

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315397	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2021
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NAME OF PROVIDER OR SUPPLIER PREFERRED CARE AT WALL	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 HOSPITAL ROAD ALLENWOOD, NJ 08720
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F 000	<p>INITIAL COMMENTS</p> <p>DATE: 3/9/21</p> <p>CENSUS: 127</p> <p>SAMPLE: 25</p> <p>A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.</p> <p>A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.</p>	F 000		
F 550 SS=D	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p>	F 550		4/7/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/01/2021
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	<p>Continued From page 1</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure residents were served their meals in a dignified manner during meal services. This deficient practice was identified on 1 of 3 nursing units (██████) and was evidence by the following:</p> <p>1. On 3/3/21 from 8:15 AM to 9:05 AM, the surveyor made the following meal observations in the dayroom on ██████:</p> <p>There were ten residents observed, who were all socially distanced and wore surgical masks at dining tables. The Licensed Practical Nurse/Unit</p>	F 550	<p>-Residents # 16, 77,101,85, and #13's trays were reorganized in the meal trucks to ensure that trays are served timely and in accordance to the dining room seating arrangement and residents who sit at the same table are served at the same time.</p> <p>On 3/8/21 a QAPI was initiated for Meal Service Delivery to include timely delivery of food trays, maintaining acceptable food temperature, serving residents together in the same table or room.</p> <p>-CNA's and nurses involved were</p>	

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F 550	<p>Continued From page 2</p> <p>Manager (LPN/UM) stated that these residents were high fall risks and could not remain in their rooms for safety reasons. The LPN/UM stated that breakfast usually arrived around 7:45/8:00 AM.</p> <p>At 8:16 AM, the surveyor observed Resident #16 in the dayroom, communicate to the LPN/UM that they were hungry. The LPN/UM informed the resident that she was aware that they were hungry and breakfast would arrive soon. At 8:30 AM, the resident, watching other residents eat breakfast, communicated to the LPN/UM that they were hungry. At this time, the LPN/UM gave the resident some juice. At 8:44 AM, the resident received their breakfast tray.</p> <p>At 8:20 AM, the surveyor observed the dining truck arrive to [REDACTED] and the food was immediately served by the nursing staff. There were ten residents sitting in the dayroom for breakfast. Six out of the ten residents received their meal trays and were eating breakfast. The LPN/UM stated that the other four residents' meal trays were on a separate truck.</p> <p>At 8:30 AM, Resident #77 was in the dayroom and stated that they were hungry. At this time, six other residents around him/her were all eating breakfast. At 9:05 AM, the resident received their breakfast tray.</p> <p>2. On 3/3/21 between 1:00 PM and 1:48 PM, the surveyor made the following meal observations in the dayroom on [REDACTED]</p> <p>At 1:04 PM, the lunch trays arrived to [REDACTED] dayroom. Seven of the eleven residents were eating lunch. The four residents not eating lunch were waiting for their meals on a separate dining</p>	F 550	<p>provided with 1:1 re-education on 3/9/21 with regards to serving tray in a timely manner and to offer snacks or juice if there is a delay in the meal truck delivery.</p> <p>- Residents who dine in the [REDACTED] dayroom have the potential to be affected by the cited practices.</p> <p>The Food Service Director and dietary staff were in- serviced regarding timely food truck delivery to the units, maintaining food temperature and proper organization of meal. This in service was initiated on 3/9/21.</p> <p>Meal trucks delivery were re-arranged in accordance with the dining room/day room seating arrangement to ensure that residents who eat in same table are served at the same time.</p> <p>Changes on the seating arrangement of residents who dine in the dining room / day room will be communicated by Unit Manager to the FSD.</p> <p>Nursing staff was re- in-serviced regarding meal service being served timely when meals are delivered. Those at the same tables are to be served at the same time. If while trays are being delivered resident request something to eat, staff will offer snack until delivery of trays can be made. This in service was initiated on 3/10/21 and on-going.</p> <p>The in-services will be given annually and during orientation for newly hired Nursing and Dietary staff and when deemed necessary.</p>		

