STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315126	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop McCarthy Center for Rehab & Healthcare	1045 E Chestnut Ave Vineland, NJ 08360

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 33106 Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to a.) obtain a physician's order for application and removal times of an orthotic device and b.) develop a comprehensive care plan for the use of an orthotic brace for 1 of 3 residents (Resident # 153) reviewed for positioning/mobility. This deficient practice was evidenced by the following: The Admission Record indicated that Resident #153 was admitted to the facility with diagnoses that included, but were not limited to, cerebral infarction (stroke), cyclist injured in a collision with car, and traumatic brain injury. The admission Minimum Data Set (MDS), an assessment tool that facilitates the care of a resident, dated 02/20/24, indicated that Resident #153 rarely understood verbal content and rarely had the ability to make him/herself understood. The MDS also reflected that Resident #153 had limited range of motion to the lower extremities. On 03/18/24 at 12:37 PM, the surveyor observed Resident #153 sitting up in the geri-chair (reclining chair) at the nurse's station with a hinged brace on the right lower leg. The resident was sitting up in the chair and communicated with gestures and head nods. The resident had no complaints of pain or discomfort and no issues concerning the brace on the right lower leg. On 03/21/24 at 02:05 PM, the surveyor observed the resident sitting at the nurse's station watching a video on his/her phone and the resident was wearing a hinged brace on the right lower leg. The surveyor reviewed the Physicians Order (PO), dated 03/04/24, which indicated the following: hinged brace to right leg. The surveyor reviewed Resident #153's Care Plan (CP) which did not include the resident's usage of a hinged brace to the right leg. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/22/24 at 11:16 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that she had been employed in the facility for eight (8) months. She stated that Resident #153 was alert and oriented, non-verbal and could follow directions. She continued to add that the resident could understand writing and required total care with all aspects of activities of daily living (ADLs). She stated that the resident also required complete assistance with feeding and was incontinent of bladder and bowel and had intact skin. She stated that the resident had a right lower leg brace which remained intact to the right lower leg and did not get removed. She stated that the resident even wore the brace during the hours that he/she slept. She stated that the brace could be removed when the resident got a shower, but then physical therapy had to re-apply the brace. She stated that the brace was only removed for showers and that therapy provided training on how to remove the brace. On 03/22/24 at 11:23 AM, the surveyor interviewed the Director of Rehabilitation (DOR) who stated that Resident #153 wore a hinged brace on the right leg and the brace was utilized to prevent flexion contracture (the inability to fully straighten or extend the knee) of the right knee. She stated that the facility was trialing the brace to see how long the resident tolerated the brace. The treating Physical Therapist (PT) was present during the interview and explained that Resident #153 was tolerating wearing the brace 24 hours a day. The DOR then added that the brace could be removed for care and for skin checks. The DOR reviewed the flexion brace order with the surveyor and confirmed that the order needed to be revised and clarified to include how long the brace could remain intact, when it could be removed and then stated that it could be removed for care and for skin checks. On 03/22/24 at 11:32 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding Resident #153's right lower leg brace. The LPN stated that the hinged brace was to be always worn 24-hours a day, but could be removed for care, skin checks and weekly body checks. The LPN reviewed the PO with the surveyor and confirmed that the order for the right lower leg brace was an incomplete order and did not tell the reader all the information that should be included, such as when it should be applied and when it should be removed. She also stated that it should be documented on the CP and the Treatment Administration Record (TAR) regarding the application of the brace and removal times. The LPN stated that it would have been important to have a complete order so that staff knew why the brace was being used and any precautions associated with the use of the brace and so that the resident could be monitored for skin issues associated with the use of the brace. On 03/22/24 at 11:38 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that she would clarify the order for the right lower leg brace to include time of application and when to remove the brace. The RM/UM also confirmed that there was no documentation on the CP regarding the potential contracture of the right knee and application and trialing of the right lower leg brace. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/24 at 09:06 AM, the surveyor interviewed the Director of Nursing (DON) who stated that residents were screened on admission for any special needs associated with the use of braces or splints. She stated that therapy (physical therapy and occupation therapy) was responsible to set up a schedule for splint or brace usage to include when the resident was supposed to wear the device and when the device was to be removed. She stated that the therapist would then educate the staff on the device and how to apply and remove the device. She confirmed that nurses were then responsible to get a physician's order for the device and put the order on the Treatment Administration Record (TAR) so that the device could be signed off by the nurse. She stated that the device use would then be included in the resident's CP. She confirmed that it would be important to get a physician's order for the device so that there is follow through. She continued to add that it would also be important to put the usuage of the brace on the CP because the CP directs the care of the resident. The facility policy dated 04/2023 and titled, Orthotic Devises indicated that if limitations were evident and an orthotic device was indicated, a physician's order for such treatment would be requested. When the orthotic device was obtained, the orthotic device would be applied and observed. The policy also indicated that findings and recommendations would be documented in the resident's medical record. The wearing time for an orthotic device is based on the individual residents need (per physician's order therapist recommendations). The comprehensive Care Plan would be updated to include any changes in status, goals and recommendations which reflect the wearing of the orthotic device. NJAC 8:39 27.2 (m)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 33106 Based on observation, interview, and record review, it was determined that the facility failed to provide the necessary respiratory care and services for 1 (one) of 2 (two) residents (Resident # 100) reviewed for respiratory services. This deficient practice was evidenced by the following: According to the Admission Record (AR) Resident #100 was admitted to the facility with diagnoses that included, but were not limited to, cerebral infarction (stroke) and chronic respiratory failure. The quarterly Minimum Data Set (MDS), an assessment tool, dated 02/23/24, indicated that the resident was cognitively intact and required extensive to total care with all aspect of activities of daily living (ADLs). The MDS also indicated that the resident required tracheostomy care (a surgical opening in your neck that delivers oxygen to your lungs). On 03/18/24 at 10:13 AM, during tour, the surveyor observed Resident #100 lying in bed with a tracheostomy (trach). The resident was pleasant and did not have any complaints. The resident communicated by typing on his/her phone. The surveyor did not observe an emergency tracheostomy kit [The emergency tracheostomy kit should contain a spare tracheostomy tube (same size) with obturator and ties assembled and normal saline (e.g., nebules; a water-soluble lubricant)] in sight near the resident. There was a suction machine close to the resident's bed and an emergency ambu bag (a medical tool which forces air into the lungs of patients who have either ceased breathing completely or who are struggling to breathe properly and need additional assistance) next to the resident's bedside. On 03/19/24 at 10:02 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that Resident #100 received trach care every shift. LPN #1 stated that the necessary supplies that should be located at the resident's bedside was a suction machine and trach supplies. She also stated there should be an emergency trach set up located in the resident's room in case the resident decannulated (when a tracheostomy tube becomes dislodged from a person's neck). LPN #1 accompanied the surveyor to the resident's room and located an emergency trach care kit size 6CFS in the resident's bedside drawer. The LPN reviewed the physicians order in the presence of the surveyor and confirmed that the emergency trach kit that was observed in the resident's drawer was the wrong size trach, size 6CFS. Another nurse (LPN #2) was standing at the nurse's station and stated that Resident #100 used to have a trach size 6CFS, however, the resident had tracheostomy surgery on 2/23/24 and the trach size was changed a size 4 UN65R trach. Both LPNs confirmed that the emergency trach care kit trach size 6CFS was not the right size and should have been the correct size of 4 UN65R or a size smaller. LPN #1 further reviewed Resident #100's Treatment Administration Record (TAR) in the presence of the surveyor and stated that the current treatment order dated 03/11/23 to Clean inner cannula Q shift and PRN [as needed] for airway management every shift for Trach Care was not a clear order and that the order did not specify how the cannula was supposed to be cleaned and with what solution the inner cannula was to be cleaned with. LPN #1 continued to explain that the resident had disposable inner cannulas, and she did not think that it needed to be cleaned. The LPN stated that it should be thrown away and replaced with a new one. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Order Summary Report (OSR) dated 12/06/23, indicated that the resident had a trach size of 4 UN65R cuffless. The OSR also reflected a physician's order dated 03/11/23: Trach Care: Clean the inner cannula every shift and as needed for airway management. This order was not reconsiled or clarified for over 1 year. The resident Care Plan (CP) dated 11/16/21, reflected an intervention to maintain replacement tracheostomy tube and ambu bag at the resident's bedside. On 03/19/24 at 10:40 AM, the surveyor interviewed LPN #2 who stated that the current order to clean the inner cannula q shift and PRN for airway management needed to be clarified because the resident had a disposable inner cannula that was not supposed to be cleaned. The inner cannula was to be thrown away and replaced with a new inner cannula every shift. LPN #2 stated that the order did not reflect that, however, when she was assigned to the resident, she changed the disposable inner cannula for a new one every day. LPN #2 confirmed that the emergency trach care kit that was in the resident's drawer was the wrong size and needed to be the correct size in case the resident accidently decannulated him/herself. Stated a spare tracheostomy kit should always be the correct size or a size smaller. LPN #2 further stated it was important to assure correct sizing in case of an emergency and to maintain the resident's airway. On 03/19/24 at 10:41 AM, the surveyor interviewed the Director of Nursing (DON) who stated that Resident #100 had surgery to his tracheostomy site and that when the resident's trach size changed, the orders should have changed to reflect the new size of the resident's trach. She confirmed that the emergency trach kit that was at the resident's bedside should have been the correct size or size smaller for airway management in case of an emergency. The DON also reviewed the tracheostomy care treatment order with the surveyor and confirmed that the resident had a disposable inner cannula and that the order to clean the inner cannula q shift and PRN for airway management needed to be clarified because the staff should not be cleaning the disposable inner cannula, they should be replacing it. On 03/19/24 at 12:28 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) regarding Resident #100's respiratory care. The RN/UM stated the resident had surgery in February and had a follow-up next week. He stated that emergency supplies that should be kept at the resident's bedside would be the appropriate size trach, or a size smaller, and an ambu bag. He stated that it would be important to have this equipment for emergencies in case the resident de-cannulates and staff needed to keep the resident's airway patent. The RN/UM also confirmed that the order to clean the inner cannula q shift and PRN for airway management was an inaccurate order and should have been discontinued. He stated that there should have been an order to change the disposable inner cannula during trach care every shift. The facility policy dated 04/2022 and titled, Emergency Tracheostomy Care indicated that the purpose of this procedure was to guide nursing for the need of emergent tracheostomy care should extubation (refers to removal of the endotracheal tube) occur. The policy specified that emergency intervention to prevent respiratory complications are to be implemented immediately to include: a replacement tracheostomy tube must be available at the bedside at all times should tracheostomy become dislodged. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy with a revised date 03/2024 and titled, Care of a Tracheostomy Resident indicated Care of the resident included: Ensure that there is an emergency tracheostomy set up at the patient's bedside which includes a tracheostomy care kit, ambu bag, and a smaller size tracheostomy tube for immediate use. NJAC 8:39-19.4(a)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43307 Complaint: NJ171634 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to serve hot and cold foods at an acceptable temperature for the residents. This deficient practice was identified on 1 of 3 nursing units (Third Floor Dining Room) during the lunch meal service. The deficient practice was evidenced by the following: On 03/27/24 at 11:15 AM, the surveyor met with the Dietary Director (DD) in the kitchen