STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING ______ B. WING ______	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBOY CARE CENTER	1 LINDBERG AVENUE PERTH AMBOY, NJ 08861

(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: 5/23/19 CENSUS: 137 SAMPLE SIZE: 30 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 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		7/3/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 06/21/2019

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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F 623	Continued From page 1 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide notification to the resident and the resident's representative in writing about residents that were transferred to hospitals. This was found with 2 of 5 residents (Resident #93 & #121) reviewed for hospitalizations.	F 623	F-623 1. The Director of Social Service was in-serviced in regards to the Notification to Residents or Resident Representatives as to the Bed Hold Policy. 2. All residents have the potential to be	

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F 623	Continued From page 3 This deficient practice was evidenced by the following: 1. On 5/22/19 at 10:00 a.m., the surveyor reviewed the record for Resident #93 which revealed a New Jersey Universal Transfer Form (NJUTF) dated [redacted] for the transfer from the facility to the hospital emergency room. The resident was hospitalized from [redacted] for a [redacted]. 2. On 5/22/19 at 10:30 a.m., the surveyor reviewed the record for Resident #121 which revealed a NJUTF dated [redacted] for the transfer from the facility to the hospital emergency room. The resident was hospitalized from [redacted] [redacted] for chest pain. On 5/22/19 at 12:28 p.m., the surveyor asked the Regional Director if they had evidence that the resident and/or residents representative received written notification that the resident was transferred to the hospital. The Regional Director stated that neither the residents nor the residents representatives had been provided with written notification that the residents were transferred to the hospital. N.J.A.C. 8:39 - 5.1(a)	F 623	affected by this deficient practice. A review of the last six months showed that the facility was not sending out the notification to the residents and resident representatives. The facility had identified this issue and a QAPI was done to resolve this deficient practice. 3. The Social Service Director was in-serviced on sending or giving a copy of transfer notice of an unplanned discharge to the hospital of a resident or resident representative. 4. The Administrator will review weekly the copy of written notification of transfer to the hospital weekly x 60 days then bi-weekly x 30 days periodically ongoing. All findings will be reviewed at the Quality Assurance meeting x 2 quarters.	
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	F 625		7/3/19

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F 625	Continued From page 4 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 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 provide residents with the facilities notice of bed hold policy. This was found with 3 of 5 residents (Resident #81, #93, and #121) reviewed for hospitalizations. This deficient practice was evidenced by the following: 1. On 5/21/19 at 10:40 a.m., the surveyor reviewed the record of Resident #81 which revealed that the resident was transferred to the hospital on [redacted] at 8:45 p.m., following a fall. According to a Nurses Note dated [redacted] the resident returned to the facility on [redacted] at 11:30	F 625	F-625 1. The facility implemented a new format and current Bed Hold Policy which will be given to the Resident or Resident Representative. The Social Service Director will follow up with the resident or resident representative with a phone call that reviews the bed hold policy signed upon Admission when they are transferred and admitted to a hospital setting. The facility was unable to go back in time for resident #93 and resident #121 who were discharged to the hospital and returned. 2. All residents have the potential to be	

