STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315324	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Healthcare & Rehab	512 Union Street Trenton, NJ 08611

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Based on observation, interview, and review of pertinent documents it was determined that the facility failed to ensure the smoking policy was followed to screen and assess a resident for the ability to safely smoke cigarettes. The deficient practice occurred for 1 of 5 residents reviewed for accidents (Resident #127) and was evidenced by the following: On 4/30/24 at 10:18 AM, during the entrance conference, the facility provided a Smoking Policy and Procedure and the Smoking Schedule which revealed that Resident #127 was listed as smoking during shift #1 from 9:00 AM-9:10 AM, 10:30 AM-10:40 AM, 2:00 PM-2:10 PM, 5:00 PM-5:10 AM. On 5/2/24 at 8:40 AM, Resident #127 was observed self-propelling from the designated smoking area onto the elevator. On 5/2/24 at 8:59 AM, the surveyor reviewed the electronic medical record (EMR) which revealed the most recent signed Smoking assessment dated [DATE] indicated 1. Is Resident a Smoker, and No was checked off. A review of the Admission Record for Resident #127 revealed diagnoses which included, but were not limited to, traumatic subdural hemorrhage, tobacco use and other seizures. A review of the most recent 48-page Interdisciplinary Care Plan (including canceled items) initiated 2/1/24 did not contain a focus area for smoking. A review of the most recent quarterly Minimum Data Set, dated dated dated [DATE], revealed the resident scored 6 out of 15 on the Brief Interview of Mental Status which indicated the resident was cognitively impaired. On 5/2/24 at 10:44 AM, the surveyor interviewed the Receptionist about Resident #127 and asked if the resident smoked, as the Receptionist was observed distributing cigarettes to residents. The Receptionist stated Resident #127 smoked and he/she smoked this morning. The surveyor asked what the process entailed, and the Receptionist stated there was a Smoke Aide outside who lit the cigarettes, and at that time, the surveyor observed the Smoke-Aide sitting in the smoking area. The Receptionist stated all the residents received two cigarettes in the morning, and except for one resident who was blind and needed help smoking, and stated everyone else was independent. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 11:46 AM, the surveyor reviewed the paper medical record for Resident #127 which revealed a document titled Smoking Contract which had a hand-written slash over it, and Do Not Smoke was written on the documented which was dated, 12/20/23 and signed by staff. On 5/2/24 at 11:51 AM, in the presence of another surveyor the, the surveyors interviewed Resident #127 in the resident's room. The surveyors asked if the resident was a smoker and the resident confirmed that he/she smoked. Resident #127 informed the surveyors that the facility held the cigarettes at the front desk. On 5/2/24 at 11:54 AM, the surveyor, in the presence of another surveyor, conducted an interview with the Unit Manager/Registered Nurse (UM/RN). The surveyors asked the UM/RN if there were residents that she was aware of that smoked on the unit, and the UM/RN stated, yes we do. The surveyors asked how she would know, and she stated, it was included in the admission assessment and if residents are alert, they could tell you. The UM/RN stated we have a Smoking Contract and the surveyor asked if the resident was required to sign it and the UM/RN stated, yes, they have to sign it. The UM/RN stated the resident was informed that they needed to adhere to the smoking schedule and they were not allowed to have smoking paraphernalia in the room. The UM/RN stated we have a Smoking Assessment, and that was completed on admission, then repeated quarterly and annually. On 5/2/24 at 11:57 AM, the surveyor asked the UM/RN if Resident #127 was a smoker, and they replied [the resident] doesn't smoke. The surveyor asked the UM/RN if she was aware that Resident #127 was listed on the smoking schedule and smoked. The UM/RN looked at the most recent smoking assessment and confirmed that it was documented that Resident #127 was not a smoker, and confirmed that she had not been aware, and she completed the assessment. The surveyor asked the UM/RN if she should have been aware and she stated, I should be aware, and maybe he just started smoking again. The UM/RN stated, [he/she] probably told me [he/she] was not smoking, because when I asked [him/her] and [he/she] stated [he/she] doesn't smoke. The surveyor asked where the breakdown in communication occurred and the UM/RN stated, that she was not sure since it was a team effort. On 5/2/24 at 12:04 PM, the surveyor asked the UM/RN if the resident was care planned for smoking and the UM/RN stated, we don't care plan smoking. The