STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315522	A. Building B. Wing	04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accelerate Skilled Nursing and Rehab Piscataway	10 Sterling Drive Piscataway, NJ 08854

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some Note: The nursing home is disputing this citation.	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 38079 Based on interview and record review, it was determined that the facility failed to complete and transmit Minimum Data Sets (MDS), an assessment tool, within 14 days of completing the resident's assessment. This deficient practice was identified for 32 of 32 residents reviewed for MDS records over 120 days old and not transmitted and was evidenced by the following: On 04/11/19 at 12:38 PM, the surveyor reviewed a report for MDS records over 120 days old. The report revealed that 18 of 32 resident MDS' that had been discharged with return not anticipated, were still in progress. The 18 resident MDS' ranged in date from 12/03/18 through 01/18/19, all were over 14 calendar days past the resident discharge date . The report also revealed that 14 of 32 discharged resident MDS' were export ready. The 14 resident MDS' ranged in date from 11/26/18 through 12/13/18, all were over 14 calendar days past the resident discharge date . During an interview with the surveyor on 04/11/19 at 12:40 PM, the Registered Nurse (RN) MDS coordinator stated that the MDS' should have been completed and transmitted within 7 to 14 days of the resident's discharge date . The RN MDS coordinator stated that she runs the report to check the status of the MDS' every week but has been back logged and busy. The RN MDS coordinator further stated the importance of the MDS' and their submittals were for the insurance companies and government to be able to assure that the care and billing matched for accuracy. The surveyor reviewed the facility, CASPER Report MDS 3.0 Missing OBRA (Omnibus Budget Reconciliation Act) Assessment report that was provided by the Administrator, with a run date of 04/11/19. The report revealed 77 resident MDS' were missing and listed the target dates the MDS should have been completed by. The surveyor reviewed the facility, Submission in Progress report, dated 04/11/19 and timed 2:28 PM, provided by the Administrator. The report revealed 47 assessments that were ready to be exported to the insurance companies and government. The report revealed that 45 were over 14 calendar days from the time they should have been submitted. The assessment dates ranged from 11/11/18 through 3/30/19. (continued on next page)

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

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some Note: The nursing home is disputing this citation.	The surveyor reviewed the Resident Assessment Instrument (RAI) 3.0 manual (updated October 2018). According to this latest version of the RAI 3.0 manual, discharge refers to the date a resident leaves the facility (page 2-11). The MDS completion discharge date is +14 calendar days (page 2-18) and the discharge transmission date to be no later than the MDS completion date +14 calendar days (page 2-18). NJAC 8:39-11.2 (e)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39229 Based on observation, interview, medical record review, and review of other facility documents, it was determined that the facility to develop and implement a person-centered care plan (CP) for 4 of 4 residents (Residents #156, #221, #6, and #161) reviewed. This deficient practice was evidenced by the following: 1. On 04/12/19 at 8:17 AM, the surveyor observed Resident #156 in bed, feet covered. The Registered Nurse (RN) Clinical Director (CD) accompanied the surveyor to the resident's room and lifted the sheets to reveal the resident's feet were not off loaded and were directly on the bed. The resident was slightly turned to the left side, with the lateral (outside) and the right medial (middle) ankle against the bed sheet. The sides of the resident's heels were touching the bed. The surveyor observed the resident had a sock on the left foot covering the ankle. The CD stated that the resident's feet should have been off-loaded on a pillow and that the nurses should have checked the resident to make sure it was done. The surveyor reviewed the medical record of Resident #156 and the following was revealed: According to the facility Admission Record, Resident #156 was admitted on [DATE] with diagnoses which included: cerebrovascular disease (stroke), left-sided hemiplegia (weakness) and diabetes (elevated blood sugar). Review of the Admission Minimum Data Set (MDS), an assessment tool dated 03/01/19, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicating moderately impaired cognition. The resident required extensive assistance of two persons with bed mobility and transfers. The MDS further revealed that the resident was at risk for pressure ulcers, but did not have pressure ulcers on admission. Review of Resident #156's Skin Check-V3, dated 02/22/19 revealed that the resident's skin was intact. Additional review of Resident #156's Skin Check-V3, dated 03/01/19, 03/08/19, 03/15/19, and 03/22/19, did not indicate redness to the resident's heels. Review of the Admission Nursing Assessment, dated 02/27/19, revealed that the resident's mobility was very limited and was unable to make significant changes in position independently and needed extensive assistance. In addition, the resident had functional limitation in range of motion which included, weakness to the left and right leg. The assessment revealed that the resident's skin was intact. Review of the Braden Scale for Predicting Pressure Sore Risk assessment revealed that on 03/01/19 the resident had a score of 13 that indicated the resident was at moderate risk for developing a pressure ulcer. On 03/08/19, the resident's score was 15 and on 03/15/19 the resident's score was 16, both indicating mild risk. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Wound Consults completed by the Nurse Practitioner (NP) dated 03/20/19, revealed that the resident had a Stage 1 right heel non-healed pressure ulcer which measured 3 centimeters (cm) x 3 cm x 0, with erythema (redness of the skin). The NP had recommended a treatment to apply skin prep (a liquid film-forming dressing) with an abdominal gauze pad (ABD) daily and Prevalon boots (protect heels from pressure injuries) to bilateral feet while in bed. Review of subsequent Wound Consults dated 03/27/19 and 04/03/19 revealed no changes in the right heel treatment. Review of Resident #156's March 2019 Treatment Administration Record (TAR) reflected a physician order, dated 03/20/19, to apply skin prep (a treatment that forms a protective film to help reduce friction) to the right heel, cover with ABD (gauze bandage) and Kling (rolled gauze) daily every day shift. Review of the April 2019 TAR revealed the 03/20/19 skin prep order for the right heel skin and to cover with ABD and Kling daily, discontinued on 04/7/19. The TAR also included a new order dated 04/07/19 to apply skin prep and Allevyn (a non-stick dressing that absorbes moisture and protects the skin) daily every day for heel protection, discontinued on 04/09/19. Both the March and April 2019 TARs did not reflect the Wound Care Consultant's recommendation for the Prevalon boots. Review of Resident #156's Progress Notes (PN) dated 02/22/19 through 04/10/19 revealed the following: Review of Resident #156's Care Plan (CP), created 02/23/19, revealed that the resident was at risk for developing pressure ulcers/injuries related to advanced age and incontinence. There were no goals listed. The CP intervention, dated 03/08/19 and revised on 04/06/19, indicated to encourage the resident to consume all fluids of choice during meal. There were no additional interventions documented on the CP. An additional CP for Restorative Range of Motion, created on 03/23/19, revealed the resident demonstrated loss of range of motion (ROM) in the lower extremities due to functional deterioration with a goal to prevent contractures and maintain skin integrity. The CP intervention included teaching the resident and resident's family to perform ROM exercises. During an interview by the surveyor on 04/09/19 at 12:49 PM, the Assistant Director of Nursing (ADON) stated that the Care Plan Interventions for Resident #156's risk for skin breakdown were not completed and should have been more thorough than the listed intervention. The ADON further stated that the CPs are computer uploaded and then the nursing staff was to personalize the CP. She also revealed that the Clinical Director (CD) and any nurse on the unit was responsible to make sure the CP was completed. During an interview by the surveyor on 04/10/19 at 10:06 AM, the Director of Nursing (DON) stated that she would have expected to have seen a Goal and added CP interventions in place for Resident #156's risk of skin breakdown. The DON also stated that the CP should have also included a Focus and interventions for the right heel wound. