STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315448	A. BUILDING ______ B. WING ______	10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOME OF SOUTH JERSEY	**303 BANK AVE RIVERTON, NJ 08077**

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F 000	INITIAL COMMENTS STANDARD SURVEY 10/18/2019 CENSUS: 51 SAMPLE SIZE: 13	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow acceptable standards of clinical practice with medication administration by not following cautionary directions, physician's orders, and/or acceptable time frames. This deficient practice was identified for 2 of 2 nurses who administered medications to 4 of 6 residents (Residents # 8, #15, #43, and #47) and was cited at a level E as both nurses observed made errors, which involved 4 of 6 residents. The findings include: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through	F 658	1. LPN #1 was educated to proper medication administration for [redacted] and proper medication administration pass with pharmacy consultant. LPN #2 was educated to proper medication administration for [redacted] and proper medication administration pass with pharmacy consultant to include meal vs. food as cautionary. All nurses were educated to observing cautionary when transcribing orders to the MAR and following cautionary and timing of medications related to these cautionary when transcribing orders to the MAR and following cautionary and timing of medications related to these cautionary at medication administration. They were also educated to new updated medication administration policy which indicates proper medication administration and observing cautionary and was updated by the Director of Nursing.	12/10/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/07/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."

Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

1. On 10/16/19 at 8:39 AM, the surveyor observed Licensed Practical Nurse (LPN #1) prepare medications for administration to Resident #8. The medications included [redacted] medication for the treatment of [redacted], that is administered [redacted] The Medication Administration Record (MAR) included a Pharmacy-printed cautionary that directed to "wait [redacted]." LPN #1 gave both puffs to the resident without waiting between the [redacted]. When interviewed after the surveyor and LPN #1 returned to the medication cart, the LPN acknowledged she had not waited between [redacted] per the cautionary and stated, "that was an error."

2. On 10/16/19 at 9:44 AM, the surveyor

F 658

Resident #47 was ordered [redacted] mg 1 tab at 8 am with meal. Resident was given medication at 10am. No sign or symptom of [redacted] was noted as assessment. 4pm [redacted] was [redacted]. Physician was made aware verbally by the DON

[redacted] mg was orders for 10am and cautionary to be given with food was noted. Physician order shows change to be administered at 8 am with food.

Resident #15 was ordered [redacted] mg 1 tab every other day to be given with food at 8 am. Physician notified of medication given at 10am on 10/16/19. No change to order.

[redacted] was ordered at 10am. medication has cautionary of to be given with first meal of the day. Medication is changed to 8am by physician's order.

2. All residents have the potential to be affected by this deficient practice. Resident MAR's were audited by consultant pharmacist and corrected by DON accordingly to reflect timing of medications as related to cautionary of specific medications.

3. Weekly medication administration pass will be completed with observation of the DON with a nurse on each shift. Consultant pharmacist will do education/training for proper medication administration with staff monthly and submit report to the DON.

The DON will ensure consultant pharmacy recommendations for proper

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F 658	Continued From page 2 observed LPN #2 prepare medications for administration to Resident #43. The medications included [redacted] mg. The MAR had a Pharmacy-printed cautionary that directed the medication to be administered, "take with meals." The MAR also noted the medication was scheduled to be administered at "8AM." Professional Standards for medication administration allow a 1-hour window on either side of the scheduled administration time. Therefore, it would be acceptable to administer the [redacted] between 7 AM and 9 AM. However, a cautionary noting "take with meals" generally means to administer the medication while the meal is being eaten. Following the medication pass observation, the surveyor reconciled the medications with the "Physician's Order Form" and observed the physician's order as [redacted] tab by mouth twice daily with meals." The surveyor reviewed the facility's meal times schedule that was provided by the Director of Nursing. A review of the breakfast schedule revealed that Resident #43 should have received the breakfast meal at approximately 7:45 AM. 3. On 10/16/19 at 9:59 AM, the surveyor observed LPN #1 prepare medications for administration to Resident #47. The medications included the diabetes medication [redacted] mg 1 tab every day, and the [redacted] medication [redacted] mg 1 tab every day. The [redacted] was noted on the MAR for administration at 8 AM. Per professional standards, the LPN should have administered the [redacted] by 9 AM. The [redacted] was on the MAR for administration at 10 AM. However, a Pharmacy-printed cautionary on the	F 658	medication administration and cautionary are documented to the MAR and medication is timed accordingly. 4. The Director of Nursing will audit MAR's and consulting pharmacy recommendations weekly and submit a report to the Administrator monthly x6. This will be reviewed at QAPI quarterly x2. The DON will submit monthly report for Nurse Medication Administration competencies for medication pass x 6 months. This will be reviewed at QAPI quarterly x2.	