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F 625	Continued From page 5 a.m. 2. On 5/22/19 at 10:00 a.m., the surveyor reviewed the record of Resident #93. The record revealed that the resident was hospitalized from [redacted] for a [redacted] following the discovery of a [redacted] [redacted] 3. On 5/22/19 at 10:30 a.m., the surveyor reviewed the record for Resident #121. The record revealed that the resident was hospitalized from [redacted]. On 5/22/19 at 12:28 p.m., the surveyor asked the Regional Director if they provided written information about the facility's bed hold policy for Resident #93 when the resident was transferred to the hospital for the [redacted] on [redacted]. The Regional Director stated, "We don't have a bed hold policy, we would never give a residents bed away, even if they were gone for 30 days, We might just box up their stuff and move it temporarily." On 5/23/19 at 12:43 p.m., when notified of the concern with Resident #81 and Resident #121 being transferred to the hospital without notification of the bed hold policy, the Regional Director stated once again that the facility did not have a bed hold policy and they did not provide notification of the bed hold policy to the resident or their representatives. On 5/23/19 at 12:55 p.m., the Regional Director stated that they did have a bed hold policy but that it had not been reviewed or revised since 2017. The policy was not provided for review by the survey team.	F 625	affected by this deficient practice of not providing information on the Bed Hold Policy. A QAPI was done to correct this deficient practice. A copy of the current bed hold policy will be mailed or given to the resident or resident representative. 3. An in-service was done with the Admissions Director and Social Service Director on the updated policy and procedure regarding the Bed Hold Policy. 4. The Administrator will ensure that each resident currently residing at the facility or resident representative will receive sign a copy of the Bed Hold Policy. The Administrator will ensure the policy is being followed by checking 5 discharges to a hospital for a copy of the social services documentation as proof families/residents are reminded of the bed hold policy , weekly x 30 days and ongoing there after . All findings will be reviewed at the Quality Assurance meeting x 2 quarters.	

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F 625	Continued From page 6 N.J.A.C. 8:39 - 5.1(a)	F 625		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to revise and update a resident's individualized care plan to reflect the current interventions in place.	F 657	F-657 1. The Care Plan for resident #69 was updated to reflect the changes in the use	7/3/19

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F 657	Continued From page 7 This deficient practice was identified for 1 of 30 residents reviewed for individualized care plans (Resident #69). This deficient practice was evidenced by the following: On 5/15/19 at 1:24 p.m., the surveyor observed Resident #69 in the day room in a tilt in space wheelchair with a Hoyer (mechanical lift) lift pad on chair and Posey (gel-foam cushion) cushion on left arm of the chair. The resident's knees were bent with a cushion positioned between his/her knees and their feet were resting on the seat of the wheelchair. The resident was reaching out with their right hand and attempting to grab whomever walked by. On 5/15/19 at 1:30 p.m., the resident's Licensed Practical Nurse (LPN) stated that the resident was . The LPN stated that the resident's history was . The LPN further stated that the resident had The surveyor then reviewed the face sheet (an admission summary) for Resident #69 which reflected that the resident was admitted to the facility on with diagnoses not limited to a	F 657	of the Call bell. 2. All residents have the potential to be affected by this deficient practice when care plan are not updated. All residents with the same issues were reviewed and care plans were updated accordingly. 3. All unit managers were in-serviced on care plan updates as they occur to ensure accuracy. 4. The Director of Nurses and the Assistant Director of Nurses will check 4 care plans weekly x 60 days then periodically ongoing to ensure care plan updates to reflect current situation. All findings will be reviewed at the Quality Measure meeting x 2 quarters.	

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F 657	Continued From page 8 . Review of the most recent annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated reflected that the resident had a . The tool further identified the resident had . The resident was also identified as having The surveyor then reviewed Resident #69's individualized Care Plan for initiated 4/12/19 which read: . On 5/20/19 at 12:48 p.m., the surveyor observed Resident #69 sitting in a tilt in space wheelchair had grabbed the LPN's hand and gestured with his/her middle finger while pushing and pulling the LPN by the arm. The LPN gently removed her hand from the resident's grasp. On 5/23/19 at 10:11 a.m., the surveyor interviewed the facility's Rehabilitation Director, who stated to the surveyor Resident #69 had . The Rehabilitation Director added that the resident had been able to The Rehabilitation	F 657		

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F 657	Continued From page 9	F 657		

Director further stated the resident had a history of [redacted].

On 5/23/19 at 10:46 a.m., the surveyor observed the resident in bed resting. The resident's call bell was located on resident's right side of the bed, tied to the wall but able for the resident to access. The resident's bed control was tied tightly to the left side of the resident's bed and within the resident's reach.