UM/RN stated the Social Worker reviewed the contract and confirmed that the only contract in effect was the one that was crossed off. The UM/RN confirmed that the smoking contract dated 12/20/23 was completed on admission and when asked if there was another contract, the UM/RN stated, I don't see anything here. On 5/6/24 at 12:40 PM, the facility administration was made aware of the above concerns. On 5/7/24 at 10:42 AM, the Director of Nursing, in the presence of the Licensed Nursing Home Administrator, confirmed that there was no smoking contract that was located in the medical record and confirmed the smoking was not in Resident #127's Interdisciplinary Care Plan. The Smoking Policy and Procedure, Revised 11/2024, provided during the entrance conference on 04/30/24 at 10:18 AM revealed: Purpose: To provide a safe environment for all at [Facility Name] and provide clear directions for residents that are active cigarette smokers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure/Protocol: 1. Residents will be screened for the use of tobacco products and for their ability to smoke safely upon admission, and a smoking assessment will be completed with the Admission MDS, Quarterly .; 2. All Residents will be places into one of the following categories based on the most recent smoking assessment: a. Independent-requires no supervision, b. line of sight supervision or c. direct supervision; 3. Based on the most recent assessment the IDC [Interdisciplinary] team will address smoking interventions the care plan for those Resident's assessed as requiring line of sight or direct supervision. Determination of the Resident's level of supervision when smoking will also be noted on the Nursing Assistant Kardex; 4. All resident who smoke will sign the facility smoking contract upon admission prior to being allowed to smoke. NJAC 8:39-27.1(a)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38080 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure safe and appetizing temperatures of food for 3 of 4 entree meals observed on 1 of 3 nursing units (Third Floor). This deficient practice was evidenced by the following: On 5/3/24 at 10:07 AM, the surveyor conducted a Resident Council meeting which included four residents (Resident #13, #27, #46, and #48). Resident #46 stated lunch and dinner were served cold and in takeout containers and not on hot plates since February of 2024. On 5/8/24 at 11:32 AM, the surveyor informed the Dietary Director (DD) they wanted to observe the lunch meal for the day including food temperatures. The surveyor asked the Cook to calibrate two thermometers in their presence; which the Cook completed using an ice bath, and the thermometers reached 32 degrees Fahrenheit (F). On 5/8/24 at 11:33 AM, the surveyor observed the Cook using one of the thermometers calibrated to 32 F and took the following temperatures for the lunch meal: Barbecue chicken 178 F Scalloped potatoes 178 F Lima beans 160 F Sausage and peppers 170 F Chopped chicken 168 F Pureed lima beans 168 F Mashed potato 182 F Pureed chicken 158 F Carrots 200 F Yogurt 47 F Milk 41 F On 5/8/24 at 11:47 AM, the surveyor observed dietary staff began plating lunch. The DD stated the facility used insulated bases and dome lids, pellets (plate liner), and heated plates to maintain food temperatures. The DD stated the facility currently did not have enough insulated bases and dome lids to plate all the residents food, so they used disposable Styrofoam containers with lids to serve residents at all three meals. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 12:40 PM, the surveyor observed the dietary staff began to plate the last food cart using disposable trays. At 12:44 PM, the last meal was plated, and the surveyor requested four test tray meals; a regular texture, alternative regular texture, and ground texture meals. The regular meal contained barbecue chicken, lima beans, scalloped potatoes, milk, and yogurt; the alternative regular meal included sausage and pepper sandwich, lima beans, and lactaid milk; the mechanical soft meal contained chopped chicken, scalloped potatoes, and lima beans; and the pureed meal contained pureed chicken, mashed potatoes, and pureed lima beans. At this time, the Dietary Aide accompanied by the surveyor and DD left the kitchen with the dining cart and proceeded to the Third-floor nursing unit. On 5/8/24 at 12:45 PM, the lunch meal arrived on the Third-floor nursing unit. On 5/8/24 at 12:50 PM, the Certified Nursing Aide (CNA) began delivering the meal trays to the residents. On 5/8/24 at 12:57 PM, the CNA delivered the last resident meal. On 5/8/24 at 12:58 PM, the DD informed the surveyor that hot food should be served at 135 F or higher, and cold food should be 41 F or lower. At this time, the DD using the calibrated thin probe digital thermometer obtained the following food temperatures: Regular meal texture: Barbecue