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted by the surveyor on 04/10/19 at 12:44 PM, the CD stated that Resident #156's current CP, dated 04/06/19, should have had interventions in place to reduce skin breakdown. The CD stated that when the resident was admitted on [DATE], he had initially completed a CP which included the resident's risk for skin breakdown and additional interventions. The CD stated that the CP that the surveyor reviewed in the computer was not the CP he had created on 02/23/19. He stated he could not find the CP in the computer. After surveyor inquiry on 04/10/19, the CD provided the surveyor an updated CP for Resident #156, created by the CD on 04/10/19, that revealed the following: Focus: the resident was at risk for skin breakdown related to advanced age and and actual wound as evidenced by the deep tissue injury to the left heel and Stage 1 to the right heel; Goal: The resident will not show signs of skin breakdown for 90 days and wound would heal. Interventions included, but were not limited to: Off Load/Float heels while in bed with pillows. During an interview conducted by the surveyor on 04/10/19 at 1:16 PM, the DON stated that Resident #156's CP interventions for skin breakdown on 02/23/19 were not comprehensive. The DON also explained that when a nurse performed a Skin Check Assessment, that their name was automatically generated on the CP and then the nurse can select the care area, the interventions and goals. She also looked on the computer, with the surveyor present, and said that she could not find any resolved CPs in the computer, which would have indicated that one would have been completed on 02/23/19. She stated if there was a previous 02/23/19 CP, it would be kept in the resolved section and there was not one that she could find. Lastly, she stated that she had not heard of any issues with the computer deleting portions of CPs. On 04/11/19 at 9:18 AM, the DON provide the surveyor with an additional CP for the resident's risk of skin breakdown, dated 02/23/19 with a resolved date of 03/15/19. Review of the CP included that the resident was at risk for skin breakdown, with the goal that the resident would show no signs or symptoms of breakdown. Interventions included, provide preventative skin care, barrier cream, observe skin condition daily with ADL care, report any abnormalities, and pressure redistribution surface to bed as per guideline. At that time, the DON stated that the facility computer company was going to look into why the 02/23/19 CP was not viewable. The DON acknowledged that the CP was marked as resolved on 03/15/19. The DON was unable to show a CP from 03/15/19 until the CP revision on 04/06/19. The DON stated that the nursing staff would have not been able to see the 02/23/19 CP in the computer prior to her requesting computer support. She also stated that she did not know who would have resolved the 02/23/19 CP or why. During an interview by the surveyor on 04/11/19 at 09:42 AM, the CD stated that he did not know why the original 02/23/19 CP was resolved by another nurse on 03/15/19. The CD stated that the Certified Nursing Assistant (CNA) should have told the nurse about the right heel and then an incident report should have completed. Lastly, the CD stated that the staff nurses should have been documenting Resident #156's skin checks in the PN. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview by the surveyor on 04/10/19 at 11:07 AM, the facility Wound Care Registered Nurse (WC/RN) stated she checked the PO prior to Resident #156's wound care and that the facility had been treating the right heel wound. The WC/RN added that when she reported to work on 04/09/19, the left heel was being treated. She reviewed the Skin Integrity Report on the unit with the surveyor, which revealed that there was an assessment for the right heel for 03/20/19 and 03/27/19; however, there was no assessment for the left heel. The WC/RN stated that an assessment should have been completed as soon as the left heel wound was identified. During a follow up interview by the surveyor on 04/11/19 at 9:52 AM, the CD stated that he was unaware that Resident #156 had a right heel wound until he was informed by the Wound Care Nurse on 04/10/19. The CD stated that if he had known about the heel wound, he would have updated Resident #156's CP. During an interview by the surveyor on 04/11/19 at 10:10 AM, a third floor unit CNA stated that she checks the resident's skin everyday during bathing and if she sees an issue, she notifies the nurse and documents her findings in the computer. During an interview by the surveyor on 04/11/19 at 12:15 PM, the DON stated that on admission, the nurse performs a Skin Check Assessment, and would initiate a skin risk care plan. The CD would review the information and add appropriate CP interventions. During an interview by the surveyor on 04/11/19 at 1:30 PM, a third floor RN stated that the facility had a protocol to follow for any resident identified with a wound or skin change. She showed the surveyor the Wound Care Guideline and explained that the nurses would refer to that when any skin breakdown was observed and would place any resident's new non-emergent skin condition on a clip board for the facility NP. She also stated that the CD was responsible to update to the CP. Review of the facility Wound Care Guideline (undated) revealed the following wound types: Suspected Deep Tissue Injury; Definitions: localized area of discolored intact skin due to damage of underlying soft tissue from pressure and/shear with no wound depth. Stage 1 pressure ulcer is intact skin with non-blanchable redness of a localized area, The prevention guidelines for both DTI and Stage 1 included, but not limited to: offloading device to keep heels off bed. During an interview by the surveyor on 04/11/19 at 1:42 PM, the CD stated that off-loading the resident's heels should have been a CP intervention. During an interview conducted by the surveyor on 4/11/19 at 2:19 PM, a facility NP stated that she reviewed every NP note in Resident #156's medical record and there were no notes regarding heel redness. The NP further stated that heel redness upon assessment would include the following the interventions: notified the Wound Care Registered Nurse and suggest off-loading the heels. She stated that she was just made aware of Resident #156's heel wounds on 04/11/19 by the surveyor. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted by the surveyor on 04/12/19 at 08:44 AM, the CD stated that the DON received the Wound Care Center NPs recommendations of the Prevalon boots first by email. The DON would then forward the email to him and he was responsible to put the NP's recommendations on the CP; however, the CD stated he did not receive the Wound Care NP's recommendations from the DON. He stated that although he did not receive the email, it was still his responsibly to have looked at the Wound Care Reports on the resident's chart. He stated that the Prevalon boots should have been added to the CP. During an interview conducted by the surveyor on 04/12/19 at 08:58 AM, the DON stated that she would review the resident Wound Reports sometimes and the facility wound nurse RN would do that as well. She also stated that the wound care RN should take off the Wound Center recommendations and carry through with any physician orders. The DON then stated that the 03/20/19 Wound Care Report was emailed on Saturday 03/22/19 at 10:45 PM. The DON stated that she emailed the report to Resident #156's physician, several of the NPs, the third floor unit clerk, the facility dieticians, and the ADON. She added that she did not send the report to the CD and that the CD would usually review the Wound Care Report. The DON stated that the Prevalon boots should have been included in the CP and implemented. Review of the Skin Integrity Management policy and procedure, dated 11/28/16, revealed the following: Staff continually observes and monitors for changes and implements revisions to the plan of care as needed; Practice Standards: Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated; Determine the need for heel protectors and heel lift devices; Review care plan weekly and revise as indicated. 38079 2. According to the facility Admission Record, Resident #221 was admitted to the facility on [DATE] with a diagnosis that included, hypertension (elevated blood pressure [BP]). Review of Resident #221's CP, dated 10/04/18, revealed one of the diagnoses as hypertension. The CP did not reveal any focus area or goals and interventions that pertained to the diagnosis of hypertension. Resident #221 had a physician order, dated 12/08/18, for Clonidine HCL tablet(medication to lower BP) 0.1 mg (milligram) by mouth three times a day for essential hypertension and hold for systolic (top BP number) blood pressure (SBP) less than 120. The order was discontinued on 01/17/19. Review of the December 2018 and January 2019 Medication Administration Records (MAR) reflected the 12/08/18 physician order for Clonidine HCL tablet 0.1 mg give one tablet by mouth three times a day. Hold for SBP less than 120. The MAR confirmed Resident #221 received the Clonidine medication from 12/08/19 to 01/17/19. During an interview conducted by the surveyor on 04/10/19 at 10:26 AM, the Social Worker (SW) stated that a resident's CP usually consisted of input from the SW, therapy department and nursing, only if nursing had any questions. The SW further stated that nursing would have been the ones to enter the hypertension on the CP. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted by the surveyor on 04/10/19 at 12 PM, the DON stated that no one from nursing had attended the baseline CP meeting for Resident #221 so the hypertension had not been entered. The DON further stated it was the CD's responsibility to create the CP. 3. According to the facility Admission Record, Resident #6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included, end stage renal disease (ESRD). Resident #6 had a physician order dated 03/24/19 for dialysis (hemodialysis) on Monday, Wednesday, and Friday. Review of Resident #6's MDS, an assessment tool dated 03/30/18 revealed an admitted [DATE]. The MDS confirmed the resident is receiving dialysis. Review of Resident #6's undated CP did not contain documentation of a focus area, goals or associated interventions that pertained hemodialysis. During an interview conducted by the surveyor on 04/10/19 at 11:40 AM, the second floor CD stated that all the nurses initiate care plans and must check each other. The CD reviewed Resident #6's CP and acknowledged that Resident #6 was receiving hemodialysis and that the hemodialysis should have been addressed on the CP. The CD also stated that she had not attended the wellness meeting (care plan meeting). During an interview conducted by the surveyor on 04/10/19 at 11:43 AM, the DON stated the nurse who admitted Resident #6 should have added hemodialysis to the CP. The DON further stated that the following morning after Resident #6 had been admitted , the CD should have reviewed and entered nursing issues such as hemodialysis into the CP. In addition, the DON stated issues that could result from the hemodialysis not on the CP would be that the staff would not be aware how to care for the resident. 40042 4. According to the facility Admission Record, Resident #161 was admitted to the facility on [DATE] with diagnoses that included ESRD. The resident had a physician order, dated and revised on 02/13/19, for dialysis every Monday, Wednesday and Friday. Review of the resident's CP, last reviewed 04/03/19 and printed on 04/09/19, did not reflect evidence of a CP for hemodialysis. Review of the resident's CPs reflected a CP for risk due to impaired renal function and risk for complications related to hemodialysis that was created and revised on 04/10/19, after surveyor inquiry. During an interview with the surveyor on 04/10/19 at 10:01 AM, the DON stated that the CDs were responsible for reviewing the CPs and sometimes she does as well. During a follow up interview with the surveyor on 04/10/19 at 11:43 AM, the DON stated that the nurse that admitted the resident should start the CP and the next morning the CD should have reviewed the CP and made sure nursing issues such as dialysis were reflected in the CP. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, the DON stated that base line care plans should be developed within 48 hours and this is important because not everyone knows how to treat a resident on dialysis. During an interview with the surveyor on 04/12/19 at 08:00 AM, the CD stated that he developed and updated care plans unless he was not on shift, in which case, a supervisor would do so and he would review the care plan the following day. The CD stated that there should have been a hemodialysis care plan in place for Resident #161. Review of the CD job description revealed that the CD was responsible for the coordination and direction of nursing and patient care for the assigned unit. It also revealed that the CD was responsible to plan, organize, direct and supervise nursing care provided on the unit. Review of the facility, Person-Centered Care Plan policy dated 03/01/18 revealed a baseline person centered care plan within 48 hours for each patient that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care. A comprehensive, individualized care plan will be developed within 7 days after completion of the comprehensive assessment for each patient to meet a patient's medical, nursing, nutrition and mental and psychosocial needs. The care plan will be prepared by the interdisciplinary team that includes: a registered nurse with responsibility for the patient. Practice Standards 1) a baseline care plan within 48 hours to include but not limited to initial goals based on admission orders; 2) a comprehensive care plan must describe the following services that are to be furnished. Documentation will show evidence of: patient's goals and preferences. The care plan will be reviewed and revised by the interdisciplinary team after each assessment. NJAC 8:39-11.2 (e), NJAC:8:39-27.1(a)(e)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on observation, interview and record review, it was determined that the facility failed to 1.) prepare medications at the time of administration; 2.) follow a physician's ordered hold parameter for 1 of 25 residents (Resident #221) reviewed for medications; 3.) follow a physician's order to discontinue a fluid restriction for 1 of 25 residents (Resident #163); and 4.) indicate a dosage amount for a liquid protein supplement for 2 of 25 residents (Resident #163 and Resident #161). This deficient practice was evidenced by the following: 1. On 04/04/19 at 09:49 AM, the surveyor, in the presence of the Registered Nurse (RN) Clinical Director (CD), inspected a medication cart on the second floor. When the cart was opened by the medication RN, the surveyor and CD observed a small plastic medication cup that contained eight pills. During an interview conducted by the surveyor on 04/04/19 at 09:49 AM, the medication RN stated that the eight pills should not have been left in the cup. The medication RN explained that he had prepared the eight medications for a resident prior to checking if the resident was in the room and the resident had gone downstairs. He stated he left the cup that contained the eight pills in the medication cart because he planned to hold onto the medications until the resident returned to the floor. The CD, who was also present, stated nurses should not keep any poured medication in the medication cart and that the medication needed to be poured when ready to give. A review of the facility, Medication Administration: General policy, dated 07/24/18, revealed to remain with the patient until administration is complete and if the patient refuses, to discard medication and attempt to administer at a later time. 2. According to the facility Admission Record, Resident #221 was admitted to the facility on [DATE] with diagnoses that included; hypertension (BP-elevated blood pressure). A review of the physician order sheet (POS) revealed a physician order dated 12/08/18 for Clonidine HCL (medication to lower BP) 0.1 milligram (mg) give 1 tablet by mouth three times a day HOLD for SBP (top BP reading) below 120. A review of the December 2018 and January 2019 electronic Medication Administration Records (MAR) revealed the Clonidine was administered when the SBP was below 120 on the following dates: 12/13/18 at 1 PM, SBP 107 12/13/18 at 5 PM, SBP 111 12/16/18 at 5 PM, SBP 98 12/29/18 at 1 PM, SBP 105 01/03/19 at 1 PM, SBP 112 (continued on next page)

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Accelerate Skilled Nursing and Rehab Piscataway	10 Sterling Drive Piscataway, NJ 08854

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 04/10/19 at 10:01 AM, the Director of Nursing (DON) stated that blood pressure are taken prior to medication administration and should be documented on the MAR. The DON stated that if the blood pressure was outside of the hold parameters, the nurses should not have administered the medication. The DON stated that not every resident's MAR had been reviewed for accuracy. The DON stated that if the Clonidine was administered outside the parameters, the resident could become hypotensive (low BP), could get clammy and may have had an altered mental status. During an interview on 04/12/19 at 10:26 AM, the second floor medication Licensed Practical Nurse (LPN) stated that if a blood pressure medication had a hold parameter and the BP had been less than that parameter, she would have held the medication. The LPN stated that if the anti-hypertensive had been given outside the parameter, the resident's BP could drop even lower and could have caused dizziness and a lot could go wrong. During an interview on 04/12/19 at 10:30 AM, the second floor medication Registered Nurse (RN) stated that the nurse should always check the BP prior giving an anti-hypertensive medication. The RN stated the nurses should have checked the resident's BP first for the parameters and not give the medication if the BP is outside the parameters. The RN stated a resident with low BP who had been given an anti-hypertensive medication could go into hypotensive crisis. The Administrator provided the surveyor with the facility, Clinical Competency Validation Medication Administration-Licensed Nurse that revealed, critical elements 2. Demonstrates knowledge of actions & interactions b. reports vital signs that are outside parameters. 3. Prepares for medication administration a. verifies medication orders in MAR matches medication label. checks specific administration directions. 40042 3. According to the facility's Admission Record, Resident #163 was admitted to the facility on [DATE] with diagnoses which included; congestive heart failure, hypo-osmolality and hyponatremia (a low level of sodium in the blood). A review of the resident's Physician's Order Sheets (POS) reflected the resident had a 1200 milliliter (mL) fluid restriction order, which was discontinued on 03/29/19. A review of the resident's March 2019 MAR reflected a discontinued 1200 mL fluid restriction order dated 03/29/19. A review of the resident's April 2019 MAR reflected no order/accountability for a fluid restriction. A review of the resident's person centered care plan, dated last reviewed on 04/01/19, reflected that the resident was on a 1200 mL fluid restriction. A review of the resident's Progress Notes reflected the following: On 03/30/19 at 00:00, a Nurse Practitioner's (NP) note reflected increased fluid restriction to 1500 mL/day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/30/19 at 00:51, a Skilled Nursing note reflected, fluid restriction in place. On 04/01/19 at 01:33, a Skilled Nursing note reflected, fluid restriction in place. On 04/02/19 at 00:00, a NP note reflected, continue fluid restriction 1500 mL/day. On 04/03/19 at 00:00, a NP note reflected, continue fluid restriction 1500 mL/day. On 04/05/19 at 00:00, a NP note reflected, continue fluid restriction. On 04/05/19 at 01:45, a Skilled Nursing note reflected, fluid restriction in place. On 04/06/19 at 00:11, a Skilled Nursing note reflected, fluid restriction in place. On 04/07/19 at 23:37, a Skilled Nursing note reflected, fluid restriction in place. On 04/08/19 at 00:00, a NP note reflected, will discontinue fluid restriction. On 04/08/19 at 23:38, a Skilled Nursing note reflected, fluid restriction in place. On 04/10/19 at 00:38, a Skilled Nursing note reflected, fluid restriction maintained. During an interview with the surveyor on 04/08/19 at 10:46 AM, the Food Service Account Manager (FSAM) and the Food Service District Manager (FSDM) stated that when there is a new admission or a diet change for a resident, nursing should send a diet slip communication sheet to the kitchen. During an interview with the surveyor on 04/10/19 at 09:12 AM, the Licensed Practical Nurse (LPN) stated that the resident was on a fluid restricted diet and that nursing provides 420 mL of fluid and dietary provides the remainder. Upon review of the current POS and MAR in the presence of the surveyor, the LPN acknowledged that the fluid restriction order had been discontinued and was not indicated on the current POS or the MAR. On 04/10/19 at 09:22 AM, the surveyor and the LPN reviewed the resident's meal ticket on his/her breakfast tray which indicated a fluid restricted diet of 800 mL of liquid to be provided by dietary. During an interview with the surveyor on 04/10/19 at 10:24 AM, the Registered Dietitian (RD) stated that the resident was on a 1200 mL fluid restriction and she thought it was increased to 1500 mL. She further stated that there should have been a physician's order for that and it should have been on the MAR. On 04/10/19 at 10:55 AM, in the presence of the FSDM, the RD stated that the kitchen did not receive any diet communication slips from nursing in regards to the discontinuation of the fluid restriction order on 03/29/19. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 04/10/19 at 11:28 AM, the RD and the FSDM stated that when there is a new admission or a change in a residents diet, nursing is supposed to fill out a diet communication slip. They stated a white copy should be sent to the kitchen and a yellow copy should stay in the resident's chart. The RD stated it could be a problem if a resident was on a fluid restriction after it should have been discontinued. During an interview with the surveyor on 04/11/19 at 08:20 AM, the CD stated that the resident's fluid restriction was discontinued approximately two weeks prior and should not have been receiving a fluid restriction from nursing or the kitchen. He stated that nursing should fill out a communication slip to notify the kitchen of a diet change and he was not sure if that was done. A review of the facility's Communications policy, revised on 06/15/18, reflected that a diet order and communication form indicating a residents name/room, bed and diet order is completed by nursing upon admission, diet change, discharge or room change. The form was to be promptly routed to the Food and Nutrition Services Department and diet changes are implemented immediately. 