STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammonton Center for Rehabilitation and Healthcare	43 N White Horse Pike Hammonton, NJ 08037

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 34423 Based on interview and review of other facility documentation, it was determined that the facility failed to issue the required beneficiary notices for 2 of 3 residents reviewed for Beneficiary Protection Notification (Resident # 140 and Resident # 162. This deficient practice was evidenced by the following: A review of a facility policy on 07/29/2024 at 8:32 AM, titled Notice-Advanced Beneficiary Notice (ABN) with a creation date of 7/2019, revealed under the Policy section; The Advanced Beneficiary Notice of non-coverage (ABN) is issued by the facility to original Medicare (fee for service-FFS) beneficiaries in situations where Medicare payment is expected to be denied. Medicare requires SNF's (Skilled Nursing Facilities) to issue SNFABN to Original Medicare, also called FFS beneficiaries prior to providing care that Medicare usually covers but may not pay for in this instance because the care is: not medically reasonable and necessary or considered custodial. On 07/23/2024 at 01:45 PM, the surveyor requested 3 random residents, 1 resident who went home and 2 residents who remained in the facility beneficiary notification forms from the Assistant Administrator (AA). On 07/24/2024 at 12:29 PM, the surveyor reviewed the SNF Beneficiary Protection Notification Review (SNFBPNR) completed by the facility as follows: 1. A review of the SNFBPNR for Resident #140 indicated that the last covered Medicare Part A Day was 04/12/2024 and the resident remained in the facility. The SNFBPNR further revealed that a Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage Form CMS-10055 was not given to Resident #140. There was no documentation to indicate why the form was not given to Resident #140. 2. A review of the SNFBPNR form for Resident #162 completed by the facility indicated that the last covered Medicare Part A Day was 06/24/2024. The SNFBPNR further revealed that a Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage Form CMS-10055 was not given to Resident #162. There was no documentation to indicate why the form was not given to Resident #162. During an interview with the surveyor on 07/24/2024 at 12:42 PM, the Assistant Administrator said that Director of Rehab and MDS (Minimum Data Set) helped out giving notifications to residents cut from Medicare Part A. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 07/24/2024 at 01:07 PM, the Director of Rehabilitation (DOR) said I give part B cut letter and Social Service is responsible for Part A notifications. In recent months the MDS coordinator has helped out. During an interview with the surveyor on 07/24/2024 at 01:11 PM, the MDS coordinator said I have not been giving them. They took them away from me few years ago. During a follow-up interview with the surveyor on 07/24/2024 at 01:15 PM, the surveyor reviewed that residents who remained in the facility should have received a SNFABN. The AA said I know the form and will follow up. On 07/25/2024 at 09:21 AM, the surveyor confirmed with the AA that 100% the SNFABN was not given to the residents. NJAC 8:39-4.1(a)(7)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 34423 Complaint #: NJ00173786 Based on interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to notify in writing, the representative of the New Jersey Long-Term Care Ombudsman's office (LTCO) of resident emergency transfers to the hospital/discharges, when practicable, as mandated by Federal law. This deficient practice was identified for 2 of 37 sampled residents (Resident #54 and Resident # ADD NUMBER) and was evidenced by the following: On 07/25/2024 at 04:00 PM, a review of a facility policy titled NJ Ombudsman Mandatory Reporting with last revised date of 2/2023 under procedure section Transfer/Discharge, Copies of all facility-initiated (non-resident-driven) discharge notices shall be provided to the LTCO. 1. On 07/22/2024 at 01:29 PM, the surveyor reviewed the Electronic Medical Record (EMR) for Resident # 54 which revealed the following: Resident # 54 was admitted to the facility with diagnoses including but not limited to: Urinary Tract Infection, Urinary Calculus (kidney stones), and Hydronephrosis (excess fluid in the kidney due to a backup of urine). A review of the Discharge Return Anticipated Minimum Data Set (DRAMDS) revealed under the Entry/Discharge reporting section that Resident #54 was discharged with return anticipated on 2/28/2024, 3/27/2024, 4/19/2024 and on 6/20/2024. 2. On 07/24/2024 at 10:20 AM, the surveyor reviewed the EMR for Resident #516 which revealed that the resident was admitted to the facility with diagnosis that included, but not limited to: Osteoarthritis of left shoulder (degenerative joint disease), Diabetes Mellitus, Chronic Obstructive Pulmonary Disorder (long-term lung disease that makes it hard to breathe). A review of the DRAMDS revealed under the Entry/Discharge reporting section that Resident #516 was discharged with return anticipated on 2/1/24. During an interview with the surveyor on 07/24/2024 at 09:26 AM, the Director of Social Work (DSW) said he has been here a few months. When asked if he was responsible to send resident discharges to the hospital to the LTCO the DSW replied since he has been here, he has not sent any notifications to the LTCO of resident discharges to the hospital. He said I wasn't told I had to do that here. I am familiar with the process. During a follow-up interview with the surveyor on 07/24/2024 at 09:28 AM, the DSW said I don't send OMB (ombudsman) notifications. During an interview with the surveyor on 07/24/2024 at 09:31 AM the Assistant Administrator (AA) said the Social Worker (SW) is responsible to send notification to the LTCO office when residents are discharged to the hospital as well as send a monthly list. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/24/2024 at 10:25 AM, the AA told the surveyor he found the binder in the SW office, and it has not been done since the new SW started. On 07/24/2024 at 10:33 AM, a review of the binder provided by the facility contained a form titled Discharge Log by each Month. The form indicated resident name, discharge date , columns for Home, SNF (Skilled Nursing Facility), ALP (Assisted Living), AMA (Against Medical Advice), other as well as Home Care and DME company used. There was no column that indicated a discharge to the hospital. There was no documentation regarding the LTCO being notified of hospitalization s. During a follow-up interview with the surveyor on 07/24/2024 at 11:56 AM, the AA said It doesn't look like they were sending notifications of the discharged residents to the hospital, just AMA and discharged to home. We will now be notifying the LTCO of residents discharged to the hospital. On 07/25/2024 at 04:00 PM, a review of a facility policy titled NJ Ombudsman Mandatory Reporting with last revised date of 2/2023 under procedure section Transfer/Discharge, Copies of all facility-initiated (non-resident-driven) discharge notices shall be provided to the LTCO. NJAC 8:39-4.1(a) 32 45209