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F 658	Continued From page 3	F 658		

MAR directed the medication to be administered, "take with or immediately after the meal." The breakfast schedule noted Resident #47 should have received the breakfast meal at approximately 7:45 to 7:55 AM. The breakfast schedule also indicated that no meals were scheduled to be served at 10 AM.

4. On 10/16/19 at 10:04 AM, the surveyor observed LPN #1 prepare medications for administration to Resident #15. The medications included the [redacted] medication [redacted] 1 tab every other day, and the [redacted] medication [redacted] mg 1 tab every morning. The MAR had a Pharmacy-printed cautionary for the [redacted] that directed, "take with food." Resident #15 routinely ate breakfast in the facility's main dining room. On 10/17/19 at 8:45 AM, the surveyor observed that the resident had already finished the breakfast meal. When interviewed at that time, a dietary employee in the main dining room, stated the breakfast meal in the main dining room started at 7:30 AM. The MAR had a Pharmacy-printed cautionary for the [redacted] that directed, "Take with 1st meal of day." The [redacted] was noted on the MAR for administration at 10 AM, much later than the scheduled breakfast time.

Following the medication pass observation, the surveyor asked the Director of Nursing (DON) for any facility policies related to medication administration. On 10/17/19 at 11:17 AM, the DON provided the surveyor with an "In-Service Training Report" that had been presented by the Consultant Pharmacist on [redacted]. The DON said the packet of information presented at the in-service was in the front of the MAR books. Upon review, the surveyor observed that the

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F 658	Continued From page 4 packet included that the medication [redacted] should be taken with food, and the medication [redacted] should be taken with meals. The in-service packet also contained, "Problems Commonly Associated with Improper Medication Administration." Listed under this was, "One minute not seen allowed [sic] between [redacted] ", "Medication ordered with food, juice, milk, etc. must be offered with the required item", and, "Also, if med is ordered with food, nurse may offer 2 crackers to serve as food." The surveyor also observed that neither LPN #1 nor LPN #2, had attended that in-service training. On 10/17/19 at 10 AM, the DON provided the surveyor with a policy titled "Administration Of Medications" with a revised date of "9/11," which was crossed out, and a date of "10/19" was handwritten over the 9/11. The policy noted, "all medications are administered safely and appropriately....." and "Responsibility of the nursing professional to be aware of the classification, action, correct dosage and side effects of a medication before administration." The policy did not specifically note the following of cautionary warnings from the pharmacy. NJAC 8:39-11.2 (b)	F 658		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		12/10/19

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(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or