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F 550	<p>Continued From page 3 truck.</p> <p>At 1:14 PM, Resident #101, who was eating lunch, asked Resident #77 if they were not eating lunch today. Resident #77 responded that they were hungry, and waiting for lunch. At 1:26 PM, Resident #77 informed staff that they were hungry, and staff stated that the lunch trays were on the way. At this time, an Activity Aide began clearing the residents' meal trays that were already served lunch, who were finished eating.</p> <p>At 1:32 PM, one of the four residents (Resident #16) who was in the dayroom still waiting on lunch, received their meal tray.</p> <p>At 1:42 PM, an additional resident (Resident #40) arrived to the dayroom stating they were hungry. That resident self-propelled to a table with a resident currently eating lunch, and took the sherbet off of that resident's tray and began eating it.</p> <p>At 1:48 PM, the last resident in the dayroom who had not received a meal tray, Resident #85, received their lunch.</p> <p>3. On 3/5/21 from 8:00 AM to 8:46 AM, the surveyor made the following meal observations in the [REDACTED] dayroom:</p> <p>At 8:14 AM, the first meal truck arrived to [REDACTED]. At 8:19 AM, the surveyor observed six of the ten residents in the dayroom receive their breakfast trays.</p> <p>At 8:22 AM, the surveyor observed three residents (Resident #13, #77, and #85), socially distanced and masked, sitting at one table. Resident #77 complained that they were hungry</p>	F 550	<p>The Food Service Director or designee will perform weekly audits x 4 weeks then monthly x 5 months for inspection of tray organization in meal cart and timely delivery of meal trucks to ensure they are in proper arrangement in accordance with seating arrangement. Audits will be completed for 5 trucks alternately covering all meals. Action will be taken for any negative result.</p> <p>Unit Managers and or designee will perform weekly audits for 15 residents alternately covering all meals x 4 weeks and then monthly x 5 months for timely meal delivery to residents in accordance to residents seating arrangement. Any negative result will be addressed immediately.</p> <p>Reports of audits will be presented to Quality assurance committee Who meet quarterly who will review and determine frequency and necessity for future audits.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 550	<p>Continued From page 4</p> <p>and asked staff for breakfast. The resident then stated to the other two residents that they were "starving."</p> <p>At 8:27 AM, Resident #77 and #85 began banging their hands on the table shouting, "We want food." Staff observed this, and no actions were taken.</p> <p>At 8:29 AM, Resident #85 told the Certified Nursing Aide (CNA) to go to the kitchen and tell them that we are hungry; The CNA did not respond.</p> <p>At 8:38 AM, the second meal truck arrived to [REDACTED] Residents #77 and #85 received their breakfast trays at 8:42 AM and Resident #13 received their breakfast tray at 8:46 AM.</p> <p>A review of the Meal Service list provided by the Licensed Nursing Home Administrator (LNHA) from entrance conference reflected that breakfast on the [REDACTED] was served at 7:45 AM and lunch was served at 12:30 PM. The paper indicated to please allow fifteen minutes plus or minus on delivery times.</p> <p>On 3/9/21 at 9:16 AM, the LNHA in the presence of the Director of Nursing (DON), Assistant Director of Nursing (ADON), and survey team, stated that residents on [REDACTED] should have been fed at the same time.</p> <p>At this time, the DON acknowledged that staff should have offered the residents who were expressing hunger something to eat at that time.</p> <p>A review of the facility's Nutritional Services policy dated 3/14/14 and revised date 3/9/15 included that the Dietary Department will develop an order</p>	F 550			

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F 550	Continued From page 5 of service for all meals which best suits the needs of the residents. The scheduled order will be followed.	F 550			
F 755 SS=D	<p>N.J.A.C. 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced</p>	F 755		4/7/21	

