [redacted] center to obtain the missing or incomplete information. During an interview conducted by the surveyor on 8/14/19 at 11:46 AM, the Licensed Practical Nurse (LPN #1) stated that when a resident goes to [redacted], the communication form goes with them. LPN #1 further stated the nurses fill out the top section of the communication form and note any medications taken before [redacted], the resident's vital signs, name and their room. LPN #1 stated the facility nurse signs the form before	F 698		

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F 698	Continued From page 9	F 698		

sending it with the resident to [redacted]. LPN #1 stated that at [redacted] the [redacted] nurses writes in their information and signs the [redacted] communication form. When the resident returns to the facility, the nurse has to check the form for missing information and any communication or recommendations and then follow up on the information. LPN #1 stated if any information is missing, the nurse would call the [redacted] center immediately to obtain the information. LPN #1 stated the communication forms are "important" because the information like vital sign or issues during [redacted] need to be addressed. LPN #1 stated all of the nurses are responsible to follow up with missing or incomplete [redacted] communication information.

During an interview with the surveyor on 8/14/19 at 11:54 AM, the Regional RN who was filling in for Director of Nursing (DON), stated that the nurses are to send the [redacted] form with the facility section completed and signed. If a form comes back with any missing information or missing signatures on the bottom of the form from the [redacted] center, the nurses need to call, obtain the missing or incomplete information and make a progress note.

During an interview with the surveyor on 8/16/19 at 8:47 AM, the Regional RN stated the facility could not locate a [redacted] communication for the treatment on 6/27/19 and had the [redacted] unit send over a print out of the care during that treatment.

During an interview with the surveyor on 8/21/19 at 9:19 AM, the DON stated if the resident's [redacted] communication sheet is not filled out, the facility nurses would call the [redacted] center

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F 698	Continued From page 10 immediately to obtain the information. The DON stated the facility would need to know "immediately and not after the fact" because if there are medications, labs values or issues, the facility would need to know what to monitor or look for and how to treat the resident. Review of a memorandum, titled, "All Nurses," dated 12/1/18, located at the [redacted] nurses' desk, revealed that [redacted] patients would be using the [redacted] communication form and to ensure that the [redacted] center completed their section. Review of the, "[redacted] Policy/Procedure," dated April 2019, revealed it is the policy to prepare and monitor residents who receive [redacted] and maintain ongoing communication with the satellite [redacted] center to prevent avoidable complications. A communication notebook is sent with each resident to the [redacted] center with each treatment for communication purposes between satellite [redacted] unit and facility. NJAC 8:39-27.1(a)	F 698		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 730		9/23/19

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F 730	Continued From page 11 Based on interview and review of facility documentation, it was determined that the facility failed to provide 12 hours of required training for 6 of 6 Certified Nursing Assistants (CNA) reviewed for mandatory yearly training. This deficient practice was evidenced by the following: Review of the in-service records provided by the facility for six randomly selected CNAs revealed that all six CNAs did not have the required 12 hours of annual in-service training by their anniversary date. 1. CNA #5 had a date of hire [redacted] and had no documented in-service hours of training from [redacted]. 2. CNA #6 had a date of hire [redacted] and had no documented in-service hours of training from [redacted]. 3. CNA #7 had a date of hire [redacted] and had 4 hours of documented in-service training from [redacted]. 4. CNA #8 had a date of hire [redacted] and had 4 hours of documented in-service training from [redacted]. 5. CNA #9 had a date of hire [redacted] and had 8.75 hours of documented in-service training from [redacted]. 6. CNA #10 had a date of hire [redacted] and had 2 hours of documented in-service training from [redacted]	F 730	F730-S/S D Nurse Aide Perform-Review-12/hr/yr In-Service 1. No Residents were affected by this deficient practice. 2. All Residents have the potential to be affected by this deficient practice. All education records, and in-service sign in sheets for the facility CNAs were audited to determine and quantify the hours of education completed year to date. 3. The Regional DON re-educated the DON on the requirement for Certified Nurse□s Aide mandatory annual education / in-services and the maintaining of the educational records. 4. The Regional DON will audit the CNA educational records monthly x 3. The DON will report results during the monthly QAPI meeting. The QAPI is attended by the NHA, DON and Medical Director.	

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F 730	Continued From page 12 During an interview with the surveyor on 8/20/19 at 9:04 AM, the Director of Nursing (DON) stated it was "important" for the CNAs to have their mandatory in-service training for educational purposes, to maintain their certification and to keep in compliance with up to date practices that would enable them to provide care to the residents. During a follow up interview with the surveyor on 8/21/19 at 9:19 AM, the DON acknowledged that the six CNAs did not have the required 12 hours of annual, mandatory in-services. The DON further stated that she would have to work on a plan because there was no time, content or constructive manner to quantify the training provided to the CNAs. NJAC 8:39-43.17 (b)	F 730		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		9/23/19

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F 761	Continued From page 13 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to remove expired medications from 1 of 2 medication rooms [redacted] and 1 of 4 medication carts [redacted] This deficient practice was evidenced by the following: On 8/12/19 at 9:35 AM, the surveyor inspected the [redacted] medication room, in the presence of Licensed Practical Nurse (LPN #2), and observed the following expired over the counter (OTC) medications: [redacted] At that time, the surveyor informed LPN #2 of the	F 761	F761- S/S D Labels / Store Drugs and Biologicals 1. No Residents were affected by this deficient practice. All expired medications that were identified were removed, destroyed and replaced. 2. All Residents have the potential to be affected by this deficient practice. All the facility medication carts and Medication Rooms were immediately audited, and any expired medications were removed, destroyed, and replaced. 3. The DON re-educated all nurses on the policy and procedure for medication administration, which included checking the expiration dates prior to administering a medication to a Resident. The central supply clerk was re-educated immediately on stock rotation and the checking for expiration dates, which included the policy for destruction of expired medications. 4. The DON / designee will audit the medication carts / supply in medication room for expired medications weekly x 1 month and then monthly x 3 months. The DON will report results during the monthly QAPI meeting. The QAPI is attended by the NHA, DON and Medical Director.	

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F 761	Continued From page 14	F 761		

expired medications. The LPN stated she would remove the expired medications and dispose of them using a drug buster (a chemical to destroy medications).

On 8/12/19 at 9:52 AM, the surveyor inspected Medication [redacted] on [redacted] and observed the following expired OTC medications:

[redacted]

At that time, the surveyor interviewed the Registered Nurse (RN #2) in charge of Medication [redacted] regarding the expired medications. RN #2 stated that none of her residents take the medications that were expired, but that she would destroy the medications with a drug buster.

During an interview with the surveyor on 8/12/19 at 10:09 AM, LPN #1 stated that all nurses are accountable for checking the medication rooms for expired medications. LPN #1 also stated that the medication carts are checked each shift and afterwards, the nurses sign off on a form titled, "Expired meds, OTC Shift to Shift Accountability Sheet."

