STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315058	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Salem County	438 Salem-Woodstown Road Salem, NJ 08079

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43307 Based on observation, interview and review of facility documentation, it was determined the facility failed to maintain a comfortable and homelike environment for 3 resident rooms (room numbers 211, 212, and 213) on the C/D unit of the facility. The evidence of this deficient practice includes: 1. During the initial tour of the unit on 03/04/24 at 11:32 AM, in room [ROOM NUMBER], the surveyor observed the side table missing the middle drawer handle, the walls behind and next to the bed with gouges, the opposite wall with scratches and missing paint, the closets with scratches and missing laminate on the edges exposing the raw edge, and the closet drawer handle hanging perpendicular to the drawer. In the bathroom, the surveyor observed a brown discolored ceiling tile, a black bucket under the bathroom sink with water in it, and water on the floor under the sink. 2. On 03/04/24 at 11:40 AM, in room [ROOM NUMBER], the surveyor observed that the bottom of the window blind was broken in half. The resident stated that the blind did not raise up and down and that it bothered him/her. There were scratches and missing paint on the wall under the window, the laminated edge of the dresser was missing and exposed the raw edge, and there was a large, spackled area on the bathroom wall. 3. On 03/05/24 at 10:18 AM, in room [ROOM NUMBER], the surveyor observed the bottom edge of the window blind broken in half and hanging from blind. At that time, there was a Certified Nursing Assistant (CNA) in the room. The surveyor interviewed the CNA about the window blind and the CNA acknowledged that the window blind was broken and stated, it's been broken a while. The CNA stated that if she had found something broken and needed repair in a resident's room that she would have told maintenance by recording the request in the maintenance binder or that she would have verbally told maintenance and then it would have been completed. The surveyor inquired about the walls, furniture and bathroom observations and the CNA acknowledged that the room should not look like that and was not considered homelike, stating, personally, no, it sucks. 4. On 03/05/24 at 12:46 PM, in room [ROOM NUMBER], the surveyor observed discolored wallpaper that was peeling from three of the walls in the room. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/05/24 at 12:49 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) of the C/D unit who stated that if she had found something broken or that needed repair in a resident's room that she would write the room location and the issue in the maintenance book at the nurse's station. The LPN stated that maintenance comes on the unit daily and checks the maintenance book and that if she wrote in the book and it was still not fixed that she would have gone to the maintenance department or called him to communicate the issue. The surveyor and the LPN toured rooms [ROOM NUMBER] together and discussed the surveyor's findings. The LPN stated that it was important for safety that the toured rooms were homelike and that she would call maintenance to address the issues. The surveyor and the LPN reviewed the unit's maintenance book together. The Maintenance Request form revealed sections for Location of Repair Requested, Your Name and Shift, Date, Description of Problem, Repaired by, Date, and Resolution. The LPN stated that after finding an issue on the unit that the nurse would record on the maintenance request the room number, their name and date, and the issue to be resolved. She then stated that when maintenance reviewed the log that they would have signed and dated and gave a description of what was done. The surveyor reviewed the Maintenance Request form. On one page there was an entry for room [ROOM NUMBER]B on 01/25/24 that was filled in completely; an entry for the Med Room on 01/25/24 that was filled in completely; an entry for Location of Repair Requested: room [ROOM NUMBER] (bathroom), Your Name and Shift: [CNA's name] 7-3, Date 01/26/24, Description of Problem: Sink is leaking, water all over the floor, Repaired by: no entry, Date: no entry, Resolution: no entry; and an entry for room [ROOM NUMBER]B on 01/26/24 that was filled in completely except for Date of repair. On 03/05/24 at 01:12 PM, the surveyor interviewed the C/D LPN Unit Manager (LPN/UM) who stated that the process for finding something not working or broken on the unit was to have it recorded on the maintenance log and then maintenance would have checked the log periodically throughout the day. The LPN/UM stated that if the issue required immediate attention, that staff would log it and then call maintenance immediately or page them overhead or they could have told maintenance if they were seen on the unit. The surveyor and the LPN/UM toured rooms [ROOM NUMBER] together and discussed the surveyor's findings. The LPN/UM acknowledged that the rooms were not homelike and stated, I wouldn't want my home looking like that. The LPN/UM stated that if she notified maintenance of an issue and it was not fixed that she would have gone up the chain of command and made her direct supervisor know about the issue. The surveyor and the LPN/UM reviewed the unit's maintenance book together. The LPN/UM acknowledged that the repair request marked room [ROOM NUMBER] (bathroom), dated 01/26/24, Description of Problem: Sink is leaking, water all over the floor, had blank spots under Repaired by, Date, and Resolution. She stated that the staff would write in their findings and request for repair then the maintenance man would have fixed the issue then signed when it was done. The surveyor inquired as to the blank spots on the entry for room [ROOM NUMBER] on 01/26/24 and what it meant when Repaired by, Date, and Resolution were unsigned. The LPN/UM stated, That looks like that was completely skipped over. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/05/24 at 01:21 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the process a resident had something in their room that needed repair or was broken was that the nurse would report it to maintenance by recording it on the maintenance log. The DON stated that the maintenance man was on the unit daily and would check the log and then would have repaired the issues and when done he would sign off on the maintenance log. The DON stated that the staff would also interrupt the maintenance man to inform him of issues verbally and that he would stop and do whatever was needed. She stated, He never says no and is always available. Adding, We are all guilty of stopping him in the middle of things and should have wrote it down. The surveyor reviewed with the DON photos of rooms [ROOM NUMBER]. The DON acknowledged that the resident rooms should not have appeared that way and that the rooms should have looked more like someone's home. The surveyor and the DON reviewed the maintenance book together. The DON acknowledged the entry