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F 755	<p>Continued From page 6</p> <p>by: Based on observation, interview, and record review, it was determined that the facility failed to:</p> <p>a) properly store medication; and b) accurately administer medication for 2 of 2 residents during medication administration (Resident #37 and Resident # 44).</p> <p>This deficient practice was evidence by the following:</p> <p>1. On 03/02/21 at 11:46 AM, on the [redacted] Unit during medication administration, the surveyor observed LPN #1 walk into Resident #37's room to administer medication. LPN #1 placed the following items on the resident's bedside table: [redacted], which was stored in a clear bag, a [redacted], a container of [redacted], and an [redacted]. LPN #1 stated that she had to get an alcohol pad before testing Resident #37's [redacted]. LPN #1 walked out of the room, then later returned, holding the alcohol pad in her hand. Resident #37 was alone in the room, and the items mentioned above remained on the bedside table out of sight of the nurse.</p> <p>According to the facility admission record, Resident #37 was admitted in [redacted] with diagnoses that included but were not limited to, [redacted] and [redacted].</p> <p>A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1 [redacted], revealed that Resident #37's [redacted].</p>	F 755	<p>LPN #1 was re-educated on 3/3/21 regarding proper medication storage, keeping cart within view at all times, and not leaving [redacted] medication at bedside and preparing for medication administration to ensure all needed items are readily available. Med Pass observation competency was completed with LPN #1 on 3/3/21 to ensure proper facility's policy and procedures for medication storage are followed, and medication cart is locked and secured when unattended, and not leaving [redacted] at bedside.</p> <p>LPN #2 was re-educated on 3/2/21 regarding facility's protocol for unavailable medication. This included a No Borrowing Policy. Informing the pharmacy of needed medications and checking the backup medication for availability and the process for timely re-ordering medication refills. Medication Administration Observation was conducted on 3/5/21 for LPN #2</p> <p>Resident # 44 [redacted] medication was ordered and received from the pharmacy on [redacted]. Resident received the [redacted] medication as ordered.</p> <p>Residents that require [redacted] administration and residents who have a physician's order for [redacted] have the potential to be affected by this cited deficient practices.</p> <p>Re-education for Licensed nurses was initiated on 3/11/21 and on-going on the following:</p>	

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F 755	<p>Continued From page 7</p> <p>A review of the Physician Order Summary Report (POS) dated [REDACTED] revealed an order for [REDACTED]. The POS had a start date of [REDACTED] and no end date.</p> <p>On the same day at 11:53 AM, the surveyor interviewed LPN #1, who stated, "I should have brought everything with me." LPN #1 also mentioned that the facility's policy was not to leave medications at the bedside.</p> <p>On 03/05/21 at 12:22 PM, the surveyor interviewed the Infection Prevention Officer (IPO). The IPO stated that she was responsible for educating staff and for the completion of medication administration competencies. The IPO added that medication administration competencies consisted of handwashing, medication administration time, reading of medication, types of medication and how they were given, signing off of medications, storing medications, side effects, and what to monitor. IPO stated that medications should not be left at the bedside unattended, "Because somebody may come in and take them."</p> <p>On the same day, at 1:51 PM, the surveyor interviewed the Administrator and Director of Nursing (DON) in the presence of the survey team. The DON stated that LPN #1 should have taken the [REDACTED] with her. The DON added that competency was an observation of skill and done with staff by the IPO.</p> <p>A review of the LPN #1 Orientation Checklist revealed a performance skill that consisted of Medication Administration: Medication Pass dated [REDACTED]</p>	F 755	<p>a. medication storage,</p> <p>b. medication administration of [REDACTED] policy to ensure all needed items for [REDACTED] administration are readily available and not leaving [REDACTED] medication at the resident's bedside.</p> <p>c. and facility's "No Medication Borrowing" policy.</p> <p>d. Proper procedures of re-ordering of medications per facility's policy.</p> <p>e. Back-up Medication availability These In-services will be provided annually, during orientation for newly hired Nurses, and when deemed necessary. Unit Managers and or Nurse designee will complete a Medication Pass observation for 5 license nurses per week x 4 weeks and then monthly x 5 months to ensure that [REDACTED] medication are not left in the residents room, nurses are not borrowing medication, and medication carts are not left unlocked and unattended. Any negative findings will be addressed immediately by giving one on one re-education and or disciplinary actions as appropriate. Unit Managers and or nurse designee will audit 10 residents per week x 4 weeks and then monthly x 5 months to ensure the proper procedures when re-ordering for medication refill to the pharmacy is followed.</p> <p>Reports of audits will be presented to Quality assurance committee Who meet quarterly who will review and determine frequency and necessity for future audits.</p>		