On 5/23/19 at 10:47 a.m., the surveyor interviewed the resident's Certified Nurse Aide (CNA) who stated that the call bell was intentionally tied tightly behind the bed and that the bed control secured to the side of the bed so that the resident could not get the cord and hurt themselves. The CNA added that when the resident was really active he/she grabbed at things. The CNA stated she had not observed the resident try and hurt himself/herself but that was why the resident was routinely in the dayroom and that someone was always with them.

On 5/23/19 at 11:36 a.m., the surveyor interviewed the resident's other Licensed Practical Nurse (LPN #2) who stated the resident was able to [redacted]
The LPN acknowledged that the resident had a Care Plan to address the resident's [redacted] LPN #2 stated that the facility tried different types of call bell options such as tap for service type call bell and a bike horn, neither of those options worked. The facility then zip tied the call bell cord to the side rail of the bed so the

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F 657	Continued From page 10 resident was able to reach the bell but not able to harm himself/herself. At that time, LPN #2, together with the surveyor, went into the resident's room and observed that the call bell had been zip tied and was hanging from the wall on the right side of the resident's bed. The bed control was wrapped around the left side of bed rail so the resident did not have access to the cord. LPN #2 stated she had not witnessed any incidents of the resident attempting to harm himself/herself. On 5/23/19 at 12:38 p.m., the survey team met with the Director of Nursing (DON), the facility Administrator and the Regional Director (RD). The RD acknowledged the Care Plan interventions were conflicting, the resident Care Plan had been updated to reflect the resident's risk for self harm but had not been updated to remove the intervention to keep call bell and frequently used items within reach. The DON confirmed that the Care Plan should have been updated/revised to reflect the current interventions in place. N.J.A.C. 8:39-11.2	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to	F 658	F-658	7/3/19

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F 658	Continued From page 11	F 658		

a.) properly label equipment for resident use for 2 of 27 residents reviewed (Resident #55 and #85) and b.) obtain laboratory tests within the physician noted timeframe for 1 of 27 (Resident #70) residents reviewed.

This deficient practice was evidenced by the following:

Reference: New Jersey Statues, Annotated Title 45, Chapter. 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 such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being, and executing a medical regimens 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 with in 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 5/14/19 at 11:03 a.m., the surveyor observed Resident #85 in a wheelchair (WC) in the residents room. The resident was awake, alert and said that they had an

Provider's Plan of Correction (F 658):

1. Resident #85 Resident #70 the lab test was done on . Resident #55 the was changed and dated.

2. All residents have the potential to be affected by this deficient practice. A review of all residents with were checked for appropriate information as per policy. An audit was done on the labs to ensure no other labs were missed. A check of was done to ensure proper dating.

3. An in-service was done with all nurses on ensuring An in-service was also done with the nurses to ensure lab sheets are done on a timely basis. An in-service was done with the nurses on the policy of weekly.

4. The Director of Nurses will audit weekly x 60 days the information on the residents , all physician lab requests sheets are made out and that is labeled weekly according to facility policy. The audit will continue bi-weekly x 30 days and weekly x 30 days. All findings will be reviewed at the Quality Assurance meeting x 2 quarters.

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The was labeled with: The label on the bottle of was not dated, timed, and did not have the residents name on it.

On 5/20/19 at 10:04 a.m., the surveyor reviewed the resident's record which revealed a Physician's Order Form for Resident #85 which indicated they had been admitted to the facility on with diagnoses which include The current Physician's Order contained an order which was dated 3/1/19 and read:

On 5/21/19 at 9:07 a.m., the surveyor observed the resident in bed. There was of a and into the resident. The only information on the bag was the residents name, the date it was started of 5/20/19, and the room number. The information was written on the bag with a marker.

