STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **315468**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE ONE AT MORRIS	**100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of other pertinent documents, it was determined that the facility failed to a.) implement and revise interventions in a timely manner to impede a cognitively impaired resident with a history of intrusive wandering, from repeatedly wandering into a resident's room and b.) ensure a resident with a history of intrusive wandering (Resident #4) did not wander into multiple resident's room. This deficient practice was identified for 1 of 2 residents reviewed for choices (Resident #28) and 5 of 5 residents who participated in a group meeting (Resident #67, #51, #69, #46 and #13). This deficient practice was evidenced by the following: On 03/05/20 at 10:18 AM, the surveyor observed a white mesh sign with a stop sign in the center, affixed to one side of Resident #28's door. The sign was attached from one side of the doorway and was hanging toward the floor. Resident #28's bed was located next to the entrance of the room. The surveyor interviewed Resident #28 who stated Resident #4 would repeatedly self-propel himself/herself using his/her wheelchair and entered their room. Resident #28 stated, I don't know how long ago this is going on, but I am so nervous. Resident #28 stated Resident #4 would wander into the room and would call Resident #28 by their spouse's name. Resident #28 stated that Resident #4 had wandered into the room for a long time and I take anxiety pills. Resident #28 stated this would go on every night and that the stop sign did not deter Resident #4. Resident #28 stated that he/she would barricade the door to the room with a chair so Resident #4 could not enter. Resident #28 stated that the events would keep him/her up all night because that was when Resident #4 wandered. Resident #28 also stated when Resident #4 entered the room, Resident #28 would press the call button and the staff would remove Resident #4. Resident #28 stated, I can't take it. It goes on and on, it is every single night and I try not to scream but I get nervous. The surveyor noted that Resident #4's room was the room immediately next door to Resident #28. At that time, the surveyor observed two chairs directly placed to the side of the doorway in the immediate interior of Resident #28's room. Resident #28 stated when Resident #4 would enter the room, Resident #28 would scream at Resident #4 to please get out. Resident #28 also stated that he/she informed the wandering resident's son and granddaughter about what was happening and that Resident #4's family told Resident #4 not to go into Resident #28's room. Resident #28 stated he/she had also told the previous administrator that the wandering resident had not stopped and that the previous administrator had not addressed the issue. Review of Resident #28's Admission Record revealed had [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 01/15/20, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Review of the section, mood interview (PHQ-9), revealed the resident experienced feeling down, depressed or hopeless; had trouble falling asleep or sleeping too much which occurred for two to six days a week over the previous two-week period prior to 01/15/20. Review of the Annual MDS dated [DATE] section, mood interview (PHQ-9), revealed the resident never experienced feeling down, depressed or hopeless; had trouble falling asleep or sleeping too much for the previous two-week period prior to 04/15/19. Review of the Psychiatric Progress Note (PPN) completed by the Psychiatric Nurse Practitioner (NP) for Resident #28 dated 11/06/19 indicated that he/she was seen for an increase in depressive symptoms related to a close friend who was currently very ill with a poor prognosis. The PPN indicated that the resident was having difficulty sleeping, a poor appetite, and had a positive family history of depression. The PPN made recommendations for the resident to be administered the antidepressant medication [MEDICATION NAME] 20 mg by mouth daily for depression and Trazadone 25 mg at nighttime for [MEDICAL CONDITION]. Review of March 2020 Order Summary Report (OSR) indicated the resident had a Physician order [REDACTED]. A further review of the March 2020 OSR indicated the resident had a PO dated 11/09/2019 for the medication Trazadone 25 mg by mouth at bedtime for [MEDICAL CONDITION]. Review of the January 2020 Medication Administration Record (MAR) indicated that Resident #28 was administered the medication [MEDICATION NAME] 20 mg by mouth daily for depression at 9:00 AM. Further review of the January 2020 MAR indicated that the resident was administered Trazadone 25 mg by mouth at bedtime for [MEDICAL CONDITION] at 9:00 PM. Review of the February 2020 MAR indicated that Resident #28 was administered the medication [MEDICATION NAME] 20 mg by mouth daily for depression at 9:00 AM. Further review of the February 2020 MAR indicated that the resident was administered Trazadone 25 mg by mouth at bedtime for [MEDICAL CONDITION] at 9:00 PM. Review of the March 2020 MAR indicated that Resident #28 was administered the medication [MEDICATION NAME] 20 mg by mouth daily for depression at 9:00 AM. Further review of the March 2020 MAR indicated that the resident was administered Trazadone 25 mg by mouth at bedtime for [MEDICAL CONDITION] at 9:00 PM. Review of the Grievance/Concern Report, date received 01/13/20, completed by the Social Worker (SW) indicated that Resident #28 reported that Resident #4 kept wandering into his/her room despite the stop gate being up and the door being closed. The Grievance/Concern Report indicated that the concern was reported to the Interdisciplinary Care Team (IDCT). The action taken to resolve the concern was that the SW