chicken 145 F Scalloped potatoes 141 F Lima beans 129 F Whole milk 56 F Yogurt 69 F Regular alternative meal texture: Sausage and pepper sandwich 121 F Lima beans 129 F Mechanical soft meal texture: Chopped chicken 108 F Scalloped potatoes 141 F Lima beans 124 F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pureed meal texture: Pureed chicken 114 F Mashed potatoes 132 F Pureed lima beans 105 F At this time, the DD acknowledged the only food served at acceptable temperature was the barbecue chicken and scalloped potatoes. On 5/10/24 at 10:21 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing and survey team acknowledged the food and beverages were served at unacceptable temperatures. A review of the facility's Food Serving Policy and Procedure dated revised May 2024, included food items will be served to the residents at proper temperatures; hot food will be served at a minimum temperature of 135 degrees when the resident receives their tray; cold food items will be served at a maximum temperature of 41 degrees . NJAC 8:39-17.4(a)(2)

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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. 38080 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) store, label, and date potentially hazardous foods to prevent food-borne illness; b.) discard potentially hazardous foods past their date of expiration; and c.) maintain storage areas in a sanitary manner. This deficient practice was evidenced by the following: On 5/2/24 at 8:49 AM, the surveyor with the Dietary Director (DD) toured the kitchen and observed the following: 1. The handwashing sink had no paper towels. The DD acknowledged there should be paper towels by the sink at all times. 2. In the walk-in refrigerator, one gallon of ranch dressing dated opened 3/30/24. The rim of the bottle, lid, and outside of the container all contained ranch dressing spillage. The DD acknowledged the bottle should have been cleaned after use to prevent bacterial growth. 3. In the walk-in refrigerator, one opened jug of salsa dated received 1/18/24. The was no opened date, and the packaging indicated best within seven to ten days after opening. 4. In the walk-in refrigerator, one gallon of hot sauce dated opened 4/30/24. The outside of the container and rim contained hot sauce spillage. 5. In the walk-in refrigerator, one-gallon jar of dill pickle chips. The lid of the container had a large slit in the top exposing the inside contents to air, and there was visible condensation in the bottle. The DD stated the slit was made with a knife to open the jar more easily. The DD confirmed the contents should not be exposed to air. 6. In the walk-in refrigerator, one opened gallon of sweet relish dated received 7/6/23 with no opened date. The packaging indicated to use by 4/20/24. There was green fuzzy debris on the outside packaging and the inside contents. 7. In the walk-in refrigerator, one opened gallon of French dressing dated received 1/8/24. There was no date when opened. The DD stated dressing was good for three months after opening. 8. In the reach-in refrigerator, one five-pound container of sour cream opened with no date. The packaging indicated to use by 5/28/24. 9. In the reach-in refrigerator, two opened boxes of portion control packets of sour cream dated use by 2/2/24. The one box contained approximately twenty packets, and the second box contained approximately forty packets. 10. In the reach-in refrigerator, one opened box of portion control containers of cream cheese. The box contained approximately twenty containers, and was dated received 10/19/23 with no use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. The ice cream freezer chest had ice accumulation on the sides approximately one-inch thick as well as the inside of the sliding glass doors. The ice accumulation prevented the DD from sliding the freezer door opened from the left side. The DD acknowledged the ice accumulation prevented air circulation and was a sanitation concern. 12. In the milk refrigerated box, one opened half gallon container of milk not dated when opened. 13. In the Cook's refrigerator, one portion control container of cole slaw with no date when prepared or when to use by. 14. In the Cook's refrigerator, a bin which contained sliced provolone cheese dated opened 3/6/24, and additional undated package that was dried that contained no date. The DD identified the second packaging as provolone cheese and stated both packages should be discarded. 15. In the Cook's refrigerator, a container of sliced tomatoes labeled prepared 4/28/24 and discard 5/1/24. 16. In dry storage, the door was being held open by a box of condensed tomato soup that was placed directly on the floor. The box contained five fifty-ounce cans of soup with the lids that contained black debris. The DD acknowledged food should not be stored on the floor, and the lids should remain free of debris and dust. 17. In dry storage on the can rack, one large can with no manufacture's product label. The can contained a label that indicated pears, and there was a large visible dent on the can. The DD acknowledged dented cans should not be with inventory. 