STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
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** Based on observation, interview and record review, it was determined that the facility failed to follow professional standards of clinical practice by not carrying out physician ordered treatment for 1 of 37 residents (Resident #2) and was evidenced by the following: Reference New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; The practice of nursing as a licensed practical nurse is defined as performing task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist. According to the Admission Record (AR) dated 2/27/2020, Resident # 2 had the [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) an assessment tool, dated 2/16/2020 indicated that Resident # 2 was cognitively intact and able to understand information and communicate information. The MDS also reflected that the resident required set up help with dressing, bathing and personal hygiene. On 02/25/20 at 10:17 AM, the surveyor observed Resident # 2 sitting in a lounge chair with both feet raised. Resident # 2 was interviewed at this time and said that he/she had a lot of swelling and fluid in his/her lower legs. The resident added that he/she goes out to the vascular doctor who told him/her to wear compression stocking to help and relieve the swelling. He/ she also added that he/she was supposed to be wearing TED ([MEDICAL CONDITION]-Embolic-Deterrent) stockings (Compression stockings) but did not think the stockings were ordered yet. The resident stated Where are they ordering the stockings from, fifth and jabit. He/she said it had been a week or two since the staff put the TED stocking on his/her legs. The surveyor observed that the resident was not wearing TED stockings at this time. On 02/26/20 11:35 AM, the surveyor interviewed Resident # 2 who said that the staff had not applied TED stockings to his/her lower legs since last week. The resident then showed the surveyor their legs and the surveyor observed that the resident was again not wearing the TED stockings. The Physician order [REDACTED].# 2's Care Plan which indicated that Resident # 2 had increased swelling in both lower legs due to the [DIAGNOSES REDACTED]. The Vascular Surgery Consultation dated 1/25/2020, indicated that Resident # 2 had chronic severe [MEDICAL CONDITION] stage 3 of the lower extremities, [MEDICAL CONDITION], [MEDICATION NAME] and [MEDICAL CONDITION]. The consultation also indicated the physician had advised the resident to utilize compression stockings daily to both lower extremities. The Treatment Administration Record (TAR) dated 2/25/2020 and 2/26/2020 at 6:00 AM hours contained nursing signatures that documented TED stockings were applied for the [DIAGNOSES REDACTED].# 2's legs on the dates the nursing staff documented that the stockings had been applied. On 02/26/20 at 11:49 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) that was caring for Resident # 2 who said that the resident required partial care for his/her activities of daily living (ADL's) and required treatments to his/her lower extremities. The LPN added that Resident # 2 also wore compression stockings during the day and removed at night. The LPN revealed that the compression stockings were supposed to be applied around 6 am and that she was not aware that the resident did not have the TED stockings on as ordered, because she did not apply them and was not working at the time they were supposed to be applied. On 02/26/20 at 12:11 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN UM) who said that she was not sure why Resident #2 was not wearing the TED stockings as ordered, but would check and obtain the correct compression stockings for the resident. The LPN UM was able to locate the appropriate compression stockings that were ordered by the physician in the facility central supply room. On 02/27/20 at 10:08 AM, the surveyor interviewed the LPN UM who stated that the resident was not wearing the TED stockings as ordered on [DATE] and that the resident also informed her that the stockings had not been put on since Saturday 2/23/2020. The Director of Nursing (DON) provided the surveyor with a statement dated 2/28/2020 at 11:22 AM from the LPN that worked on 2/25/2020 at 11:00 PM to 2/26/2020 at 6:00 AM. The LPN documented in the statement that she charted in error that the compression stockings were in place and was wrong for charting that she applied the stockings. The statement read I charted in error at the time of application. I should have written a note about the refusal and I was wrong for charting that I applied them. There was no documentation in the medical record that Resident #2 refused the application of the compression stockings on 2/25/2020 and 2/26/2020 at 6:00 AM. On 03/03/20 at 02:56 PM, the surveyor interviewed the DON who said that the facility did not have a policy specific to the application of compression stockings, but indicated that this was a physician's orders [REDACTED]. The policy titled Administration Procedures for all Medications dated (NAME)2019, indicated that after administration of a treatment or medication the nurse was to document administration in the Medication Administration Record [REDACTED]. NJAC 8:39-29.2(d)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to adhere to the accepted standards of infection control practices for (a) a resident on contact isolation precautions for Resident #170, 1 of 1 resident's reviewed for infection and (b) proper storage of respiratory equipment for Resident #121, 1 of 4 residents observed for respiratory care. This deficient practice was evidenced by the following: A.) On 02/25/20 at 11:25 AM, the surveyor observed the Licensed Practical Nurse (LPN), at Resident #170's bedside handling the resident's respiratory equipment. During the observation, the LPN was observed wearing gloves but not a gown or mask. When the LPN exited Resident 170's room, she informed the surveyor Resident #170 tested positive for [MEDICAL CONDITION] (MRSA), a multi drug resistant organism. The LPN said she should have been wearing a gown and stated, She knows better. Situated outside the door of Resident 170's room was a rolling cart containing