offered Resident #28 a room change to the other end of the hallway. The resident declined the offer. The Grievance/Concern Report did not indicate that Resident #28's Care Plan (CP) was updated to reflect the resident's concerns or if any interventions were implemented until 3/3/20. The resolution further indicated that the SW instructed the resident to press the call bell to have the wandering resident removed from the room. The resolution was signed by the Administrator, Unit Manager, Registered Nurse Supervisor (RNS) and the SW. A follow up note from the Grievance/Concern Report, dated 01/20/20, indicated that the resident was offered a room change and educated on different disease process' such as dementia and that Resident #28 was partially receptive to the discussion. The grievance follow-up note did not address any further interventions for Resident #28 and did not include follow up with Resident #28 regarding Resident #4's intrusive wandering, after the resident had declined the room change and was not fully receptive to the education. A SW Progress Note dated 01/13/20 at 16:10 revealed Resident (#28) spoke with this SW regarding having an issue with a confused resident who keeps wandering into (his/her) room. Resident states that the stop gate does not to do anything at this time and also (he/she) tries to keep the door close but the other resident will open it. SW validated feeling expressed and notified Nursing of concern. SW offered resident a room change to the opposite end of the hallway. Resident stated that (he/she) will take a look and if (he/she) decides to move will alert this SW. SW also added to notify staff if resident keeps entering room. Review of Resident #28's Care Plan (CP), created by the RNS, dated 03/03/20, revealed a focus area of a resident wandering into Resident #28's room. The CP goal was for no other residents to wander into the resident's room. Interventions of the CP included to alert staff to any residents wandering into the room, offer room change if available and placement of netted stop sign/gate all created by the UMRN and initiated 03/03/20. During an interview with the surveyor on 03/05/20 at 11:07 AM, the Certified Nurse Aide (CNA), stated she cared for Resident #4 and he/she wandered into every person's room and called other residents by his/her spouse's name. The CNA stated Resident #4 was confused and would enter Resident #28's room and Resident #28 would shout, get out of here, this is not your room! The CNA stated that Resident #28 did not like residents of the opposite sex going into their room so there was a stop sign up

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) now. The CNA stated that she had witnessed Resident #4 enter Resident #28's room last night. The CNA stated she was providing care to another resident in their room when she heard Resident #28 yell, get out of the room and she observed Resident #4 in the doorway of Resident #28's room. The CNA stated Resident #28 had placed a chair at the doorway in front of the mesh stop sign to keep Resident #4 out of the room. The CNA stated she escorted Resident #4 away from the room and sat him/her in front of the fish tank with a snack. The CNA stated it depended on Resident #4's mood and that Resident #4 may go into Resident #28's room a few times per week and it has been going on for months. The CNA stated Resident #4 would also go into other resident rooms that did not have a stop sign. The CNA stated that she had been Resident #28's CNA for a long time and that Resident #28 had been getting more upset and very mad about Resident #4 entering the room. The CNA stated this had been going on for months and Resident #28 was bothered by Resident #4 calling them their spouse. Review of Resident #28's PPN, dated 01/08/20 at 15:28, completed by the NP, revealed NP was asked to see resident for possibly worsening depression. Snapping more often, less patient. The signs and symptoms were anxiety and depression and the NP received information from the resident, medical chart, nurse and staff. The history of present illness (HPI) revealed the resident was calm and alert, very irritated by their neighbors and by one man/woman who comes into their room nightly and thinks Resident #28 was that resident's spouse. NP noted that this caused Resident #28 to have difficulty sleeping and irritability. The [DIAGNOSES REDACTED]. During an interview with the surveyors on 03/05/20 at 12:20 PM, NP #1 stated she had seen Resident #28 on 1/8/20. The NP stated Resident #28 was cognitively intact and was seen for [MEDICAL CONDITION] medications and for worsening depression quarterly and the staff requested that she see Resident #28 for anxiety and agitation which may be been exacerbated by Resident #4 behavior. NP #1 stated Resident #4 was severely demented and would wander with their wheelchair into Resident #28's room. The NP #1 stated that annoyed Resident #28 and Resident #4 also wandered into other resident's rooms. The NP stated that she was aware the facility added the stop sign across Resident #28's door. The NP stated she could not recall how frequently Resident #4 entered Resident #28's room and that she had increased Resident #28's Trazadone because Resident #28 had sleep changes related to being disturbed by Resident #4's wandering. During an interview with the surveyors on 03/05/20 at 12:50 PM, the SW stated she was the person responsible for any grievances on Resident #28's unit. The SW provided a copy of a Grievance/Concern Report, dated 01/13/20. The survey team interviewed the SW about the report which revealed Resident #28 had reported that Resident #4 kept wandering into their room despite a stop gate being up and the door closed. SW stated that it had to have bothered Resident #28 because the resident made a complaint with nursing and filed