for Location of Repair Requested: room [ROOM NUMBER] (bathroom), Your Name and Shift: [CNA's name] 7-3, Date 01/26/24, Description of Problem: Sink is leaking, water all over the floor, Repaired by: no entry, Date: no entry, Resolution: no entry, and acknowledged the entry's blank spots. The DON stated that staff wrote in their findings and request for repair then maintenance would sign the log when it was completed. The DON stated that if the log was not signed then it was not done, and that the maintenance man may have gotten interrupted. On 03/05/24 at 01:33 PM, the surveyor interviewed the Interim Maintenance Director (IMD) who stated that there was him and one other maintenance man for the facility. He stated that the process when a resident's room needed repairs was that there was a book at each nurse's station and that the staff would write in the book or they would have told him and he would address the issue. The IMD stated that the staff would write the resident's room number, the issue, and the date it occurred in the book and that he would have tried to respond immediately to resolve the issue. The surveyor inquired as to what his responsibility with the maintenance book was and he stated that the staff would sign off on the repair that was made and that if it was not signed off that it usually meant it wasn't looked at yet, or that staff may have caught him in the hallway and told him about the issue and that he did not look at the book. The IMD stated that usually things would have gotten done as soon as they brought them up. The IMD acknowledged that he was responsible for any broken drawer handles, peeled wallpaper, broken blinds, cracked furniture and leaking sinks and stated, Everything is my responsibility. I do it on priority of the task. We are redoing rooms one at a time. The surveyor inquired as to what redoing meant and the IMD stated that it depended on the room, if wallpaper needed to be taken down that they would have taken it down and painted the walls, stating, rehab it like a house flip. The surveyor reviewed with the IDM pictures of rooms [ROOM NUMBER]. The IDM acknowledged all of the issues that needed repair and stated, We didn't have everything done, they need to be resolved. The IDM stated that it was important to make the resident's rooms homelike for dignity, adding, This is their home where they stay, we want it to be nice as possible. The surveyor and the IDM reviewed the maintenance log together. The IDM stated that staff would write their concerns and when maintenance repaired it that they would sign it too. The IDM acknowledged the entry for Location of Repair Requested: room [ROOM NUMBER] (bathroom), Your Name and Shift: [CNA's name] 7-3, Date 01/26/24, Description of Problem: Sink is leaking, water all over the floor, Repaired by: no entry, Date: no entry, Resolution: no entry, and when the surveyor inquired about the empty blank spaces the IMD stated, It slipped by me. I don't know what happened. The surveyor requested any other communication in regard to maintenance issues and the IMD stated that there was no other repair information and he acknowledged that the bathroom sink in room [ROOM NUMBER] was not fixed. The IMD stated, It wasn't done, it's still leaking now, we are aware of it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the undated facility policy, Reporting Maintenance Concerns, revealed, Policy Interpretation and Implementation: The maintenance book is checked daily and signed as the work is completed. A review of the undated facility policy, Maintenance Repairs, revealed, Policy Interpretation and Implementation: The maintenance book is checked daily and signed as the work is completed. A review of the facility provided Director of Maintenance job description revealed, Personnel Functions: Make daily rounds to assure that maintenance personnel are performing required duties and to assure that appropriate maintenance procedures are being rendered to meet the needs of the facility. Equipment and Supply Functions: Make periodic rounds to check equipment and to assure that necessary equipment is available and working properly. NJAC 8:39-4.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 33106 Based on observation, interview, and review of electronic medical records and other pertinent facility documentation, it was determined that the facility failed to follow professional standards of clinical practice with respect to obtaining a diagnosis for the use of an antibiotic intravenous medication for 1 of 1 residents (Resident #184) reviewed for antibiotics. This deficient practice was evidenced by the following: 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. According to the Admission Record, Resident #184 was admitted to the facility in March of 2024. The resident did not have a comprehensive Minimum Data Set (MDS) and was not due for the assessment at the time of the survey. The admission assessment (AA) indicated that the resident was admitted to the facility with IV antibiotic therapy and rehabilitation. The AA indicated that the resident had the diagnoses of cellulitis and that the resident had a single lumen peripherally inserted central catheter (PICC) located in the right upper arm. On 03/04/24 at 10:47 AM, during tour, the surveyor observed that there was a sign on Resident 184's door indicating that the resident was on transmission-based- precautions/contact isolation. The sign also indicated that to enter the room you must wear a protective gown and gloves. The surveyor observed an intravenous (IV) medication bag and vile of medication were hanging on the IV pole that was next to the resident's bed. The IV bag was labeled with the resident's name and the bag indicated that the medication, Vancomycin 750mg (milligrams) into 250 ml (milliliter) bag was to infuse every 12 hours over 75 minutes. The resident was interviewed at this time and stated that he/she did not know why he/she was on the medication or what infection he/she had. Resident #184 stated that the nurse hung the IV last night on 03/03/24, but didn't think he/she got any of the medication. On 03/04/24 11:17 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated she was employed through an agency. The LPN stated that the facility provided her with competencies such as medication pass, abuse, infection control, and dementia training. She stated that she was also provided with an orientation packet prior to employment. The LPN stated that Resident #184 was on IV antibiotics for an infection, but that she was not sure what type of infection the resident had because it was not documented on the physician's order. She stated that it would have been important to know what type of infection the resident had and why the resident was being treated with IV antibiotics. The LPN reviewed the IV antibiotic order with the surveyor who confirmed that there were no diagnoses associated with the IV antibiotic order and she was not sure what type of infection the resident had. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the resident's Medication Administration Record (MAR), dated 03/01/24, which contained a physician's order for Vancomycin HCL Intravenous solution use 750 mg intravenously every 12 hours for antibiotic. There were no diagnoses documented for the use of the IV antibiotic medication. On 03/04/24 at 11:29 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated that Resident #184 was ordered an IV antibiotic for methicillin-resistant Staphylococcus aureus (MRSA-a potentially dangerous type of staph bacteria that is resistant to certain antibiotics and may cause skin and other infections) in the blood. The LPN/UM also confirmed that the physicians order for the IV antibiotic should have had a diagnosis associated with the use of the medication and that she would adjust the order to include a diagnosis. On 03/05/24 09:55 AM, the surveyor interviewed the Director of Nursing (DON) who explained the policy for residents admitted with a PICC line. The DON explained to the surveyor that when a resident was admitted to the facility with a PICC line, the nurse assessed resident's PICC line and checked for patency by flushing the line with NSS to make sure the line was functional. She stated that the nurse was also responsible to make sure is a cap was on the end of the PICC line. The DON further explained that physician orders should be obtained to flush with normal saline solution (NSS) and sometimes heparin (blood thinner) depending on what the physician ordered. The DON also stated that diagnoses for the PICC and what the resident was on the IV antibiotic for should be included in the antibiotic order. On 03/12/24 at 01:39 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who confirmed that the physician's order for the use of the IV antibiotic should have had a diagnosis associated with the use of the medication. The facility's undated policy titled, Medication and Treatment Orders indicated that orders for medications and treatments will be consistent with principles of safe and effective order writing. The policy reflected that orders for medications must include clinical condition or symptoms for which the medication is prescribed. NJAC 8:39-27.1

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Complaint # 155679, 165123, and 168629 Based on interviews, review of electronic medical records, and review of other pertinent facility documents, it was determined that the facility failed to a.) obtain a physician order for the treatment of a skin tear that was obtained during a fall and b.) update a resident's Care Plan (CP) with fall prevention interventions after the resident fell on [DATE]. This was deficient practice was identified for 1 of 5 residents (Resident #334) reviewed for accidents and was evidenced by the following: According to the Admission Record (AR), Resident #334 was admitted to the facility with the diagnoses that included, but were not limited to, osteomyelitis (infection of the bone), sepsis (occurs when your immune system has a dangerous reaction to an infection), and malignant neoplasm of the brain. The admission Minimum Data Set (MDS), an assessment tool that facilitates a resident's care, dated 09/07/23, reflected that the resident was cognitively impaired and had a history of falls prior to admission to the facility. The resident was unable to be interviewed as he/she was not currently a resident in the facility. On 03/03/24 at 11:48 AM, the surveyor reviewed the facility's fall investigation and fall incident report, dated 10/08/23, which revealed the following information: According to the Incident Report (IR), dated 10/08/23 at 09:07 AM, Resident #334 had an unwitnessed fall and was noted to be lying on the floor at the foot of the bed. The resident indicated that he/she was trying to get something out of his/her closet and lost his/her balance and fell . The resident indicated that he/she was not utilizing the walker at the time of the fall and was not wearing any shoes or socks on his/her feet. The documentation indicated that the resident had developed a skin tear on the right elbow during the fall. The IR indicated that physician (PCP) and responsible party (RP) were notified, and that the resident was currently on therapy's caseload. The IR indicated that the resident was educated to utilize the walker during ambulation and that the resident's CP was updated. According to the Fall Investigation Report (FIR), dated 10/08/23 at 09:07 AM, Resident #334 was noncompliant with the use of his/her assistive device, had a fall, and developed a skin tear to the right elbow which was cleansed with normal saline solution and was left open to air. The FIR also indicated that the resident's CP was updated to include additional interventions to prevent falls. The surveyor reviewed Resident #334's CP and there was no documentation that the resident's CP was updated to reflect a new intervention to prevent reoccurrence of falls after Resident #334 fell on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the Nursing Progress Notes (NPN) in the Electronic Medical Record (EMR) and there was no documentation pertaining to the events of the fall that occurred on 10/08/23 at 09:07 AM. The surveyor reviewed the Physician Order Summary Report (POSR), dated October 2023, and there was no documentation that the facility had ordered a treatment for Resident #334's right elbow skin tear that occurred on 10/08/23. The surveyor reviewed the Treatment Administration Record (TAR), dated 10/01/23-10/31/23, and there was no documentation that the facility obtained a treatment for Resident #334's skin tear that occurred on 10/08/23. On 03/07/24 11:29 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated she had been employed in the facility since June of 2023. The LPN explained the process of an unwitnessed fall to the surveyor. She stated that she would notify the supervisor that the resident fell and the supervisor would conduct a full assessment of the resident to include a full set of vital signs (VS), range of motion (ROM) of all extremities, ask the resident if they had any pain, and neuro-checks (neurological assessment) would be done. If the resident had an injury or skin impairment, then a treatment order would be obtained from the physician. On 03/07/24 at 11:37 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that if she found a resident on the floor and the fall was unwitnessed, she would immediately call the nurse. She further added that the nurse would assess the resident and complete any necessary documentation. She added that the only form that she would have to complete would be a statement form. On 03/07/24 at 11:40 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who explained the process the facility conducted if a resident had an unwitnessed fall. The LPN/UM stated that if a resident fell , witnessed or unwitnessed, the supervisor would be notified, the resident would be assessed for injury, and vital signs obtained, which would include asking the resident if they had pain. She stated that if the resident had an unwitnessed fall, the facility required that the resident be assessed neurologically. She continued to explain the nurse would assess the resident's ROM and if the resident was