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 49094 NJ COMPLAINT #: 169607 Based on interview and review of pertinent facility documents, it was determined that the facility failed to complete a significant change in status assessment using the Resident Assessment Instrument (RAI) process for a resident who elected hospice services. This deficient practice was identified for 1 of 6 residents reviewed for accidents (Resident #565), and was evidenced by the following: A review of facility's Electronic Submission of MDS policy dated revised August 2023, included that all MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge and reentry records will be completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data .a Significant Change in Status (SCSA) Comprehensive has a MDS Completion Date is the 14th calendar day after determination of significant change in status . A review of the facility's Centers Health Care MDS Coordinator Job Description document dated 12/6/22, included . Complies with federal and state regulations regarding completion and coordination of the RAI process. Maintains the frequent and accurate data entry of resident information into appropriate computerized MDS programs. The surveyor reviewed the medical record for Resident #565. A review of the Admission Record Face Sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses including but not limited to; Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), metabolic encephalopathy (problems with your metabolism cause brain dysfunction) and dysphagia (difficulty swallowing). A review of the most recent Minimum Data Set (MDS), an assessment tool dated 12/7/23, revealed the resident had a brief interview for mental status (BIMS) score of 8 out of 15, which indicated moderately impaired cognition. Section I - Active Diagnoses of the MDS revealed Resident #565 had an active diagnosis of Alzheimer's disease. According to section O - Special Treatments, Procedures, and Programs revealed Resident #565 received hospice care (provides physical comfort and emotional, social, and spiritual support for people nearing the end of life) while a resident. A review of the current physician's order sheet (POS) included a physician's order (PO) dated 11/17/23, for hospice evaluation and treat. The POS reflected a physician's order dated 11/18/23, for Hospice Services related to Alzheimer's disease. A review of the Progress Notes dated 11/20/23, included documentation that the resident was admitted to hospice care on 11/18/23, with a diagnosis of Alzheimer's disease. A further review of the MDS assessments revealed Resident #565 had a quarterly MDS completed on 12/7/23. There was no documentation that the facility completed a significant change in status assessment (SCSA) within 14 days after the resident was admitted to hospice care on 11/18/23. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 7/29/24 at 1:40 PM, the MDS Coordinator stated that she was made aware of significant changes with a resident during morning meetings or the unit manager informed her verbally. The MDS Coordinator stated that a significant change in status was completed when there was a decline in the resident's status that was permanent or if a resident was placed on hospice. She also stated it should be completed within 14 days from discovery of the significant change in status. The MDS Coordinator confirmed that Resident #565 was admitted to hospice care on 11/18/23, and that a SCSA MDS was not completed. During an interview on 7/30/34 at 1:38 PM, the Director of Nursing in the presence of the Licensed Nursing Home (LNHA) and the survey team, stated when the resident was placed on hospice care, a SCSA MDS should have been completed within 14 days of the change. The surveyor reviewed the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, updated October 2023, which revealed a SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). NJAC 8:39-11.2(i)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40039 Based on observation, interview, review of the medical record, and review of pertinent facility documents, it was determined that the facility failed to consistently implement and revise a care planned intervention (use of heel booties (prevent pressure ulcers from forming) for 1 of 2 residents (Resident #78) reviewed for position/mobility. This deficient practice was evidenced by the following: The surveyor reviewed the facility policy titled Care Plans - Comprehensive, Last Date Revised: 10/2019. The following was revealed at POLICY: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The following was revealed under PROCEDURE: 8. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. c. Describe services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights to refuse. i. Reflect the resident's expressed wishes regarding care and treatment goals. 13. Assessments of resident's are ongoing and care plans are revised as information about the residents and the residents' conditions change. On 07/22/2024 at 11:05 AM, during the initial tour of the facility the surveyor observed Resident #78 lying in bed. Resident #78 had their lower extremities exposed and the surveyor observed Resident #78 with bilateral lower extremity contractures. The lower left extremity was contracted against the right lower extremity, and they were in contact. The surveyor asked Resident #78 if the facility provided any intervention to help with his/her lower extremity contractures. Resident #78 stated, Sometimes they give me a pillow to put between my legs but not all the time. There was no pillow between the resident legs on this observation and Resident #78 had bare feet. On 07/23/2024 at 12:53 PM Resident #78 was observed lying in bed. Resident #78 gave the surveyor permission to lift the bed sheet to observe the resident's feet. Upon permission, the surveyor lifted the sheet and observed Resident #78's bilateral feet/lower extremities. There were no heel protectors in place to the feet, as described in the care plan. No heel protectors were observed in the room. On 07/24/2024 at 12:00 PM Resident #78 was observed seated in a Geri-chair in his/her room. Resident #78's feet were observed to have anti-skid socks on bilaterally while in the Geri-chair. No heel protectors were present on this observation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/2024 at 09:15 AM Resident #78 was observed lying in bed. Resident #78 permitted surveyor permission to observe resident's feet under the bed covers. Upon lifting the top sheet, the surveyor observed Resident #78's bilateral feet covered with blue non-skid socks. There were no heel protectors present, as indicated on Resident #78's care plan. No heel protectors were visible in the room. On 07/30/2024 at 09:01 AM Resident #78 was observed lying in bed and watching television. Resident #78 allowed the surveyor permission to observe their feet under the bed sheet. Upon lifting the sheet, the surveyor observed Resident #78's feet had no heel protectors in place and were bare. According to the Transfer/Discharge Report, Resident #78 was admitted to the facility with the following but not limited to diagnoses: Chronic pain syndrome, multiple sclerosis, difficulty in walking, and muscle weakness. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 6/24/2024, Resident #78 had a Brief Interview for Mental Status score of 12/15, which indicated moderately impaired cognition. Section E revealed that Resident #78 did not reject care. Section GG revealed that Resident #78 had functional limitation in range of motion on both sides of the lower extremity. Resident #78 also was dependent on staff for toileting, hygiene, to shower/bathe self, lower body dressing, and putting on/taking off footwear. Section GG further indicated Resident #78 required partial/moderate assist to eat, oral hygiene, and personal hygiene. Section M indicated that Resident #78 was at risk for developing pressure ulcers but had no pressure ulcers at time of assessment. Section O revealed that Resident #78 was not currently receiving occupational or physical therapy. A review of the 7/1/2024-7/31/2024 Treatment Administration Record for Resident #78 did not include any reference to heel booties. A review of the individualized comprehensive care plan for Resident #78 reviewed a care plan Focus of: Resident is at risk for impaired skin integrity r/t (related to) decreased ROM (range of motion) of the legs Date Initiated: 07/25/2018. The following was care planned as an intervention for the risk of skin integrity r/t decreased ROM of legs: Heel protectors to be worn when in bed/remove for hygiene and skin checks. Date Initiated: 07/25/2018. On 07/30/2024 at 09:07 AM, the surveyor conducted an interview with the Certified Nursing Assistant (CNA #1) assigned to Resident #78 on that shift. The surveyor asked CNA #1 if f she provided Resident #78 with any special interventions, specifically heel protectors when caring for the resident. CNA #1 replied, I'm not sure if the resident is to have heel protectors or not, I'm agency. You should ask the nurse because they are more familiar with the resident. The surveyor then proceeded to interview the nurse assigned to Resident #78 on that shift. On 07/30/2024 at 09:09 AM, Registered Nurse (RN #1) stated that he regularly provided care to Resident #78. The surveyor asked RN #1 if any interventions were in place for heel protection. RN #1 said, Did he/she have a pillow under their feet? The surveyor stated that resident #78 did not have a pillow under their feet on surveyor observations. RN #1 then stated, Let me check [name of electronic medical record] and see if there is an order. RN #1 told the surveyor he did not see an order for heel protectors. He further stated, If he/she already has an air mattress they might not need them, but it would be helpful. Let me check and see if there is an air mattress. After going into Resident #78's room RN #1 told the surveyor, No, he/she does not have an air mattress. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/30/2024 at 10:45 AM, the surveyor asked Registered Nurse/Unit Manager (RN/UM #1) to assess Resident #78 to see if heel protectors were in place. When the surveyor and RN/UM #1 went to Resident #78's room and observed his/her feet after gaining permission Resident #78 was observed to have a pillow under his legs on this observation. The surveyor asked the RN/UM #1 to locate the heel protectors. RN/UM #1 was able to find one heel protector in the bottom of Resident #78's closet/cabinet next to the head of the bed. RN/UM #1 could not locate a second heel protector. RN/UM #1 then told the surveyor, It's not an order it's a comfort thing. They need to be discontinued because the resident does not want to wear them. Resident #78 verbalized that he/she would prefer a pillow and did not want the heel booties. At that time Resident #78 told the surveyor that the last time he/she wore the heel protectors was approximately 3 years ago and said, I just want to wear the socks. On 07/30/2024 at 02:02 PM, the surveyors interviewed the facility Director of Nursing (DON). The surveyor asked the DON when are care plans updated for residents. The DON responded, Care plans are reviewed quarterly, when a significant event occurs, annually, and as needed. On 07/31/2024 at 12:34 PM, the facility Assistant Director of Nursing told the survey team that when care plans are updated all disciplines are involved in care plan development and the unit manager is ultimately responsible for resident care plans. The facility DON had provided the surveyor with a schedule of care plan updates for Resident #78 dating back to 8/10/2018. The review history provided revealed that Resident #78 last had their care plan updated on 06/27/2024. The surveyor reviewed the facility policy titled Care Plans - Comprehensive, Last Date Revised: 10/2019. The following was revealed at POLICY: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. NJAC 8:39-11.2(3)(h)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49094 Complaint #: NJ00172065 and NJ00169138 Based on interview and review of pertinent facility documents, it was determined that the facility failed to revise comprehensive care plans in a timely manner following an allegation of abuse. This deficient practice was identified for 2 of 36 residents (Resident #515 and #265) reviewed for care plans. A review of the facility's Care Plan policy, last revised 10/2019, included .13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. A review of the facility's undated Job Description Licensed Practical Nurse document included .Participate in the development of a plan of care for each resident. A review of the facility's undated Job Description Registered Nurse document included .Reviews and regularly evaluates resident care plans to meet nursing goals. A review of the facility's undated Job Description Unit Manager document included .Responsible for the evaluation and monitoring of all levels of resident care through on-site observations and audits, including the monitoring and the evaluation of Care Plans for quality, appropriateness and effectiveness of their unit. A review of the facility's undated Job Description Assistant Director of Nursing document included .Ensure resident assessments, care plan development and updates are completed within the required time frames on admission, quarterly, and with change in condition. This deficient practice was evidenced by the following: 1. The surveyor reviewed the medical record for Resident #265. A review of the Admission Record Face sheet (an admission summary) reflected that Resident #265 was admitted to the facility with diagnosis that included, but not limited to chronic obstructive pulmonary disease (long-term lung disease that makes it hard to breathe), type 2 diabetes mellitus (pancreas doesn't make enough insulin), and legal blindness (vision is 20/200 or less in your better eye). A review of the Facility Reportable Event (FRE) dated 10/29/23, included Resident #265 was involved in a employee to resident abuse allegation. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 6/26/23, that [Resident #265] is at risk for misappropriation, neglect, abuse and/or exploitation [related to] reported missing funds. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ICCP did not include an update that the resident had an allegation of physical and what interventions were put into place after the incident. There was no evidence of an updated focus area and interventions related to the staff-to-resident abuse allegation after the incident. 45209 2. The surveyor reviewed the medical record for Resident #515. A review of the Admission Record face sheet (an admission summary) reflected that Resident #515 was admitted to the facility with diagnosis that included, but not limited to; Chronic Obstructive Pulmonary Disorder (long-term lung disease that makes it hard to breathe), Diabetes Mellitus, and Hypothyroidism (underactive thyroid). A review of the Facility Reportable Event (FRE) dated 3/12/24, included Resident #515 was involved in a staff-to-resident abuse allegation A review of the individualized comprehensive care plan (ICCP) included a focus area dated 11/22/19, that [Resident #515] was at risk for misappropriation, neglect, abuse and /or exploitation [related to] congregated living. The ICCP did not include an update that the resident had an allegation of staff-to-resident abuse with any interventions put into place after the incident. During an interview with the surveyor on 7/29/24 at 10:42 AM, the Licensed Practical Nurse (LPN #6) stated that the ICCP should have included any allegation of abuse because it summed up how to directly care for the resident from psychosocial to the medical need. LPN #6 further indicated that the ICCP should have been updated by the unit manager with any change to the resident needs. During an interview with the surveyor on 7/29/24 at 11:01 AM, the Registered Nurse/Unit Manager (RN/UM) confirmed that unit managers, or Supervisors resumed the responsibility for updating the ICCP. The RN/UM described an ICCP was a way to track interventions to determine what made an impact on the resident's care. The RN/UM further explained that the ICCP was updated based on clinical meetings, chart reviews, and nurse input. The RN/UM confirmed that abuse allegations were to be included on the resident's ICCP. During an interview with the surveyor on 7/30/24 at 11:18 AM, the Director of Nursing (DON) identified that a ICCP should be updated with interventions following any allegation of abuse regardless if the abuse was substantiated or unsubstantiated. The DON explained that the ICCP was important to update because it was to display what did and did not work with the resident, and what should be implemented to prevent another allegation of abuse. During an interview with the surveyor on 7/31/24 at 11:18 AM, the Assistant Director of Nursing (ADON), in the presence of the Licensed Nursing Home Administrator, DON, Senior Resource Director, Assistant Administrator, confirmed that the ICCP was updated with any/all allegations (substantiated or unsubstantiated) of abuse with interventions. NJAC 8:39-27.1(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. 39460 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to follow hold parameters for administration of insulin (a diabetic medication) in accordance with the resident's physician's orders and in accordance with professional standards of practice. This deficient practice was identified for 1 of 36 residents reviewed for professional standards of practice (Resident #39). A review of the facility's Medication Administration policy dated revised 12/2023, included medications must be administered in accordance with orders, including any required time frame . 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. The evidence was as follows: On 7/22/2024 at 12:32 PM, the surveyor observed Resident #39 seated at a dining room table with another resident drinking a diet ginger ale. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included paranoid schizophrenia, major depressive disorder, and diabetes. A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated 5/20/24, reflected the resident had a brief interview for mental status score of 15 out of 15, which indicated a fully intact cognition. A review of the Order Summary Report, included the following medication: Novolog solution 100 unit/milliliter (ml) (insulin aspart) inject 13 units subcutaneously before meals for DM (diabetes mellitus) HOLD for BS (blood sugar) < 100 [milligrams/ deciliter (mg/dl)] Doses were scheduled at 8:00 AM, 12:00 PM, and 5:30 PM A review of the July 2024 Medication Administration Record (MAR) revealed on five occasions the resident had BS >100 and the nurse documented 12 which according to the key indicated no insulin required. The dates were as follows: 7/6/24 8:00 AM, BS 129 7/11/24 8:00 AM, BS 123 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/11/24 12:00 PM, BS 124 7/11/24 5:30 PM, BS 124 7/24/24 12:00 PM, BS 121 During an interview with the surveyor on 7/30/24 at 11:45 AM, the assigned Licensed Practical Nurse (LPN #1) for Resident # 39 who stated a 12 on the MAR indicated no insulin required. At that time the surveyor and LPN #1 reviewed the July MAR. LPN #1 acknowledged the nurse recorded the resident's BS >100 on the above referenced dates and times and confirmed the nurse should have administered the Novolog according to the physician's orders. During an ointerview with the surveyor on 7/30/2024 at 11:58 AM, the Licensed Practical Nurse Unit Manager (LPN/UM #1) who confirmed after reviewing the July 2024 MAR that on the above referenced dates the BS was documented as >100 and the nurse should have administered the Novolog as ordered according to the physician's orders. On 7/30/2024 the Survey team met with the facility Administration. The surveyor and the Director of Nursing (DON) reviewed Resident #39's July MAR. The DON confirmed the nurse indicated on the above referenced dates and times the resident's BS >100, and the nurse should have administered the resident's Novolog in accordance with the physician's orders. NJAC 8:39-11.2(b); 27.1(a)