At 9:10 a.m., the surveyor asked the Licensed Practical Nurse (LPN) who was assigned to the resident about the . The LPN stated, "Nights hangs it, but it's probably , what probably happened is that they didn't have a so they put in here for the . It's not on the because

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[the resident] is [redacted] and tells us to stop it sometimes and start it later. [The Resident] [redacted] and tells us sometimes to stop it so we do." The surveyor asked the LPN what was supposed to be written on the [redacted]. The LPN stated, [redacted]

On 5/22/19 at 12:15 p.m., the surveyor asked the Regional Director what should have been written on the label of the [redacted] . [redacted]

On 5/22/19 at 12:30 p.m., the surveyor reviewed the facility's policy and procedure titled, [redacted] -Safety Precautions. Under Preventing errors in administration; Number 1 read: Check the [redacted] . Check the following information:

a. Resident name, ID and room number;
[redacted]

2. On 5/21/19 at 9:03 a.m., the surveyor interviewed Resident #70 in their room. The resident was [redacted] and was lying in bed in on their side holding a cell phone. Resident #70 stated that they were able to take care of themselves.

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F 658	Continued From page 14 At 9:09 a.m., the surveyor then reviewed the face sheet form which revealed that Resident #70 was originally admitted to the facility on [redacted] with diagnoses not limited to [redacted] The surveyor then reviewed the most current Physician's Order Form with a review date of 4/2019 that identified under Labs, an order dated 9/28/2017 for [redacted] The surveyor then reviewed a lab result dated [redacted] for the [redacted] with a result that read: [redacted] the normal range identified was less than [redacted]. The surveyor could not locate a more recent result nor could the residents Licensed Practical Nurse (LPN). The surveyor then reviewed Resident #70's most recent quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted] which revealed under Section C: Cognitive Patterns that the residents Brief Interview of Mental Status (BIMS) score [redacted]. [redacted] Under Sections N: Medications, revealed that Client #70 received [redacted] The surveyor then reviewed the Resident Plan of	F 658		

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Care dated 12/9/18 for Resident #70 that identified under Problem: .

On 5/22/19 at 1:32 p.m., the surveyor brought it to the attention of the facility administration, which included the Director of Nursing (DON).

On 5/23/19 at 12:33 p.m., the DON confirmed that the had not been done as ordered and that the lab had been notified and the test was drawn on after the surveyor brought it to the attention of the staff.

3. On 05/14/19 at 11:57 a.m., the surveyor observed Resident #55 in the dayroom, sitting at a table with two other residents, their was across the floor under the table against the wall. The large had set to administer and the was not dated.

The surveyor then reviewed the face sheet of Resident #55 that reflected the resident was admitted to the facility on with diagnoses which included .

Further review of the most the significant change MDS dated , reflected that the resident was receiving , within the last 14 days while a resident at the facility.

A review of the physician's order sheet (POS) signed by the physician for May 2019 reflected an

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F 658	Continued From page 16 order under treatments dated 4/14/19 read: [redacted] weekly on Sunday on (11-7) shift. On 05/17/19 at 12:07 p.m., the surveyor interviewed the Certified Nurse Aide (CNA) who stated that the nurse changes the [redacted] on the evening shift. The CNA further stated that the nurse [redacted] but that she was responsible to ensure the machine was working and inform the nurse if it wasn't. On 5/17/19 at 12:09 p.m., the surveyor attempted to speak with resident but was unable to continue when resident became upset and began to cry. The surveyor observed there was no date indicated on the resident's [redacted]. On 5/17/19 at 12:14 p.m., the surveyor interviewed the Licensed Practical Nurse Unit Manager (UM) who stated that the resident began to decline after their last hospital stay last month for [redacted] and that the resident had become [redacted] and was [redacted]. The UM added that Resident #55 had been on [redacted] since their admission. On 5/20/19 at 12:20 p.m., the resident was observed in his/her room with [redacted] in use and the [redacted] was not dated. On 5/20/19 at 12:22 p.m., the resident's Licensed Practical Nurse (LPN) stated that the resident was recently hospitalized for an [redacted] The LPN stated that only nursing should [redacted] and that the [redacted] was changed weekly on the 11-7 shift or as needed. At that time, the LPN,	F 658		