injured, the resident would get first aid, and treatments would be ordered by the physician. She added that the nurse would also notify the family and the RP. The nurse would be required to complete an incident report, initiate the investigation, and would get statements. The DON would complete the investigation. She further added that the nurse would be responsible to document the fall in the EMR, assesses the resident, update the care plan with interventions to prevent falls, and document the notifications of family and physician in the progress note. On 03/07/24 11:54 AM, the surveyor interviewed the Registered Nurse (RN) that was caring for Resident #334 on 10/08/23 at the time the resident fell . The RN stated that she did not remember the incident and did not remember documenting the fall in the progress notes (PN). On 03/07/24 at 01:05 PM, the surveyor interviewed the Director of Nurse (DON) who confirmed that there was no documentation or nursing PN located in the EMR pertaining to Resident #334 falling on 10/08/23. The DON further confirmed that there were also no treatment orders obtained to the resident's right elbow for the unwitnessed fall of 10/08/23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/24 at 10:32 AM, the surveyor interviewed the Regional Clinical Director (RCD) who reviewed Resident #334's CP and physician's orders in the presence of the surveyor and confirmed that the CP was not updated to include new interventions to prevent further reoccurrence of falls on 10/08/23, and that if first aid was performed to the right elbow, a one-time treatment order should have been obtained from the physician. On 03/12/24 at 10:40 AM, the surveyor interviewed the DON regarding Resident #334's fall of 10/08/23 at 09:07 AM, and the DON confirmed that a treatment order should have been obtained for the skin tear that the resident obtained during the fall and she also confirmed that the resident's CP was not updated with new interventions after the resident fell on [DATE]. The DON stated that it was important to update the CP with new interventions to prevent further reoccurrence of falls. The facility policy titled, Incidents and Accidents, with a revised date of February 2023, indicated that the purpose of incident reports included: Assuring that appropriate and immediate interventions were implemented and corrective action were taken to prevent reoccurrence and improve the management of resident care, first aid would be given for minor injuries such as cuts and abrasions, the nurse would contact the resident's practitioner to report any injuries and obtain orders. The policy also indicated that documentation would include date, time, nature of incident, location, initial findings, immediate interventions, notifications, and orders obtained for follow-up interventions. The facility policy titled Wound Treatment and Management, dated 2019, indicated that wound treatments will be provided in accordance with physician orders, including cleansing method, type of dressing, frequency of dressing changes. The policy indicated that indicated that in the absence of treatment orders, the licensed nurse would notify the physician and obtain treatment orders. The policy also indicated that treatment would be documented in the Treatment Administration Record (TAR) in the electronic health record. The facility policy, with revised date of 10/17/23, titled, Comprehensive Care Plan indicated that the facility would develop and implement a comprehensive person-centered CP for each resident and that resident specific interventions would reflect the resident's needs and preferences. The policy also indicated that qualified staff responsible for carrying out interventions specified in the CP would be notified of their roles and responsibilities for carrying out interventions when changes were made. NJAC 8:3.9-27.1(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41260 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) ensure an indwelling urinary catheter drainage bag did not touch the floor and b.) ensure the urinary catheter drainage bag was kept below the level of the bladder for 1 of 3 residents (Resident #67) reviewed for urinary catheter. This deficient practice was evidenced by the following: On 03/04/24 at 9:58 AM, the surveyor observed Resident #67 lying in bed. The resident had a urinary catheter (a tube placed in the body to empty urine) with a drainage bag secured to the bed. The bottom of the urinary catheter drainage bag was touching the floor. According to the Admission Record, Resident #67 had diagnoses which included, but were not limited to, retention of urine. Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 01/08/24, included the resident had a Brief Interview for Mental Status score of 15, which indicated the resident's cognition was intact. Further review of the MDS included the resident had an indwelling catheter. Review of the Order Summary Report, as of 03/05/24, included a physician's order to change the urinary catheter drainage bag weekly and as needed, dated 01/13/24. Review of the Care Plan, initiated 01/15/24, included a focus that Resident #67 had an indwelling urinary catheter due to urinary retention and an intervention to keep the urinary catheter drainage bag below the resident's bladder. On 03/05/24 at 9:52 AM, the surveyor knocked on Resident #67's door, but the Certified Nursing Assistant (CNA) stated she was performing care on Resident #67 and asked the surveyor to come back later. At 10:35 AM, the surveyor observed Resident #67 lying down flat in bed, fully dressed, with his/her urinary catheter drainage bag secured to his/her pants waist band. The drainage bag was level with the resident's bladder, not below the level of the bladder. At 10:36 AM, the surveyor observed Resident #67's CNA in the hallway using the CNA kiosk. The surveyor waited in the hallway for the CNA to become available. At 10:42 AM, the surveyor observed the CNA walk away from the kiosk. At that time, the surveyor interviewed the CNA regarding urinary catheter care. The CNA stated that for residents with catheters, she ensures the urinary catheter drainage bag is secured below the resident's bladder and not touching the floor to prevent bacteria from entering the resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Salem County	438 Salem-Woodstown Road Salem, NJ 08079