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F 758	Continued From page 6 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to document an appropriate rationale for the ongoing use or duration of a PRN (as-needed) [redacted] medication [redacted] that was in place past 14 days. This deficient practice was cited at a level E, as the PRN [redacted] had been in place since at least [redacted]. The findings were identified for 1 of 5 residents reviewed for unnecessary medications (Resident #37), and was evidenced by the following: On 10/16/19 at 11:43 AM, the surveyor interviewed the resident's [redacted], who said Resident #37 was in the facility as he/she could no longer take care of him/her due to the resident's [redacted] At that time, the surveyor observed Resident #37 sitting in a wheelchair at a table in the [redacted]" area of the nursing unit waiting for the noon meal. The resident was sitting quietly, and when spoken to, the resident stared at the surveyor but would not respond. The surveyor reviewed the physician's orders in the medical record of Resident #37. The surveyor noted that the resident had current physician's orders, ordered by the resident's physician (who was also the facility's Medical Director) to receive [redacted] mg 1 PO (by mouth) qhs (every bedtime) and q4h (every 4 hours) prn up to 2 doses daily. The surveyor reviewed the 10/19 Physician's Order Form (POF) and observed that	F 758	1. Res #37 order for [redacted] was reviewed and remains [redacted] mg po at hs and q4h prn is now 90 day length of therapy order related to resident history. This will be reviewed monthly with DON and Physician for possible reduction Dx: was written for [redacted] by physician which is appropriate to resident. Medical Director was educated by DON to support regulatory process of any prn order for psychotropic medications need a 14 day and stop. Reassess need and document justifications to support diagnosis and need for medication to continue. Physician was also educated to importance of answering the consulting pharmacist recommendation with supporting and documented justification for his decision to disagree with recommendation for either continued use of a specific medication or for the discontinuance of a specific medication. Failure to meet this standard ongoing may result in the termination of his credentialing to practice at the facility. 2. All residents requiring the use of psychotropic medications have the potential to be affected by this deficient practice. An audit of residents receiving psychotropic medications was completed. Medication and diagnosis were audited to reflect proper use of medication and prn	

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the PRN Xanax order did not have a stop date. The entry on the [redacted] POF included an order date of [redacted]" and noted the diagnosis for use was [redacted] which was one of the resident's diagnoses. The surveyor then reviewed the previous POFs that were in the medical record and observed that the PRN [redacted] order was on every POF going back to and including [redacted] of 2019 (there were no POFs in the chart prior to [redacted] Each month the POF included the order for the PRN [redacted] without any stop date.

The surveyor reviewed the Medication Administration Records (MAR) from [redacted] 2019 forward and observed the PRN [redacted] order on each month's MAR. The MARs also did not include any stop date and were available for use throughout each month. The surveyor observed that the resident received the PRN [redacted] twice in April, 14 times in May, four times in June, none in July or August, once in September, and none as of [redacted] for October.

The surveyor reviewed the notes from the Consultant Pharmacist (CP). The surveyor then identified that the CP had asked the Physician to review the PRN [redacted] almost monthly. On [redacted], the CP wrote, "suggest prn [redacted] order indicate x 14 days." The Physician's written response was, "No, chronic." On [redacted], the CP wrote, "suggest prn [redacted] order include a length of therapy." The Physician's written response was "long term." The CP noted the same on [redacted] there was no response from the Physician. On [redacted], the CP wrote, "suggest prn [redacted] order includes a length of therapy." The Physician's written response was "long term." On [redacted], the CP wrote, "suggest prn [redacted] order includes a length of therapy." The

Provider's Plan of Correction (continued):

orders were checked to ensure a stop date was indicated on the MAR. If medication needed to continue, a documented justification and order were written by the physician and order written as a standing order or specific length of therapy.

3. Residents receiving psychotropic medications will be audited q week by the Unit Manager for prn's, supporting diagnosis,and justification documented for continued use of specific medication, correct transcription to MAR's, behaviors present/not present. Unit Manager will give audits weekly to Director of Nursing for review monthly x6 months.

4. Director of Nursing will submit monthly report of psychotropic medication usage and audit. Reports will be summited to the Administrator monthly x 6 months. These reports will be reviewed at QAPI quarterly x 2 quarters.

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F 758	Continued From page 8 Physician's written response was "chronic, we have decreased dose." During a follow-up meeting on 10/18/19 at 9:30 AM, the Director of Nursing said she had spoken with the Physician. The DON told him that the use of PRN psychotropic medications was not acceptable in long term care and that he needed to be aware that the 14 days for psychotropic medications was a regulation. Additionally, that he needed to write the order for just 14 days and then re-evaluate it, the DON said the Physician's response was, "I guess I'll have to." The DON said the resident did have behaviors that included [redacted] and can get out of control with the [redacted] and can get lethargic from the medications. The DON said at times the resident felt the facility was poisoning him/her and wouldn't eat and the resident [redacted] when the [redacted] leaves. The surveyor reviewed the facility's "Psychotropic Medication Use" policy which noted "PRN orders for psychotropic drugs should be limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate duration for the PRN order." NJAC 8:39-27.19(a) 29.3 (a)1	F 758		
F 809 SS=B	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the	F 809		12/10/19