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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. 38080 NJ Complaint #:163266 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure a resident who smoked cigarettes was assessed for safety; educated on facility rules and safety for smoking; and care planned for smoking to ensure resident safety. The deficient practice was identified for 1 of 7 residents reviewed for accidents (Resident #266), and was evidenced by the following: A review of the facility's Smoking Program dated revised October 2022, included a Smoking Assessment will be completed by the nurse for all new admissions who are identified as patients who smoke. If a resident previously identified as a nonsmoker expresses the desire to begin smoking, the Smoking Assessment will be completed at that time .An individualized plan of care will be developed for the resident to ensure his/her smoking safety based on the outcome of the Smoking Assessment . On 7/25/24 at 8:45 AM, the surveyor requested from the Assistant Administrator (AA) to provide a copy of Resident #266's Facility Report Event (FRE) that was reported to the New Jersey Department of Health (NJDOH). On 7/25/24 at 11:18 AM, the surveyor reviewed the closed medical Record for Resident #266. A review of the FRE dated 4/9/23, which indicated Resident #266 reported that they provided $40 to the Smoking Aide (SA) to purchase cigarettes. The investigation concluded that the SA used their own money to purchase cigarettes for Resident #266, and that the resident had cigarettes. Resident #266 stated that they had not seen the SA in a while and hoped that the Licensed Nursing Home Administrator (LNHA) would provide the resident with money. A review of the Transfer/Discharge Report face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included but not limited to; chronic atrial fibrillation (abnormal heart rhythm); difficulty walking; and major depressive disorder. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 3/31/23, indicated the resident had a brief interview for mental status (BIMS) score of 15 out of 15, which indicated a fully intact cognition. A further review in Section J Health Conditions reflected the resident did not use tobacco. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 5/17/23, that the resident was a smoker. Interventions included to educate on benefits of smoking cessation program; educate resident on smoking rules/policy, designated smoking areas, and that they will be regularly assessed for safety; and have all smoking material individually labeled and kept in secure location. The ICCP was initiated over thirty days after the resident reported the SA was purchasing them cigarettes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Admission/Readmission Evaluation dated 3/25/23, did not include the resident was a smoker. A review of the Quarterly Evaluation dated 6/19/23, indicated the resident was a smoker and could smoke safely. A review of the resident's Smoking Rules and Safety Agreement was signed by Resident #266 on 5/18/23, which was over thirty days after they reported the SA was purchasing the cigarettes. During an interview with the surveyor on 7/30/24 at 10:34 AM, the Activities Director (AD) stated that residents were assessed upon admission and quarterly for smoking which included safety; if they were able to hold their own cigarettes. The AD continued that the ICCP was initiated for smoking including interventions for safety, and residents were not permitted to hold their own lighters. The AD stated that Resident #266 was a smoker, and could not speak to why there was no smoking assessment until 5/18/24. During an interview with the surveyor on 7/30/24 at 11:18 AM, the Director of Nursing (DON) stated that smoking assessments were completed upon admission and quarterly. The DON stated that smoking was self reported by the resident, and Resident #266 denied they were a smoker. The DON stated when the facility observed the resident ask another resident for a cigarette, the facility initiated the smoking contract. During an interview with the surveyor on 7/31/24 at 9:16 AM, the Licensed Nursing Home Administrator (LNHA) stated that Resident #266 initially denied smoking cigarettes so that was why the smoking assessment and ICCP were not initiated until 5/18/23. At that time, the surveyor reviewed the FRE dated 4/9/23, with the LNHA that indicated Resident #266 had cigarettes at that time. The surveyor asked the LNHA that if the facility was aware on 4/9/23, that the resident had cigarettes, should the facility have completed a smoking contract, assessment, and ICCP at that time, and the LNHA confirmed yes. During an interview the surveyor on 7/31/24 at 12:30 PM, the LNHA confirmed that Resident #266 was not found smoking in areas that were prohibited. NJAC 8:39-27.1(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 34423 Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to follow physician orders specifically to change the piston syringe (a device intended for medical purposes that consists of a calibrated hollow barrel and a movable plunger) every 24 hours for 1 of 2 residents reviewed for Tube Feeding, (Resident #37.). This deficient practice was evidenced by the following: A review of facility policy on 07/24/2024 at 12:08 PM, titled Enteral Feedings with last revised date of 4/2023, did not include documentation of the care and changing of the piston syringe kit. On 07/31/2024 at 10:26 AM, the DON provided the surveyor the same policy titled Enteral Feedings. The following was highlighted under the Procedure section: 4. Ensure that equipment and devices are working properly by performing any calibrations or checks as instructed by manufacturer. 12. Administration and feeding sets. a. Feeding may be reused for next scheduled feed as long as it is free from contamination, however; b. Replace tubing and feeding sets every 24 hours or if contamination has occurred before that time c. store in designated, clean location until next use. During the initial tour of the unit on 07/22/2024 at 11:06 AM, the surveyor observed the piston syringe kit in a clear plastic bag hanging from the Intravenous (IV) Pole that was dated 7/19/24. On 07/23/2024 at 11:58 AM, the surveyor observed the piston syringe kit in a plastic bag hanging on the IV pole and it was dated 7/19/24. A review of the Electronic Medical Record on 07/23/2024 at 11:15 AM, revealed the following: Resident #37 was admitted with diagnoses including but not limited to; UNSPECIFIED SEVERE PROTEIN-CALORIE MALNUTRITION, Adult Failure to Thrive, and Gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food.) A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 6/21/2024, revealed Resident #37 had severe cognitive impairment. The MDS further indicated that Resident #37 had a feeding tube, and 51% or more calories were received through tube feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Order Summary Report with Active Orders as of 07/24/2024 revealed a physician order to Change Enteral feeding administration setup (tubing, Piston Syringe, Graduated cylinder) every 24 hours every night shift for tube feeding care AND as needed when compromised. A review of the Treatment Administration Record TAR) for July 2024 had signatures in the box for the order and was timed at 11pm for 7/20, 7/21, and 7/22/2024. On 07/23/2024 at 11:59 AM, the surveyor accompanied by Licensed Practical Nurse/Unit Manager (LPN/UM #1) went to Resident #37's room. LPN/UM #1 confirmed the date of 7/19 on the bag and 7/19/24 on the piston/syringe bottle. During an interview with the surveyor at that time, LPN/UM #1 said it should be changed daily. When asked should