4. According to the facility Admission Record, Resident #161 was initially admitted on [DATE] and had diagnoses which included, end stage renal disease (kidney failure) and heart failure. A review of the resident's POS, dated 02/14/19, indicated an order for a protein liquid one time a day. There was no evidence of the amount of protein liquid to be given one time a day. A review of the resident's February 2019 MAR reflected that starting on 02/14/19, a protein liquid was given one time a day without accountability for the amount given. A review of the resident's March 2019 MAR reflected that a protein liquid was given one time a day for the entire month without accountability for the amount given. A review of the resident's April 2019 MAR reflected that a protein liquid was given one time a day from 04/01/19 through 04/09/19 of the month without accountability for the amount given. A review of the resident's person centered care plan last reviewed on 04/03/19 reflected an intervention to provide a protein liquid supplement daily as ordered. There was no evidence of the amount of protein liquid to be given daily. During an interview with the surveyor on 04/10/19 at 08:47 AM, the RN stated that the liquid protein supplement was given as a one ounce dose. Upon review of the current POS and MAR in the presence of the surveyor, the RN acknowledged that the amount was not indicated on the current POS or the MAR. She stated the amount should be indicated on both. During an interview with the surveyor on 04/10/19 at 10:10 AM, the Director of Nursing (DON) stated there should be a dose amount for liquid protein supplement orders. During an interview with the surveyor on 04/10/19 at 10:24 AM, the RD stated that a dose amount was usually one ounce but sometimes it could be more and therefore there should have been an amount indicated on the order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 04/11/19 at 08:20 AM, the CD stated that an amount should have been indicated on the POS and MAR for a protein liquid supplement. NJAC: 8:39 - 27.1 (a)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39229 Based on observation, interview and record review, it was determined that the facility failed to ensure that recommendations from the Wound Care Center (Prevalon boots to bilateral feet) were implemented for Resident #156, 1 of 4 residents reviewed for pressure ulcers. This deficient practice was identified for evidenced by the following. On 04/12/19 at 8:17 AM, the surveyor observed Resident #156 in bed, feet covered. The Registered Nurse (RN) Clinical Director (CD) accompanied the surveyor to the resident's room and lifted the sheets to reveal the resident's feet were not off loaded and were directly on the bed. The resident was slightly turned to the left side, with the lateral (outside) and the right medial (middle) ankle against the bed sheet. The sides of the resident's heels were touching the bed. The surveyor observed the resident had a sock on the left foot covering the ankle. The CD stated that the resident's feet should have been off-loaded on a pillow and that the nurses should have checked the resident to make sure it was done. The surveyor reviewed the medical record of Resident #156 and the following was revealed: According to the facility Admission Record, Resident #156 was admitted on [DATE] with diagnoses which included: cerebrovascular disease (stroke), left-sided hemiplegia (weakness) and diabetes (elevated blood sugar). Review of the Admission Minimum Data Set (MDS), an assessment tool dated 03/01/19, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicating moderately impaired cognition. The resident required extensive assistance of two persons with bed mobility and transfers. The MDS further revealed that the resident was at risk for pressure ulcers, but did not have pressure ulcers on admission. Review of Resident #156's Skin Check-V3, dated 02/22/19 revealed that the resident's skin was intact. Additional review of Resident #156's Skin Check-V3, dated 03/01/19, 03/08/19, 03/15/19, and 03/22/19, did not indicate redness to the resident's heels. Review of the Admission Nursing Assessment, dated 02/27/19, revealed that the resident's mobility was very limited and was unable to make significant changes in position independently and needed extensive assistance. In addition, the resident had functional limitation in range of motion which included, weakness to the left and right leg. The assessment revealed that the resident's skin was intact. Review of the Braden Scale for Predicting Pressure Sore Risk assessment revealed that on 03/01/19 the resident had a score of 13 that indicated the resident was at moderate risk for developing a pressure ulcer. On 03/08/19, the resident's score was 15 and on 03/15/19 the resident's score was 16, both indicating mild risk. Review of the Physician Order Summary and Order Audit Report revealed the following orders: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/22/19: A pressure redistribution mattress (a mattress applied to the bed to help against skin breakdown) to bed; 03/19/19: Skin prep to the right heel and cover with ABD and kling daily, discontinued 04/07/19: Skin prep and Allevyn (an absorbent foam dressing) daily every day shift for heel protection; 04/09/19 at 5:18 PM: Apply skin prep to left heel cover with Allevyn every day for heel protection; 04/10/19 at 11:14 AM: Apply skin prep to the right heel, cover with Allevyn every day shift for heel protection. There was no physician order (PO) for the Prevalon boots. Review of the Wound Consults completed by the Nurse Practitioner (NP) dated 03/20/19, revealed that the resident had a Stage 1 right heel non-healed pressure ulcer which measured 3 centimeters (cm) x 3 cm x 0, with erythema (redness of the skin). The NP had recommended a treatment to apply skin prep (a liquid film-forming dressing) with an abdominal gauze pad (ABD) daily and Prevalon boots (protect heels from pressure injuries) to bilateral feet while in bed. Review of subsequent Wound Consults dated 03/27/19 and 04/03/19 revealed no changes in the right heel treatment. Review of both March and April 2019 Treatment Administration Record (TAR) did not reflect the Wound Care Consultant's recommendation for the Prevalon boots. On 04/10/19 at 1:33 PM, a Wound Care Note indicated that a dressing change was done to the left and right heel and described the area as 90% redness and 10% dark discoloration and the left heel had 100% fading redness. During an interview by the surveyor on 04/10/19 at 11:07 AM, the facility Wound Care Registered Nurse (WC/RN) stated she checked the PO prior to Resident #156's wound care and that the facility had been treating the right heel wound. The WC/RN added that when she reported to work on 04/09/19, the left heel was being treated. She reviewed the Skin Integrity Report on the unit with the surveyor, which revealed that there was an assessment for the right heel for 03/20/19 and 03/27/19; however, there was no assessment for the left heel. The WC/RN stated that an assessment should have been completed as soon as the left heel wound was identified. Review of the Progress Notes (PN), dated 02/22/19 through 04/10/19 revealed the following: On 03/27/19 at 4:10 PM, a unit nurse note revealed that the resident was seen for a right heel wound and that treatment was ongoing. On 03/28/19 at 12:36 PM, the Registered Dietician indicated that on wound rounds the resident had a pressure ulcer Stage 1 to the right heel and had recommended a protein supplement for wound healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #156's Plan of Care Response History revealed CNA documentation that the resident had no skin redness observed on 03/14/19 through 03/18/19, 03/25/19 through 03/27/19, and 03/30/19 through 04/11/19. During an interview by the surveyor on 04/11/19 at 10:10 AM, a third floor unit Certified Nurse Aide (CNA) stated that she checks the resident's skin everyday during bathing and if she sees something she tells the nurse and documents in the computer that the skin is reddened. During an interview conducted by the surveyor on 04/12/19 at 8:17 AM, the CD stated that the CNAs should document everyday on the resident's skin and that they should have documented that Resident #156 had redness of the heels. The surveyor reviewed Resident #156's Care Plan (CP), created 02/23/19, which revealed that the resident was at risk for developing pressure ulcers/injuries related to advanced age. There were no goals listed. The CP intervention dated 03/08/19 and revised on 04/06/19, indicated to encourage the resident to consume all fluids of choice during meal. There were no additional interventions on the CP. During an interview by the surveyor on 04/11/19 at 12:15 PM, the DON stated that on admission, the nurse performs a Skin Check Assessment, and would initiate a skin risk care plan. The CD would review the information and add appropriate CP interventions. The DON stated that the staff should have off-loaded Resident #156's heels and further stated that the facility would only do a change of condition for a skin tear and an actual wound but not for redness. During an interview by the surveyor on 04/11/19 at 1:42 PM, the CD stated that off-loading the resident's heels should have been an intervention. He further stated that there were never heel protectors or Prevalon boots ordered or applied to the heels. The CD acknowledged that he believed the heel wounds were avoidable. During an interview by the surveyor on 04/11/19 at 1:30 PM, a third floor RN stated that the facility had a protocol to follow for any resident identified with a wound or skin change. She showed the surveyor the Wound Care Guideline and explained that the nurses would refer to that when any skin breakdown was observed and would place any resident's new non-emergent skin condition on a clip board for the facility NP. She also stated that the CD was responsible to update to the CP. During an interview conducted by the surveyor on 04/11/19 at 1:40 