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F 809	Continued From page 9 facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide documented evidence that bedtime snacks were being delivered on a nightly basis to the residents. This deficient practice was identified for 6 of 6 alert and oriented residents at a resident's group meeting (Residents #17, #2, #15, #26, #16 and #12), and was evidenced by the following: On 10/15/19 at 1:30 PM, the surveyor met with a group of six alert and oriented residents (3 additional residents at the meeting had [redacted] [redacted]). When asked about bedtime snacks, all 6 of the oriented residents stated the staff did not offer them snacks at night. Resident #15 said, "they used to, but they stopped coming around to offer snacks about a year ago."	F 809	1. Residents were visited by Food Service Director to discuss snacks. Residents were also invited to attend our monthly Food Committee meeting and snacks were discussed by the Food Service Director. Preferences, bedtime, keeping food at bedside and use of containers to store their snacks was discussed. The discussion of snacks was added to the current agenda for future meetings. This will also be added to Resident Council discussion monthly. Dietary staff and nursing staff were in-service to the hs snack delivery, proper distribution and documentation. Dietary will deliver cart at approximately 6:30pm and have nurse examine the cart and sign for delivery. The dietary staff will	

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F 809	Continued From page 10 Resident #26 told the surveyor that he/she saved the crackers from his/her lunch for a snack in the evening. Resident #16 stated he/she kept his/her snacks in the bottom drawer of a bedside cabinet because he/she wasn't offered them at night. Residents #12, #2, and #17 also stated they were not offered snacks in the evening. On 10/17/19 at 8:25 AM, the surveyor interviewed the Director of Food Services (DFS) about nightly resident snack distribution. The DFS provided a sheet titled "Night Snack Sheet, Nursing Unit," which listed the various snack items that were sent to the unit. The DFS stated the nursing department was supposed to sign the snack sheet and return the sheet to the DFS after the distribution of resident snacks. The DFS stated he "used to" have them sign the sheet and return it to him, but it had "slacked off lately." The DFS said the snacks were delivered to the nursing staff who distributed the snacks to the residents. However, the DFS could not provide snack sheets for the month, indicating that snacks were delivered to the nursing unit. On 10/17/19 at 9:00 AM, the surveyor reviewed the sign-out sheets for nightly snack delivery from April 9, 2019 to October 17, 2019. There were only ██ snack sheets completed during those six months. On 10/17/19 at 9:19 AM, the surveyor interviewed the DFS about the procedure for nightly snack delivery. During the interview, the DFS stated the following: "I send down an ice chest of snacks. The kitchen is open until 7:30 PM, so they can come back for additional snacks if needed. There is a backup of snacks in the cabinet on the nursing unit. We review the snack distribution list "once in a while" and change it. The last time it was updated was two weeks ago to	F 809	then take the "Night Snack Sheet" and give to the manager on duty in Food Service. Nursing will examine the cart and sign showing acceptance. The staff will offer snacks to all residents and document acceptance or denial of snack on the MAR. Additional snacks are also stored in the nursing pantry for use at anytime and restocked daily. 2. All residents have the potential to be affected by this deficient practice. FSD interviewed to determine preferences to encourage resident consumption of snacks. 3. An audit of the "Night Snack Sheet" for time of delivery and proper signature of acceptance by nursing will be done weekly by the AFSD and submitted to the FSD each week x 6 months. An audit of the bedtime snack acceptance/not accepted, by the resident will be done weekly by the Nursing Supervisor and submitted to the Director of Nursing weekly x 6 months. Both the FSD and DON will meet monthly to review and determine compliance during their meeting. 4. The Food Service Director will submit monthly report to the Administrator x 6 months. The Director of Nursing will submit monthly report to the Administrator x 6 months. These reports will be submitted for review at QAPI quarterly x2 quarters.	