On 8/12/19 at 10:19 AM, the surveyor reviewed the "Expired meds, OTC Shift to Shift Accountability Sheet" for Medication [redacted] on [redacted] RN #2 stated she was working a double and did not check for expired medications at the beginning of her 11 PM to 7 AM shift. The RN

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F 761	Continued From page 15 further stated that she only checked the top drawer of the medication cart for expired medications around 1 AM. The accountability form revealed that RN #2 signed indicating that she checked the cart on 8/11/19 at 11 PM and 8/12/19 at 7 AM. During an interview with the surveyor on 8/20/19 at 10:11 AM, the DON stated the nursing staff was responsible for frequently checking the medication room and medication carts for expired OTC medications. During a follow up interview with the surveyor on 8/21/19 at 9:21 AM, the DON further stated the floor nurses were responsible for checking the medication rooms and medication carts every shift and that there was "no excuse" for expired medications to be in the medication cart. Review of the facility's "Over the counter/Stock Medications" policy, dated January 2019, revealed, "The Licensed Nurse going off duty and Licensed Nurse coming on must audit/check the expiration dates of the OTC stock medications in the medication cart/supply cabinet and justify opened bottles are dated and not expired at the change of each shift," and "Any expired medications found will be removed immediately and replaced." NJAC 8:39-29.4(c)	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		9/23/19

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F 812	Continued From page 16 §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 maintain proper kitchen sanitation practices and properly store potentially hazardous foods in a safe and sanitary environment to prevent the development of food-borne illness. This deficient practice was evidenced by the following: During a tour of the kitchen with two surveyors and the Lead Cook (LC) on 8/12/19 at 9:25 AM, the surveyors observed the following: 1. Dietary Aide (DA #1) was observed working on the dish machine and had facial hair more than a quarter inch long without a beard restraint. 2. There were two freezer chests that had logs that did not show evidence of temperature monitoring since the morning of 8/10/19. The LC	F 812	F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 1,3,17,18,34 .DA #1 was observed working on the dish machine and had facial hair more than a quarter inch long without a beard restraint. The Lead cook was observed without a beard restraint. DA #3 was observed wearing a beard restraint around his neck and not restraining his facial hear. DA #4 was observed entering the kitchen with facial hear without a beard net. DA #3 was again observed in the kitchen with facial hair wearing his beard net around his neck and not restraining his facial hair. 1. No residents were affected by this deficient practice. Dietary Aids 1, 3, 4, and lead cook immediately put on a beard restraint and covered the facial hair, and were re-in serviced about the	

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F 812	Continued From page 17 stated that the cook or supervisor was responsible for ensuring the freezers were at the proper temperature and to record the temperature on the log. He further stated that he was responsible for that task today and could not speak to why it was not done. 3. The LC was observed with facial hair more than a quarter inch long without a beard restraint. The LC stated that there were beard nets in the kitchen and that he should have worn one. 4. The LC was observed washing his hands with a friction time of seven seconds and performed friction under running water. He stated that the handwashing process should have been 40-60 seconds and that he was unable to get a good lather because the dispenser had sanitizer inside and not soap. The LC further stated that he thought it was acceptable to use sanitizer in the kitchen. A housekeeping employee confirmed it was hand sanitizer. 5. DA #1 was observed wearing gloves as he loaded dirty dishware into the dish machine. DA #1 then retrieved clean dishware from the dish machine without removing his soiled gloves, washing his hands and reapplying clean gloves. DA #1 stated that he operated the dish machine in this manner for a short time before he gets assistance and acknowledged that was not appropriate. 6. The dish machine temperatures were observed to be 150 degrees Fahrenheit (F) for the wash cycle and 160 degrees F for the rinse cycle. DA #1 stated that the temperatures should have been 160 degrees for the wash cycle and 180 degrees for the rinse cycle. He acknowledged that the	F 812	need to wear a beard net in the kitchen to cover facial hair. 2. All residents have the potential to be affected by this deficient practice. An audit of all dietary staff was completed to ensure that their hair and facial hair with the hair and beard nets. 3. The Food Service Director re-educated all dietary staff on the need to wear hair and beard nets in the kitchen to cover their facial hair. NHA re-educated Director of Food Service on the need for all dietary staff to wear hair and beard nets in the kitchen and his responsibility to assure that hair net are being worn and restraining the facial hair . 4. The NHA will audit the dietary staff that they are wearing hear and beard nets that restrain facial hair in the kitchen. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. NHA will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY #2 2 freezer chests that had logs that did not show evidence of temperature monitoring 1. No residents were affected by this deficient practice. The Food Service Director immediately obtained temperatures for the 2 chest freezers and recorded same. Both freezers temperatures were in acceptable range. The lead cook immediately was re-educated about the need to monitor	

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F 812	Continued From page 18 rinse cycle did not reach 180 degrees F and could not state how he ensured the dishware was properly cleaned and sanitized. The LC stated the dish machine could also function as a low temperature machine using a sanitizer; however, he was unaware of how to test for the presence of sanitizer. The Food Service Director joined the tour at 10:02 AM. He stated the dish machine temperatures should have been 160 degrees F for the wash cycle and 180 degrees F for the rinse cycle and acknowledged the rinse cycle did not reach 180 degrees F. The FSD stated that dishware could be sanitized in the three compartment sink but was unclear how long items needed to be submerged in the sanitizer solution to be properly sanitized. He first stated five seconds and then stated five minutes. 7. The surveyors observed that the logs for both the dish machine and the sanitizer sink had been filled in for both lunch and dinner for that day. DA #1 could not state why he filled in the logs prematurely. Both DA #1 and the FSD acknowledged that should not have been done. 8. There was food debris on the stainless-steel table extension of the clean end of the dish machine where clean dishware was placed above. DA #2 and the FSD acknowledged the debris should not be on the clean and sanitized side of the dish machine. 9. There was a condensation on the ceiling and pipes that was observed dripping onto clean dishware and trays. 10. There were two areas on the tiles and wall directly above the dish machine with dotted blackish substance.	F 812	and log the temps of 2 chest freezers daily 2. All residents have the potential to be affected by this deficient practice. All other logs in the kitchen were checked to assure they were up to date. 3. NHA re-educated Director of Food Service on his role to check logs daily. The Food Service Director re-educated all cooks on the need to monitor and log the temperature of the 2 chest freezers. 4. The Registered Dietician will audit the 2 chest freezers to ensure that the temperatures are monitored and logged. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Registered Dietician will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY A. The LC was observed washing his hands with a friction of time of seven seconds and performed friction under running water 1. No residents were affected by this deficient practice. The Lead Cook immediately washed his hands with proper hand hygiene washing and was re-educated about the need how and when to preform proper hand hygiene. 2. All residents have the potential to be affected by this deficient practice. All other dietary staff were audited to assure adherence to the proper hand hygiene	