PM, a facility NP stated that she didn't recall a nurse reporting that Resident #156 had a wound. She subsequently revealed at 2:19 PM, that she had reviewed every single note by the facility nurse NPs and there was no a skin assessment found. The NP stated that a skin assessment should have been done by a facility NP. She further stated that if she had known about Resident #156's heel redness, she would have assessed the heels, notified the WC/RN and suggested off-loading the heels. The NP also stated that she was just made aware of the heel wounds on 04/11/19 by the surveyor. Lastly, the NP stated that the DON could have placed Resident #156 on the visit list for the NPs as well for a reddened heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Closer review of the facility Wound Care Guideline revealed the following wound types: Suspected Deep Tissue Injury; Definitions: localized area of discolored intact skin due to damage of underlying soft tissue from pressure and/shear with no wound depth. Stage 1 pressure ulcer is intact skin with non-blanchable redness of a localized area, The prevention guidelines for both DTI and Stage 1 included, but not limited to: offloading device to keep heels off bed. Review of the Skin Integrity Management policy and procedure, dated 11/28/16, revealed the following: Staff continually observes and monitors for changes and implements revisions to the plan of care as needed; Practice Standards: Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated; Determine the need for heel protectors and heel lift devices; Review care plan weekly and revise as indicated. Review of the Clinical Director job description revealed that the CD was responsible for the coordination and direction of nursing and patient care for the assigned unit. It also revealed that the CD was responsible to plan, organize, direct and supervise nursing care provided on the unit. NJAC 8:39-27.1(a)(e)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on observation, interview and record review, it was determined that the facility failed to ensure that all medications were administered without an error of 5% or more. During the medication pass on 04/08/19, the surveyor observed 2 nurses passing medications to 3 residents. There were 28 opportunities and 2 errors which calculated to a medication administration error rate of 7.14%. This deficient practice was identified for 1 of 2 nurses administering medication to 1 of 3 residents (Resident #377) and was evidenced by the following: 1. On 04/08/19 at 9:03 AM, the surveyor observed the third floor medication Registered Nurse (RN) prepare Docusate Sodium (medication for constipation) liquid 50 milligram (mg)/5 milliliter (ml). The medication RN poured the thin liquid medication into a medication cup and proceeded to bring it into Resident #377's room. The surveyor had to intervene as the medication RN was about to assist the resident to drink the thin liquid medication. At this time, the surveyor interviewed the medication RN who stated that she was aware the resident was on nectar thick liquids and wasn't sure why she did not thicken the liquid medication prior administration. According to the facility Admission Record, Resident #377 was admitted on [DATE] with diagnoses that included, dysphagia (difficulty swallowing). Resident #377 was admitted with a physician order, dated 04/05/19, for nectar thickened liquids. A physician order also dated 04/05/19 revealed to administer 20 ml Docusate Sodium by mouth two times a day for constipation. 2. On 04/08/19 at 09:15 AM, the surveyor observed the same third floor medication RN prepare Glycolax Powder (a powder laxative) for Resident #377. The medication RN reconstituted the Glycolax medication, thickened the medication and brought it into Resident #377's room. The medication RN assisted the resident with approximately half the amount of the medication and then left the remaining half of the medication on the resident's over bed table. The medication RN then exited the resident's room and began documenting. At this time, the surveyor interviewed the medication RN who stated that she had completed the medication pass for Resident #377 and was moving on to the next resident. The medication RN acknowledged that medication was not entirely administered as the resident did not consume the contents of the cup and also that the medication should have been left unattended in the resident's room. The surveyor reviewed the facility's Medication Administration: General policy, dated 07/24/18, that was provided by the Administrator. The policy reflected that accepted standards of practice will be followed when administer medication and to not leave medications at patient's bedside. NJAC 8:39 - 29.2(d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38079 Based on observation, interview and review of facility documents, it was determined that the facility failed to properly secure medications in a locked medication cart. This deficient practice was identified for 1 of 4 medication carts reviewed and was evidenced by the following: On 04/04/19 at 09:40 AM, the surveyor, in the presence of the Registered Nurse (RN) Clinical Director, observed a third floor medication cart. The surveyor observed that the medication cart was unlocked and the medication Licensed Practical Nurse (LPN) was at the other end of the hall. On 04/04/19 at 09:41 AM, the surveyor interviewed the medication LPN who stated the medication cart was her responsibility. The medication LPN stated she should not have left the medication cart unlocked because anyone would have had access to it. During an interview conducted by the surveyor on 04/04/19 at 1:24 PM, the Director of Nursing (DON) stated medication carts should be locked when the nurse is not in the immediate area or control of it. A review of the facility, Medication Administration: General policy, provided by the Administrator and dated 07/24/18, revealed, maintain security of cart and keys at all times. NJAC 8:39- 29.4(h)

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on observation, interviews, and record review, it was determined that the facility failed to ensure that a resident, who had a diagnosis of dysphagia (difficulty swallowing) and was at risk for aspiration (when material such as food or drink enters the respiratory tract), was given cola (soda) with the appropriate consistency of nectar like thickness and when the Regisitered Nurse (RN) attempted to administer thin liquid oral medication. This deficient practice was identified for 1 of 12 residents (Resident #377) reviewed that required liquids to be altered for thickness consistency before consuming. The facility's failure to ensure the appropriate liquid consistency for a resident at risk for aspiration resulted in an immediate jeopardy situation to the resident's health and safety who had difficulty swallowing. According to the Speech Therapist's hospital discharge instructions, dated 04/04/19 at 08:00 AM, Resident #377 was to consume liquids with a nectar consistency. A review of the admission physician orders, dated 04/05/19 at 15:18 (3:18 PM), revealed an order for thick liquids-nectar like consistency. This Immediate Jeopardy (IJ) was identified on 04/08/19 at 08:51 AM when Resident #377 was provided with regular (thin consistency) soda that was not altered to nectar thicken consistency and the resident consumed the soda. The IJ was identified by the surveyor and relayed to the Administrator and DON on 04/08/19 at 3:08 PM. The immediacy was corrected on 04/08/19 at 4:35 PM based on an acceptable removal plan that included; physician assessment of the resident, facility reviewed all residents with an order for altered liquid consistency to ensure no thin liquids were present in their rooms; facility immediately in-serviced the staff that was involved in Resident #377's care: Certified Nurse Aide (CNA), Registered Nurse (RN), and RN Clinical Director on aspiration precautions and thickened liquids. On 04/11/19, the facility completed in-service education on aspiration precautions and thickened liquids to all staff and the survey team verified implementation of the removal plan throughout the remainder of the survey. This deficient practice was evidenced by the following: On 04/08/19 at 08:51 AM, during a medication pass observation, the surveyor and third floor medication Registered Nurse (RN #1) arrived at Resident #377's and observed the resident holding an 8-ounce can of soda with a straw in his/her right hand that the resident then placed onto the breakfast tray. The surveyor noted that there was another 8-ounce can of soda on the resident's breakfast tray. At that time, the surveyor brought the soda to the attention of the DON and the RN #1. The DON entered the resident's room picked up the two cans of soda. The DON reported that one of the cans of soda was empty and the other was mostly full and not thickened. The DON asked Resident #377 if he/she had drank the soda and the resident stated yes. The DON and RN #1 both stated that Resident #377 was ordered thickened liquids and should not have been provided the soda without being thickened to nectar like consistency. At that time, the surveyor attempted to interview the resident but was unable due to the resident's aphasia (difficulty speaking). (continued on next page)