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:44 AM, the surveyor accompanied the CNA to Resident #67's room. The CNA acknowledged the urinary catheter drainage bag was not secured below the resident's bladder and that the CNA was waiting for the physical therapy staff to get the resident out of bed. The CNA then left the room to get a privacy cover for the drainage bag so that it could be secured below the resident's bladder. The surveyor waited in the resident's room. At 10:47 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) entered the resident's room, put on gloves, removed the drainage bag from the resident's waistband, and secured the drainage bag to the bedframe below the resident's bladder. During an interview with the surveyor on 03/05/24 at 10:52 AM, the LPN/UM stated that the CNAs should secure the urinary catheter drainage bags in downward position to allow the urine to free flow by gravity, and prevent the backflow of urine into the resident. The LPN/UM further stated the drainage bag should not touch the floor for, sanitation reasons. During an interview with the surveyor on 03/05/23 at 10:58 AM, the Director of Nursing (DON) stated the CNAs should secure the urinary catheter drainage bags below the level of the resident's bladder for proper urinary flow and the bag should not touch the floor for infection control reasons. At that time, the surveyor informed the DON of the observations made on 03/04/24 and 03/05/24. The DON stated that after the CNA performed care, she should have secured the urinary catheter drainage bag to the side of the bed, below the resident's bladder, and not touching the floor. Review of the facility's Catheter Care policy, dated 11/2023, included, It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care, and, Ensure drainage bag is located below the level of the bladder to discourage backflow of urine. The policy did not indicate if the drainage bag should be kept off the floor. NJAC 8:39 - 27.1(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33106 Based on observation, interview, and review of other pertinent facility documents, it was determined that the facility failed to label and dispose of medications in accordance with accepted professional principles for 1 of 1 residents (Resident #184) reviewed for antibiotic therapy. This deficient practice was evidenced by the following: According to the Admission Record, Resident #184 was admitted to the facility in March of 2024. The resident did not have a comprehensive Minimum Data Set (MDS) completed at this time. The admission assessment (AA) indicated that Resident #184 was admitted to the facility with intravenous (IV) antibiotic therapy and rehabilitation. The AA indicated that the resident had the diagnoses of cellulitis and that the resident had a single lumen peripherally inserted central catheter (PICC) located in the right upper arm. On 03/04/24 at 10:47 AM, during tour, the surveyor observed a sign posted on the resident's door indicating that the resident was on transmission-based- precautions/contact isolation. The sign also indicated that to enter the room you must wear a protective gown and gloves. The surveyor observed an IV medication bag and vile of medication hanging on the IV pole that was next to the resident's bed. The IV bag was labeled with the resident's name and the bag indicated that the medication Vancomycin 750mg (milligrams) into 250 ml (milliliters) bag was to infuse every 12 hours over 75 minutes. There was no date or labeling on the IV tubing. The resident was interviewed at this time and stated that he/she did not know why he/she was on the medication or what infection he/she had. Resident #184 stated that the nurse hung the IV last night on 3/3/24, but didn't think he/she received any of the medication. Review of the physician Order Summary Report (OSR), dated 03/01/24, reflected a physician's order for Vancomycin HCL IV solution use 750 mg IV every 12 hours for antibiotic. Review of the resident's Medication Administration Record (MAR) indicated that the IV medication Vancomycin HCL IV solution use 750 mg IV every 12 hours was to be administered at 09:00 am and 2100 hours (09:00 pm). The MAR also indicated that on 03/03/24 at 2100 hours (9:00 pm) the IV Vancomycin was held (not given). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/24 11:17 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated she was employed through an agency. The LPN stated that the facility provided her with competencies such as medication pass, abuse, infection control, and dementia training. She stated that she was also provided with an orientation packet prior to employment. The LPN stated that Resident #184 was on IV antibiotics for an infection, but was not sure what type of infection the resident had because it was not documented on the physician's order. She stated that it would have been important to know what type of infection the resident the resident had and why the resident was being treated with IV antibiotics. She stated that when she came in to work that morning, she was given report by the 11:00 pm-7:00 am nurse who told her that the resident's PICC line was clogged the night prior, and the resident did not receive the dose of medication that was ordered to be given at 9:00 pm. She stated that the IV medication that was hanging on the IV pole must have been from the 9:00 pm dose that was ordered to be given 03/03/24 at 9:00 PM. The LPN further stated that the 11:00 pm-7:00 am nurse should have discarded the medication when she realized the resident's PICC line was clogged and that she could not administer the medication at that time. On 03/04/24 at 11:29 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated that Resident #184 was ordered an IV antibiotic for methicillin-resistant Staphylococcus aureus (MRSA-a potentially dangerous type of staph bacteria that is resistant to certain antibiotics and may cause skin and other infections) in the blood. She explained that the nurse had documented on 03/03/24 at 22:49 (10:49 PM) that the peripherally inserted central catheter (PICC) line was clogged, notified the Nurse Practitioner (NP), and called the PICC line specialist company to come to the facility to unclog the PICC line. The LPN/UM stated that she heard that the resident did not get the 9:00 pm dose of IV antibiotic on 03/03/24. The surveyor explained to the LPN/UM that the resident's IV medication was still hanging on the IV pole since the missed dose and the LPN/UM stated that the medication that was hanging on the IV pole should have been discarded when the nurse was not able to administer the medication. The LPN/UM went to the resident's room with the surveyor and confirmed that the IV medication and tubing was not dated or timed, so she was not sure how long the medication or tubing had been hanging. The LPN/UM then stated that the antibiotic medication that was hanging on the IV pole should have been discarded. On 03/05/24 09:55 AM, the surveyor interviewed the Director of Nursing (DON) who explained the policy for residents admitted with a PICC line. The DON explained to the surveyor that when a resident was admitted to the facility with a PICC line, the nurse assessed the resident's PICC line to check for patency by flushing the line with NSS to make sure the line was functional. She stated that the nurse was also responsible to make sure is a cap was on the end of the PICC line. She stated that physician orders should be obtained to flush with normal saline solution (NSS) and sometimes heparin (blood thinner) depending on what the physician ordered. The DON explained that if the tubing was clogged the nurse should call the MD and then call the PICC line services to come unclog the tubing. She stated that the PICC line was unclogged on 03/04/24, in the afternoon, and the resident received the dose of antibiotic that the resident