and informed her a temperature test tray was requested for the Third Floor. On 03/27/24 at 11:31 AM, the dining staff started plating trays for the food cart for the Third floor. The surveyor observed the DD calibrate a digital thermometer in a cup of ice water, and the temperature read 32 degrees Fahrenheit (F). On 03/27/24 at 11:43 AM, the surveyor observed the cook plate a regular meal and the DD tested the food temperatures on the test tray: Sliced roast beef, 144.9 degrees F. Mashed potatoes with gravy, 146.5 degrees F. Mixed vegetables, 146.5 degrees F. Individual cups of pineapple chunks, 60.3 degrees F. During an interview at that time, the DD stated that the pineapple chunks should have been 41 degrees F or below. On 03/27/24 at 11:49 AM, the Third Floor food cart left the kitchen. The surveyor and the DD accompanied the cart to the Third Floor. On 03/27/24 at 11:51 AM, the food cart arrived on the Third Floor. On 03/27/24 at 11:59 AM, all the trays were delivered from the cart. The DD then tested the food temperatures on the test tray: Sliced roast beef, 118.9 degrees F. Mashed potatoes with gravy, 126.3 degrees F. Mixed vegetables, 103.5 degrees F. Individual cups of pineapple chunks, 65.3 degrees F. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview at that time, the DD stated that the hot food temperatures when they left the kitchen should have been between 120-130 degrees F and stated that the cold food temperature, can go up to 50, I have to double check, at least 50 or below. The DD stated that it was important to maintain proper food temperatures so foodborne illnesses were prevented and food complaints were avoided. On 03/27/24 at 12:36 PM, the surveyors met with the administration team, and they were made aware of the test tray food temperature concerns. A review of the facility document entitled, Cooks Temp Log, Date: 3/27/24, Day: Wednesday, revealed under Lunch section: Menu Item: Roast Beef, Cook Temp: 170 Menu Item: Mash Pot, Cook Temp 188 Menu Item: Mix veg, Cook Temp 185 Menu Item: Pineapple Tidbits, Cook Temp 37 A review of the undated facility policy titled, Food Temperatures, revealed, Procedure: 1.b. Hot food items may not fall below 135 degrees after cooking .2. All cold food items must be maintained and served at a temperature of 41 degrees F or below. 6. Foods sent to the units for distribution (such as meals, snacks, nourishments, oral supplements) will be transported and delivered to maintain temperatures at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods. NJAC 8:39-17.4 (a)

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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. 43307 Based on observation, interview, and review of facility documentation it was determined that the facility failed to 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 03/18/24 from 09:43 AM until 10:33 AM, the surveyor toured the kitchen in the presence of the Dietary Director (DD) and observed the following: 1. On the clean pots and pans drying rack, there were two sets of two 4-inch long pans nested, with clear liquid between the pans. The DD acknowledged that the pans were wet nested and stated that it was important to make sure the pans were dried correctly for bacterial prevention. 2. On the clean pots and pans rack there were: two large red cutting boards with brown smudges and scratches; one white cutting board with brown stains, black smudges, and scratches; one green cutting board with black smudges; two white cutting boards with brown stains and black smudges; and one dark green cutting board with black smudges and scratches. The DD acknowledged the smudges, stains, and scratches and stated that it was important for infection control that the cutting boards were cleaned and sanitized. 3. The DD lifted the lid to the ice machine and on the inside of the ice machine, on the white plastic guard, there was pink and black debris. The surveyor wiped the area with a white paper towel and the pink and black debris was observed on the towel. The DD acknowledged the debris and stated that it should not have been on the ice machine. The DD stated that the ice machine was used for resident hydration and that the staff was responsible for cleaning and sanitizing the machine monthly and that maintenance was responsible for cleaning the machine quarterly. The DD further stated that it was important that the ice machine was cleaned and sanitized for infection control. 4. On a metal table was an uncovered deli slicer. There was white debris on the handle and on the slicer blade, and there was pink debris on the slicer arm. The DD stated that the slicer was cleaned each time it was used and that it was cleaned this morning. The DD acknowledged the debris and stated that it should not have been there. The DD further stated that it was important that the slicer was cleaned correctly for infection control. 