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/08/19 at 09:03 AM, the surveyor observed the RN #1 prepare the liquid medication, Docusate Sodium (medication for constipation) 50 milligram (mg)/5 milliliter (ml), 20 ml. RN #1 poured the 20 ml of medication into a plastic medication cup. RN #1 had not thickened the liquid medication to a nectar like consistency. RN #1 brought the liquid medication to Resident #377's room and had begun to lift the cup to the resident's mouth, when the surveyor intervened because the liquid had not been thickened. RN #1 stated she had been aware the resident was on nectar thick liquids and was not sure why she had not thickened the liquids medication when she had prepared it. According to the Admission Record, Resident #377 was admitted to the facility on [DATE] with diagnoses that included: hemiparesis (weakness of one side of the body), and dysphagia. Resident #377's Care Plan, dated on admission 04/05/19 and was on-going, revealed the resident had expressive language impairments and dysphagia with a goal of NLL (nectar-like liquids) as ordered and interventions that included to maintain strict aspirations precautions at mealtime. Resident #377 had a physician order dated 04/05/19 for Docusate Sodium 20 ml by mouth two times a day. A review of a Skilled Nursing PN, dated 04/05/19, revealed the resident was to receive a puree diet and nectar thickened liquids. A review of Resident #377's Skilled Nursing Note, dated 04/05/19, revealed a history of right thalamic hemorrhage (bleeding around the brain) with left hemiparesis and dysphagia. The Skilled Note also revealed, strict aspiration precaution. A review of the food service resident diet list, dated 04/08/19, revealed Resident #377 was to receive nectar like liquids. A review of Resident #377's dietary slips for breakfast, lunch and dinner for 04/08/19 revealed nectar like liquids. During an interview conducted by the surveyor on 04/08/19 at 08:52 AM, the medication Registered Nurse (RN) stated Resident #377 was to receive thickened liquids and should not have been given the cans of soda without being thickened to a nectar-like consistency because of the risk of choking. During an interview conducted by the surveyor on 04/08/19 at 10:55 AM, the third floor CD stated that he had brought the soda cans into the resident's room and left the unopened cans out of the reach of the resident. The RN/CD stated he was aware that the resident had to have thickened liquids and that he had not thickened the soda because he thought the nurse would do it. During an interview conducted by the surveyor on 04/08/19 at 11:15 AM, the Certified Nurses Aide (CNA), who had cared for Resident #377, stated that food trays were handed out by staff other than CNAs most of the time. The CNA stated that if he were to hand out a tray, the nurse would check the diet to ensure the food and liquid were correct first. (continued on next page)

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview conducted by the surveyor on 04/08/19 at 12:38 PM, the Speech Therapist (ST) stated Resident #377 had been admitted with an order for NLL (nectar-like liquids). The ST stated if the resident were to get the thin liquids, there could be a risk of aspiration or pneumonia. The ST stated that everyone in the facility should have provided Resident #377 with nectar thick liquids because it was a doctors order and the resident was at risk for choking or aspiration. The ST stated she evaluated the resident on 04/08/19 for dysphagia and recommended the resident remain on nectar thick liquids. A review of the facility RMS Event Summary Report (incident report), dated 04/08/19, included, Resident admitted to center 4/5 on nectar like liquids. On 04/08/19 at approximately 8:10 am the Resident requested soda from the clinical director. The clinical director went to to the kitchen and brought back two cans of cola which he left on the bedside table a few feet away from the resident. during that time period someone opened the sodas and placed a straw and gave to the resident. The resident drank (1) 8 oz can of cola. During a follow up interview conducted by the surveyor on 04/08/19 at 1:14 PM, the third floor Registered Nurse Clinical Director (CD) stated Resident #377 had been on thick liquids because of effects of stroke. The CD stated he had been aware the resident is ordered nectar thick liquids and that the staff would have also known from verbal reports. The CD further stated that if someone on thickened liquids received thin liquids, they could choke. The CD stated the resident had asked him for soda, and he went to the kitchen and obtained two cans of soda. He then had left the two unopened sodas in the resident's room, on a bedside table a few feet away from the resident, but didn't tell anyone he had done so. He acknowledged that he should not have left the soda without notifying anyone. The CD stated the resident was unable to open the can of soda and that someone would had to have opened the can for the resident. During a follow up interview conducted by the surveyor on 04/08/19 at 1:46 PM, the DON stated that kitchen staff would thicken orange juice or milk before being sent up on the food tray and that all other liquids, such as soda, would be thickened by the nurses. The DON stated the CD should have checked the resident's liquid status and should not have left the soda in the resident's room, even if left unopened, because the resident could have asked anyone to open it. The DON stated that Resident #377 could have aspirated on the thin liquid. Furthermore, the DON stated that staff are aware of resident's diets because the diets are listed in the computer system, on the tray ticket from the kitchen, on the physician order sheet, and given in the daily report. The DON also stated that if a resident requested liquids, the staff inform the resident's nurse and ask what diet the resident was on before providing it to the resident. If a resident is ordered nectar thick liquids and requested thin liquids, the nurse would have to be notified in order to obtain and thicken the liquid to the appropriate consistency. A review of the facility policy, Dysphagia Diet-Liquids provided by the Administrator and dated 06/15/16, revealed residents were to receive liquids in compliance with the physician order, to provide consistent delivery of appropriately thickened liquids. Special request cold beverages are thickened by trained staff members at point of service, and that all spoon thick items are thickened at point of service by trained staff members. A review of the facility policy, Aspiration Precautions provided by the DON and dated 01/02/14, revealed the resident identified as being at risk for aspiration or with a physician order for aspiration precautions will receive appropriate nursing interventions. (continued on next page)

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility policy, Meal Service in Patient's Room provided by the Administrator dated 01/02/14, revealed check items on tray against diet card to ensure correct meal is served and provide beverages as indicated on diet card. A review of the facility policy, Consistency Alterations and Therapeutic Menus provided by the Administrator dated 06/15/18, revealed thickened liquid modifications include Nectar-like. 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 - 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** 40042 Based on observation, interview and review of documentation provided by the facility, it was determined that the facility failed to maintain proper kitchen sanitation practices and properly store potentially hazardous and dry foods in a safe and sanitary environment to prevent the development of food borne illness. This deficient practice was observed during the initial tour of the kitchen and was evidenced by the following: On [DATE] at 09:13 AM, during the initial tour of the kitchen the surveyor observed a Dietary Aide in the kitchen without a hair or beard restraint. In the presence of the Lead Chef, the surveyor observed the following: 1. The Lead Chef washed his hands at the handwashing sink, with a friction time of approximately ,d+[DATE] seconds. During the friction time the Lead Chef reintroduced running water to his hands. The Lead Chef stated that he usually conducted the friction portion of the process for ,d+[DATE] seconds whereby he counts the time in his head. The Lead Chef was unaware that he should not have reintroduced running water to his hands during the friction process. 2. Underneath a prep table (where there was also a prep sink) towards the rear of the kitchen, there was a large orange salad [NAME] which had a brownish substance on top. The Lead Chef acknowledged there was debris and stated it looked like something spilled on it. 3. Underneath a prep table (where there was also a prep sink) towards the rear of the kitchen, there was a robocoupe base and a vita-mix base covered with a brownish substance. The Lead Chef stated it looked like debris. 4. Underneath a prep table (where there was also a prep sink) towards the rear of the kitchen, there was a large white scoop wrapped in clear plastic. The scoop and the plastic were covered with a brownish/reddish substance. The Lead Chef stated he could not identify the substance on the scoop and it should not be used. He removed the scoop and stated that when equipment is covered with plastic it usually indicated that the item had been cleaned and sanitized. 5. Underneath a prep table (where there was also a prep sink) towards the rear of the kitchen, there was a slicer covered with clear plastic. The Lead Chef removed the plastic and stated it had debris on it. 6. A table mounted can opener (on the prep table with the prep sink toward the rear of the kitchen), which the Lead Chef removed from the base. There was a buildup of sticky black and white substances. The Lead Chef acknowledged the buildup and stated it should be cleaned after use. 7. A green cutting board (on the prep table with the prep sink toward the rear of the kitchen), which the Lead Chef stated was used to cut produce, had multiple gouges, as well as a brown and black substance. The Lead Chef was able to rub some of the black substance off the cutting board and stated that this was more debris. He further stated it should not be this way and should not be used. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. A red sanitizer bucket, which had a green scrub pad for cleaning and a white rag inside the liquid content. The Lead Chef tested the water with the chemical test strip and the test strip read zero. He stated it should read 200 ppm (parts per million) to be an effective sanitizing solution. He further stated it should not be used and should have been tested and changed every two hours. He also stated the green scrub pad did not belong in the red bucket because that is used for cleaning not sanitizing. 9. Underneath the other prep table toward the rear of the kitchen, there was a kitchen aide base covered in clear plastic. The Lead Chef uncovered the kitchen aide which revealed a caked on brown and white substance to the underside of the equipment which would be directly over the mixing bowl and potential food product. He stated the white substance could be a splatter/debris from making whipped cream and if it was covered should have been clean. 