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F 755	<p>Continued From page 8</p> <p>A review of the facility's policy and procedure titled Medication Storage, created 11-17, read: Medications housed on our premises are stored in the medication carts and or medication rooms according to State, Federal, and the manufacturer's recommendations. All medications are stored in designated areas sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.</p> <p>A review of the facility's undated policy and procedure titled Medication Administration Procedures, read under Procedures A:</p> <p>Security: All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/aide.</p> <p>On 03/8/21 at 1:35 PM, the surveyor interviewed the Consultant Pharmacist (CP), who confirmed that medications should not be left at the resident's bedside.</p> <p>2. On 03/04/21 at 11:32 AM, the surveyor, observed LPN #2's medication cart located on [REDACTED] Unit. Upon inspection, it revealed no [REDACTED] mg available for Resident #44, yet the Medication Administration Record (MAR) reflected that the medication was administered that morning by LPN #2.</p> <p>According to the facility admission record, Resident #44 was admitted in [REDACTED] with diagnoses that included but were not limited to [REDACTED]</p>	F 755			

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F 755	<p>Continued From page 9</p> <p>A review of the Quarterly Minimum Data Set (MDS) dated [REDACTED] revealed that Resident #44's cognition was [REDACTED].</p> <p>A review of the Physician Order Summary Report (POS) dated [REDACTED] revealed an order for [REDACTED] MG, Give one tablet by mouth one time a day related to [REDACTED]. The POS had a start date of [REDACTED] and no end date.</p> <p>At that time, the surveyor interviewed LPN #2, who stated that she had administered [REDACTED] milligrams (mg) to Resident #44. LPN #2 also mentioned that the medication was borrowed from Resident #70. LPN #2 stated that the process for acquiring medication when out of stock was to inform the pharmacy by fax and obtain the medication from the backup house stock locked on [REDACTED] Unit and notify the physician.</p> <p>A review of the POS for Resident #70 revealed an order for [REDACTED] MG, give one tablet by mouth one time a day for [REDACTED]. The POS had a start date of [REDACTED] and no end date.</p> <p>At 12:00 PM, the surveyor interviewed the Unit Manager (UM), who stated that when a medication was not available, the process was to call the physician informing them that the medication was not available at the facility, receive orders whether to hold or give another medication and obtain the medication from the backup box located on [REDACTED] Unit. The UM stated medications were not to be borrowed from other</p>	F 755		

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F 755	<p>Continued From page 10</p> <p>residents, and it was not good practice. The UM continued to mention that it was the ownership of the resident whose medication was borrowed from and that the resident can run out, resulting in the medication not being given as scheduled. The UM mentioned that documentation in the MAR should reflect awaiting delivery and not available.</p> <p>At 1:21 PM, the surveyor interviewed LPN #2 in the presence of the survey team. LPN #2 stated she would need to clarify the facility's borrowing protocol. LPN #2 mentioned that the nursing practice was not to borrow from other residents and that she did not check the medication backup box.</p> <p>At 1:41 PM, the surveyor interviewed the DON in the presence of the survey team. The DON confirmed that the facility does not have a borrowing protocol. The DON stated that the process was for obtaining the resident's medications was to remove the sticker and place it on paper to fax to the pharmacy, call the physician and follow through with the orders obtained. The DON mentioned that Pantoprazole was not one of the medications stored in the backup box. The DON also confirmed that medications were not borrowed from other residents because, "That's somebody else's medication, they paid for it."</p> <p>On 03/05/21 at 09:23 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and DON in the survey team's presence. The LNHA stated that nurses should not be borrowing medications from any resident. The LNHA and DON confirmed that the facility did not have a borrowing protocol, and the DON then added that she looked on the backup box medication list and noticed that Pantoprazole</p>	F 755			