5. On the floor of the bottom oven there was black debris, and on the inside of the oven doors there was brown greasy debris. The DD acknowledged that the debris should not have been there and that it was important that the ovens were cleaned for infection control. 6. On the cook area, there was an uncovered box of clear plastic wrap. The DD stated that the wrap was used to cover food and acknowledged that the box should have had a cover. The DD stated that it was important that the plastic wrap was covered so no debris fell on to the wrap. (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 the utensil rack, there was one large box that contained a clear bag of large coffee filters with a stack of filters resting on top of the clear bag. The filters were uncovered and exposed to air. The DD acknowledged the filters were exposed to air and stated that it was important for infection control to keep the coffee filters covered. On 03/27/24 at 12:36 PM, the surveyors met with the administration team and were made aware of the kitchen concerns. A review of the undated facility policy, General Food Preparation and Handling, revealed, Procedure: 1.a. The kitchen and equipment are clean and sanitized as appropriate. 5. Equipment, a. All food service equipment should be cleaned, sanitized, dried, and reassembled after each use. A review of the undated facility policy, Cleaning Instructions: Ice Machine and Equipment, revealed, Policy: The ice machine and equipment (scoops, etc.) will be cleaned on a regular basis to maintain a clean, sanitary condition. Procedure: 2. Wash the interior thoroughly . A review of the undated facility policy, Production, Storage and Dispensing of Ice, revealed, Procedure: 1. The ice dispenser is cleaned and sanitized at least monthly, and/or as needed. Inside and outside of the machine are cleaned. A review of the undated facility policy, Cleaning Instructions: Cutting Boards, revealed, Policy: Cutting boards will be cleaned and sanitized after each use. NJAC 8:39-17.2(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 Based on interview, record review, and review of facility documents, it was determined that the facility failed to maintain medical records that were accurate and consistent for 1 of 32 (Resident # 89) medical records reviewed. This deficient practice was evidenced by the following: According to the Admission Record, Resident #89 was admitted to the facility with diagnoses that included, but were not limited to, end stage renal failure. The admission Minimum Data Set (MDS), an assessment tool that facilitated a resident's care, dated 02/22/2024, reflected that the resident had moderate cognitive impairment and required moderate to dependent assistance with activities of daily living. The MDS also indicated that the resident received hemodialysis (process that filters waste, salts, and fluid from the blood when the kidneys are no longer healthy enough to do this work adequately). On 03/18/24 at 10:34 AM, during tour, Resident #89 was not present in his/her room because he/she was at dialysis. The Certified Nursing Assistant (CNA) indicated that the resident went to dialysis on Monday, Wednesday, Friday, and had an AV fistula (where an artery and vein are connected directly, causing blood to flow between them) in the left upper arm. Review of Resident #89s Care Plan, dated 02/17/24, indicated that the resident was on dialysis and had a limb alert to the left upper extremity (LUE). Review of the Medication Administration Record (MAR), dated 03/03/24 - 03/31/24, reflected a physician's order: Dialysis Limb Alert NO Blood Pressure (BP)/Venipuncture in the LUE. There were nursing signatures on the MAR that indicated that the nurses were documenting that they were not taking the resident's blood pressure in the left arm. On 03/19/24 at 09:25 AM, the surveyor reviewed the vital signs (VS) record and there was documentation that nurses were taking blood pressures in the resident's left arm. The physicians order dated 02/16/2024 indicated that Resident #89 was on left upper extremity limb alert and there were to be no blood pressures (BPs) taken in the left arm nor vena punctures in the left arm. Review of the Electronic Medical Record (EMR) blood pressure exceptions indicated that the facility documented that blood pressures were taken in the resident's left arm on the following dates: -03/01/24 at 10:26 AM. -03/02/24 at 09:54 AM. -03/15/24 at 21:12 (09:12 PM). -03/17/24 at 06:59 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 03/19/24 at 09:45 AM, the surveyor interviewed Resident #89 who showed the surveyor his/her left arm AV fistula site. The surveyor asked the resident if the nurses took the resident's BPs in the left arm and the resident stated, once in a while and then stated, but it's OK. On 03/19/24 at 09:47 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that she had worked in the facility for seven (7) years. The LPN stated that the resident was alert and was able to answer questions. She also explained that the