18. In dry storage on the can rack, one large can with no manufacture's label or written label. The can was written in black marker TD, and the DD stated he did not know what the product was or how long it had been there. On 5/8/24 at 10:40 AM, the surveyor interviewed the DD in the presence of the Licensed Nursing Home Administrator (LNHA) who confirmed the cream cheese packets were only good for six months so should have been discarded; milk was only good for seven days once opened; salad dressing was good for two months after opening; and sour cream was only good for two weeks after opening. On 5/10/24 at 10:21 AM, the LNHA in the presence of the Director of Nursing (DON) and survey team, acknowledged the kitchen findings. A review of the facility's Food Storage policy dated reviewed February 2018, included dry food and food supplies shall be stored in a clean, dry location not exposed to splash, dust, or other contamination .all foods and supplies will be stored at least six feet off the floor .food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants .the inside surfaces of any refrigeration units must be free of chipping, cracking, corrosion, debris, moisture, ice build-up, and condensation . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Labeling and Dating Procedure in the Dietary Department dated revised July 2023, included food items as appropriate will be labeled and dated upon by dietary staff using the facility labeling system .all perishable products will be dated using the date of production, dated product will be used up to and including the third day of production unless otherwise marked. All products after this date will be discarded; perishable foods are checked daily for spoilage by the [Food Service Director]/designee .food items will be labeled with an open date once individual item is opened for use . NJAC 8:39-17.2(g)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45209 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to a.) perform hand hygiene during and after medication administration; b.) perform hand hygiene before and after serving residents meals; and c.) maintain enhanced barrier precautions to maintain infection control standards. This deficient practice was identified on 2 of 3 nursing units (Second and Third Floor), and was evidenced by the following: 1. On 5/8/24 at 10:29 AM, the surveyor observed Unit Manager/Licensed Practical Nurse (UM/LPN #1) perform tracheostomy (a small surgical opening that is made through the front of the neck into the windpipe) care on Resident #47 and observed the following: UM/LPN #1 performed hand hygiene with soap and water lathering outside the flow of running water for thirteen seconds and put on a pair of gloves. UM/LPN #1 then cleaned the bedside table and removed the pair of gloves, and performed hand hygiene with soap and water lathering outside the flow of running water for ten seconds. At 10:40 AM, UM/LPN #1 opened the tracheostomy kit and touched the inside of the sterile items with their gloved hand; then proceeded to change gloves without performing hand hygiene. UM/LPN #1 then applied the left sterile glove by touching the palm area with the right non-sterile glove hand. During tracheostomy care from 10:44 AM to 10:48 AM, UM/LPN #1 completed a glove change without performing hand hygiene in between. On 5/8/24 at 11:00 AM, the surveyor interviewed UM/LPN #1 who confirmed that handwashing was not completed for the required 15-20 seconds lathering outside the flow of running water, and that alcohol based hand rub (ABHR) should have been used between glove changes. UM/LPN #1 also admitted that sterility was broken upon opening the tracheostomy kit and while applying gloves. On 5/8/24 at 11:02 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN) who stated that hand sanitizing using ABHR was required between every resident, but was not able to answer if hand hygiene was necessary between glove changes. When asked regarding opening sterile packing, if touching the inside items with a gloved hand or applying a sterile glove with a non sterile glove was best practice, the IP/RN answered no, sterile was sterile. The IP also confirmed that hand washing should be at least 20 to 30 seconds lathering outside the flow of running water. On 5/8/24 at 1:39 PM, the surveyor interviewed the Director of Nursing (DON) who acknowledged that hand hygiene should be completed between glove changes; hand hygiene with soap and water lathering for twenty second outside the flow of running water, and and you would not touch the inside of a sterile object or glove with a non-sterile glove. A review of the facility's undated Competency Tracheostomy Care document included .remove gloves and perform hand hygiene . A review of the facility's undated Protocol for Suctioning of Tracheostomy Tube document included .use sterile technique to open package .designate a sterile and non-sterile hand . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During medication pass on 5/2/24 at 8:40 AM, the surveyor observed Licensed Practical Nurse (LPN #1) administer medications to Resident #31, and then proceed to perform hand hygiene using soap and water lathering outside the flow of running water for ten seconds. LPN #1 then picked up oxygen tubing from the floor, and performed hand hygiene again lathering with soap outside the flow of running water for five seconds. On 5/2/24 at 8:53 AM, the surveyor interviewed LPN #1 who acknowledged that handwashing should be completed by lathering with soap outside the flow of running water for thirty seconds, and confirmed that they did not wash their hands for that amount of time. On 5/8/24 at 1:39 PM, the surveyor interviewed the Director of Nursing (DON) who stated when performing hand hygiene with soap and water, you lathered outside the flow of running water for twenty seconds. On 5/10/24 at 10:21 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON, acknowledged the surveyor's above identified concerns. 3. On 5/3/24 at 12:03 PM, while on the Second Floor nursing unit identified as the high end, the surveyor attempted to use ABHR at the dispensers located in between Resident room [ROOM NUMBER] and #222; #229 and #230; and #217 and the Activity Room. All three dispensers were empty. On 5/3/24 at 12:24 PM, the surveyor interviewed LPN #2 and LPN #3 who were seated together, and stated hand hygiene was to be completed all the time both in between and during patient care. LPN #2 and #3 acknowledged that hand hygiene could be completed either by washing with soap and water for twenty-six seconds or by ABHR. Both LPN's confirmed that they were not required to carry ABHR on their person since it was available on the medication cart or on the walls. On 5/3/24 at 12:26 PM, the surveyor in the presence of UM/LPN #1 attempted to use the above identified ABHR dispensers and confirmed that they were empty. UM/LPN #1 confirmed that they needed to be filled. On 5/10/24 at 10:21 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON, acknowledged the surveyor's above identified concerns. 41072 4. On 5/2/24 at 11:39 AM, the surveyor observed outside Resident #51's room, a sign that indicated the resident was on Enhanced Barrier Precautions (EBP) which included: everyone must clean their hands, including before entering and when leaving the room; wear gloves and a gown for the following high-contact resident care activities which included .dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use including central line, urinary catheter, feeding tube (gastrostomy tube; a tube inserted through the belly that brings nutrition directly to the stomach), tracheostomy; wound care including any skin opening requiring a dressing. The surveyor observed a bag containing personal protective equipment (PPE) hanging on the closet door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, the surveyor knocked on the door and upon entering observed a staff member behind the resident's curtain wearing only gloves on both hands. The staff member stated that she was a Licensed Practical Nurse (LPN #4), and had just completed flushing the resident's gastrostomy tube (g-tube). LPN #4 then stated that she should have been wearing a gown with the gloves when she performed care. The surveyor interviewed the Registered Nurse (RN) who stated the resident was on EBP and LPN #4 should have been wearing a gown with the gloves when providing direct care such as flushing the g-tube (the process of flushing a g-tube with water to help prevent clogging.). On 5/6/24 at 9:04 AM, the surveyor interviewed UM/LPN #1 who stated that when a resident was on EBP, the nurse wore a gown and gloves when providing direct care. When asked if flushing a g-tube was providing direct care, LPN/UM #1 stated No, only gloves were needed when flushing a g-tube. On 5/6/24 at 9:51 AM, the surveyor interviewed the IP/RN who stated that EBP were used for any resident that had a break in their skin, such as g-tubes, wounds, Foley catheters; the staff were to wear a gown and gloves when doing direct care to that particular area. The IP/RN further stated that flushing a g-tube was providing direct care and a gown and gloves were to be worn. The IP/RN then stated that it was important to wear a gown and gloves when providing direct care to a resident on EBP because it decreased the spread of potential multi drug resistant organisms (MDRO's). The IP/RN stated that all the staff including LPN #4, RN and UM/LPN #1 were educated on EBP and provided the sign-in sheets for the education completed in April 2024. On 5/7/24 at 10:27 AM, the DON stated that a gown and gloves should have been worn when flushing a g-tube. A review of the facility's policy titled Policy and Procedure Infection Control Program Standards, dated 07/2023, revealed that Contact Precautions/Enhanced Barrier Precautions are used to prevent transmission of illnesses easily spread through contact with residents or contaminated items in their environment. Enhanced Barrier Precautions are used when a resident has any break in the skin and direct care is being administered. 