this have been changed, she replied yes should have been changed on the 20th, 21st, 22nd. LPN/UM #1 discarded the set dated 7/19. During a follow up interview with the surveyor on 07/24/2024 at 10:02 AM, LPN/UM #1 was asked to review the TAR for July 2024. LPN/UM #1 confirmed the piston syringe kit was dated 7/19 and should have been changed on 7/20, 7/21 and 7/22. LPN/UM #1 said Yes there are initials there (in the blocks of the TAR) and that is the user. LPN/UM #1 explained that means they signed it out on the TAR as completed. LPN/UM #1 confirmed it (piston syringe kit) wasn't changed according to what we saw yesterday. During an interview with the surveyor on 07/29/2024 at 08:52 AM, the surveyor questioned as to what the facility practice was regarding use of piston syringe kits for tube feeding residents? The Director of Nursing (DON) replied, We change it every 24 -48 hours and label it with pt (patient) room number/or name and date. If there is a physician order to change the piston syringe kit, then we will go by the physician order, and it will be documented on the TAR. The surveyor asked why it was important to change them (piston/syringe kits) every day? The DON said it is part of infection control to prevent infection and clogging of the tube. NJAC 8:39-27.1(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40039 Based on observation, interview, review of the medical record, and review of other pertinent facility records, it was determined that the facility failed to implement infection control measures for the handling and storage of respiratory equipment for 2 of 4 residents reviewed for respiratory care (Resident #22 and Resident #63). This deficient practice was identified by the following: The surveyor reviewed the facility policy titled Nebulizer Medication/COVID 19, Last Revised Date: 1/2023. The following was revealed under the heading POLICY: Nebulization is used to deliver medications along the respiratory tract and is indicated for various respiratory problems and diseases. The therapy must be prescribed by a properly licensed physician or physician extender. The purpose of the procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Nebulizer treatments will be given by licensed nursing staff or respiratory therapists as directed, using proper technique and universal precautions. The following was revealed under the heading PROCEDURE: 21. Rinse and disinfect the nebulizer equipment a. Wash pieces with warm soapy water b. Allow to air dry on a paper towel 23. When equipment is completely dry, store in a plastic bag with resident's name and date on it. 1. On 07/22/2024 at 10:36 AM, during the initial tour of the facility the surveyor observed Resident #22 lying in bed and asleep. The surveyor observed the nebulizer mask placed on the top of the over bed table. The nebulizer mask was undated, uncovered, and exposed while not in use. On 07/24/2024 at 12:12 PM, Resident #22 was observed lying in bed with O2 (oxygen) via N/C. The nebulizer mask was observed on the over the bed table. The nebulizer mask was not currently in use and the mask was resting on top of the bed side table. The mask was uncovered and exposed. The nebulizer and tubing had no dates on observation. Resident #22 said Yes when the surveyor asked if he/she had a nebulizer treatment today. Review of Resident #22's 7/1/2024-7/31/2024 Medication Administration Record (MAR) revealed that Resident #22 received a nebulizer treatment at 0900 (9:00 AM) on 7/24/2024 and the next scheduled nebulizer treatment was 1300 (1:00 PM). On 07/30/2024 at 08:55 AM Resident #22 was observed lying in bed with O2 at 3L/min via n/c. The nebulizer mask was observed on the over the bed table next to bed, as seen previously. A plastic T -s shaped inhaler was on top of the table. The T-shaped inhaler was not covered and was exposed while not in use. The nebulizer tubing was undated. Review of Resident #22's MAR revealed Resident #22 received a nebulizer treatment at 2100 (9:00 PM) on 7/29/2024 and received a nebulizer treatment at 0900 on 7/30/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility provided Transfer/Discharge Report Resident #22 was admitted to the facility with the following but not limited to diagnoses: Chronic obstructive pulmonary disease (COPD) (a type of progressive lung disease characterized by long term respiratory symptoms and air flow limitation), acute respiratory failure with hypoxia (a condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level). A review of the Minimum Data Set (MDS), an assessment tool, dated 6/21/2024, revealed Resident #22 had a Brief Interview for Mental Status score of 8/15 which indicated moderate cognitive impairment. Section O of the MDS revealed that Resident #22 received oxygen therapy while a resident at the facility. A review of the Order Summary Report, dated 7/30/2024 revealed the following physician orders for Resident #22: PRN (as necessary) Supplemental Oxygen via Nasal Cannula (NC) at 2L/Min (liters per minute) to maintain Oxygen SATS (saturation) greater than 90% (Hx of COPD 88%) very shift Check O2 sat every shift Start Date: 04/08/2024 Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML (milligrams/milliliter) 3ml inhale orally four times a day for COPD Start Date: 04/06/2024 A review of Resident #22's MAR (Medication Administration Record) revealed that Resident #22 had received a nebulizer treatment at 0900 on 7/25/2024 and the next treatment was scheduled for 1300. A review of Resident #22's individualized comprehensive care plan revealed a Focus of Resident has an alteration in respiratory system r/t (related to) COPD, acute/chronic respiratory failure Date Initiated: 04/06/2020. The following intervention was included in the care plan under Interventions/Tasks: Administer treatments (nebulizer) (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs. Commonly used for the treatment of asthma, cystic fibrosis, COPD, and other respiratory diseases) & medications per MD orders. Date Initiated: 04/06/2020. On 07/25/2024 at 09:50 AM, Resident #22 was observed on the 1D hallway speaking with the nurse at the medication cart between room [ROOM NUMBER] and 104. Resident #22 had portable O2 on via nasal cannula. After gaining permission to enter room [ROOM NUMBER]-B from Resident #22's roommate, the surveyor observed Resident #22's nebulizer mask on top of the over the bed table. The nebulizer mask was not in use and was observed to be lying on top of a sheet of paper that appeared to be a word search puzzle. The mask was not covered and was exposed while not in use. The nurse asked the resident if he/she had a nebulizer treatment this AM and the resident stated, Yes. The surveyor then interviewed the Licensed Practical Nurse (LPN #2) previously observed speaking with Resident #22. The surveyor asked what the facility practice was for nebulizer mask maintenance between treatments. LPN #2 stated, Nebulizer masks should be covered when not in use because of germs LPN #3 further stated that both nursing and