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F 658	Continued From page 17 along with the surveyor reviewed the the physician's order to change the [redacted] weekly. The LPN acknowledged that the resident's [redacted] should have been labeled with the date it was changed, the nurses initials and the time the [redacted] was changed. On 5/20/19 at 12:38 p.m., the surveyor and LPN, observed the resident in their room. The LPN acknowledged that the resident's [redacted] was not dated, initialed or timed. On 5/20/19 at 12:40 p.m, the UM stated to the surveyor, that [redacted] should be changed weekly and dated and initialed by the nurse. On 5/22/19 at 12:35 p.m., the survey team met with the facility Administrator, Director of Nursing (DON) and the Regional Director (RD). The DON stated that [redacted] should be changed weekly on Sunday and on the evening shift and should indicate the date, time and initials of the nurse [redacted]. The RD confirmed the [redacted] should have been dated and initialed. A review of the facility policy titled: [redacted] Policy and Procedure, reviewed 2/11/18 read: On a weekly basis the [redacted] N.J.A.C. 8:39-27.1 (a)	F 658		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		7/3/19

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F 755	Continued From page 18 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that the facility failed to ensure an accurate ordering and receiving of narcotic medications. The required Federal Narcotic Acquisition forms (DEA 222 forms) were not completed with sufficient detail to enable accurate reconciliation for 4 of 4 forms reviewed. This deficient practice was evidenced by the	F 755	F-755 1. The DEA 222 forms are being filled out as per regulations. 2. All residents have the potential to be affected. A QAPI was done to correct the deficiency. 3. The Director of Nurses and Assistant	

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F 755	Continued From page 19 following: On 5/17/19 at 12:52 p.m., the surveyor reviewed the facility's controlled substance ordering form DEA 222 receipts which revealed that the facility did not record the number of packages of controlled substances received or the date each medication was received as instructed on the reverse of the DEA 222 form. The inaccuracies were as follows: Order Form: #184183331 revealed no quantity of packages received and no date received. Order Form: #184183330 revealed no quantity of packages received and no date received. Order Form: #184183329 revealed no quantity of packages received and no date received. Order Form: #184183328 revealed no quantity of packages received and no date received. On 5/20/19 at 9:34 a.m., the surveyor interviewed the Director of Nursing (DON) who stated that she was unaware of the procedure for documenting the receiving of controlled substances and had just followed what the previous DON had done. The DON then confirmed that the DEA 222 forms did not indicate the date of receipt or the quantity received on the four DEA 222 forms reviewed. A review of the instructions for submission of the DEA 222 form located on the reverse of the form read: When items are received, the date of receipt and the number of items received must be recorded in the spaces provided on the triplicate copy. N.J.A.C. 8:39-29.4(l)	F 755	Director of Nurses and all nursing supervisors were in-serviced on how to fill out the DEA-222 in its entirety. 4. The Director of Nurses and Assistant Director of Nurses will check the DEA 222 form daily and ongoing to ensure compliance. The pharmacy consultant will also review monthly to ensure compliance. All findings will be reviewed at the Quality Assurance meeting x 2 quarters.	

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F 761	Continued From page 20	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to 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 review of facility documentation, it was determined that the facility failed to properly label medications in 1 of 3 medication carts inspected. This deficient practice was evidenced by the following: On 5/17/19 at 10:47 a.m., the surveyor in the	F 761	F-761 1.The [redacted] in question were labeled with the date opened. 2. All residents have the potential to be affected . The pharmacy consultant along with the nurses checked all other [redacted] to ensure they were dated when opened.	7/3/19

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F 761	Continued From page 21 presence of the Licensed Practical Nurse (LPN) inspected the [redacted] medication cart. The inspection revealed the following opened medications: [redacted] [redacted]. At that time, the surveyor interviewed the LPN who stated that the medications should have been labeled with the resident's name and the date opened. On 5/28/19 at 9:30 a.m., the surveyor reviewed the facility's policy titled, Administering Medications with a reviewed date of 9/12/2018	F 761	3. The nurses were in-serviced on dating inhalers when opened and checking the expiration/beyond use date on the mediation label checked before administering. 4. The Director of Nurses, Assistant Director of Nurses and Unit Managers will check the inhalers weekly to ensure the inhalers are dated appropriately after it is opened. All findings we be reviewed at the Quality Assurance meeting x 2 quarters.	