missed at 9:00 AM. The DON confirmed that the IV medication that was hanging at the resident's bedside should have been labeled and tubing dated and should have been discarded if the nurse was not going to administer the medication. On 03/12/24 at 01:39 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who confirmed that the IV medication should have been disposed of after the nurse realized that the IV PICC line was not functional and that she was unable to administer the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy facility policy titled, Discarding and Destroying Medications indicated that medications that cannot be returned to the dispensing pharmacy (e.g., non-unit-dose medications, medications refused by residents, and/or medications left by residents upon discharge) are to be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste, and controlled substances. The facility policy, dated 2022, titled, Intravenous Therapy indicated that IV tubing was to be changed every 96 hours or sooner if contamination or integrity of system is compromised. There was no documentation on the facility policy on labeling and dating of IV tubing. The facility provided the surveyor with a Nursing Inservice form, dated 03/05/24, which indicated that the nursing staff were educated on the following: Be sure to date IV bag and tubing. Tubing was good for 24 hours. If unable to administer antibiotic medication, remove from the residents room. N.J.A.C. 8:39-29.4(h)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43307 Based on observation, interview, and review of facility documentation it was determined that the facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses and b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination. This deficient practice was observed and evidenced by the following: On [DATE] from 09:54 to 11:03 AM, the surveyor toured the kitchen in the presence of the Dietary Director (DD) and observed the following: 1. On a metal rack in the walk-in refrigerator, there were two boxes marked raw chicken drumsticks that were resting on a parchment paper lined metal tray and the paper was marked pull with no date. The DD acknowledged there was no pull date and stated that it was important that expired food was not served, and that the box should have had a label with a pulled and use by date. 2. There was a box marked fresh leaf lettuce with a sticker dated [DATE]. The lettuce was wilted, dry, had brown edges and there was black lettuce observed in the box. The DD stated that the sticker was dated when the lettuce was delivered and that it was good for 7 to 14 days. The DD acknowledged the wilted and black lettuce and stated that it was no longer fresh and removed the box from the refrigerator. 3. There were three stacked trays of undated, lidded cups of various liquids, each marked with liquid contents. The DD stated the cups of liquids were prepped for the day, but acknowledged that she was unsure how old they were and stated that they should have had the date they were prepped. 4. In the walk in freezer, there was one sealed, clear plastic bag that contained thin white ovals, with no label nor date. The DD identified the food item as scalloped potatoes and acknowledged that the bag should have had a date that the food was received, the date it came out of the box and a use by date. The DD discarded the bag of scalloped potatoes. 5. There were three 20 pound (lb) pork loins. One pork loin was manufacturer marked best by or freeze by with an unreadable date. The DD acknowledged that she was unsure how old the undated pork loin was and stated that there was no label and that it should have had a label when it was received. One pork loin was manufacturer marked with the date [DATE], and there was a hole in the packaging with the meat opened and exposed to air. The DD acknowledged the hole and stated that the hole should not have been there, that it was freezer burnt, and that it should not have been served. The DD discarded the two pork loins. 6. On a rack in the dry storage area, there was one 108 ounce dented can of sweetened applesauce. The DD acknowledged the dent and removed the can to the dented can section. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On a metal prep table there was a slicer covered with a plastic bag. The DD stated that once equipment was used that it was cleaned and sanitized then covered with a plastic bag. The DD removed the bag and there was tan debris observed on the base, the slicer, and the blade arm. The DD stated she did not know what the debris was as she removed the debris with her finger. She acknowledged that the debris should not have been there and stated that cleaned and sanitized equipment avoided cross contamination. 8. On a rack in the dry pots and pans area, there was a white cutting board with a large brown circular stain. The DD acknowledged the stain and stated that it was important that the cutting boards were clean so germs and cross contamination were prevented. On [DATE] 01:36 PM, the administrative team was made aware of the kitchen concerns. A review of the facility policy, Food Receiving and Storage, reviewed and updated-[DATE], revealed, Policy Interpretation and Implementation: Dented cans will be stored in a designated area and returned to vendor. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). The freezer must keep frozen foods solid. Wrappers of frozen foods must stay intact until thawing. A review of the facility policy, Sanitation, reviewed and updated [DATE], revealed, Policy Interpretation and Implementation: All utensils, counters, shelves and equipment shall be kept clean .All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils .Cutting boards will be washed and sanitized between uses. Manual washing and sanitizing will employ a three-step process for washing, rinsing, and sanitizing. Scrape food particles . A review of the facility policy, Food Preparation and Service, reviewed and updated-[DATE], revealed, Policy Interpretation and Implementation: Appropriate measures are used to prevent cross contamination. These include: Cleaning and sanitizing work surfaces (including cutting boards) and food-contact equipment between uses . NJAC 8:,d+[DATE].2(g)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 33106 Complaint NJ# 168629 Based on interview and review of medical records and other facility documents, it was determined that the facility failed to maintain an accurately documented and complete medical record for 1 of 22 reviewed (Resident #334). This deficient practice was evidenced by the following: According to the Admission Record (AR), Resident #334 was admitted to the facility with diagnoses that included, but were not limited to osteomyelitis (infection of the bone), sepsis (occurs when your immune system has a dangerous reaction to an infection), and malignant neoplasm of the brain. The admission Minimum Data Set (MDS), an assessment tool that facilitates a resident's care, dated 09/07/23, reflected that the resident was cognitively impaired and had a history of falls prior to admission to the facility. The resident was