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F 755	<p>Continued From page 11 was included.</p> <p>A review of the LPN #2 Orientation Checklist provided by the DON revealed a performance skill that consisted of Medication Administration: Medication Pass dated [REDACTED].</p> <p>A review of the facility's form titled, Patient Medication Usage Form read under procedures:</p> <ol style="list-style-type: none"> 1. Remove medication from Back-up Box 2. Complete replacement request form indicate quantity used 3. Fax completed form to the pharmacy <p>The form revealed under the section labeled Non-Antibiotics, [REDACTED] MG Tab [REDACTED] was listed as a medication in the backup box.</p> <p>A review of the Consultant Pharmacists guidance provided by the facility, indicated under Administration of Medication - State Regulation (Pour, Pass, and Sign); under number 3, it read, medication not in the medication cart must be obtained from the backup pharmacy/alternate source. Not available is not acceptable. Never borrow.</p> <p>On 3/8/21 at 1:35 PM, the surveyor interviewed the CP, who confirmed that medications should not be borrowed from another Residents medications.</p>	F 755			
F 804 SS=D	<p>NJAC 8:39 - 29.2</p> <p>Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)</p> <p>§483.60(d) Food and drink Each resident receives and the facility provides-</p>	F 804		4/7/21	

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F 804	<p>Continued From page 12</p> <p>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;</p> <p>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure appetizing and palatable temperature of food for a resident who required assistance for eating. This deficient practice was observed for 1 of 2 residents reviewed for feeding assistance (Resident #70), and was evidenced by the following:</p> <p>On 3/1/21 at 12:40 PM, the surveyor observed Resident #70 lying in bed. The resident refused to speak with the surveyor.</p> <p>The surveyor reviewed the medical record for Resident #70.</p> <p>A review of the Admission Record reflected that the resident was admitted to the facility in [REDACTED] with diagnoses which included [REDACTED]</p> <p>A review of the most recent quarterly Minimum Data Set (MDS), a tool used to facilitate the management of care dated [REDACTED], indicated that the resident had a Brief Interview for Mental Status (BIMS) score of [REDACTED] which indicated that the resident had a [REDACTED]</p>	F 804	<p>Resident #70's tray and the roommate were moved to the second truck delivery, to ensure that meal trays will be delivered on a timely manner and staff are available to provide assistance in feeding for the resident.</p> <p>The involved Nursing staff were re-educated 3/10/21 regarding timely delivery of meal tray to residents that are in the same room and providing assistance to resident who requires feeding assistance.</p> <p>The Food Service Director and dietary staff were in- serviced regarding timely meal delivery, food temperature and proper organization of meal trays in the food trucks on 3/9/21</p> <p>QAPI for Food Service Delivery to include timely delivery of food trays, maintaining acceptable food temperature, serving residents together in the same table or room was initiated on 3/8/21 and implementation of the QAPI was initiated on 3/9/21.</p> <p>Residents who eat in their rooms and who require feeding assistance have the potential to be affected by this cited deficient practice.</p>	

