STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315111	A. BUILDING _____ B. WING _____	**08/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PREFERRED CARE AT HAMILTON	**1501 STATE HWY 33 HAMILTON SQUARE, NJ 08690**

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** NJ 894 Based on observation, interview, and record review, it was determined that the facility failed to document: a.) an assessment for a newly opened pressure ulcer, and b.) notification of a family representative when the pressure ulcer opened. This deficient practice was identified for 1 of 4 residents reviewed for wounds (Resident #8). Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The evidence was as follows: On 8/27/20 at 11:30 AM, the surveyor reviewed the closed medical record for Resident #8. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted with [DIAGNOSES REDACTED]. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 3/2/20 indicated that the resident had a brief interview for mental status score of 6 out of 15, indicating a moderate cognitive deficit. It further reflected that the resident was admitted to the facility with a Stage I pressure ulcer (non-blanchable redness over a bony prominence with intact skin). The MDS reflected that the resident had a pressure relieving mattress and was receiving the application of an ointment/cream to the area. A review of the resident's individualized care plan dated 2/26/20 included interventions to keep the resident's skin clean and dry, apply a pressure reducing mattress, and a obtain a dietician consultation. A review of the March 2020 physician's orders [REDACTED]. There was no documented evidence of a wound treatment to non-intact skin to the sacrum in the POS for March and April 2020. A review of the May 2020 POS reflected a new telephone physician order [REDACTED]. The order specified to cover the wound with a bordered gauze dressing daily and as needed. A review of the Treatment Administration Record (TAR) for May, June, and July 2020 reflected the corresponding physician's orders [REDACTED]. The TARs reflected that the nurses were signing daily for the accountability of the dressing change to the sacrum in accordance with physician's orders [REDACTED]. A review of the electronic Skilled (nursing) Evaluations revealed there were no Skilled Evaluation notes dated 5/15/20 through 6/4/20 to correspond with the physician order [REDACTED]. A review of the electronic Weekly Skin Review dated 6/5/20 reflected that the resident had a sacral pressure injury measuring 1 x 0.5 x 0.3 centimeters (cm) with drainage. The wound note indicated to cleanse the ulcer daily with normal saline solution and apply [MEDICATION NAME] cover with bordered foam daily. The note did not address notification of family. On 8/27/20 at 2:52 PM, the surveyor interviewed the Social Worker (SW) who stated that she communicated with family representatives for non-medical reasons. She stated that she was not responsible for notifying family with the resident developed an open wound, because she wouldn't be able to speak to the nursing assessments if the family had questions. The SW stated that nurses would be responsible for notifying family of a new open wound. The SW confirmed she never informed the family of Resident #8 that he/she had a newly opened wound. On 8/28/20 at 8:28 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who worked on 5/31/20 and obtained the telephone order from the physician for the treatment to the sacral ulcer. The LPN stated that the resident had a pressure relieving mattress, received getting barrier cream to the sacrum and buttocks every shift and went to the [MEDICAL TREATMENT] center three days a week and was out of the building for multiple hours. She stated that she worked on Sunday 5/31/20 and found that the wound had opened and that the sacrum had been opened and healed and then reopened again. The LPN stated that she couldn't recall exactly what happened on 5/31/20 when she found the wound, but that she thought the resident had mentioned his/her bottom hurt and when she assessed the area she found the wound and called the doctor for a treatment order. She stated that she repositioned the resident and that it relieved his/her discomfort to the area without needing to medicate for pain. She stated that the bordered gauze the doctor ordered also had padding on it for comfort. The LPN stated that there should be a nurses note documenting the assessment of the sacral wound in the ePN or the electronic Skilled Evaluation notes in the resident medical record for 5/31/20. The surveyor asked the LPN when a family representative would be notified of a change, and the LPN stated that if a resident had a fall or developed a skin tear than she or the Unit Manager (UM) would notify the family. The surveyor asked if a resident had a pressure ulcer that opened if she would need to notify the family, and the LPN stated that she would not need to notify the family for a pressure ulcer that opened because the wound developed from sitting and it opened a little and since it was not trauma from an incident like a skin tear, she would not need to notify the family. She stated that she didn't call the family but maybe the unit manager did. She confirmed it should be documented in the resident's medical record. The surveyor asked the LPN to show her the progress note or wound evaluation dated 5/31/20 and the LPN was unable to produce documented evidence of her notes. On 8/28/20 at 8:44 AM, the surveyor interviewed the LPN/UM who stated that he conducted an investigative report dated