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F 761	Continued From page 22 which indicated: under number 7: The individual administering the medication must check the label three times to verify the right resident..... under number 9: The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container. N.J.A.C. 8:39-29.4(a)	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and 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;	F 880		7/3/19

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

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F 880	Continued From page 24 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to follow its infection control policies and procedures for proper hand hygiene, glove use and [redacted] treatment. This was identified for a.) 4 of 4 residents (Resident #6, #77, #93, and #115) observed during [redacted] treatments; and b.) 2 of 3 nurses observed during the medication pass observation. This deficient practice was evidenced by the following: 1. On 5/17/19, starting at 7:35 a.m., the surveyor observed three nurses administer medication to six residents. After LPN #1 administered medication to the first resident, she washed her hands for 10 seconds. Then after LPN #1 administered medication to the second resident, she washed her hands for 10 seconds in and out of the flow of running water. On 5/17/19 at 8:27 a.m., the surveyor observed LPN #3 prepare medication for the fourth resident. Prior to administering the medication, she washed her hands for four seconds and then rinsed her hands for 10 seconds. After administering the medication, she washed her hands for 12 seconds under the flow of running water. After administering medication to the fifth resident, LPN #3 washed her hands in and out of the flow of running water for 20 seconds.	F 880	F-880 1. LPN, #1 and #3 were given individual in-servicing on proper technique of hand washing. LPN #2 was given an individual in-service on treatment techniques which included hand washing. 2. All residents have the potential to be affected when hand washing techniques are not followed according to policy. 3. The nurses were in-serviced on the hand washing policy with demonstration. 4. The Director of Nurses and the Assistant Director of Nurses will watch 2 nurses a week on hand washing technique during med pass/treatments x 60 days then 1 nurse a week x 30 days, then periodically there after. All findings will be reviewed at the Quality Assurance meeting x 2 quarters.	

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After administering medication to the sixth resident, LPN #3 washed her hands for 12 seconds.

2. On 5/22/19 at 8:52 a.m., the surveyor observed the [redacted] care LPN (LPN #2) perform a [redacted] treatment on Resident #93. Prior to preparing the clean field on the resident's bedside table, LPN #2 cleaned the table with a sanitizing wipe without wearing gloves and then proceeded to take supplies out of the cart that included [redacted]

When finished preparing the supplies, LPN #2 washed her hands appropriately but used the wet paper towel that she dried her hands with to turn off the faucet and then rolled the paper towel in her hands before throwing it in the garbage can. The LPN repeated the same technique when she washed her hands after removing the old dressing, after cleaning the [redacted] and after she applied the border gauze.

3. On 5/22/19 at 9:15 a.m., the surveyor observed LPN #2 perform a [redacted] treatment for Resident #6. LPN #2 washed her hands, put on a pair of clean gloves and cleaned the over bed table with a sanitizing wipe. Every time LPN #2 washed her hands, she used the wet paper towel that she dried her hands with to turn off the faucet, and rolled the paper towel in her hands before throwing it in the garbage can. She didn't use a new paper towel to turn off the faucet.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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4. On 5/20/19 at 10:31 a.m., the surveyor observed a yellow-sign outside the room of Resident #77 which read "Please see nurse before entering room." There was also a small bin with Personal Protective Equipment (PPE - gown, gloves, and masks) outside the room. The Resident was observed in bed.