personal protective equipment (PPE). There was a STOP sign taped to the room number on the wall outside the resident's door, indicating to see the nurse before entering. There was a sign attached to the isolation cart which read, Contact precautions. This sign indicated gloves and a gown should be worn when entering the resident's room. The surveyor attempted to interview Resident #170 but the resident declined to be interviewed. According to the Admission Record, Resident #170 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Order Summary Report revealed Resident #170 was on contact isolation precautions [MEDICAL CONDITION] in the nares. A review of Resident #170's care plan revealed a focus [MEDICAL CONDITION] in the sputum with an intervention of contact precautions. A review of hospital interdisciplinary progress notes revealed a critical result communication dated 4/18/19 for [MEDICAL CONDITION] of the nares. On 03/02/20 at 11:53 AM, the Certified Nursing Assistant (CNA) told the surveyor Resident #170 was on isolation. The CNA said staff were required to wear a gown and gloves to enter the resident's room and she wears a face mask when giving direct care to the resident. On 03/02/20 at 12:02 PM, the Unit Manager (UM) revealed Resident # 170 was on contact isolation [MEDICAL CONDITION] in the sputum and the nares. The UM said if a resident is on contact isolation, staff were required to put on a gown and gloves prior to entering the room and a mask when near the resident. The UM said if someone was on contact isolation, There is no reason not to wear personal protective equipment (PPE) prior to entering the room. The UM said the LPN should have put on PPE prior to entering Resident #170's room. On 03/02/20 at 02:38 PM, the DON if staff were touching an isolated resident or the resident's care items, they should wear isolation PPE. The DON confirmed the LPN should have worn PPE when working with

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Resident #170's nebulizer, because there was, A risk of coming into contact with secretions and or fluids. The policy entitled, Isolation- Categories of Transmission-Based Precautions, revealed a gown and gloves should be worn when entering a room of a resident on contact precautions. The policy further [MEDICAL CONDITION] as an example of an infection that required contact precautions. B.) During the initial tour on 02/25/20 at 9:52 AM, the surveyor observed Resident #121 sitting in his/her wheelchair awake and alert changing his/her [MEDICAL CONDITION] appliance. The surveyor observed a nebulizer treatment machine (a device used to change liquid respiratory medication into a mist for administration to treat respiratory conditions) lying directly on the resident's bedside table with the tubing and facemask attached to the machine. The tubing and face mask were not labeled or dated and were uncovered and exposed to air. Resident #121 said that he/she used the nebulizer machine only occasionally for shortness of breath. Resident #121 said, I let my nurse know and then she helps me set it up. According to the Admission Record, Resident #121 was admitted to the facility with a [DIAGNOSES REDACTED]. The Order Summary Report indicated that Resident #121 had an order for [REDACTED]. The Annual MDS (minimum data set) dated (NAME)30, 2019 indicated that Resident #121 had a BIMS (Brief interview for Mental Status) summary score of 15, which indicated Resident #121 with intact cognitive responses On 03/02/20 at 2:22 PM, the surveyor observed Resident # 121 in bed with eyes closed. On the dresser, across the room from the bed and under the television, the surveyor observed a nebulizer with a facemask attached. The nebulizer machine, the mask and the tubing were not dated, and the mask was placed directly on top of the dresser, uncovered and exposed to air. On 03/03/20 at 11:28 AM, the surveyor observed Resident #121 sitting in a wheelchair in his/her room watching TV. The surveyor did not observe a nebulizer treatment machine in the resident's room. The surveyor asked Resident #121 where his/her nebulizer treatment machine was located today. Resident #121 said Oh, I used it a few days ago, it's right here in my bottom drawer. Resident #121 opened the bottom drawer of his/her nightstand and the surveyor observed the nebulizer treatment machine, with tubing wrapped around the facemask and face mask attached to the nebulizer treatment machine. The tubing and face mask were uncovered and lying on top of the residents' personal belongings. On 03/03/20 at 12:36 PM, the surveyor Interviewed the Unit Manager (UM) who said that if residents are on routine and scheduled oxygen and nebulizer treatments, the respiratory equipment, tubing, and facemasks should be labeled, dated, and covered. In addition, the UM said that the respiratory tubing and masks get changed every Friday on the 11:00 AM to 7:30 PM shift. If the resident is on a as needed nebulizer treatment, the respiratory tubing and facemask does not have to be dated and covered. The UM added, because the resident is not always using the respiratory equipment. The surveyor asked the UM for a copy of the facility's policy regarding the care and maintenance of respiratory equipment. The UM stated that he/she will direct the request for a copy of such policy to the Director of Nursing (DON). On 03/03/20 at 2:53 PM, the Director of Nursing (DON) stated to the surveyor that there is no facility policy for management of respiratory equipment. The DON said, We only use standards of care with regard to management of respiratory equipment. The DON also stated that the nursing staff is educated on the storage, labeling, and changes of respiratory equipment. It is part of their orientation skill area. A policy titled, Infection Prevention and Control Program Guidelines 2019-20; on page 67 with subtitle, Oxygen Tubing and Respiratory Products revealed that when all nebulizer tubing and equipment shall be dated and stored in a oxygen bag when not in use and replaced every 7 days. It is the responsibility of both nurse and CNA to ensure that the tubing and oxygen bag are clean, dated and the tubing is stored properly when not in use at all times. N.J.A.C. 8:39-19.4(a)