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accommodate two new puree snacks. The snacks are delivered once a day, the sheets should be done every day. The sheets are signed by a dietary employee, not nursing. The sheet then goes to nursing, and if nobody is there, my guys sign it. The snack cart comes back empty; that's how I know the snacks had been distributed." The Director of Food Services then stated, "This is a big problem, and I need to fix it on my end. There is a definite flaw in the system." The DFS stated, "I don't think there is a problem (with residents getting snacks) because if there were a problem, I would be getting lots of complaints." The DFS stated he is not in the facility at night, and the night supervisor was responsible for snack distribution to the nursing units in the evening.

On 10/17/19 at 9:27 AM, the DFS stated the snack sheets were updated two weeks earlier to accommodate two new puree snacks for the residents. A review of the "Night Snack Sheet, Nursing Unit," noted the snack sheets had not been updated since April 9, 2019.

On 10/16/19 at 9:45 AM, the surveyor reviewed the facility policy titled "Resident Snacks." According to the policy, "Snacks will be provided for residents based on request or as part of appropriate therapeutic diets, an H.S. (evening snack) is offered daily to every resident including texture-modified diets, to provide nourishment during the period from evening meal to breakfast." The policy further noted, "Snacks are delivered in the afternoon and evening to the nursing stations."

On 10/18/19 at 11:30 AM, the surveyor reviewed the "Nursing Unit Snack Book" for Residents #26,

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F 809	Continued From page 12 #15, #16. The book noted Resident #26 refused a snack on [redacted] and accepted a snack every night for the rest of the week ([redacted] The surveyor went to speak with Resident #26 and showed him/her the snack book. The resident stated he/she had not been offered a snack in over a month. The resident reported that he/she saves the crackers from the lunch meal to have as a snack later in the evening. The surveyor reviewed the entries for Resident #16, which noted the resident accepted a snack every night for the week [redacted]). The surveyor went to speak with Resident #16 and showed him/her the snack book. The resident stated he/she hadn't received a snack from the facility all week. The resident reported he/she kept snacks in his/her bedside cabinet drawer (which the surveyor observed) for consumption at night. The surveyor reviewed the snack sheet for Resident #15 for the week, which had the resident refusing snacks on [redacted] and accepting snacks from [redacted] Resident #15 stated, "No, I didn't receive a snack this week, or last week or ever, absolutely not." NJAC 8:39-17.4(b)	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		12/10/19

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F 812	Continued From page 13 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods in a safe and consistent manner. This deficient practice was evidenced by the following: On 10/9/19 from 11:59 AM to 12:52 PM, the surveyor, accompanied by the Executive Chef (EC), observed the following in the kitchen: 1. On entry to the kitchen, the surveyor observed the EC perform handwashing at the designated handwashing sink. The EC proceeded to turn on the water and rinse his hands under the running water. The EC then applied soap and performed vigorous handwashing for 10 seconds. The EC then rinsed his hands under the running water and then turned off the faucets with his bare hands. The EC then grabbed a hand towel from the dispenser attached to the wall, dried his hands, and threw the towel in the trash can.	F 812	1. Dumpster lid was closed immediately. Staff was re-in-service to proper handwashing technique and policy. 2. Notation was made immediately on the refrigerator temperature log and recorded at that time. 3. Plastic wrap was discarded immediately and replaced and a plastic wrap holder installed to prevent contamination. 4. Staff was re-in-service to proper closure of the dumpster. Signage is present to remind staff to close the dumpster after using. 5. Staff was in-service to proper handwashing technique and policy. 1. Staff was re in-serviced and new employees in-serviced to proper procedure of recording dishwasher temperatures and the proper procedure for using the dish machine. All residents have the potential to be affected by this deficient practice.	