Certified Nursing Aide (CNA) staff were responsible for maintaining the protection of oxygen equipment when not in use, specifically keeping the nebulizer mask covered when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 07/22/2024 at 11:20 AM, the surveyor observed Resident #63 in their room during the initial tour of the facility. Resident #63 was awake and alert. The surveyor observed a nebulizer machine and mask on top of bedside table. The nebulizer tubing was dated 7/18/24. The nebulizer mask was lying on top of the bedside table and was exposed while not in use. Resident #63 stated that he/she had received nebulizer treatments twice a day when asked by the surveyor. On 07/23/2024 at 08:50 AM the surveyor observed that Resident #63 was out of the room at this time. The surveyor observed a nebulizer mask on top of the bedside table. The mask was resting on top of a plastic bag and was not in use. The nebulizer mask was exposed while not in use. On 07/24/2024 at 12:28 PM Resident #63 was observed lying in bed. Resident #63 stated that they are to discharge home tomorrow. The surveyor observed a nebulizer mask on the bedside table as seen on previous observations. The nebulizer mask was not in use and was not bagged and was exposed while not in use. A review of Resident #63's Transfer/Discharge Report revealed that Resident #63 was admitted to the facility with the following but limited diagnoses: Chronic obstructive pulmonary disease. A review of Resident #63's comprehensive MDS, dated [DATE], revealed that Resident #63 had a BIMS score of 15/15, indicating intact cognition. Review of section J indicated Resident #63 had shortness of breath with exertion and while lying flat. Section O indicated Resident #63 was receiving oxygen therapy while a resident in the facility. A review of Resident #63's Order Recap Report with Order Date: 07/01/2024-07/31/2024 indicated Resident #63 had the following physician orders: Change and date nebulizer kit and storage bag once weekly on Sunday every night shift every Sun for neb (nebulizer) maintenance. Order Date: 6/13/2024 Rinse and disinfect nebulizer equipment after each use Wash pieces with warm soapy water. Allow to air dry on a paper towel. Store only when completely dry every shift for neb maintenance Order Date: 06/13/2024 Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 1 vial inhale orally four times a day for COPD via nebulizer Order Date: 06/12/2024 A review of the 07/01/2024-07/31/2024 MAR revealed that Resident #63 received a nebulizer treatment on 7/22/2024 at 10:00 AM. A review of Resident #63's individualized comprehensive care plan revealed a care plan Focus of Resident has an alteration in respiratory system r/t COPD with orthopnea (shortness of breath while laying flat) Date Initiated: 06/12/2024 The following was a care planned Intervention: Administer treatments (nebulizer) & medications per MD orders. Date Initiated: 06/12/2024 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/2024 at 09:40 AM, the surveyor observed a nebulizer mask placed on top of bedside table in Resident #63's room. The nebulizer was not in use and was not covered. The mask was exposed on the bedside table. The surveyor then conducted an interview with the nurse assigned to Resident #63 on that shift. The surveyor asked LPN #3 while in Resident #63's room if the nebulizer mask should be protected when not in use. LPN #3 stated, Well, it's not being used right now but it should be covered when it's not being used. The surveyor asked LPN #3 why the nebulizer mask should be covered when not in use. It's an infection control issue. The surveyor then asked LPN #3 who was responsible for making sure the oxygen equipment is stored properly when not in use? LPN #3 responded, It could be anybody but usually the CNA's or nurses who are responsible for maintaining the oxygen equipment. On 07/30/2024 at 01:34 PM, the surveyor conducted an interview with facility administration, which included the Licensed Nursing Home Administrator, Assistant Administrator, Director of Nursing (DON), and Senior Resource Director. The surveyor asked what the facility expectation was for nebulizer masks when they are not in use by a resident receiving treatment. The DON told the surveyor, The expectation is that the machine is cleaned, and the tubing and mask are to be cleaned, air dried, and bagged between use once dried. It is important to bag between uses for sanitation and infection control. N.J.A.C. 8:39- 27.1 (a)

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	315209	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammonton Center for Rehabilitation and Healthcare	43 N White Horse Pike Hammonton, NJ 08037

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39460 Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to ensure an accurate ordering and receiving of narcotic medications on the required Federal narcotic acquisition forms (DEA 222 forms) were completed with sufficient detail to enable accurate reconciliation for 3 of 3 forms provided. The evidence was as follows: A review of the facility's provided Medication- Narcotic Management policy with a revised date of 4/2023 did not include information related to the completion of the DEA 222 forms. On 7/30/2024 at 10:15 AM, the surveyor reviewed the facility provided DEA 222 forms which revealed on three of the three provided forms Part 5, had not been completed upon receipt of the medications from the provider pharmacy as instructed on the reverse of the ordering form. The forms were as follows: Order form number: 221690894; 221690895; and 221690896. On 7/30/2024 at 1:39 PM, the surveyor and Director of Nursing (DON) reviewed the provided DEA 222 forms. The DON acknowledged she should have completed the Part 5 as instructed on the reverse of the DEA 222 form as required. A review of the Instructions for DEA Form 222, under Part 5. Controlled Substance Receipt, 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item . NJAC 8:39-29.7(c)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 40039 Based on observation, interview, and review of other facilioirty documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: A review of the facility policy titled Food Storage, Last Date Revised [DATE], revealed the following under the heading POLICY: Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry, and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. The following was revealed under the PROCEDURE section: 10. Food will be stored a minimum of 6 inches above the floor, 18 inches from the ceiling and 2 inches from the wall on clean racks or other clean surfaces, and is protected from splashes, overhead pipes, or other contamination (ceiling sprinklers, sewer/waste disposal pipes, vents, etc.). 12. Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within ,d+[DATE] hrs (hours). Check state regulations as state regulations may allow shorter time frames for use of leftovers. 