Sunday 5/31/20 regarding the open pressure ulcer to the sacrum. The LPN/UM and surveyor reviewed the investigative report dated 5/31/20 together which revealed that the resident had an abrasion measuring 0.5 x 0.5 x 0.2 cm. The report reflected the name of the physician that was notified at 10:00 AM, but there was no name recorded for the family representative that was notified. The LPN/UM stated that he had called the family at the same time he called the physician, but he was unable to speak to who he spoke to. The LPN/UM stated that there should be a progress note regarding who he spoke to in the resident's medical record. The LPN/UM stated that when a new wound opens or if a wound re-opens, the nurse who found the wound was responsible for documenting the wound location, the wound size, any signs or symptoms of infection, a pain assessment, responses and treatment to pain if indicated, physician and family notification and the resident's response to the wound treatment after the physician's orders [REDACTED]. At 3:55 PM, the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) were unable to provide documented evidence of the sacral ulcer identified on 5/31/20 or documented evidence of the name of the family representative that was notified of the new wound. A review of the facility's Notification of Changes Policy created 5/2017, included that Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident .The objective of the notification policy is to ensure that the facility staff makes appropriate notification .to the resident and/or the resident representative when there is a change in the resident's condition, or an accident that may require physician intervention The nurse will notify the resident, resident's physician and the resident representative(s) for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician. Document the notification and record any new orders in the resident's medical record. A review of the facility's Wound Care policy revised 10/2019,

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

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) includes that the Nurse will assess and measure wounds weekly. Document findings. NJAC 8:39-11.2(a), 27.1(b), 29.2(b)
F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** NJ 988 Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure: a.) the facility's cooking thermometer was calibrated to ensure safe and appetizing temperatures, and b.) resident council complaints of unappetizing food temperatures was addressed since January 2020. This deficient practice was identified for 1 of 3 meals served on 8/28/20 on 1 of 2 Units (North Unit). The evidence was as follows: On 8/27/20 at 10:00 AM, the surveyor observed Resident #2 awake in his/her room in bed. At that time the surveyor interviewed the resident and the resident stated that he/she attended the Resident Council meetings. The resident stated that the meals were served in the room within 30 minutes of each scheduled meal time. The surveyor asked the resident about the temperature and palatability of food served and the resident stated that It used to be cold all the time, but it's getting better. The resident denied ever being served undercooked food. The resident further stated that the facility used a plate cover and a heating mechanism on the plate, but the food would still sometimes be cold. The resident stated that he/she kept notes on the meal tickets to give to the Food Service Director (FSD) or the Licensed Nursing Home Administrator (LNHA) regarding his/her perception of each meal, including if an item on the tray was served cold or not. The resident stated that it may be because the meal trucks sit on the unit and aren't passed out right away. The resident reported that food temperature concerns were brought up in the Resident Council in the past. The surveyor reviewed the Resident Council Minutes dated 1/29/20 which reflected that Old Business: Food issues continue. Under New Business one resident in the council addressed that the kitchen sends the food to the floors hot, it will sometimes take a while to distribute them. The minutes referenced cold eggs and coffee .regularly. The meeting minutes did not include action by the facility to address the concern. A review of the Resident Council Minutes dated 2/25/20 included that Overall, the food issues have been resolving from the last month, but distribution of trays once they are sent to the floors continues to be a challenge at times. The meeting minutes did not include action by the facility to address the concern of the timely distribution of trays. A review of the Resident Council Minutes dated 4/27/20 included that residents addressed that they liked the variety of foods but the food isn't as hot as it should be. Another resident stated that the trays will sit awhile before it was served. The meeting minutes did not include action by the facility to address the concern of the timely distribution of trays and appetizing temperature of food. A review of the Resident Council Minutes dated 5/28/20 included old business in which food is not distributed soon enough; some items are not hot enough. In the New Business of the meeting one resident indicated that although the food is very good, it sometimes is not as hot as it should be by the time it is delivered .The Dietary Manager will be informed of this issue following the meeting. The meeting minutes did not include action by the facility to address the unresolved concern affecting food temperatures. On 8/28/20 at 11:30 AM, the surveyor entered the Kitchen with the FSD. At that