The surveyor reviewed the medical record of Resident #77 which revealed a physician order (PO) sheet with a review date of 5/2019 which included multiple [redacted] treatments orders and a PO dated 5/16/19 for the [redacted] for the diagnosis of the [redacted]

On 5/22/19, beginning at 9:45 a.m., the surveyor observed LPN #2 perform the [redacted] treatment on Resident #77. LPN #2 confirmed that the resident was on [redacted] and that the resident had an [redacted]. LPN #2 brought the treatment cart to the residents room and checked the Treatment Administration Record (TAR). LPN #2 then donned an isolation gown and a pair of clean gloves and wiped the over bed table with a sani wipe (a germicidal disposable wipe).

At 9:46 a.m., the surveyor observed LPN #2 wash her hands for 25 seconds outside the flow of water and then rinsed her hands. LPN #2 then grabbed two paper towels from the dispenser, dried her hands and used the balled up paper towels to shut off the faucet and then discarded the towels in to the waste basket. She didn't use a new paper towel to turn off the faucet.

LPN #2 then prepared the supplies to complete

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F 880	Continued From page 27 the [redacted] treatment on Resident #77's sacrum (the area at the base of the spinal column). The resident, assisted by LPN #2, turned to their [redacted]. LPN #2, with gloved hands, removed the dressing from the resident's [redacted] and discarded it into the bag on the end of the bed. LPN #2 then removed her gloves, washed her hands with soap and water for 25 seconds outside the flow of water before rinsing them. LPN #2 then grabbed two paper towels from the dispenser, dried her hands and used the same paper towels to shut off the faucet. She didn't use a new paper towel to turn off the faucet. At 10:01 a.m., LPN #2 put on a clean pair of gloves and cleaned the [redacted] [redacted] [redacted]. LPN #2 then applied the prescribed [redacted] At 10:04 a.m., LPN #2 removed her gloves and discarded them and the remaining supplies into the garbage bag at the end of the bed. At 10:07 a.m., the surveyor then observed LPN #2 remove her isolation gown and wash her hands with soap and water for 21 seconds and then rinsed them under the flow of water. LPN #2 then grabbed three paper towels and dried her hands and then used the same paper towels to shut off the faucet. She didn't use a new paper towel to turn off the faucet. The surveyor also did not observe LPN #2 clean the bed side table after the [redacted] treatment was completed.	F 880		

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According to the Resident #77's face sheet, the resident was originally admitted to the facility on [redacted] with diagnoses not limited to status [redacted]

The surveyor then reviewed Resident #77's Annual Minimum Data Set (MDS), an assessment tool, dated [redacted] which revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted].

The surveyor then reviewed Resident #77's Plan of [redacted].

5. On 5/20/19 at 10:26 a.m., the surveyor observed that Resident #115 was out of the room.

At 10:28 a.m., the surveyor observed Resident #115 sitting in a Geri-chair (a recliner) in the unit dayroom. The resident was awake and made eye contact with the surveyor. The residents head was elevated, legs were bent at the knees and their feet had been elevated on the leg rest of the chair.

On 5/22/19 at 10:14 a.m., the surveyor observed LPN #2 perform the [redacted] treatment on Resident #115.

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At 10:28 a.m., the surveyor observed LPN #2 wash her hands with soap and water outside the flow and water. She then grabbed three paper towels from the dispenser and after using them to dry her hands, she balled all three towels in her hand and proceeded to shut off the faucet. She didn't use a new paper towel to turn off the faucet.

LPN #2 then put on a pair of gloves, cleaned the bedside table, removed her gloves and washed her hands with soap and water for 25 seconds outside the flow of water. After rinsing her hands off with water, she grabbed two paper towels, dried her hands and used the same paper towels to shut off the faucet before discarding them in the trash can. She didn't use a new paper towel to turn off the faucet.

At 10:30 a.m., the surveyor observed LPN #2 wash her hands with soap and water for 25 seconds outside the flow of water and then grabbed two paper towels, dried off her hands and used the same paper towels to shut off the faucet. She didn't use a new paper towel to turn off the faucet.

At 10:31 a.m., LPN #2 went to the treatment cart that was outside the room of Resident #115 and gathered the needed supplies after she reviewed the Treatment Administration Record (TAR).