5. On 5/2/24 at 9:56 AM, the surveyor observed Resident #51's oxygen nasal cannula tubing dated 4/15/24, attached to the oxygen concentrator. The oxygen tubing dated 4/15/24 was observed again on 5/2/24 at 11:39 AM and on 5/3/24 at 9:06 AM. On 5/3/24 at 11:08 AM, the DON provided the surveyor with a policy titled Oxygen Administration, dated March 2024, which did not include when the oxygen tubing should be changed. On 5/6/24 at 9:04 AM, the surveyor interviewed UM/LPN #1 who stated that the oxygen tubing should have a date on it that it was changed and should be changed weekly. UM/LPN #1 stated that there was not a physician's order to change the oxygen tubing weekly, we just follow our policy. On 5/6/24 at 9:51 AM, the surveyor interviewed the IP/RN who stated that the oxygen tubing should be changed and dated every two weeks and as needed and was not documented in the Electronic Medical Record (EMR). The IP/RN further stated that it was important to change the oxygen cannula tubing because the nasal prongs contained bacteria and you need to keep the airways clean. (continued on next page)

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	315324	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Healthcare & Rehab	512 Union Street Trenton, NJ 08611

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/24 at 12:41 PM, during an interview with the DON and the LNHA in the presence of the survey team, the DON stated that the oxygen tubing should be changed and dated every two weeks. The DON further stated that the oxygen tubing change did not need a physician's order and they did not document the tubing change in the EMR. On 5/7/24 at 9:38 AM, during an interview with the IP/RN and DON, the DON stated that the facility had a Respiratory Therapist (RT) until February of 2024 who had changed all the oxygen tubing every two weeks. The RT had her own calendar and schedule for oxygen tubing changes, but they did not have a chance to put the respiratory protocols on paper until yesterday. The DON provided the surveyor with a protocol titled Protocol on Resident Respiratory Equipment, dated May 2024, which revealed that oxygen tubing was to be changed every two weeks and as needed. The oxygen tubing change will be documented in the computer under Respiratory and the oxygen tubing will be tagged with the resident name and date of change. On 5/7/24 at 10:27 AM, during an interview with the DON and the LNHA in the presence of the survey team, the DON confirmed that Resident #51's oxygen tubing should have been changed and dated on 4/30/24. The DON stated that the nurses should be checking the oxygen tubing expiration date when performing respiratory care. 36419 6. On 5/2/24 at 8:30 AM, the surveyor during Medication Pass observation with LPN #5 on the Third Floor nursing unit made the following observations: LPN #5 prepared Resident #295's medications; administered the medications; and signed for the administration in the resident's electronic medical record (eMR). The surveyor did not observe LPN #5 sanitize her hands with alcohol-based hand rub (ABHR) before or after she administered the medications. On 5/2/24 at 11:19 AM, the surveyor interviewed LPN #5 who confirmed that prior to preparing Resident #295's medications and after she administered the medications, she should have performed hand hygiene before moving on to the next resident. On 5/2/24 at 8:45 AM, the surveyor during Medication Pass observation of LPN #5 made the following observations: LPN #5 prepared Resident #133's medications; administered the medications; and signed for the administration in the resident's eMR. The surveyor did not observe LPN #5 sanitize her hands ABHR before or after she administered the medications. On 5/2/24 at 11:19 AM, the surveyor interviewed LPN #5 who confirmed that prior to preparing Resident #133's medications and after she administered the medications, she should have performed hand hygiene before moving on to the next resident. On 5/2/24 at 9:00 AM, the surveyor during Medication Pass observation of LPN #5 made the following observations: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #5 prepared Resident #85's medications; administered the medications; and signed for the administration in the resident's eMR. The surveyor did not observe LPN #5 