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F 812	Continued From page 19 11. There was a wet sheet pan nested within a few other sheet pans on the air-drying rack. In addition, there were approximately 12 serving utensils stored upright, exposed to the air and a wood rolling pin with packaging still attached nested within clean utensils. The FSD stated the rolling pin had never been used or washed. The FSD acknowledged that the sheet pans and utensils should not have been stored that way. In addition, the FSD stated that the sheet pan and utensils were not air dried properly and that the utensils stored upright and exposed to the air, had the potential to become contaminated. 12. There was a six-range stove with a heavy black build up on the top of it. The FSD stated it was cleaned each shift and couldn't speak to the heavy build up. 13. There was a stainless-steel shelf above the range with a heavy build up of a grease like substance on the entire shelf. The FSD wiped the substance with paper towels and acknowledged it should not have been that way. 14. There was a heavy buildup of a black and reddish substance on the underside of the stainless-steel shelf that was directly over an uncovered restaurant pan with a tomato-based item being cooked. The FSD stated it was dirt and oil and should not have been that way. 15. There was a wood shelf attached to the steam table. The FSD acknowledged that wood was a porous material and could not be effectively cleaned and sanitized. 16. There were three glass light covers under the	F 812	procedures. 3. NHA re-educated the Director of Food Service on the need to perform Hand Hygiene audits. The Food Service Director educated all dietary staff on how and when preform proper hand hygiene. 4. The Food Service Director will audit the dietary staff that they are performing proper hand hygiene as per policy. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food Service Director will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 5. The LC thought it was acceptable to use sanitizer in the kitchen 1. No residents were affected by this deficient practice. The lead cook immediately washed his hands with proper hand hygiene and was re-educated that it is not acceptable to use hand sanitizer in the kitchen. The housekeeper was immediately re-educated that it is not acceptable to place hand sanitizer in a soap dispenser. Hand Sanitizer was removed and soap was placed in soap dispenser. 2. All residents have the potential to be affected by this deficient practice. All soap dispensers were audited to ensure that soap was in the dispenser. 3. The Food Service Director re-educated all dietary staff that it is unacceptable to use hand sanitizer in the	

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F 812	Continued From page 20 hood over the cooking area that had a heavy caked on substance. The FSD stated it was a buildup of grease and dust. 17. DA #3 was observed in the kitchen with facial hair more than a quarter inch long wearing his beard net around his neck not restraining his facial hair. 18. DA #4 was observed entering the kitchen with facial hair more than a quarter inch long without a beard net. 19. There were multiple areas of a dried-on substance on two ingredient bins (flour and sugar). The FSD stated it may be have been from the coffee machine. 20. There was a slicer covered with a clear plastic bag. Upon removal of the bag the FSD stated that there were remnants of sliced tomato on the slicer and acknowledged it should have been cleaned before being covered. 21. There was a table top mixer covered with a black plastic bag. Upon removal of the bag, the FSD stated that the white substance caked to the underside of the mixer was splashed pudding. He stated it should not have been that way and that when plastic covers were over equipment it indicated that the equipment had been thoroughly cleaned and sanitized. 22. There was a water spray and pipe that provided water into the coffee urns with a heavy build up of a black substance that the FSD was able to wipe off with paper towels. He couldn't identify the substance and acknowledged it was not clean.	F 812	kitchen and the process to use when hand sanitizer is found in soap dispenser The Director of Housekeeping re-educated all housekeepers not to put hand sanitizers in soap dispensers. 4. The Food Service Director will audit the soap dispensers in the kitchen to ensure they have soap and not hand sanitizer. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food Service Director will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 5. DA was observed retrieving clean dishware from the dish machine without removing his soiled gloves, washing his hands, and reapplying clean gloves. 1. No residents were affected by this deficient practice. The dietary aid immediately removed soiled gloves, washed his hands, and put on new gloves. Dishes were re-washed. 2. All residents have the potential to be affected by this deficient practice. A second dietary aid was add to assist. One to feed the dirty and a second to retrieve the clean dishes. 3. The Food Service Director re-educated all dietary staff to have two people, one feeding the machine and one emptying the machine so that they maintain proper sanitation and if there is only one person, not to retrieve clean dishware from the dish machine without removing the soiled gloves, washing your	

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F 812	Continued From page 21 23. There was a three door reach in refrigerator that had four white fan covers with a brownish/grayish fuzzy matter on them. The FSD wiped them with a paper towel and stated it was dust. 24. There was an opened five-pound tub of cottage cheese in the refrigerator with an open date of 7/26. The FSD stated that once opened that should have been discarded after seven days. The FSD removed and discarded it. 25. The entire back of the ice machine bin had a blackish substance that the FSD was able to wipe off with a paper towel. In addition, there was a heavy build up of a brownish/grayish fuzzy substance on the ice machine vent. The FSD stated it looked like dust and dirt. 26. DA #1 was again observed wearing gloves as he loaded dirty dishware into the dish machine. DA #1 then retrieved clean dishware from the dish machine without removing his gloves, washing his hands and reapplying clean gloves. 27. There was a fan cover and two suspended grates labeled "RD FRESH" in the walk-in refrigerator that had a heavy build up of a brownish/grayish fuzzy substance. The FSD wiped these areas with a paper towel and stated it was dust. 28. In the walk-in refrigerator, there were a dozen raw eggs stored directly on top of a case of liquid whole pasteurized eggs. The FSD removed it and stated it should not have been stored that way because it could cross contaminate salmonella.	F 812	hands and reapplying new gloves. NHA re-educated Director of Food service on the need for all dietary staff to follow that practice. 4. The Registered Dietician will audit the dietary staff to assure that two people operate the dish machine and are maintaining proper sanitation. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Registered Dietician will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 6. The dish machine temperatures were observed to be 150 degrees F for the wash cycle and 160 degrees F for the rinse cycle. The temperature needs to be 160 degrees F for the wash cycle and 180 f for the rinse cycle. 1. No residents were affected by this deficient practice. Meals were served on paper products. The dishes were sanitized using the 3 compartment sink soaking in a minimum of 200ppm for a minimum of 60 seconds after running the dishes through the dish machine cycle. The dietary aid was immediately re-educated on the need for the dish machine temperature of the wash cycle to be at 160 degrees F and the rinse cycle at 180 degrees F, and if not, to sanitize in the 3 compartment sink soaking in a minimum of 200pm solution for a minimum of 60 seconds.	

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F 812	Continued From page 22 29. In the walk-in refrigerator there was a vertical rack with raw turkey breast thawing over a thawing roast beef. The FSD stated it should not have been stored that way due to potential cross contamination. 30. There were three opened, undated five-pound bags of biscuit mix in the dry storeroom. 31. There were multiple open spices with no opened dates in the dry storeroom. The FSD stated he was responsible to check that the spices were properly dated. 32. There were seven bags of opened pasta with no dates in the dry storeroom. The FSD stated he was supposed to monitor this. 33. There were 35 cases of one-gallon bottles of water stored directly on the floor. During a follow up kitchen tour with the FSD on 8/12/19 at 12:33 PM, the surveyors observed the following: 34. DA #3 was again observed in the kitchen with facial hair more than a quarter inch long wearing his beard net around his neck and not restraining his facial hair. 35. The can opener had a heavy black gooey build up on the opener, blade and base. The FSD stated it was a buildup of juice, grease and dirt and further stated he had not checked it in a couple of days. 36. There was a small restaurant pan and scoop with debris inside the sanitizer sink. The FSD stated it was dirty and should not have been in	F 812	2. All residents have the potential to be affected by this deficient practice. Vendor was called to service the dish machine. The dish machine was repaired 8/16. 3. The NHA in-serviced the FSD on the above procedure for using the sanitizing sink. The Food Service Director re-educated all dietary staff on the need for the dish machine temperature for the wash cycle to be 160 degrees F and 180 degrees F for the rinse cycle, and if using the 3 compartment sink for sanitizing to soak in a minimum of 200pm solution for a minimum of 60 seconds. 4. The Food Service Director will audit to ensure that the dish machine temperature is 160 degrees F for the wash cycle and 180 F for the rinse cycle. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food Service Director will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 7. The logs for the for the dish machine and the sanitizer sink had been filled in for both lunch and dinner 1. No residents were affected by this deficient practice. The dietary aid was immediately re-educated on not filling in the temperature logs prematurely. The Food Service Director assessed both the dish machine and sanitizer sink and recorded during both lunch and dinner. 2. All residents have the potential to be affected by this deficient practice. The dish machine and sanitizer sink logs were	