time, the food was being plated by the Cook. The surveyor interviewed the Cook who stated that the menu included Stuffed Tilapia and a grilled ham and cheese sandwich as the main entree, and the cook identified food on the steam table as carrots, rice, green beans and mashed potatoes as sides. The surveyor asked regarding the cooking temperature of the Tilapia and she stated that it was to be cooked between 145 degrees to 165 degrees Fahrenheit. She stated that she checked the temperatures of all the foods before the surveyor entered the kitchen and recorded it in the food temperature log. The surveyor asked about the thermometer she uses to check the temperatures of foods and she showed the surveyor a digital thermometer. She stated that she did not have to calibrate the thermometer because they were already calibrated by the manufacturing company. She acknowledged she never calibrated the thermometer. At 11:45 AM, the surveyor interviewed the FSD about the thermometer, and the FSD stated that the digital thermometers do not need to be calibrated. He continued that the manufacturer designed the thermometer that they do not need to be calibrated. The FSD stated that the Tilapia had to be cooked at a minimum of 145 degrees Fahrenheit. At 11:50 AM, the surveyor requested three sample test trays (Regular, Mechanical Soft and Pureed trays). Using the surveyor's calibrated thermometer and the facility's uncalibrated thermometer the surveyor and FSD took the temperatures of the food simultaneously. The surveyor observed the Tilapia and it appeared to be fully cooked with a white center and no translucent/opaque coloring. The FSD's uncalibrated thermometer consistently read notably higher than the surveyor's calibrated thermometer. The differences in temperatures were as follows: Regular Tray Stuffed Tilapia: 14 degrees Fahrenheit (F) Carrots: 15 degrees F Rice: 12 degrees F Mechanical Soft Stuffed Tilapia: 21 degrees F Mashed Potatoes: 19 degree F Carrots: 28 degrees F Pureed Stuffed Tilapia: 16 degrees F Green Beans: 16 degrees F Mashed Potatoes: 14 degrees F At 11:59 AM, the FSD provided the surveyor a copy of the manufacturer instructions for the facility's digital cooking thermometer that corresponded with the model. The instructions included, If recalibration is necessary, for best results calibrate within the temperature range most commonly used. Always utilize a reliable source as a benchmark when calibrating. If a verified reference temperature cannot be achieved in the usage range, then calibrate in an ice bath as described in Step 1. Instructions for how to calibrate the digital thermometer were provided in the instruction manual. At 12:00 PM the FSD acknowledged the digital thermometer instructions from the manufacturer indicated steps on how to calibrate the thermometer. He acknowledged that the instructions did not indicate that calibration was not needed. At 12:08 PM, the three sample test trays with the warming palettes and plate lids were loaded onto the meal truck with the other resident meals for the North Unit, and the FSD exited the kitchen with the truck. The surveyor observed that two lids were not secure to the plates exposing the base of the plates during transportation to the unit. At 12:10 PM, the meal truck arrived to the North Unit with the three sampled trays. A Certified Nursing Aide (CNA), Assistant Director of Nursing (ADON) and the Licensed Practical Nurse/Unit Manager (LPN/UM) began passing out the lunch trays to the residents. The lunch meals were finished being passed to the residents on the North Unit at 12:25 PM. The surveyor and FSD tested the temperatures of the three sample trays at that time. The temperatures were as follows using the surveyor's calibrated thermometer: Regular Tray Stuffed Tilapia: 118 degrees F Carrots: 110 degrees F Rice: 116 degrees F Mechanical Soft Stuffed Tilapia: 112 degrees F Mashed Potatoes: 128 degrees F Carrots: 108 degrees F Pureed Stuffed Tilapia: 116 degrees F Green Beans: 110 degrees F Mashed Potatoes: 114 degrees F. The temperatures were as follows using the FSD's uncalibrated thermometer: Regular Tray Stuffed Tilapia: 133 degrees F Carrots: 124 degrees F Rice: 124 degrees F Mechanical Soft Stuffed Tilapia: 126 degrees F Mashed Potatoes: 128 degrees F Carrots: 119 degrees F Pureed Stuffed Tilapia: 122 degrees F Green Beans: 122 degrees F Mashed Potatoes: 122 degrees F At 1:00 PM, the surveyor continued to interview the FSD who acknowledged the discrepancy of the food temperatures using the surveyor's calibrated thermometer and his uncalibrated digital thermometer. He stated that using his uncalibrated thermometer, the temperatures appear to be at a more palatable temperature at the point of service, but acknowledged that without calibrating the thermometer it could impact the accurate readings of each food item. The FSD acknowledged that the difference in temperature readings were that his temperature readings were approximately 12-15 degrees F higher than the surveyor's calibrated thermometer, and if a thermometer read higher because it was not calibrated it could affect the true appetizing temperature of the food. The surveyor asked if the facility had done any test trays in the last six months, and the FSD stated that he had not conducted any test trays to verify temperatures until today with the surveyor. The FSD stated that he started working at the facility in March 2020 and that he was not aware of any complaints regarding food that was not at an appetizing temperature or distribution of trays. The FSD stated that had he known of any