sanitize her hands with ABHR before she administered the medications. After LPN #5 administered the medications, she stated that she would now wash her hands with soap and water since it was the facility policy to wash her hands after every third resident. On 5/2/24 at 11:19 AM, the surveyor interviewed LPN #5 who confirmed that prior to preparing Resident #85's medications, she should have performed hand hygiene and sanitized her hands between residents. The LPN further stated that the facility's policy was to sanitize hands between residents and in addition to sanitizing between residents she should wash her hands with soap and water after passing medications to every three residents. On 5/6/24 at 10:35 AM, the surveyor interviewed the IP/RN who stated LPN #5 should have sanitized her hands between residents during medication administration. On 5/8/24 at 10:53 AM, the surveyor interviewed the DON who confirmed that LPN #5 should have sanitized her hands with ABHR before she prepared the medications and after she administered the medications to each resident. The DON further stated that the LPN should have washed her hands with soap and water after administering the medications to the third resident per the facility policy. Review of LPN #5's Medication Pass Observation dated 3/19/24 provided by the DON revealed .during the medication pass . hands washed appropriately per facility policy; before and after the use of gloves .after direct contact and when visibly soiled; after 3 uses of alcohol gel/per facility policy. 7. On 4/30/24 at 12:26 PM, the surveyor observed outside Resident room [ROOM NUMBER] a sign that indicated the resident was on EBP. The surveyor observed PPE which included but not limited to isolation gowns, disposable gloves and ABHR stored in a container that was affixed to the outside of the resident's bathroom door. At that time, the surveyor observed Certified Nursing Assistant (CNA #1) enter Resident room [ROOM NUMBER] without performing hand hygiene or using ABHR. The surveyor observed CNA #1 set up the lunch tray for the resident in bed A. CNA #1 removed the lid, buttered the bread, opened the drinks, and then left the room without performing hand hygiene or using an ABHR. CNA #1 re-entered the room with a towel and proceeded to feed the resident without performing hand hygiene or using an ABHR. On 5/2/24 at 12:00 PM, the surveyor observed outside Resident room [ROOM NUMBER] a sign that indicated the resident was on EBP. The surveyor observed PPE which included but not limited to isolation gowns, disposable gloves and ABHR stored in a container that was affixed to the outside of the resident's bathroom door. At that time, the surveyor observed the Home Health Aide (HHA) entered Resident room [ROOM NUMBER] without performing hand hygiene or using an ABHR. The surveyor observed the HHA placed a cup of tea on the resident in bed A's bed side table (BST) . The HHA moved the resident's BST closer to the resident and left the room without performing hand hygiene or using an ABHR. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/2/24 at 12:10 PM, the surveyor interviewed the HHA who stated that hand hygiene only had to be performed when providing direct care to the resident. The surveyor asked the HHA if she should be following the sign outside Resident room [ROOM NUMBER] which instructed before entering and exiting the room, you must perform hand hygiene. The HHA did not respond to the surveyor. On 5/2/24 at 12:15 PM, the surveyor observed the Unit Manager/Registered Nurse (UM/RN) who approached the food cart, removed a tray and entered Resident room [ROOM NUMBER]. The surveyor observed the UM/RN place the tray on the BST of the resident in bed B and moved the BST closer to the resident. The UM/RN left the room and went directly to the food cart, removed a tray for the resident in Resident room [ROOM NUMBER] with no observed hand hygiene. On 5/2/24 at 12:20 PM, the surveyor observed the UM/RN approach the food cart, removed a tray, entered Resident room [ROOM NUMBER] and placed the tray on the BST of the resident in bed B. The UM/RN, opened the milk and poured it into a cup, removed the silverware from the plastic and moved the BST closer to the resident. The UM/RN then left the room with no observed hand hygiene. On 5/2/24 at 12:25 PM, the surveyor observed the UM/RN approach the food cart, removed a tray, entered Resident room [ROOM NUMBER] and placed the tray on the BST of the resident in bed A. The UM/RN removed the top and moved the BST closer to the resident. The surveyor observed the UM/RN then left the room and picked up the hall phone with no observed hand hygiene. On 5/2/24 at 12:34 PM, the surveyor observed LPN #5 entered Resident room [ROOM NUMBER] with no observed hand hygiene. The surveyor observed LPN #5 feed the resident in bed B with no observed hand hygiene. On 5/2/24 at 12:37 PM, the