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F 812	Continued From page 23 that sink. 37. There was a five-well steam table observed with food for lunch, opened and exposed directly under an area of wall and ceiling and a speaker like item with a heavy build up of debris. The FSD stated it was a dust build up and should not have been that way. During an interview with the surveyors on 8/12/19 at 10:16 AM, the FSD stated that the handwashing process should be 40-60 seconds. He first stated that the friction time should be 10 seconds, then stated 15 seconds, then stated 20 seconds. He further stated that friction could be performed outside and inside the water. During an interview with the surveyor on 8/12/19 at 10:21 AM, DA #2 stated that DA #1 typically ran the dish machine without her until she was finished cleaning off the dirty breakfast trays. During an interview with the surveyors on 8/12/19 at 11:01 AM, the Registered Dietitian (RD) stated that the log for the dish machine should not have been prematurely filled out. She further stated she was unaware that the staff did that. The RD also stated that the purpose of using the logs was to ensure the dish machine was operating at the proper temperatures and that the FSD should have been monitoring that. During an interview with the surveyor on 8/13/19 at 12:30 PM, the FSD stated that he utilized a cleaning schedule and that the staff sign after the assigned cleaning was completed. He also stated that the company that serviced the dish machine came to the facility but could not fix it and that another service employee was going to be sent	F 812	filled in at the proper times 3. NHA re-educated Director of Food Service on the need for all dietary staff to follow that practice The Food Service Director re-educated all dietary staff on not to prematurely log temps. 4. The NHA will audit the logs in the kitchen that they are not being filled prematurely. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. NHA will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 8. There was food debris on the stainless-steel table extension of the clean dish machine where clean dishware was placed. 1. No residents were affected by this deficient practice. The dietary aid immediately removed the food debris, cleaned the table extension. The clean dishware was re-washed. 2. All residents have the potential to be affected by this deficient practice. The kitchen was audited to assure that no clean dishes are placed on dirty surfaces. 3. NHA re-educated Director of Food Service on the need for all dietary staff to follow that practice. The Food Service Director re-educated all dietary staff on keeping the clean end of the dish machine free from any food debris. 4. The Registered Dietician will audit the clean end of the dish machine to ensure it is free from any food debris. Audits will	

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F 812	Continued From page 24 out. During an interview with the surveyors on 8/14/19 at 1:00 PM, the RD stated that she performed sanitation audits to ensure that the kitchen was functioning "in a sanitary manner and following regulation." She stated that she recorded things that were a problem and things that had not yet been resolved. The RD stated she gave a copy of her audits to the FSD, the Administrator, the Director of Nursing and the Maintenance Director; however, no one reports back to her to ensure the problem areas were resolved. She further stated that she does not follow up until the following audit a month later. The RD stated she did not recall when she performed the July audit, as none of the audits provided to the surveyors were dated. The RD could not state how long a container of cottage cheese would have been good for once opened. In addition, she could not speak to the proper water temperature when thawing food under running water. She stated that raw foods needed to be stored below cooked foods but was unaware of the order in which raw foods should be stored. The RD stated that raw eggs should not have been stored over liquid pasteurized eggs. She further stated that some of the things she checks in the kitchen are that the staff are using proper thawing methods, that all spices are dated and labeled, and that the back of the stove, refrigerators and ice machine are clean. During an interview with the surveyor on 8/15/19 at 9:37 AM, the FSD stated the dish machine company returned to service the dish machine and stated that the rinse cycle wasn't reaching 180 degrees F due to faulty elements in the booster.	F 812	be completed 4 days a week x 2 weeks then weekly x 3 months. Registered Dietician will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director/ F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 9. There was condensation on the ceiling and pipes that was observed dripping onto clean dishware and trays. 1. No residents were affected by this deficient practice. The Dietary Aid immediately removed those dishware and trays and had them re-washed and sanitized. The area was dried and maintenance contacted a contractor and a new exhaust fan was ordered for the kitchen. 2. All residents have the potential to be affected by this deficient practice. The ceiling and pipes in the kitchen were checked for condensation and dripping and no condensation and dripping was observed. 3. NHA re-educated the Food Service Director to inspect the kitchen for any condensation and dripping from the ceiling and pipes and report this to the Director of Maintenance. The Food Service Director re-educated all dietary staff on not to have any dishes or trays under pipes or ceiling that are dripping. NHA re-educated Director of Food Service on the need for all dietary staff to follow that practice. 4. The Director of Maintenance will audit for any condensation on the ceilings and	

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F 812	Continued From page 25 The facility provided the surveyors with multiple in-service forms that had only a topic and signatures filled in. The forms were not dated and there was no topic information provided. During an interview with the surveyors on 8/15/19 at approximately 9:30 AM, the Administrator stated that if the summary section of an in-service form was not filled out and there was no date, he would not know what was discussed or when it occurred. He further stated he believed the Director of Nursing (DON) completed hand hygiene in-services for the kitchen staff. During an interview with the surveyor on 8/15/19 at 9:45 AM, the FSD stated that without filling out the date and summary section of an in-service form, no one could be sure when the in-service was conducted and what the content of information was. The FSD stated that no one performed in-services in the kitchen. He stated that new kitchen employees received in-services on handwashing from Human Resources during orientation. He further stated that he was unaware of what the RD looks at during a kitchen audit and he was not sure if he still had the reports. During an interview with the surveyors on 8/15/19 at 10:30 AM, the Administrator could not speak to why the in-service forms did not have dates or the summary of information and acknowledged they should not be that way. During an interview with the surveyors on 8/16/19 at 8:45 AM, the Administrator stated the FSD did not perform any documented kitchen audits. He further stated there was no documented	F 812	pipes in the kitchen that are dripping. Audits will be completed 3 times a week x 2 weeks, weekly x 3 months. Director of Maintenance will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 10. There are 2 areas on the tiles and wall directly above the dish machine with dotted blackish substance. 1. No residents were affected by this deficient practice. The area was immediately cleaned. 2. All residents have the potential to be affected by this deficient practice. All the walls and tiles around the dish machine was checked and cleaned. 3. NHA re-educated Director of Food service on the proper cleaning of the kitchen tiles and walls. The Food Service Director re-educated all dietary staff on the proper cleaning of the kitchen walls and tiles. 4. The Food Service Director will audit the kitchen to ensure that the tiles and walls are clean. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. NHA will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 11. Nesting/improper storing of dishes and utensils	