unable to be interviewed as he/she was not currently a resident in the facility. On 03/03/24 at 11:48 AM, the surveyor reviewed the facility's fall investigation and fall incident report, dated 10/08/23, which revealed the following information: According to the Incident Report (IR), dated 10/08/23 at 09:07 AM, Resident #334 had an unwitnessed fall and was noted to be lying on the floor at the foot of the bed. The resident indicated that he/she was trying to get something out of his/her closet and lost his/her balance and fell . The resident indicated that he/she was not utilizing the walker at the time of the fall and was not wearing any shoes or socks on his/her feet. The documentation indicated that the resident had developed a skin tear on the right elbow during the fall and that physician (PCP) and responsible party (RP) were notified. The IR also reflected that Resident #334 was currently on therapy's caseload and was educated to utilize the walker during ambulation. The surveyor reviewed the Nursing Progress Notes (NPN) in the Electronic Medical Record (EMR) and there was no documentation pertaining to the events of the fall that occurred on 10/08/23 at 09:07 AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/07/24 11:29 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) stated she had been employed in the facility since June of 2023. The LPN explained the process of an unwitnessed fall to the surveyor. She stated that she would notify the supervisor that the resident fell and that supervisor would conduct a full assessment of the resident which included a full set of vital signs (VS), range of motion (ROM) of all extremities, assess for pain, and neuro-checks (neurological assessment) would be done. She stated that all unwitnessed falls required neuro-checks in case the resident hit their head. She continued to explain that the nurse would write an incident note (progress note) in the Electronic Medical Record (EMR), fill out incident report form, and obtain statements from the person that found the resident, the primary care nurse, and the primary care CNA. She further added that the primary nurse assigned to that resident would document the fall in the progress notes. On 03/07/24 at 11:37 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that if she found a resident on the floor and the fall was unwitnessed, she would immediately call the nurse. She further added that the nurse would assess the resident and complete any necessary documentation. She added that the only form that she would have to complete would be a statement form. On 03/07/24 at 11:40 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who explained the process the facility conducted if a resident had an unwitnessed fall. The LPN/UM stated that if a resident fell , witnessed or unwitnessed, the supervisor would be notified, the resident would be assessed, and VS would be taken, including pain. If the resident had an unwitnessed fall, the facility required that the resident be assessed neurologically. She continued to explain the nurse would assess the resident's ROM, and if the resident was injured, the resident would get first aid, and treatments would be ordered by the physician. She added that the nurse would also notify the family and the RP, complete an incident report, initiate the investigation and get statements from staff. She further added that the Director of Nursing (DON) would complete the investigation. She stated that it would be the nurses responsiblity to document the fall in the EMR, assesses the resident, update the care plan with interventions to prevent falls, and document the notifications of family and MD in the progress note. She verified that it would be important to document in the progress any changes in condition that occurred with residents so that there was accurate communication between disciplines. She further stated it was also important to keep accurate documentation in the progress notes because the progress notes were a legal document. The LPN/UM reviewed Resident #334's progress notes and confirmed that there was no documentation regarding Resident #334 fall of 10/08/23. On 03/07/24 11:54 AM, the surveyor interviewed Registered Nurse (RN) that was caring for Resident #334 on 10/08/23 at the time the resident fell . The RN stated that she did not remember the incident and did not remember documenting the fall in the progress notes. On 03/07/24 at 12:00 PM, the surveyor interviewed the Regional Clinical Director (RCD) and she confirmed the nurses were responsible to complete progress notes to include what happened at the time the resident fell , assessment, injuries, notification of family and doctor, and disposition of the resident. She stated that the resident's PN were required for any changes in a residents condition. She stated that PN were a form of communication between disciplines, a legal document and assisted the writer in recollection of the events. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/07/24 at 01:05 PM, the surveyor interviewed the Director of Nurse (DON) who confirmed that there was no documentation or nursing progress notes located in the EMR pertaining to Resident #334's fall on 10/08/23. On 03/12/24 at 10:32 AM, the surveyor interviewed the RCD who confirmed that that there was no documentation in the resident's progress notes regarding the resident's fall of 10/08/23. The facility policy, dated February 2019, titled, Charting and Documentation indicated that all services provided to the resident, progress notes toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective, complete, and accurate. NJAC 8:39-35.2 (d)6, 16(e)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43307 Based on observation, interviews, and review of facility documentation, it was determined that the facility failed to follow appropriate infection control practices and perform hand hygiene as indicated during meal tray pass observed in the Main Dining area. The deficient practice was evidenced as follows: On 03/04/24 at 12:07 PM, the surveyor observed the following: The Licensed Practical Nurse (LPN) was standing at Resident #19's table, and with her bare hands, she opened a packet of powder, emptied the powder into a cup of white liquid and mixed it with a spoon with her left hand. With her right hand she removed a phone from her pocket and touched the phone screen then placed it back into her pocket. The LPN continued to stir the liquid with her left hand and added more powder from the packet with her right hand then continued to stir. The LPN then moved the cup onto the resident's tray and placed the spoon on the tray. The LPN returned to the food cart area and placed her hands in her pockets. She then approached the food cart, removed a food tray, and placed it in front of Resident #68. The LPN removed the plastic food lid and walked away. The LPN stopped and spoke with Resident #46, then went to the piano area where she grasped an empty cup and a lid, placed the lid on the cup, then presented the cup to Resident #46. The LPN then went back to the food cart area and placed her hands in her pockets. The