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2. The surveyor reviewed the "Refrigeration Monitoring Logs" with the EC. Observation of the logs revealed that refrigeration temperatures were not recorded for 7 AM and 11 AM on 10/9/19. During the Kitchen observations, the EC stated, "We check temps four times a day at 7 AM, 11 AM, 2 PM and 7 PM. The early morning and evening cook positions are responsible for taking the temperatures. The EC further stated, "they should have been done for the 7 AM and 11 AM times today."

3. In the prep area, the surveyor observed an opened box of plastic wrap used for food storage/preparation. The container had no lid, and the plastic wrap was exposed. When interviewed at that time, the EC stated, "I'm gonna dispose of that and get a new one. It should have a lid; somebody cut it off." The EC threw the exposed container of plastic wrap in the trash.

4. Observation of the outside garbage area revealed 1 of 2 waste dumpsters had the lid open, which exposed the garbage contents inside. The EC stated, "They should be closed at all times." The EC further stated, "All departments are responsible for maintenance of the area, including keeping the doors closed."

5. The surveyor observed the dishwasher (DW)/dietary aide (DA) at 12:32 PM perform handwashing at the designated handwashing sink. The DW/DA turned on the faucets and wet his hands under the running water. The DA/DW then applied soap to both his hands, washed his hands vigorously for 5 seconds, and then proceeded to rinse his hands under the running

Staff will be in-serviced randomly and a timer available to remind the staff to wash for minimum of 20 seconds. Audits for handwashing will be conducted by AFSD randomly/weekly (one on day shift and one on night shift) x 6 months and report submitted to FSD for review weekly x 6 months.

An audit of refrigerator temperature logs will be conducted by EC daily and weekly report will be submitted to the FSD x6months.

A plastic holder was purchased for the plastic wrap and aluminum foil to ensure it is always enclosed. This will be monitored with nightly check list on daily basis. This is reviewed by the FSD daily to ensure compliance. Report will be submitted to the Administrator monthly x6 months
This audit will be reviewed quarterly at QAPI x 2 quarters.

Audits of dumpster lid closure when not in use, will be conducted daily, day shift by the Maintenance Director and Nightly by the Cook Supervisor and reports will be submitted to FSD weekly x 6 months.

Dishwasher will have daily temperature audits by the EC daily x 6 months and random audits of staff for proper technique for dishwasher procedure will be conducted by the AFSD weekly x 6 months.

Report of audits will be given to the Food

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F 812	Continued From page 15 water while continuing to perform vigorous hand washing, effectively removing the soap from his hands. The DW/DA then proceeded to dry his hands with a hand towel and then turned off the faucets using the hand towel. The DW/DA then threw the hand towel in the designated trash can. The surveyor immediately interviewed the EC to determine how long hands should be washed after applying soap. The EC stated, "hands should be washed for at least 20 seconds." On 10/17/19 from 9:57 to 10:29 AM, the surveyor, accompanied by the Director of Food Service (DOFS), observed the following in the kitchen: 1. The surveyor reviewed the "Riverview Estates Dish-machine Temperature Log," dated October 2019. The log revealed that the "Wash" and "Final Rinse" temperature had not been recorded for the date 10/17/19. Further, inspection revealed the following: "Standards: High Temp: Wash 150-160 F Rinse: 180 F." During the review of the dish machine temperature log, the surveyor observed a kitchen staff member in the process of washing soiled dishes in the dish room area. The staff member placed racks of dirty dishes, which included pellet lids (a plastic lid used to cover resident plates during transport), and white tea/coffee cups into the operating dish machine, a "Hobart" high-temperature dish machine, per the DOFS. When interviewed at that time, the Dining Aide who was assigned to the dish machine feeding (dirty side) position stated, "I've been trained a little, I'm new." The surveyor questioned the DA how the dishwashing process was carried out. The DA stated, "I rinse the dirty dishes with the hose first. After rinsing the dishes, I place them in the rack, and when the rack is filled, I put the rack of dirty dishes into the machine to be	F 812	Service Director Weekly x 6 months. A monthly report will be submitted by the FSD to the Administrator x 6 months. These reports will be reviewed quarterly at QAPI x 2 quarters.	

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washed."