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F 812	Continued From page 26 communication in relation to the findings of the RD's kitchen audits. The Administrator also stated he could not speak to who performed high dusting in the kitchen. During an interview with the surveyor on 8/16/19 at 9:46 AM, the FSD stated that the importance of proper hand hygiene in the kitchen environment was to prevent cross contamination and for infection control. He also stated that hand sanitizer should not be used in the kitchen. The FSD further stated that the competency used for handwashing included the use of hand sanitizer and that form should no longer be used for kitchen staff because it was "confusing." During an interview with the surveyor on 8/16/19 at 10:50 AM, the RD stated that hand hygiene in the kitchen environment was "of the utmost importance" for infection control and that hand sanitizer was not an acceptable form of hand hygiene in a kitchen. During an interview with the surveyors on 8/16/19 at 12:00 PM, the DON stated that proper hand washing should include a friction time of 20-25 seconds. She also stated that hand sanitizer was not appropriate to use in kitchen environment. The DON further stated that the importance of hand hygiene in the kitchen environment was to prevent food borne illness, cross contamination and for infection control. During an interview with the surveyors on 8/21/19 at 9:48 AM, the Administrator acknowledged there was a problem with the exhaust system in the kitchen which was responsible for the dripping condensation from the ceiling.	F 812	1. No residents were affected by this deficient practice. The sheet pans in question were immediately removed and rewashed and were repositioned to properly air dry. The utensils in question was rewashed and properly positioned so that they air dry and the rolling pin in question was removed from the packaging, washed and properly air dry. 2. All residents have the potential to be affected by this deficient practice. The entire kitchen was audited to ensure that all other pots, pans & utensils are air drying properly. 3. NHA re-educated the Food Service Director of his responsibility to ensure that there is no improper air drying and to prevent nesting. The Food Service Director re-educated all dietary staff on the policy and procedure of proper air drying technique and proper storage on all utensils & dishes. 4. The Food Service Director will inspect for proper air drying and storing on all utensils and dishes to ensure that there is no nesting and to allow proper air drying. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food Service Director will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 12-16,23, 25, 27. There was a six-range stove with heavy black build up on it, a stainless-steel shelf above the range with heavy buildup of a grease like substance	

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Review of the facility policy "Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices," dated October 2008, reflected that food service employees should follow appropriate hygiene and sanitary procedures to prevent the spread of food borne illness. It also reflected that employees must wash their hands after handling soiled equipment and utensils. It further reflected that gloves were considered single use items and must be discarded after a task is completed. Then hands must be washed after gloves are removed and before gloves are applied. The document also reflected that hair nets and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment and utensils.

Review of the facility policy "Food Receiving and Storage," revised July 2014, reflected that foods should be received and stored in a manner that complies with safe food handling practices. It further reflected that the proper functioning of refrigeration will be monitored at designated intervals throughout the day and documented. It also reflected that certain cheeses have a shelf life of seven days after opening. In addition, it reflected that in order from top to bottom raw foods should be stored raw prime rib, raw meat/chops, ground beef and raw poultry on the bottom; and raw eggs should be stored on the bottom shelf with nothing underneath them.

Review of the facility policy "Hand Hygiene," dated 3/19/19, reflected that all staff would be trained and regularly in-serviced on the importance of hand hygiene. It further reflected that the proper handwashing procedure included to vigorously lather hands with soap, rubbing them together to create friction to all surfaces for

on the shelf, there was a heavy buildup of black reddish substance on the underside of the stainless-steel shelf that was directly over an uncovered pan with an item being cooked, there was a wood shelf attached to the steam table that was not cleaned, there were 3 glass light covers under the hood over cooking area that had a heavy caked substance on it, the entire back of the ice machine bin had a blackish substance and a heavy buildup of a brownish/grayish fuzzy substance on the ice machine vent, there was a fan cover and 2 suspended grates in the walk in fridge that had a heavy buildup of a brownish grayish substance/there was 3 door refrigerator that had 4 fan covers with a brownish/grayish matter on them.

1. No residents were affected by this deficient practice. The black buildup on the stove was immediately cleaned. The stainless steel shelf above the range with the heavy grease buildup was immediately cleaned. The heavy buildup of black and red substance on the underside of the steel shelf that was above the uncovered pan of tomato-based item was cleaned. The tomato-based item was discarded. The water spray and pipe that provided water to the coffee urn was thoroughly cleaned from the black substance that was built up on the pipe. The wooden shelf attached to the steam table was scrubbed with sanitizer and was covered with aluminum foil to ensure that no debris becomes entrapped in the wood. The three glass light covers under the hood over the

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F 812	Continued From page 28 at least 20 seconds. Review of the facility policy "Dishwashing Machine Use," revised March 2010, reflected that food service staff would be trained in all steps of dish machine use, in all aspects of proper use and sanitation. It also reflected that the wash cycle temperature should be 160 degrees F and the rinse cycle 180 degrees F, and that corrective action would be taken immediately if the temperatures were too low. It further reflected that the operator would check temperatures using the machine gauges with each machine cycle and would record the results on the log. Additionally, it reflected that the operator would frequently monitor the gauges and would report inadequate temperatures to the supervisor for immediate correction. The document also reflected that if the hot water rinse temperature did not meet requirements, dishware could be sanitized manually in a 200-ppm solution for a minimum of 60 seconds. Review of the "Customer Service Report" from the dish machine company, dated 8/14/19, reflected that there was a burned heating contractor and wire and that the final rinse was 179 F. Review of a work order, dated 8/20/19, reflected that a new exhaust fan was installed in the kitchen. Review of the facility policy "Sanitization," revised October 2008, reflected that cleaned items should air dry upside down on a drying rack. It further reflected that fixed equipment that cannot fit through the dish machine would be disassembled as necessary, scraped to remove	F 812	cooking area were immediately cleaned from the caked on substance. The fan covers inside the three door reach in refrigerator as well as the walk-in refrigerator fan cover were immediately cleaned from the brownish/grayish matter. 2. All residents have the potential to be affected by this deficient practice. The entire kitchen was audited & inspected to make sure all items cleaned and sanitized properly. 3. NHA re-educated Director of Food Service on the need for all these areas and the entire kitchen to be properly cleaned and sanitized. The NHA re-educated the Director of Maintenance to clean all vents weekly. The Food Service Director re-educated all dietary staff on proper cleaning and sanitizing of the kitchen. 4. The Food Service Director will audit all areas in the kitchen that they are clean as per policy and schedule. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. FSD will report results during the monthly QAPI meeting. The NHA will audit The QAPI is attend by the NHA, DON and Medical Director F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 19. There were multiple areas of a dried-on substance on 2 ingredient bins 1. No residents were affected by this deficient practice. The Lead Cook immediately cleaned the ingredient bins. 2. All residents have the potential to be affected by this deficient practice. All	