complaints than he would have done sample test trays. The surveyor showed the FSD the Resident Council Minutes dated 5/28/20, and referenced earlier Resident Council Minutes in January, February, April and May 2020 that referenced foods that were not at an appetizing temperature and concerns that meal trucks would sit on the unit and not delivered to the resident rooms timely, affecting food temperatures. The FSD acknowledged the minutes, but stated that he did not have knowledge of the issue. He confirmed there was no response to the minutes because he did not know. The FSD stated that the Activities Director (AD) attended and wrote up the meeting minutes. The FSD also provided the surveyor a copy of the lunch meal temperature log which was blank for the lunch meal on 8/28/20. The FSD stated that he was taking temperatures with the surveyor and that he just didn't record it yet. The FSD acknowledged that he was not documenting his temperatures and could not speak to the Cook who stated that she had documented the temperatures. The FSD acknowledged that they did not document the temperatures at the time of service at lunch, adding that it was because the surveyor was there. At 1:35 PM, the surveyor interviewed the Regional Dietary Director who stated that the facility used warmed plates, warmed palettes, and plate covers to insulate meals. The surveyor asked what temperature range was considered palatable and he stated, I love 120-130 degrees; that's perfect. The surveyor requested a policy regarding food temperatures. At 2:18 PM, the surveyor interviewed the AD who stated that she attended the Resident Council Meetings and that she would write up the meeting minutes and distribute them to the managers of each department. She acknowledged that if there were action responses they

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F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) would be attached to the meeting minutes. The AD acknowledged that residents at the Resident Council had complained of food that was not maintained at an appetizing temperature but that she brought it to the Manager. The AD acknowledged that there were no follow up actions addressed in the meeting minutes regarding the facility's response to the concerns. At 2:22 PM, the surveyor interviewed the Registered Dietician (RD) by phone who acknowledged that the facility had implemented a new ticket tracking system in the last 2-3 months. The RD stated that she sees residents in the facility and no resident had complained to her about food temperatures, but stated that because the facility had gone to all disposable paper products for a while secondary to COVID-19, it may have affected the holding temperature of foods. She stated that she did not go to the resident council meetings. The surveyor asked the RD about the facility's digital thermometer and the RD stated that she was not aware that the facility had not calibrated their thermometers. She stated that I thought all thermometers had to be calibrated. She confirmed that there were no food borne illnesses within the facility, and that there were no concerns with undercooked foods by residents. The RD stated that she didn't do a test tray recently at the facility to determine temperatures, but that maybe the FSD had done test trays. The RD stated that she would prefer the temperature of a meal to be over 120 degrees F for a palatable, appetizing hot meal. She acknowledged she was not aware that the resident council meetings had reported concerns with appetizing food temperatures. At 3:45 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) who were unable to provide documented evidence of a response to the Resident Council Minutes conducted since January 2020. The LNHA acknowledged the discrepancy in temperatures between the surveyor's calibrated thermometer and the FSD's uncalibrated thermometer during the lunch meal, in which the FSD's thermometer read notably higher. A review of the facility's undated Food Preparation policy included All foods will be held at appropriate temperatures, greater than 135 (degrees) F (or as state regulation requires) for hot holding, and less than 41 (degrees) F for cold holding. Temperature for TCS (Time and Temperature Control for Safety) foods will be recorded at the time of service, and monitored periodically during meal service periods. When hot pureed, ground or diced food drop into the danger zone (below 135 degrees F), the mechanically altered food must be reheated to 165 degrees F for 15 seconds if holding for hot service. The policy did not address calibrating the thermometers. A review of the facility's undated Quality and Palatability policy included that Food should be at the appropriate temperatures as determined by the type of food to ensure the resident's satisfaction and minimizes the risk for scalding and burns. The policy did not address procedures to maintain appetizing food temperatures. The policies provided did not address calibrating thermometers or appetizing temperature ranges for the various foods. A review of the nationally accredited state food safety guidelines copyright 2020 included that a thermometer that is even five degrees off can lead to serving food that is not safe or palatable to eat. It further included that a reliable thermometer is only reliable if it is calibrated often, and the frequency of how often it is calibrated depends on the type of thermometer. In general .calibrate digital thermometers every week or month and always calibrate new thermometers or a thermometer that has been dropped. NJAC 8:39-17.4 (a)