resident required extensive assistance with activities of daily living (ADLs) and was incontinent and wore protective briefs. The LPN stated that the resident had an AV fistula in the left arm. She explained that the nurse was responsible to check for bruit and thrill (an audible vascular sound associated with turbulent blood flow usually heard with the stethoscope) to make sure the AV fistula was functional. She stated that the resident was on left arm precautions and that no blood pressures were to be taken in the left arm. She stated that the resident goes out to dialysis of Monday, Wednesday, and Friday. The surveyor reviewed the VS sheet with the LPN and asked the LPN why she documented on 03/17/2024 at 06:59 AM, that she took the resident's blood pressure in the left arm. The LPN stated that she must have documented in error and that she knew that she should not take the resident's blood pressure in the left arm. She stated that it was an error in documentation. On 03/19/24 at 12:40 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated the nurses should not be documenting that they are taking blood in the resident's left arm because the resident was on left arm precautions related to the residents AV fistula. He stated that it would be important to document accurately and completely in the medical record because it was a legal document. He stated that he could not speak to why the nurses were not documenting correctly in the electronic medical record (EMR) pertaining to what arm they took the residents blood pressure in. He continued to add that the resident had not had any issues associated with his/her AV fistula and was sure that the nurses were just documenting incorrectly. On 03/25/24 at 12:30 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the nurses should have been documenting the correct arm in which they took Resident #89's blood pressure, and it would be especially important since the resident had restrictions ordered not to take the resident's blood pressures in the left arm. The facility policy with a date of 03/2024 and titled, Charting Documentation indicated that the medical record should facilitate communication between the interdisciplinary team regarding the resident condition and response to care. Nursing documentation provides evidence of the care given to our residents. The policy also indicated that documentation in the medical record would be objective, complete, and accurate. NJAC 8:39-35.2 (d)

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	315126	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop McCarthy Center for Rehab & Healthcare	1045 E Chestnut Ave Vineland, NJ 08360

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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 for 1 of 3 units (Third Floor unit) observed. The deficient practice was evidenced as follows: On 03/18/24 the surveyor observed the following in the Dining area: At 11:52 AM, the Certified Nursing Assistant (CNA) approached the lidded trash can with a plastic dome plate cover and trash in her hand then lifted the trash can lid with her hand and discarded the trash into the can. The CNA went to the food cart, removed a meal tray from the cart and placed it in front of Resident #22. The CNA then opened the resident's soda can, removed the lid from the pudding, removed the slice of bread from the plastic packaging and placed it on the plate, opened the juice lid, removed the silverware from the paper bag and placed them on the tray next to the plate, then cut up the food for the resident. The CNA then took the plastic dome plate cover and trash and approached the trash can, lifted the lid with her hand, and discarded the trash. The CNA then went to the food cart, removed a meal tray, and placed it in front of Resident #97. The CNA opened the lid of the pudding, opened the juice, removed the food items off the tray and placed them on the table in front of the resident. The CNA then took the tray and plastic dome plate cover in one hand and trash in the other, placed the tray and plate cover on a metal table and returned to the trash can, lifted the lid with her hand and discarded the trash. The CNA went to the sink in the dining area, turned on the water, attempted to dispense soap but the soap dispenser was empty, attempted to obtain a paper towel but the towel dispenser was empty, turned off the water and went to Resident #113 who was seated at a table with their tray in front of them. The CNA opened the resident's juice, removed the silverware from the paper bag, handed the spoon to the resident, and placed the remaining silverware on the table next to the plate. The CNA removed the trash from the table, approached the trash can, lifted the lid with her hand and discarded the trash. The CNA returned to Resident #97, moved the resident's plate closer to them and repositioned the fork on the plate. No hand hygiene (HH) was observed during the observation. On 03/18/24 at 