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F 812	Continued From page 29 food particles and all parts washed and sanitized. It also reflected that ice machines will be drained, cleaned and sanitized per manufacturers instructions. In addition, it reflected that all surfaces in the kitchen in contact with food would be cleaned on a regular schedule and frequently enough to prevent the accumulation of grime. It also reflected that the cooks should clean the stove top daily. The document further reflected that the FSD would be responsible to schedule staff for regular cleaning of the kitchen. Review of the facility policy "Food Preparation and Service," revised July 2014, reflected that potentially hazardous foods included meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. It further reflected that staff should change gloves when moving from a dirty area to clean/sanitized area of the kitchen/dishes. Review of the "Daily Cleaning Lists," reflected assignments that included cleaning of the ice machine, can opener and coffee machine. Review of the Monthly Kitchen Audit from the RD, dated July 2019, reflected cleaning needed to be completed on the walls behind tables and equipment. Review of the audits from February through July 2019 reflected a reminder for monthly cleaning to the high vents and pipes. Review of the facility's "Handwashing Checklist" for 11 food service employees, four of which were dated 8/15/19, reflected the training for use of hand sanitizer. NJAC 8:39-17.1(a);17.2(g)	F 812	other food bins were checked for any dirt and all were cleaned. 3. NHA re-educated Director of Food Service on the need for all dietary staff to clean all food storage bins. The Food Service Director re-educated all dietary staff on the need keep all ingredient bins clean. 4. The Food Service Director will audit the food storage bins in the kitchen and dry storage area to ensure they are clean. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food Service Director will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 20-22. There was a slicer covered with a clear plastic bag. Upon removal of the bag the FSD stated that remnants of sliced tomato on the slicer. There was a table top mixer covered with a black plastic bag. Upon removal of the bag, the FSD stated that the white substance caked to the underside of the mixer was splashed pudding. There was a water spray and pipe that provided water into the coffee urn with a heavy buildup of black substance. 1. No residents were affected by this deficient practice. The slicer, mixer and the water spray and pipe that provided water to the coffee urn was immediately cleaned. 2. All residents have the potential to be affected by this deficient practice. All equipment in the kitchen that were	

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F 812	Continued From page 30	F 812	covered were audited to assure that they were cleaned. 3. NHA re-educated Director of Food Service that no equipment in the kitchen should be covered before being cleaned properly. The Food Service Director re-educated all dietary staff on the need to not cover any equipment before they are cleaned. 4. The NHA will audit all covered equipment in the kitchen that they are cleaned. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food Service Director will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 24,. There was an opened 5lb tub of cottage cheese in the refrigerator with an open date of 7/26 the FSD stated that once opened it should have been discarded after 7 days. 1. No residents were affected by this deficient practice. The Food Service Director immediately removed and discarded it. 2. All residents have the potential to be affected by this deficient practice. All other food items that were open were checked to see if they needed to be discarded and none were found. 3. NHA re-educated Director of Food service on the need for all dietary staff to discard all open food past the acceptable date. Food Service Director and all Cooks will be responsible on checking all the	

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F 812	Continued From page 31	F 812		

open item that they are not past the date as per policy. The Food Service Director re-educated the lead cooks for their responsibility to check and discard any open food items that are past the acceptable due date and all dietary staff on the need discard all open items past the acceptable due date.
4. The Food Service Director will audit all open food in the kitchen to ensure they are discarded past the acceptable due date. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food Service Director will report results during the monthly QAPI meeting. The QAPI Meeting is attend by the NHA, DON and Medical Director.

F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY
25. The back of the ice machine bin had blackish substance.
1. No residents were affected by this deficient practice. The back of the ice machine as well as the entire ice machine was thoroughly cleaned to ensure that there was no blackish substance in the bin. The ice machine vent was thoroughly cleaned of the brownish gray-ish substance.
2. All residents have the potential to be affected by this deficient practice. An audit was completed of all ice machines to ensure it was clean.
3. The Food Service Director educated all dietary staff on how to clean the back part of the bin and assigned a designated dietary aide position to do the cleaning and sanitizing of the bin of the ice

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F 812	Continued From page 32	F 812	machine twice a day. The Food Service Director and/or the Lead Cook will check and log the cleanliness of the Ice Machine bin on daily basis. NHA re-educated the Food service Director on the need for the dietary staff to maintain a clean ice machine and schedule. 4. The Food Service Director will inspect the ice machine and vent for cleanliness. Audits will be completed 4 days a week X 2 weeks then weekly X 3 months. Food service Director will report results during the monthly QAPI meeting. The QAPI meeting is attended by the NHA, DON and Medical Director. F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 28, 29. Raw eggs stored directly on top of liquid eggs/raw turkey breast thawing over the roast beef. 1. No residents were affected by this deficient practice. The raw eggs stored over the top of whole pasteurized liquid eggs was removed and stored together with the rest of the raw eggs. The raw turkey breast thawing over a thawing roast beef was immediately switched and followed the proper thawing procedure. The employees were immediately instructed as to the policy of raw meat and egg storage. 2. All residents have the potential to be affected by this deficient practice. The entire refrigerator was checked for improper storage of raw eggs and meat to avoid cross-contamination. 3. NHA re-educated the Food Service Director of his responsibility to ensure that	

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the dietary staff follow that practice. The Food Service Director re-educated all dietary staff of proper thawing of meats and proper storage of raw eggs and pasteurized eggs. The Food Service Director re-educated the Registered Dietician on the proper thawing of food under the running water, proper thawing of meat and the proper storage of raw eggs and pasteurized eggs.
4. The Food Service Director will audit the walk in refrigerator and check for proper thawing of meats and proper placement of foods on a daily basis. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food Service Director will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director.

F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 30,31,32. Undated open biscuit mix/Undated open spices/Undated open pasta .
1. No residents were affected by this deficient practice. The undated 5 pound bags of biscuit mix as well as the multiple spices in the dry food store room in addition to the open bags of pasta all with no open dates were immediately discarded.
2. All residents have the potential to be affected by this deficient practice. The rest of the dry food store and refrigerated

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open food was checked to ensure that they were all properly dated.
3. The Food Service Director educated all dietary staff on proper policy of labeling and dating of all opened food items dry and refrigerated in addition to discarding food that have past the policy date. NHA re-educated the Food service Director of his responsibility that the dietary staff follow that practice.
4. The Food Service Director will audit daily to make sure everything is labeled and dated. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food Service Director will report results during the monthly QAPI meeting. The QAPI meeting is attend by the NHA, DON and Medical Director.