10. There were multiple opened spices observed with either no date or a receive date; none had open or use by dates. The Lead Chef stated that he did not know spices needed an open date and that spices were good for three months once opened and later stated they were good for two to three years. The following were observed in the presence of the Lead Chef: Lemon pepper received date ,d+[DATE] (no year), no open date. Curry powder no date. Celery Seed no date. Paprika received date ,d+[DATE] (no year), no open date. Fennel received date ,d+[DATE] (no year), no open date. Pickling spice received date ,d+[DATE] (no year), no open date. Old bay (1) no date. Caraway seeds received date ,d+[DATE] (no year), no open date. Crushed red pepper (1) received [DATE], with a label of use by and prep date [DATE] (the Lead Chef could not speak to the meaning of that label). Granulated garlic received date ,d+[DATE] (no year), no open date. Chili powder no date. Cayenne pepper received date ,d+[DATE] (no year), no open date. Onion powder received ,d+[DATE] (no year), no open date. Turmeric received date ,d+[DATE] (no year), no open date. Cloves received date ,d+[DATE] (no year), no open date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Black pepper (1) no date. Sesame seeds received date ,d+[DATE] (no year), no open date. Crushed red pepper (2) received date ,d+[DATE] (no year), no open date. Poppy seeds received date ,d+[DATE] (no year), no open date. Dried chives received date ,d+[DATE] (no year), no open date. Mustard powder received date ,d+[DATE] (no year), no open date. Black pepper (2) received date ,d+[DATE] (no year), no open date. Nutmeg received date ,d+[DATE] (no year), no open date. Cinnamon (1) received date ,d+[DATE] (no year), no open date. Poultry seasoning received date ,d+[DATE] (no year), no open date. Cinnamon (2) received date ,d+[DATE] (no year), no open date. Old bay (2) received date ,d+[DATE] (no year), no open date. Ground cloves received date ,d+[DATE] (no year), no open date. Dill received date ,d+[DATE] (no year), no open date. Thyme no date. Ginger received date ,d+[DATE] (no year), no open date. Chocolate syrup received date ,d+[DATE] (no year), no open date. Italian seasoning with manufacturers label and dated received ,d+[DATE] (no year); however, written on the container (twice) with black marker was JERK and a date of ,d+[DATE] (no year). The Lead Chef acknowledged the contents were a jerk seasoning. He could not explain the dates and he could not speak to whether the container could be reused and if it had been properly cleaned and sanitized prior to filling with the jerk seasoning. 11. On top of the prep table toward the rear of the kitchen, there was a white cutting board and another green cutting board. The Lead Chef stated that it was laid out for use and they should have been clean but were not. He acknowledged they had evidence of a black substance and multiple score marks. 12. Underneath the prep table toward the rear of the kitchen, there was a cardboard holder for plastic wrap with the top ripped off leaving the plastic wrap exposed to the environment. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	22. Inside the walk-in refrigerator there was an open one-gallon container of mayonnaise (1) with a received date of ,d+[DATE] (no year), no open date. When the surveyor inquired how long is it good for once opened, the FSAM stated we go by the best by date. The FSAM acknowledged there was no best by date on the container. The following opened products were observed in the walk-in refrigerator in the presence of the FSAM: One-gallon French dressing, received date ,d+[DATE] (no year), no open date or best by date. One-gallon mayonnaise (2), received date ,d+[DATE] (no year), no open date or best by date. One-gallon mustard, received date ,d+[DATE] (no year), no open date or best by date. One-gallon salsa, received date ,d+[DATE] (no year), no open date or best by date. One gallon Thousand island dressing, received date ,d+[DATE] (no year), no open date or best by date. One-gallon Italian dressing, received date ,d+[DATE] (no year), no open date or best by date. One-gallon raw garlic cloves, received date ,d+[DATE](no year), no open date or best by date. One-gallon blue cheese dressing, received date ,d+[DATE] (no year), no open date or best by date. One-gallon Caesar dressing, received date ,d+[DATE] (no year), no open date or best by date. Four-pound eight-ounce maraschino cherries, received date ,d+[DATE] (no year), no open date or best by date. Large jar lime juice, received date ,d+[DATE] (no year), no open date or best by date. 23. Inside the walk-in refrigerator, there was a large shallow plastic bin labeled with a date of ,d+[DATE] (no year). Inside the bin were loose green peppers, one yellow squash and one butternut squash. There was also a bag of fresh parsley and two bags of celery with received dates. The FSAM could not speak to when the loose produce was received and stated the date on the bin should have been changed. 24. Inside the walk-in refrigerator, there was a piece of deli provolone cheese wrapped in plastic with a date of ,d+[DATE] (no year). The FSAM stated that was the date the product was opened, and she was not sure how long it could be used for. She further stated that cheeses are used quickly and if not, she would be guided by the expiration date. There was no observed expiration date on this cheese and there was an observation of an unopened five-pound package of sliced American cheese without an expiration date. On [DATE] at 10:10 AM: 25. Inside the dry storage area, there were two uncovered plastic bins that had coffee filters stored upright and exposed to the environment. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	26. There was an opened six-pound container of rainbow sprinkles with a received date of ,d+[DATE] (no year) and no opened date. 27. There were ingredient bins for sugar and panko bread crumbs. Both containers had a yellow sticky substance on the outside rims. The FSAM acknowledged there was a sticky debris. On [DATE] at 10:16 AM, the surveyor observed the prep area toward the rear of the kitchen with the FSAM and reviewed the aforementioned concerns that were identified in the presence of the Lead Chef. The FSAM stated that the red sanitizer buckets are set up by the cooks and changed every few hours. She further stated that there was no accountability log used for this task. The FSAM also stated that the green scrub pad for cleaning should not have been in the sanitizing solution. In addition, the FSAM acknowledged that the observed cutting boards (one white and two green) had debris and gouges. 28. The single door dairy reach in refrigerator had three white racks inside which had a white and brownish substance (the FSAM was able to wipe this off with her hand). There were eight expired half gallon milks (expiration date ,d+[DATE]) and one expired half gallon milk (expiration ,d+[DATE]). The FSAM discarded this product and could not speak to why the product had remained in the refrigerator after the expiration dates. The refrigerator temperature log was filled out for the PM prematurely. 29. There was a garbage can next to and in front of cooking equipment that had open food on top. The garbage was overflowing and was uncovered. On [DATE] at 10:23 AM, the surveyor asked the FSAM for a calibrated thermometer. She stated she did not know how to calibrate a thermometer. On [DATE] at 10:25 AM, the surveyor in the presence of Sous Chef #1, Sous Chef #2 and the FSAM calibrated a [NAME] digital thermometer to 32.2 degrees Fahrenheit (F). At the end of the breakfast meal, the FSAM took the temperature of three breakfast items; eggs (mix of raw and liquid), French toast batter (eggs, cream, cinnamon and nutmeg) and pancake batter. The temperatures were as follows: 56 degrees F, 57.1 degrees F, and 57.1 degrees F. Both Sous Chef 1 and the FSAM stated that the temperatures were too high. Sous Chef 1 stated that they started at 05:30 AM and the products are placed on ice. He further stated they usually add ice, but they did not today. 30. There was a lowerator between the juice and coffee machine tables. On the bottom and perimeter of this area, were spots with black granulated and liquid substances. The FSAM stated that clean cups are stored there in an inverted position. That would expose the mouth end of the cups directly over the soiled area. The FSAM stated that the substance may be coffee grinds and it should not be there. She further stated that there could be cross contamination with the clean cups if stored there. 31. There was an under counter refrigerator under the coffee machine. There was a buildup of yellow and red liquid substance on the bottom of the refrigerator. The FSAM stated the spills should have been cleaned. 32. There was a two well plate warmer with a grease like brownish/reddish substance. The FSAM stated it was residue and dust. She stated it should have been cleaned. (continued on next page)

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	315522	A. Building B. Wing	04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accelerate Skilled Nursing and Rehab Piscataway	10 Sterling Drive Piscataway, NJ 08854

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	33. The back side and groove area of the tilted braiser had a buildup of a black substance. Sous Chef #1 stated it is cleaned daily. 34. There were five hood filters over the cooking area that had a grease-like orange build up. The FSAM stated that they are cleaned by the professional company. 35. There was a heavy buildup of a black caked on substance on the six-range stove top. Sous Chef #1 stated that it is cleaned daily and the grates are scraped off and put the dish machine every night. 36. Under the grill, was a shelf that held a sheet pan with multiple containers of ingredients on top. There was a black liquid substance on the pan and under the containers. Sous Chef 1 stated the residue was not new. 37. There was a four-well steam table filled with water one-third of the way in each. There were floating particles in all four wells. The underside of the steam table countertop (over the wells) was covered with a brownish/reddish caked on substance. 38. There was a red sanitizer bucket with liquid under the steam table. The FSAM tested the water with the chemical strips and it read zero. She stated that she was not sure what it should be, maybe 500. 39. The was a long narrow white plastic cutting board in front of the steam table with a brownish substance in the gouged areas. 40. Under the steam table there was a clear plastic container covered with plastic with a date of ,d+[DATE] (no year). The FSAM stated the product was pita chips made in-house and that date could not be correct. 41. Stored under the steam table was an opened bottle of lemon juice. The instructions on the bottle were to refrigerate after opening. The FSAM discarded the bottle. 