13. Refrigerated food storage: a. All refrigerator units will be clean and in good working condition at all times. b. TCS (temperature control for safety) foods must be maintained at or below 41 degrees F unless otherwise specified by law. Periodically take temperatures of refrigerated foods to assure temperatures are maintained at or below 41 F. Temperatures for refrigerators should be between 35 to 39 F. Thermometers should be checked at least two times each day. c. Every refrigerator must be equipped with an internal thermometer. f. All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded. 14. Frozen Foods: c. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. All frozen leftovers must be used within 30 days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor reviewed the facility provided copy of the Daily Cleaning Schedule for the facility kitchen, undated. Review of the schedule did not include cleaning of the reach-in refrigerator daily. The surveyor reviewed the facility policy titled Dish Washing and Storage Policy, Last Date Revised: [DATE]. The following was revealed under POLICY: Dishes, pot and pans will be washed and dried using procedures, chemicals and equipment that result in clean, sanitized dishes, pans, flatware, and utensils. The policy revealed the following under the heading PROCEDURE: Dish Machine Washing: 3. Dish machine temperatures are logged at each meal on the Dish Machine Temperature log. 4. Staff will monitor dish machine temperatures throughout the dishwashing process b. Low Temperature Dishwasher: Spray Type Dish Machine Using Chemicals to Sanitize Minimum Wash Temperature: 120 F Final Rinse Temperature 120 F and sanitization 50 ppm Hypochlorite (chlorine). Dishes, pots, pans, utensils and flatware must be air dried before being stored, Do not dry with towels. 7/ Employees are trained in proper dishwashing and drying procedures. Staff will be trained to report any problem with the dish machine to the director of food and nutrition services as soon as they occur. The surveyor reviewed the facility policy titled FOOD FROM OUTSIDE-SAFETY, Last Date Revised: , d+[DATE]. The following was revealed under the Monitor section: Facility staff will be appointed to check resident refrigerators for proper temperatures, food containment and quality, and disposal of items per facility policy. On [DATE] from 9:17 to 9:50 AM, the surveyor in the presence of the facility Registered Dietitian/Nutritionist (RDN), observed the following in the kitchen: 1. On an upper shelf/rack in the walk-in freezer a package of frozen sausage was removed from its original container and had no dates. In addition, a clear garbage size bag contained what appeared to be frozen zucchini slices. The bag had no dates. 2. In the walk-in refrigerator a previously opened clear plastic bag on a middle shelf contained chopped lettuce. The bag had a manufacturer's best if used by date of [DATE]. On the same shelf, a clear plastic bag contained chopped lettuce and carrots. The lettuce appeared slimy, and the bag had a manufacturer's best if used by date of [DATE]. On an upper shelf a 10 pound container of [NAME] slaw had been previously opened. The [NAME] slaw had a manufacturer's Best If Used By date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. At approximately 10:00 AM, kitchen staff were actively using the low temperature dish machine after the breakfast meal. When asked to see the dish machine temperature log the FSD stated, It's hanging on the wall. (opposite wall of dish machine). Observation of the temperature log revealed that no wash/rinse or sanitizer ppm levels (parts per million) had been recorded for the breakfast on [DATE]. The kitchen had a low temperature dish machine, according to the FSD and it had a minimum wash and final rinse temperature of 120 Fahrenheit (F). The FSD told the surveyor that they used chlorine as the sanitizing agent. At that time the facility had cleaned several racks of pellet bottoms and lids and several racks of hard plastic trays used to serve resident food. Upon observation of the sanitizer container mounted on the wall (a sanitizing agent that utilizes sodium hypochlorite to sanitize dishware) the FSD stated that it was empty. The FSD then went to the DA at the three compartment sink and asked for another bottle of sanitizer. The DA handed the FSD an approximate half bottle of sanitizer from the designated chemical closet and stated that he had more down stairs. After replacing the empty bottle of sanitizer, the FSD restarted the dish machine, and a DA assisted the surveyor in putting an empty plastic pellet lid in the plastic dish rack and the FSD then proceeded to run the rack through the wash and rinse cycle which was observed at 120 F. The rack that contained the pellet lid exited the dish machine after going through a full wash and rinse cycle. The FSD obtained a white chlorine test strip and dipped the test strip into the dishwater that had collected in the pellet lid from the wash and rinse cycle. The test strip remained white after dipping it into the collected dish machine water, indicating that no chlorine was present or 0 ppm. The surveyor then requested the FSD to attempt a second test of the sanitizer by passing the pellet lid in the dish rack through the machine a second time. The FSD dumped the previous dish water from the pellet lid. Upon placing the rack in the machine, the surveyor and FSD observed that the pump for the chlorine sanitizer was not pulling the sanitizer completely through the wall mounted pump and the chlorine sanitizer remained in the pump tubing, which was visible through the clear tubing and was unable to enter the dishwater to sanitize dishes. The FSD shut down the dishwasher at this point and told the surveyor they would contact the foodservice contract company to do necessary repairs. The surveyor told the FSD that all trays and pellet lids that had been washed would have to be rewashed and sanitized. The FSD agreed. The surveyor re-visited the kitchen at approximately 11:30 AM and the repair service had not arrived at that time. The surveyor observed the kitchen dish room, and all dish washing could be confirmed as stopped when the FSD shut down the dish machine. The FSD stated that paper products will be used for the lunch meal and until the machine is repaired. A review of the service invoice dated [DATE]T16:03:00, revealed the following: Final rinse sanitizer not working. Replaced a bad injector fitting and chemical line. Issue resolved. The sanitizer was test (sic) and adjusted to ,d+[DATE] ppm. 2. Observation of the floor of the reach-in refrigerator revealed an approximate ,d+[DATE] to ,d+[DATE] inch level of clear liquid fluid on the floor of the refrigerator. When asked what the fluid was the FSD stated, The line is leaking. We need to get a new refrigerator, but we have been using a shop type vacuum to remove the water. It just really started to leak. Beverages (iced tea containers) were observed to be above the level of the water on the bottom of the fridge. No active leakage was observed by the surveyor. NJAC 18:,d+[DATE].2(g)