F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 33,. There was 35 cases of one-gallon bottles of water stored directly on the floor.
1. No residents were affected by this deficient practice. The 35 gallons of water bottles store directly on the floor were lifted off the floor and stored properly on platforms with 6 -8 inch height from the floor.
2. All residents have the potential to be affected by this deficient practice. The entire storage was checked and made sure that nothing is being stored directly on the floor.
3. NHA re-educated the Food Service Director of his responsibility that the dietary staff follow that practice. The Food Service Director educated all dietary staff

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F 812	Continued From page 35	F 812	on proper storing of food/water 6-8 inches off the floor. 4. The Food Service Director will make a daily rounds to make sure that all water/food is stored 6-8 inches off the floor. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food Service Director will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY 35. The can opener had a heavy build up on the opener blade and base. 1. No residents were affected by this deficient practice. The can opener with the heavy black gooey buildup on the blade and the base was immediately cleaned. 2. All residents have the potential to be affected by this deficient practice. The rest of the kitchen utensils and equipment was checked for any black or gooey substance and cleaned as needed. 3. NHA re-educated Food service Director of his responsibility that the dietary staff follow that practice. The Food Service Director re-educated all dietary staff on proper cleaning of the can opener blades and base every after use. 4. The Food Service Director will audit the can opener daily and as well as the cooks will check the can opener before their shift start and after their shift. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food Service Director will report results during	

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the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director.

F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY
36. There was a small restaurant pan and scoop with debris inside the sanitizer sink.
1. No residents were affected by this deficient practice. A small restaurant pan and scoop with debris inside the sanitizer sink was removed and cleaned right away. The sanitizer sink was drained, cleaned and filled with clean and uncontaminated sanitizer.
2. All residents have the potential to be affected by this deficient practice. The Food Service Director immediately instructed the dietary staff not to place anything soiled or with the breathing it in the sanitizer sink.
3. NHA re-educated Food Service Director of his responsibility that the dietary staff follow this practice. The Food Service Director re-educated all dietary staff on making sure that the sanitizer sink is always clean from any debris at all times.
4. The Food service Director will make sure that the sanitizer sink is clean at all times. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food Service Director will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director.
F812 S/S F FOOD PROCUREMNT, STORE/PREPARE/SERVE-SANITARY
37. There was a five-well steam table

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F 812	Continued From page 37	F 812	observed with food for lunch, opened and exposed directly under an area of wall and ceiling and a speaker like item with a heavy build-up of debris. 1. No residents were affected by this deficient practice. The five steam table pans with food for lunch was inspected for any contamination and immediately covered and the speaker like item with heavy buildup of debris was cleaned. 2. All residents have the potential to be affected by this deficient practice. All items hanging over food were audited and cleaned. The Food Service Director instructed the cooks to make sure not to place anything in the steam table that is uncovered. 3. NHA educated the Food service Director of his responsibility that the dietary staff follow this practice. The Food Service Director re-educated all dietary cooks on covering all the food in the steam table and make sure that the surroundings is all clean and free from falling debris before opening the food. 4. The Food Service Director will make sure that all the food in the steam table is always covered. Audits will be completed 4 days a week x 2 weeks then weekly x 3 months. Food service Director will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director.	
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	F 880		9/23/19

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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:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 39 (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, review of medical records and other facility documentation, it was determined that the facility failed to 1.) ensure the Infection Control Policies and Procedures (ICPP) manual was revised annually and updated with current infection control practices; 2.) follow proper or adequate hand hygiene practices to minimize the potential spread of infection; 3.) provide a clean environment during and after [redacted] care for 1 of 1 residents reviewed for wound care (Resident #15); and 4.) failed to provide a clean [redacted]	F 880	F880-S/S D Infection Prevention & Control Provide a clean environment before and after [redacted] care 1. Resident #15 was affected by this deficient practice. The items left on the table during [redacted] care were disposed of and the resident received clean cup and personal items. Housekeeping cleaned the room including the table. 2. 4 residents have the potential to be affected by this deficient practice. There were no additional treatments to be completed that day. Nurses caring for the	

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F 880	Continued From page 40 delivery for 1 of 2 residents reviewed for [redacted] use (Resident #15). This deficient practices were evidenced by the following: 1. On 8/20/19 at 9:00 AM, the surveyor reviewed the facility Infection Control Policies and Procedures (ICPP) manual which revealed an outline that included but was not limited to the "Scope of Infection Control Program," not dated; the "Role of the Infection Control Coordinator," not dated; the "Agenda" for the Infection Control Meetings, not dated; and the "Objectives" of the Infection Control Committee, not dated. The ICPP manual contained 51 different disease processes and their infection control measures with the most current "updated" and/or "reviewed" listed as November 2008. During an interview with the surveyor on 8/21/19 at 9:11 AM, the Director of Nursing (DON) stated the purpose of reviewing and updating the ICPP was to keep up with the most effective practices for the well being of the residents and staff. The DON further stated that no policies have been reviewed or updated that she had been aware of. The facility was unable to provide documentation of an annual review of the ICPP manual. During an interview with the surveyor on 8/21/19 at 11:32 AM, the Regional Registered Nurse (RN) stated the policies and procedures should be reviewed annually for updates and that if there had been any updated policies or procedures for the ICPP manual that they would be in the manual, and if they were not in there, the facility did not have them. Additionally, the Regional RN stated the ICPP manual was important because	F 880	4 identified residents were instructed on preparing a clean environment during and after [redacted] care. 3. The DON/designee will re-educate all clinical staff on how to perform [redacted] care that includes preparing a clean environment during and after [redacted] care. 4. The DON/designee will audit the [redacted] care weekly X4 and monthly X3. DON will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. 880-S/S D Infection Prevention & Control Adequate Hand Hygiene Practices 1. 2 Residents were affected by this deficient practice. LPN #4 was re-educated about hand hygiene and return demonstration was successful. 2. All residents have the potential to be affected by this deficient practice. Hand Hygiene competency , including return demonstration, was completed for all nurses 3. The DON/designee will re-educate all clinical staff on how to and when to perform hand hygiene. 4. The DON/designee will audit hand hygiene daily X5, weekly X3 and monthly X3. DON will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F880-S/S D Infection Prevention & Control Infection Control Policy & Procedure Manual Reviewed/Revised Annually 1. No Residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. An	

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F 880	Continued From page 41 the facility would need to keep up to date with the most current practices for the safety of the residents and staff. According to the ICPP manual, the Scope of Infection Control Program revealed that the guidelines within the program are based on recommendations from the Center of Disease Control and other government agencies and are intended for use in the care of the individuals in the facility. The basic responsibilities included to validate that all infection control policies and procedures are implemented, followed and are updated when new revisions are issued. The agenda for the Infection Control Meetings would include the policy and procedure review and revisions. The objectives of the Infection Control Committee would include to establish policies and procedures for infection control and provide ongoing evaluation of current measure and policies within each department. 2. On 8/16/19 at 10:13 AM, the surveyor observed Licensed Practical Nurse (LPN #3) performing handwashing at the sink located in the [redacted] nurses' area. LPN #3 wet her hands, applied soap and provided friction to her hands for five seconds. During an interview with the surveyor on 8/16/19 at 10:13 AM, LPN #3 stated she had been working at the facility off and on for at least six months as an agency nurse. LPN #3 stated that the proper handwashing procedure was to wash for at least 20 seconds and that she had been trained on handwashing at another facility. LPN #3 stated she was aware of the importance of handwashing, she should have washed longer to be effective and that she had been reading the	F 880	updated Infection Control Policy & Procedure Manual was obtain, reviewed and will be presented for approval during the next Monthly Infection Control Meeting. 3. Regional Director of Nursing will re-educate the Director of Nursing on the need to annually review and revise the Infection Control Policy & Procedure Manual. 4. The NHA will audit Infection Control Meeting minutes to assure that infection control P&P are reviewed/revised/updated annually monthly X3. NHA will report results during the monthly QAPI meeting. The QAPI is attend by the NHA, DON and Medical Director. F880-S/S D Infection Prevention & Control Provide a clean [redacted] 1. Resident #15 was effected by this deficient practice. The contaminated [redacted] was discarded, new [redacted] was dated, labeled and placed on resident #15. 2. 4 residents have the potential to be effected by this deficient practice. All were audited and O2 equipment was replaced as indicated. 3. The DON re-educated all staff on the policy and procedure for [redacted], the proper storage of the [redacted], and disposing / replacing contaminated Resident equipment. 4. The DON will audit the Resident population on [redacted] to ensure that when the [redacted] is not in use it is properly stored and free from contamination. Audits will be completed	