surveyor interviewed LPN #5 who stated that staff were not required to perform hand hygiene unless providing direct care. The surveyor asked LPN #5 if serving trays and feeding residents were considered direct care, and LPN #5 did not respond. On 5/2/24 at 12:44 PM, the surveyor interviewed the UM/RN who stated that the facility policy was that staff performed hand hygiene before they pass the first meal tray and then again after the last tray was passed. The surveyor asked the UM/RN if staff should perform hand hygiene between residents including setting up meal trays and feeding residents, and the UM/RN replied, only if their hands were visibly soiled. On 5/6/24 at 10:35 AM, the surveyor interviewed the IP/RN who confirmed that staff were expected to perform hand hygiene using ABHR before entering and exiting the rooms of all of the residents, especially those residents who were on EBP. On 5/9/24 at 10:45 AM, the surveyor observed outside Resident room [ROOM NUMBER] a sign that indicated the resident was on EBP. The surveyor observed PPE which included but not limited to isolation gowns, disposable gloves and alcohol-based hand rub (ABHR) stored in a container that was affixed to the outside of the resident's bathroom door. At that time, the surveyor observed CNA #2 enter Resident room [ROOM NUMBER] without sanitizing her hands or using ABHR. CNA #2 repositioned the resident in bed A, handled items on the bedside table, and removed items from their dresser. The surveyor observed CNA #2 exit Resident room [ROOM NUMBER] without performing hand hygiene or using an ABHR. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/9/24 at 10:55 AM, the surveyor interviewed CNA #2 who confirmed that she should have sanitized her hands before entering and exiting the room. A review of the facility's Policy and Procedure Infection Control Program Standards dated 7/2023, included Contact Precautions/Enhanced Barrier Precautions (EBP) are used to prevent transmission of illnesses easily spread through contact with residents or contaminated items in their environment. Enhanced Barrier Precautions are used when a resident has any break in the skin and direct care is being administered . personnel should demonstrate a high standard of hygienic practice .hand washing is to be performed before and after each resident contact and according to the hand washing policy and procedures. 8. On 4/30/24 at 11:59 AM, the surveyor observed staff deliver lunch meal trays to the residents on the Third Floor nursing unit and observed the following: The surveyor observed the HHA who approached the food cart, removed a tray and entered Resident room [ROOM NUMBER]. The HHA placed the food tray on the bed side table (BST) of the resident in bed B; applied a clothing protector, removed the plate cover, opened the juice and the fruit, and moved the BST closer to the resident with no observed hand hygiene. On 4/30/24 at 12:17 PM, the surveyor observed the HHA enter the dining room and stated that she was going to feed the resident in Resident room [ROOM NUMBER] bed A. The surveyor observed the HHA applied soap to her hands, and immediately placed her hands under the stream of water without lathering and applying friction to her hands outside the water. The surveyor observed the HHA then dried her hands, and proceeded to feed the resident. On 5/2/24 at 12:10 PM, the surveyor interviewed the HHA who acknowledged that she should have performed hand hygiene by applying soap and lathering outside the stream of running water for at least 20 seconds. On 5/8/24 at 10:53 AM, the surveyor interviewed the DON who stated that staff should perform hand hygiene between residents when serving meal trays, setting up trays, and feeding residents. The DON further stated that staff should be lathering their hands with soap outside the stream of water for at least 20-30 seconds before placing their hands under the stream of water. On 5/10/24 at 10:21 AM, the LNHA in the presence of the DON and survey team acknowledged the surveyor's above identified concerns. A review of the facility's undated Outbreak Response Plan document included monitor all soap, paper towels, and hand sanitizer dispensers' multiple times throughout the day and replenish as needed. A review of the facility's undated Licensed Practical Nurse Staff Nurse Job Description document include . thorough knowledge of principles and methods involved in handling of sterile/clean materials and daily hygienic care of residents . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Hand Washing policy dated revised June 2023, included .hand hygiene products and supplies (sinks, towels, alcohol-based hand rub, etc) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies .employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap .The use of gloves does not replace hand washing/hand hygiene . NJAC 8:39-19.4 (a-c)(k)(n); 27.1 (a)