A second dietary aide (DA#2) had approached and stated, "We should record the wash and rinse temperature before washing dishes to ensure that the machine is running at the proper temperature before starting to wash dishes." The surveyor interviewed DA#2 and questioned why the "Wash" and "Final Rinse" temperatures had not been recorded prior to initiating dishwashing. DA#2 stated, "I guess we didn't write it down today." The surveyor had the DA and DA#2, initiate dishwashing for the surveyor's observation. The surveyor observed an initial "Wash" temperature of 170 F and a "Final Rinse" temperature of 169 F via the digital Ecolab thermostat located on the front top of the dishwasher. DA#2, at the receiving end of the machine, instructed the DA to run additional empty racks through the dish machine to allow the machine to "reach acceptable final rinse temperature." The DA ran an extra two empty racks through the machine, in which, the surveyor and DA#2 observed a wash temperature of 170 F and a final rinse temperature of 181 F. The DA then recorded the wash and final rinse temperatures on the Dishmachine Temperatures log. The DAs then rewashed the previous racks of dishes that had gone through prior to the machine reaching an acceptable final rinse minimum temperature minimum of 180 F.

On 10/17/19 10:26 AM, the surveyor interviewed the DOFS who stated, "the dietary aide running the machine is relatively new, and she was nervous. She will be re-inserviced. Our procedure is the machine is to reach the appropriate wash and rinse temperature and then record the wash and final rinse temperature prior to initiating any

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F 812	Continued From page 17	F 812		

dishwashing. There was a little bit of human error there."

The surveyor reviewed the facility policy titled "Dishwashing Machine Use", Dietary Services Policy and Procedure Manual, revised March 2010. Under Policy Statement, the policy stated: Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation."

The surveyor reviewed the facility policy titled "Food Safety-Storage and Refrigeration- Four Step Process for Recording Refrigeration Temperatures." Under Policy Interpretation and Implementation, the policy revealed the following:

2. "Cooks are responsible to record all refrigeration temperatures in the dietary department, 4 times, daily. (7 AM, 11 AM, 2 PM, and 7 PM)."

i. "Opening Cook will record temperatures from all refrigeration units at 7AM. Cook will record proper temperature, and report on any problems with refrigeration. i.e. High or Low Temperatures."

ii. "Closing Cook will record temperatures from all refrigeration units at 11AM. Cook will record proper temperature, and report on any problems with refrigeration. i.e. High or Low Temperatures."

The surveyor reviewed the facility kitchen policy titled "Correct Handwashing Method:" The policy noted the following:
1. wet hands.
2. apply soap.

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F 812	Continued From page 18 3. Briskly rub hands for twenty seconds. 4. Scrub between fingers. 5. Scrub forearm to just below elbow. 6. Rinse forearms and hands. 7. Dry hands and forearms. 8. Turn off water. 9. Discard towel. NJAC 8:39-17.2(g)	F 812		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/10/19, in the presence of facility management, it was determined that the facility failed to maintain 4 of 4 dryers completely free from lint. This deficient practice was evidenced by the following: At 11:35 AM, the surveyor and the facility's Director of Environmental Services (DES), observed that four dryers in the main laundry had a heavy accumulation of lint in only the front upper burn chamber. This is the area where there is the gas-fired exposed tubular burner assembly with an open flame. When interviewed at that time, the DES stated the rear of the units were cleaned, but the upper fronts were not. NJAC 8:39-31.2(e)	F 908	The four dryers were cleaned immediately of the accumulation of lint in the front chamber. Cleaning of dryer vents is updated to reflect cleaning the front chamber as well as the back. Maintenance and housekeeping/laundry staff were in-serviced to this cleaning schedule and process. All residents have the potential to be affected by this deficient practice. Audit for dryer/lint cleaning will be completed weekly by Maintenance Director and will be submitted to the Sr. Environmental Director x 6 months. Sr Environmental Services Director will submit monthly report of dryer cleaning/lint removal to the Administrator's review x 6 months.	12/10/19

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F 908	Continued From page 19	F 908	Monthly reports will be reviewed at QAPI quarterly x 2 quarters	