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F 880	Continued From page 42 sign above the sink as she washed that revealed handwashing for 40-60 seconds. During an interview with the surveyor on 8/16/19 at 11:32 AM, the DON stated that all staff in the facility should be in-serviced on handwashing. The DON stated that agency staff would also be oriented to facility policies on handwashing. The DON stated that she believed handwashing should be 20-25 seconds but was not sure of the facility policy and would need to check the amount of time. Review of the Hand Hygiene policy, dated 3/19/19, revealed "Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water... ." On 8/15/19 at 8:27 AM, the surveyor observed LPN #4 administer medications. The LPN did not perform hand hygiene before or after administering medications to the first resident. On 8/15/19 at 8:39 AM, the surveyor observed LPN #4 administer medications to a second resident. The LPN did not perform hand hygiene prior to preparing the resident's medications. After administering the medications, the LPN washed her hands for 60 seconds. During an interview with the surveyor on 8/15/19 at 8:54 AM, LPN #4 stated that handwashing is performed before starting the medication pass, hand sanitizer is used in-between administering medications to different residents, and handwashing is performed after every third resident. When asked if the LPN followed that procedure when administering medications in the	F 880	5 times a week x 2 weeks then weekly x 3 months. The DON will report results during the monthly QAPI meeting. The QAPI is attended by the NHA, DON and Medical Director.	

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presence of the surveyor, the LPN stated, "I did not use hand sanitizer before administering medications to [the first resident]" and, "I did not use hand sanitizer in-between [the first resident] and [the second resident]."

During an interview with the surveyor on 8/20/19 at 10:09 AM, the DON stated that nurses are to perform hand hygiene before the start of medication pass and in between administering medications to different residents. The DON further stated that hand hygiene is important due to infection control purposes.

Review of the facility's Medication Administration policy, revised March 2019, revealed, "Handwashing must be done by the medication nurse at the outset of medication pass and intermittently during medication pass using sink and running water or the hand-cleaning disinfectant selected by the facility." The facility's Hand Hygiene policy further indicated, "Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:... Before preparing or handling medications."

3. According to the Admission Record, Resident #15 was admitted to the facility on [redacted] 9 with diagnoses which included [redacted]

Review of the Care Plan, revised on 5/23/19, revealed Resident #15 was [redacted]

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F 880	Continued From page 44	F 880		

[redacted]

On 8/16/19 at 10:47 AM, the surveyors observed Resident #15's [redacted] care performed by LPN #1. LPN #1 reviewed the following physician [redacted] care orders: [redacted]

LPN #1 then performed hand hygiene, and partially covered the bedside table with a clear trash bag, next to Resident #15's water cup. LPN #1 did not disinfect the bedside table prior to placing the trash bag on the bedside table. LPN #1 performed hand hygiene, gathered her supplies and placed them on the trash bag covered side of the bedside table. LPN #1 performed hand hygiene, applied gloves and proceeded with the [redacted] care. When the [redacted] care was completed, LPN #1 performed hand hygiene, applied new gloves and put the [redacted] care supplies away. The basins used for [redacted] care and trash bag were left on the resident's bedside table. LPN #1 signed the Treatment Administration Record (TAR) and stated she was done and would call housekeeping to clean the room.

During an interview with the surveyor on 8/16/19 at 11:27 AM, LPN #1 stated the bedside table was used for eating, the residents personal items and that the resident's water cup should not have been on the table and should had been thrown

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING _____ B. WING _____	08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARDELL GARDENS AT TINTON FALLS	524 WARDELL ROAD TINTON FALLS, NJ 07753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45 away. LPN #1 stated housekeeping would wipe down the table and empty the garbage. During an interview with the surveyor on 8/21/19 at 9:31 AM, the DON stated the nurse should have disinfected the bedside table before and after [redacted] care and removed the personal items from the table prior to [redacted] care. Review of the "[redacted] Dressing" Policy/Procedure, revised 3/20/19, revealed, the purpose was to decrease the risk of [redacted] contamination and cross-contamination during dressing changes and to maintain a sterile environment and prevent contamination during dressing change. Under Procedure #4, the policy reflected to clean over-bed table and place clean barrier on the over-bed table and place supplies on the barrier. 4. According to the Admission Record, Resident #15 was admitted to the facility on [redacted] with diagnoses which included [redacted] Review of the Care Plan, revised on 4/29/19, revealed Resident #15 was on [redacted] Review of the Physician Order Sheet (POS), dated reviewed 7/28/19, revealed Resident #15 was o [redacted] On 8/16/19 at 10:47 AM, the surveyor observed	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 46 Resident #15's wheelchair by the toilet in the resident's bathroom. The wheelchair had an [redacted] on it with the [redacted]. The area of the [redacted] that is [redacted] On 8/16/19 at 11:17 AM, CNA #3 washed his/her hands and brought the resident's wheelchair to the bedside. The resident's [redacted] was lying directly on the seat cushion of the wheelchair with the foot rest on top of it. CNA #3 removed an additional [redacted], that was attached to the bedside [redacted] and placed it directly on the linen on the bed where the resident's [redacted] had just been completed. CNA #3 assisted Resident #15 into the wheelchair, sitting on top of the NC. CNA #3 removed the [redacted] from underneath the resident. CNA #3 washed his/her hands, picked up the other [redacted] that was still lying on the bed linen and went to place it back in Resident 15's [redacted]. The surveyor stopped CNA #3 before the contaminated [redacted] could be applied to Resident #15's [redacted]. During an interview with the surveyor on 8/16/19 at 11:32 AM, the DON stated when [redacted] is not in use, it should be stored inside a bag to prevent contamination. During a follow up interview with the surveyors on 8/21/19 at 9:19 AM, the DON stated the [redacted] should have been replaced and not be placed on the resident. Review of a policy titled, [redacted] Administration," revised 12/10/18, revealed, [redacted] in	F 880		

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WARDELL GARDENS AT TINTON FALLS	**524 WARDELL ROAD TINTON FALLS, NJ 07753**

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F 880	Continued From page 47 plastic bag with [resident] name on it when not in use." NJAC 8:39:19.4 (a)(1-6)(l)(n), 27.1(a)	F 880		