11:59 AM, the surveyor interviewed the CNA who stated that hand hygiene during tray pass was always completed before and after passing each tray. The surveyor informed the CNA of the meal tray pass observation and that there was no HH observation. The CNA acknowledged she should have performed HH and that it was important to prevent contamination. On 03/18/24 at 12:08 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that the CNAs were responsible for serving the meal trays and that staff should have performed HH when in contact with something dirty, and that hand wipes were used in between residents. The surveyor informed the LPN of the meal tray pass observation and the LPN acknowledged that the CNA did not perform HH correctly. The LPN stated that it was important to perform HH correctly to prevent cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/18/24 at 12:16 PM, the surveyor interviewed the LPN Unit Manager (LPN/UM) who stated that the CNAs were responsible for serving meal trays and that HH was performed once the resident's tray was passed, if the resident wanted items removed from the tray, and when trash was discarded. The surveyor informed the LPN/UM of the meal tray pass observation and the LPN/UM acknowledged that the CNA did not perform HH correctly. She stated that it was important for infection control that HH was done prior to tray pass, in between each resident, and especially when the trash can was touched. On 03/18/24 at 12:26 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the CNA and nursing staff were responsible for serving meal trays and that HH was performed between each resident and any time that they touched anything the resident touched. The surveyor informed the ADON of the meal tray pass observation and the ADON acknowledged that the CNA did not perform HH correctly. She stated that it was important for infection control that HH was performed before the resident's meal or silverware was touched, and after trash was touched. On 03/18/24 at 12:32 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the CNA was responsible for serving meal trays and that HH was performed in between each resident and as needed. The surveyor informed the DON of the meal tray pass observation and the DON acknowledged that the CNA did not perform HH correctly. She stated that it was important for cross contamination prevention that HH was performed between each resident, after food items were opened and any time the trash was touched. A review of the facility policy, Hand Hygiene, revised date 2/2024, revealed, Policy Interpretation and Implementation, 6. Hand hygiene needs to be performed before and after patient contact, for meals and as needed when hands are visibly soiled. A review of the facility policy, Assisting Residents with Meals, revised date 9/2022, revealed, Preparation: 11. Employees must wash their hands before serving food to residents. It is not necessary to wash hands between each resident tray; however, if there is contact with soiled dishes, clothing or the resident's personal effects, the employee must wash his/her hands before serving food to the next resident. A review of facility documentation entitled, Infection Control Inservice 2024, Department: Nursing/CNA revealed the CNA's name, signature and dated 2/28/24. The page CNA's Inservice, revealed, General: 2. The best way to prevent infections is by following the policies and procedures of the facility; performing hand hygiene (Most important) . NJAC 8:39-19.4 (m)(n)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48274 Complaint: NJ171634 Based on observations, interviews, and review of other facility documentation, it was determined the facility failed to maintain medication and treatment carts in a sanitary manner for 2 of 2 medication carts and 2 of 3 treatment carts on the Subacute unit, and 1 of 2 medication carts and 2 of 2 treatment carts on the North Hall unit. This deficient practice was evidence by the following: On 03/20/24 at 10:00 AM, the surveyor observed visible amounts of human hair built up in all 4 wheels of the North Hall Front medication cart. On 03/21/24 at 10:01 AM, the surveyor inspected all medication and treatment carts for the Subacute unit and observed the following: - Visible human hair in 2 of 4 wheels of the Even (side) Subacute medication cart. - Visible human hair in all 4 wheels on the Odd (side) Subacute medication cart. - Visible human hair in all 4 wheels of the Even (side) Subacute treatment cart. - Visible human hair in all 4 wheels of the Odd(side) Subacute treatment cart. On 03/21/24 at 10:06 AM, the surveyor inspected the medication and treatment carts for the North Hall unit and observed the following: - Visible human hair in all 4 wheels of the North Hall Front treatment cart. - Visible human hair in all 4 wheels of the North Hall Back treatment cart. On 03/21/24 at 10:01 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who stated that housekeeping was