At that time, the surveyor observed Resident #115 laying in bed on their right side with their eyes open. The resident was able to answer simple questions. LPN #2, assisted by a second LPN, positioned the resident to their [redacted] and LPN #2 removed the [redacted] LPN #2 removed the dressing and

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and then her gloves and placed them in the garbage bag at the end of the bed.

At 10:37 a.m., the surveyor observed LPN #2 wash her hands with soap and water for 26 seconds and then rinsed them under the flow of water. LPN #2 grabbed two paper towels and dried her hands off and used the same paper towels to shut off the faucet. She didn't use a new paper towel to turn off the faucet.

At 10:44 a.m., LPN #2 put on a clean pair of gloves and wiped the with

The surveyor did not observe LPN #2 remove her gloves between

LPN #2 then removed her gloves and wash her hands with soap and water before rinsing them under the flow of water and grabbed three paper towels and dried her hands and used the same towels to shut the faucet off. She didn't use a new paper towel to turn off the faucet.

LPN #2 then prepared to address the that was on Resident #115's . LPN #2 then cleaned the exposed with with a after the resident complained of LPN #2 stated that she would complete the when the resident was more comfortable. The resident was then positioned for comfort and LPN #2 cleaned up the supplies from the bedside table and discarded them in the garbage bag at the end of the bed.

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At 10:47 a.m., LPN #2 removed her gloves and washed her hands for 26 seconds outside the flow of water. Prior to rinsing them off, she grabbed two paper towels to dry her hands and then shut the faucet off with the same paper towels. She did not use a new paper towel to turn off the faucet.

LPN #2 then signed off the TAR for the treatment that was completed.

The surveyor didn't observe LPN #2 clean the bedside table after the treatment was completed.

According to the face sheet, Resident #115 had been admitted to the facility on [redacted], with diagnoses not limited to [redacted].

The surveyor reviewed Resident #115's Admission MDS, dated [redacted], that identified the resident ha [redacted].

A review of Resident #115's Plan of Care Skin Integrity, dated [redacted] with the identified problem: [redacted]

On 5/23/19 at 10:31 a.m., the surveyor

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interviewed the Infection Preventionist (IP) who stated that the procedure for handwashing was for the staff to scrub their hands for 20 - 30 seconds with soap and water outside the flow of water before rinsing them off, then grab a paper towel to dry their hands off, discard the towel, and get a new paper towel to turn off the faucet. The IP then confirmed that LPN #2 should have performed hand hygiene after cleaning the [redacted] and before [redacted] and that the bedside tables should be cleaned before and after a treatment.

On 5/23/19 at 10:00 a.m., the surveyor reviewed the facility's policy and procedure titled, Handwashing/Hand Hygiene and Under Washing Hands it read:

1. Vigorously lather hands with soap and rub them together, for a minimum of 10-15 seconds creating friction to all surfaces, for a minimum of 20-30 seconds (or longer) use a moderate stream of running water, at a comfortable temperature. Hot water is unnecessarily rough on hands. Duration of entire process should be 20-30 seconds.
2. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink.
3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel.
4. Discard towels into trash
5. Use lotions throughout the day to protect the integrity of the skin.

The surveyor then reviewed the facility policy titled, [redacted] Treatment Policy and Procedure with a last reviewed date of 8/12/18 under Procedure read:

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F 880	Continued From page 33 *Wash your hands *Explain the procedure to the resident/Assess for comfort * Cut the tape with your clean scissors * Put on gloves * Remove soiled dressing and place in bag at the bedside *Remove gloves and discard in the bag *Wash your hands *Put on clean gloves *Clean the wound according to the order *Clean from the center outward *Place soiled gauze used for cleaning in the bag *Wash your hands *Put on new gloves *Apply medication to the affected area *Apply clean dressing as ordered date and initial *Remove gloves and place it in a bag *Make resident comfortable *Close the bag and place it in a large plastic bag attached to the cart *Wash your hands N.J.A.C. 8:39-19.4 (a) 1	F 880		