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F 804	<p>Continued From page 13</p> <p>██████████</p> <p>A further review of the MDS Section ██████ Functional Status reflected that the resident required extensive assistance of one person physical assistance for eating.</p> <p>A review of the resident's individualized person centered Care Plan had a focus area initiated on ██████ and revised date of ██████ that read: I require assistance/potential to restore function for eating related to ████████████████████ and disease process. Interventions included; to check for food remaining in mouth after swallowing; cue to clear throat if voice is "wet" or gurgling; position upright for meals; and refer to the Therapy Plan of Treatment in the medical record for more detail.</p> <p>On 3/3/21 at 8:20 AM, the surveyor observed the meal truck arrive to ██████ Wing. Resident #70's breakfast tray was observed on that truck.</p> <p>At 8:33 AM, the surveyor observed the Assistant Director of Nursing (ADON) deliver Resident #70 roommate's breakfast tray.</p> <p>At 8:48 AM, the surveyor observed Resident #70 in bed with no breakfast tray. At this time, the surveyor interviewed the resident who confirmed he/she was hungry.</p> <p>At 8:50 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident required assistance with feeding so he/she received their meal tray when someone was available to assist and feed them. The LPN then proceeded to retrieve the resident's breakfast tray from the truck and fed the resident.</p>	F 804	<p>Meal trays are re-organized for roommates who can eat independently in the rooms and the resident who requires feeding assistance and their roommate will be in the second truck. This in service was initiated on 3/9/21.</p> <p>The Food Service Director and dietary staff were in- serviced regarding timely delivery of food trucks to ensure food temperature and proper organization of meal delivery carts are in-place. This was initiated on 3/9/21 and ongoing.</p> <p>Re-education for Nurses and CNA's were initiated on 3/10/21 and on going regarding timely delivery of meal trays and serving meal trays for residents in same room, and residents who requires feeding assistance to ensure that food temperature are maintained when serving meal trays</p> <p>The Unit Manager will provide an updated list for tray organization to the FSD for any changes</p> <p>The Food Service Director or designee will perform 5 food trucks Weekly audits x 4 weeks and then monthly x 5 months for timely Food Truck Delivery and acceptable food temperature Audits will be submitted to the Administrator. Negative findings will be corrected immediately. Reports of audits will be presented to Quality assurance committee Who meet quarterly who will review and determine frequency and necessity for future audits.</p>		

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F 804	<p>Continued From page 14</p> <p>On 3/3/21 at 12:59 PM, the surveyor observed the meal truck arrive to █ Wing. Resident #70's lunch tray was observed on that truck.</p> <p>At 1:11 PM, the surveyor observed Resident #70's roommate in their room eating lunch. The surveyor observed that Resident #70 had no lunch tray.</p> <p>At 1:37 PM, the surveyor observed Resident #70's lunch tray still on the meal truck. At this time, the surveyor observed that the resident was still not eating lunch.</p> <p>At 1:46 PM, the Staff Coordinator/Certified Nursing Aide (CNA) removed the resident's lunch tray from the meal truck and placed it on the resident's dresser. The Staff Coordinator/CNA then proceeded out of the room to obtain an over-bed table to feed the resident.</p> <p>At 1:56 PM, the surveyor observed the resident served soup by the Staff Coordinator/CNA. The resident stated that he/she disliked the soup. Upon questioning, the resident confirmed that the soup was cold and requested a peanut butter and jelly sandwich.</p> <p>On 3/8/21 at 1:25 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and ADON, who stated that when meal trays arrived to the unit, both the nurses and aides delivered the trays to the residents. Residents who were able to feed with minimal to no assistance were served first, followed by residents who required assistance to feed were then fed. The DON stated that a resident's meal tray should not be sitting on the meal cart for</p>	F 804	<p>Unit Manager and or designee will perform 3 meal pass observations alternately covering all meals x 4 weeks and then monthly x 5 months to ensure that meal trays are served by the nursing staff on a timely manner, resident's are served together on the same room and residents who requires feeding assistance are provided. Negative findings will be corrected immediately.</p> <p>Reports of audits will be presented to Quality assurance committee Who meet quarterly who will review and determine frequency and necessity for future audits.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 804	Continued From page 15 almost an hour and that the longer the food sat, the temperature decreased. The DON stated that cold food was not appetizing or appealing. A review of the facility's Nutritional Services policy dated 3/14/14 and revised date 3/9/15, included that the Dietary Department will develop an order of service for all meals which best suits the needs of the residents. The schedule will be followed. N.J.A.C. 8:39-17.4(a)2	F 804			