responsible for cleaning the medication carts and thought they cleaned the carts overnight, but was not sure. On 03/21/24 at 10:06 AM, the surveyor interviewed LPN #2 who stated she and the other nurses cleaned the outside surfaces of the medication and treatment carts before and after their shifts. On 03/21/24 at 10:07 AM, the surveyor interviewed the Registered Nurse (RN) who stated the nurses cleaned the carts before their shift and between every shift. She continued to explain that the nurses cleaned the inside areas of the cart if something spilled, otherwise the nurses kept the inside of the cart clean and organized as they worked. The RN further stated that the cleaning of the carts entailed wiping down all equipment and surfaces including the drawer faces, top, sides, and back of the carts. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/21/24 at 10:16 AM, the surveyor interviewed the Housekeeper for the North Hall and Subacute units who stated that the housekeeping department cleaned the outside of the medication carts. The Housekeeper further stated that cleaning of the medication carts was housekeeping's responsibility and the Porters (supports services in various settings, such as hotels and hospitals have duties that include maintaining cleanliness) cleaned the medication carts at night. The Housekeeper stated that she cleaned the medication carts by cleaning the entire outside of the cart, but did not know who cleaned the wheels on the carts. On 03/21/24 at 10:19 AM, the surveyor interviewed the Unit Secretary for the North Hall unit who stated that the 3:00 PM to 11:00 PM shift had a schedule for cleaning the medication and treatment carts and that housekeeping would inform the nursing staff to remove all items out of the medication cart so it could be cleaned inside and out. On 03/21/24 at 10:23 AM, the surveyor interviewed the Director of Housekeeping and Laundry (DHL) who stated that it was housekeeping's responsibility to clean the medication carts and that nursing performed a daily cleaning of the carts as well. She stated that the [NAME] wiped down the medication carts a few times a week and had a quarterly schedule to do a detailed cleaning inside and outside of the carts. She continued to explain that housekeeping conducted thorough cleaning of two medication and treatment carts per week and had all items removed from the drawers so that the carts could be cleaned. She stated that sometimes housekeeping would take the carts outside and hose them down, but they usually just wipe them down with cleaner. The DHL stated that they had a generic quarterly cleaning schedule, but it was not completed for this year (2024) because she hasn't done it yet. The DHL provided the surveyor with a blank copy of the cleaning schedule. The surveyor asked the DHL if the facility had policy and procedures for medication and treatment cart cleaning and the DHL said yes but was not able to provide a copy to the surveyor. Following the interview, the DHL accompanied the surveyor to the North Hall Front medication cart. In the presence of surveyor, the DHL observed the visible human hair built up in the 4 wheels of the medication cart and confirmed the observation of hair in all 4 wheels. The surveyor asked the DHL why it was important to clean the hair out of the wheels and the DHL replied because of infection control. The DHL later stated they did not have policy and procedure for medication and treatment cart cleaning, so the DON told the Housekeeping Director to write down what she did and that was provided to the surveyor as the Med and Tx Cart Cleaning Policy. On 03/22/24 at 10:00 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the facility did not have a policy and procedure for the Medication and Treatment Cart cleaning, however she instructed the Director of Housekeeping and Laundry to write what she did to clean the carts and label it as a policy. The LNHA signed a copy of this typed housekeeping cleaning procedure and provided this document to the surveyor and stated that this was not an actual policy. The surveyor reviewed the typed document that the DHL provided to the surveyor titled, Med and TX Cart Cleaning Policy which indicated the following: -Wipe outside of the carts 3 times per week. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Deep Cleaning is quarterly or as needed. -If any broken drawers or part observed, notify nurse/supervisor. The facility policy with a revised date of 11/2022 and titled, Cleaning and Disinfection of Care Items and Equipment indicated that resident-care equipment, including reusable items and durable medical equipment will be cleaning and disinfected according to current CDC recommendations for disinfection and OSHA blood born pathogen standard. The surveyor reviewed the policy and there was no documentation regarding cleaning of the medication carts or treatment carts. The facility could not provide any additional information. NJAC 8:39-19.8