LPN approached the food cart and touched the first tray and the items on the tray; touched a second tray; touched a third tray, lifted the lid and pushed the tray back on the cart; touched a fourth tray, lifted the lid and moved items on the tray; lifted the lid of the fifth tray and lifted items on the tray then moved the tray back on the cart; touched the sixth tray and lifted to food lid; touched the seventh tray and lifted the food lid; touched the eighth tray and lifted the food lid then pushed the tray back on the cart. The LPN then touched her nose as she stood waiting at the food cart. Another staff member handed the LPN a food tray and she placed the tray in front of Resident #11. The LPN walked to the side of the room and picked up a chair, which she placed next to the resident, then sat down. The LPN removed the lid from the plate, opened the silverware and placed it on the tray, opened the resident's milk carton, removed the straw paper from the straw and then placed the straw into the milk carton. The LPN grasped the spoon and fed the resident a bite of food. The LPN held the milk carton up to the resident to drink then again grasped the spoon and fed the resident the rest of his/her meal tray. There was no hand hygiene (HH) observed during the observation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315058	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Salem County	438 Salem-Woodstown Road Salem, NJ 08079

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/24 at 12:26 PM, the surveyor interviewed the LPN who stated she was working on the A/B unit today and was assisting in the main dining room. The LPN stated that when residents were served lunch in the dining area that it was the staff who brought the residents to the main dining area and got them set up, made sure their hands were cleaned and placed a clothing protector in place if needed. When the trays came out, the nurses checked the tray for accuracy-that the diet matched the ticket and meal slip matched the meal. The LPN stated that they would ask the resident if they needed anything opened or if they needed help to be fed and that they passed meal trays to the whole table first before moving to the next table and added that if they were self-fed then the staff would supervise them. The LPN stated that hand hygiene was done by staff in between resident contact and when trays were passed. When the surveyor inquired as to what resident contact was, the LPN stated that if she had physical contact with a resident that she would then clean her hands before touching a tray and after trays were checked and passed out that she would then clean her hands. The surveyor informed the LPN of the meal tray pass observation. The LPN stated that she did perform HH correctly when she came out initially to dining room. The surveyor explained that the observation started during the interaction with Resident #19 and inquired as to whether she performed HH correctly during the observation period. The LPN stated, Honestly, I don't remember. The surveyor inquired as to whether HH should have been done during the meal tray pass observation and the LPN stated, yes. She further stated that it was important to perform HH correctly during meal tray pass to prevent passing infection. On 03/04/24 at 12:36 PM, the surveyor interviewed the LPN Unit Manager (LPN/UM) of the A/B unit who stated the process for the meal tray pass in the dining room was that the staff arrived in the main dining room once they overhead announced the meal was being served. She stated that there was a list of residents that ate in the dining room and that it was one nurse's responsibility to check the trays for accuracy. The LPN/UM stated that all residents were served at the entire table at the same time, and that some residents needed assistance to be fed. The staff member would then obtain the next tray and continue until all the trays were served. The surveyor inquired as to when HH should have been performed and the LPN/UM stated that HH was done when staff entered the dining room, in between serving the trays and before and after feedings. The LPN/UM was told of the LPN meal tray pass observation. The LPN/UM acknowledged that the LPN did not perform HH correctly and that she should have done HH after she touched her phone, when she touched her nose, and before she sat down to feed the resident. The LPN/UM stated that it was important to perform HH correctly during meal tray pass to prevent cross contamination. On 03/04/24 at 12:45 PM, the surveyor interviewed the LPN Infection Preventionist (LPN/IP) who stated that HH was done for the staff and the residents prior to meal service and that after a tray was served that staff performed HH prior to obtaining another resident's tray. The surveyor informed the LPN/IP of the LPN's meal tray pass observation. The LPN/IP acknowledged that HH was not performed correctly and stated that HH should have been performed after she touched her phone, after she touched her nose, and before she sat down to feed the resident. The LPN/IP stated that it was important to perform HH correctly during meal tray pass for the prevention of the transmission of flu, colds, and diseases. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/24 at 12:55 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the process for meal tray pass in the dining room was that staff performed HH prior to meal tray service, the nurse looked at the meal ticket and handed the tray to staff nurse who would thicken any liquids. The residents were served by table, that no one ate until all trays were served, and that then the nurse would return to the food cart to obtain the next tray. The surveyor inquired as to when HH should have been performed for tray pass and the DON stated that handwashing was done prior to entering the dining room or that hand sanitizer was available in the dining room. When the surveyor inquired if HH should have been performed at any other time, the DON responded, no. The surveyor informed the DON of the LPN's meal tray pass observation. The DON acknowledged that the LPN did not perform HH correctly and stated that she should have used HH after she touched her nose, every time she touched her pocket or phone, any time she touched an inanimate source, and when she picked up the chair. The DON stated it was important to perform HH correctly during meal tray pass, so germs were not passed. On 03/12/24 at 01:36 PM, the administrative team was made aware of the main dining room meal tray pass observation. A review of the undated facility policy, Handwashing/Hand Hygiene, revealed, Policy Interpretation and Implementation: All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: After contact with objects .in the immediate vicinity of the resident; Before and after assisting a resident with meals. A review of the facility provided Charge Nurse/Staff Nurse job description revealed, Duties and Responsibilities: Safety and Sanitation: Ensure that your assigned personnel follow established hand washing techniques in the administering of nursing care procedures. NJAC 8:39-19.4 (m)(n)