42. Underneath the steam table, there was a cardboard holder for plastic wrap with the top ripped off leaving the plastic wrap exposed to the environment. There were particles inside the cardboard holder near the plastic wrap. The FSAM acknowledged that the debris was from food and that if the plastic wrap was used to cover food it should not be exposed. 43. To the right of the steam table, there was under counter refrigeration. In the presence of the FSAM the following was observed: A deep one-third size pan of tuna salad with a prepared date ,d+[DATE] (no year) and another date , d+[DATE]. The FSAM stated that was the prepared and use by dates. A deep one-third size pan of sliced turkey with no date. A deep one-third size pan of sliced provolone cheese (approximately ,d+[DATE] slices) with a date of , d+[DATE] (no year). The FSAM could not speak to the meaning of that date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A small clear plastic container of sliced ham dated ,d+[DATE] (no year), no use by date. The FSAM stated it was good for seven days. A five-pound jar of olives dated ,d+[DATE] (no year), no open date. A small pan of chopped ham dates of ,d+[DATE] and ,d+[DATE] (no year). The FSAM stated that was the prepared and use by dates. A large clear plastic bin of potato salad dated ,d+[DATE] (no year), no use by date. Two-thirds of a deli ham wrapped in plastic with no date. 44. Above the under counter refrigeration, there was a white plastic cutting board that had a brownish substance in the gouges. 45. To the right of the under counter refrigeration, there was a wire rack with six large clear bins. There was debris on the lids and inside bins. The bins held small wares china and plastic portioning containers. Two containers did not have lids. The FSAM stated that the bins should have covers to keep the products free from debris. 46. There were approximately 70 clean induction bottoms on a soiled drying rack. The FSAM stated that there was debris and dust on the rack and the clean induction bottoms should not be there. 47. There was an open uncovered garbage can next to a clean rack that held clean meal trays. On [DATE] at 11:20 AM: 48. The following items were observed on the clean equipment racks: A yellow cutting board with a red caked-on substance. The FSAM was able to remove some of the substance with her nail and placed the board in the dirty pot area. A half sheet pan was stored upright and exposed. It had a white powdery substance. The FSAM removed it. Twelve upright and exposed small black bowls, which the FSAM stated were used for salad dressing. On [DATE] at 11:30 AM, in the presence of the Administrator, the surveyor interviewed the Food Service District Manager (FSDM) who stated that the temperature logs for the refrigerators should not have been filled out for the PM in the morning and could not speak to why that happened. He further stated that when bulk or deli items were opened, the items would be good for seven days. He was not certain about spices. On [DATE] at 2:11 PM, in the presence of the Administrator, the surveyor observed the same Dietary Aide not wearing a beard net while portioning food into styrofoam partitioned containers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's policy Personal Hygiene, with a revised date [DATE], reflected that Food and Nutrition Services employees are to wear hair restraints such as hats, hair coverings, or nets to effectively keep hair from contacting exposed food. Facial hair coverings are used to cover all facial hair. A review of the facility's policy Hand Hygiene, with a revised date [DATE], reflected a hand hygiene technique for washing hands with soap and water as follows: Wet hands with warm (not hot) water, apply soap to both hands, and rub hands vigorously outside the stream of water for 20 seconds covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use clean, dry, disposable towel to turn off faucet. A review of the Food Services District Manager Unit Inspection Report, dated [DATE], reflected that he/she observed staff washing hands between tasks for at least 20 seconds. A review of the facility's policy Refrigeration/Freezer Temperature Standards, revised [DATE], reflected that the Director or designee record the temperatures of refrigerators and freezers daily using the Refrigerator/Freezer Temperature Log. This log indicated to take temperatures during the AM and PM shift. A review of the facility's undated Cleaning Procedure - Cleaning Clothes, reflected sanitizer bucket with sanitizing solution used for food contact and non-food contact surfaces should yield a chemical reading of , d+[DATE] ppm. It further indicated that the solution should be changed three times daily, when visibly soiled, or when the sanitizer solution falls below minimum ppm requirements. The policy indicated that cleaning clothes are placed in the solution when they are not in use. The policy did not reference scrub pads. A review of the facility's policy Cleaning Schedule, revised [DATE] reflected a purpose to maintain a clean and sanitary Food and Nutrition Services Department and prevent the growth of bacteria. The Department Cleaning Schedule included all the equipment and areas in the department, frequency of cleaning, and position assigned. A review of the Food and Nutrition Services Department Cleaning Schedule, for the weeks of [DATE], [DATE], and [DATE], did not reflect cleaning of the soiled items observed on tour. A review of the facility's policy Food Handling, revised [DATE], reflected a policy and procedure that foods are stored, prepared and served in a safe and sanitary manner to prevent bacterial contamination and the possible spread of infection. It further reflected the following: Employees utilizing thermometers can perform calibration. Foods that are prepared and not placed into service should be dated with a use by date. Once a product has been prepared or portioned, a use by date was established (Use By Dating Guidelines are referenced). Products that have been opened but not fully used, a use by date was included on the label. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's Food and Nutrition Services Use By Dating Guidelines, revised [DATE], reflected the following: The manufacturer's expiration date, when available, was the use by for unopened items. Guidelines assume that food was properly stored, covered and handled. Items such as cheese, cooked foods, produce, prepared salads, sliced meats and unused portions should have a use by date seven days after opening. Bulk items such as mustard, and salad dressing should have a use by date 30 days after opening. Liquid/flavorings such as syrup and vanilla extract should have a use by date six months after opening. Frozen foods stored in the freezer should have a use by date of 45 days after opening and properly closed. A review of the undated Food Storage and Retention Guide provided by the FSDM reflected the following: Food in a form that was edible without additional preparation to achieve food safety such as deli meats and salads can be stored at or under 41 degrees Fahrenheit for up to seven days. Herbs, dried and spices can be stored for six months once opened. A review of the facility's Cleaning Procedure - Warewashing Manual, dated [DATE], reflected that after equipment was cleaned and sanitized, place inverted to drain and air dry. NJAC 8:,d+[DATE].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. 38079 Based on observation, interview and review of facility documents, it was determined that the facility failed to minimize the exposure risk of contamination of resident care items. This deficient practice was identified for 2 of 2 clean linen storage areas reviewed and was evidenced by the following: On 04/10/19 at 08:11 AM, the surveyor observed the Clean Linen Storage Room located on the second floor and noted the door was propped open with the protective covering for the linen cart open, which exposed the supply items for resident use to the environment. Stored on a counter in the back of the storage room, the surveyor observed open cardboard boxes (without tops) that contained resident incontinent briefs. The incontinent briefs had been removed from their protective packages and were exposed to the environment. Stored on top of the linen cart, the surveyor observed clear plastic garbage bags and fitted sheets. The surveyor noted there were incontinent briefs out of their protective packages stored on the bottom of a wired shelf, exposed to the environment. The storage room floor contained debris of gloves and plastic box ties. During an interview conducted by the surveyor on 04/10/19 at 08:10 AM, a restorative Certified Nursing Assistant (CNA) who had been in the same hall stated that the door should not have been propped open, that the items in the carts should have had their protective drapes down and that the incontinent briefs should not have been removed from their protective packages. The restorative CNA stated that the items could have been dropped on the ground, exposed to dirt and become an infection control concern. During an interview conducted by the surveyor on 04/10/19 at 08:16 AM, the Director of Nursing (DON) stated that the clean linen storage room door should always be shut and that the items inside should not be left out. The DON stated it would be an infection control issue. On 04/10/19 at 08:19 AM, in the presence of the Registered Nurse (RN) Clinical Director (CD), the surveyor observed the third floor Clean Linen Storage room. The Clean Linen Storage room contained a linen cart inside the room had clear plastic garbage bags on the top, resident incontinent briefs out of their protective packaging and piled in a cardboard box with the top removed, an orange jacket on top of the wired shelving, a box of face masks with the top removed that exposed the masks inside to the environment and bags of incontinent briefs that had been torn open, on the counter and shelf as well and exposed the incontinent briefs to the environment. The storage room also contained debris of gloves and plastic box ties on the floor. The CD stated the clean linen storage room should not be like this. The CD also stated there should not have been any personal items placed on resident use items or any resident use items left exposed to the environment because it would be an infection control issue. A review of the facility, Linen Handling policy, dated 03/01/18 provided by the DON, revealed that all linen will be stored to contain and minimize exposure; to maintain clean linen in a closed storage area and keep clean linen covered using standard precautions. NJAC 8:39-19.4(a)(1-6), 19.4(l), 21.1(d)