a grievance. The documentation of facility follow-up revealed the individuals(s) designated to act on this concern was that it was reported to the Interdisciplinary team. The specific action to resolve the concern, dated 01/13/20, was that the SW had a one to one conversation with Resident #28 and offered Resident #28 a room change which Resident #28 declined. SW also instructed Resident #28 to press the call bell to have staff assist with removing Resident #4. The SW stated she was familiar with Resident #28 and that the resident was alert and oriented. The SW stated the stop gate was added to the care plan the other day and the stop sign was supposed to stop wandering residents from entering into Resident #28's room. She stated Resident #28 had been complaining about a resident wandering into the room and that she had documented this about one and a half months ago. She stated that nursing had let her know and she followed up with Resident #28. She stated she did not know when the stop net was put up and that she had not followed up with Resident #28 to determine if the stop net worked to keep Resident #4 out of the resident's room. The SW stated that if she did not hear anything from the resident or from nursing, she would assume everything was ok. The SW stated that Resident #28 came to nursing to report Resident #4's wandering in January and she put the CP in about two months later and that the CP was used as a form of communication for the staff to know the resident's needs. During a later interview with the surveyors on 03/05/20 at 1:16 PM, the SW stated she wanted to change her prior statement. She stated that she read the grievance and it was resolved unless the resident mentioned something to nursing that I haven't heard. Review of a Quarterly meeting, dated 01/20/20, revealed the RN Unit Manager (UMRN) documented Resident #28 had been offered a room change again and declined. The documentation also revealed Resident #28 had been educated on different disease processes such as dementia and that Resident #28 was partially understanding and receptive to the discussion. During an interview with the surveyor on 03/06/20 at 8:53 AM, the UMRN stated Resident #28 requested the stop net about a month or two ago to keep people from wandering into his/her room. The UMRN stated Resident #28 did not want a room change and that Resident #4 wandered at night, however, nothing was reported to her until recently, (he/she) came to me sometime in January I think. The UMRN stated it should also have been documented in last month's quarterly meeting that Resident #28 complained of the wandering. At this meeting the resident was offered a room change again, and the resident declined the room change again. The UMRN stated Resident #4 wandered, it is just what he/she liked to do and that Resident #28 didn't like Resident #4 being in his/her room and the resident was upset and asked her if there was any way to keep Resident #4 out of their room. The UMRN was unable to tell the surveyor if Resident #28 was offered a room change two or three times, however the facility was able to provide documentation that Resident #28 was offered a room change on 01/13/2020 and 01/20/2020 in which he/she declined. The UMRN was unable to tell the surveyor if Resident #4 was offered a room change. During an interview with the surveyor on 03/06/20 at 9:23 AM, UMRN reviewed a progress note dated 01/20/20 and stated that was the quarterly meeting note but that she may not have wrote it down but I put it in a grievance report instead, but I know I discussed it with him/her. The UMRN could not provide any additional documentation regarding the CP meeting and documentation regarding any revised interventions to prevent Resident #4 from wandering into Resident #28's room which caused Resident #28 to be upset. During an interview with the surveyor on 03/06/20 at 9:33 AM, Resident #28 stated Resident #4 had wandered into their room again the previous night. Resident #28 stated they put the chair against the door again and yelled for the CNA to remove Resident #4 from his/her room, but that Resident #4 returned. Resident #28 stated she told the UMRN that Resident #4 thought of Resident #28 as their spouse. Resident #28 stated they were upset that they were asked to change their room. The resident stated, if he/she is aggravating me, why do I have to move? The resident stated that Resident #4 came into the resident's room at 10:00 PM when the resident went to bed at 8:30 PM and he/she doesn't stop! The resident stated that he/she told UMRN, CNA, everybody. The resident stated that she screamed and told Resident #4 that he/she could not come in, and the chair was also at the door to keep the resident out and Resident #4 stated to her the he/she could come in anytime he/she wants. The resident stated that when the resident had to yell to get Resident #4 out of the room it is upsetting because it also is not good for his/her roommate because the roommate does not feel well, and it is also disturbing him/her. The resident stated that he/she was having nightmares of their ex-spouse and what a bad relationship it was. Resident #28 further stated, this caused him/her to tense up and caused his/her stomach to get nervous. The resident stated that at night he/she was just trying to read or watch television and that Resident #4 entering the room was disturbing and upsetting to them. During an interview with the surveyor on 03/10/20 at 9:20 AM, Resident #28 stated Resident #4 had wandered to their room last night at 10 pm. Resident #28 stated they had used the chair to barricade their door but Resident #4 came in again and Resident #28 screamed and told them not to come in but that Resident #4 told him/her that they would come in anytime they wanted. During a telephone interview with the surveyors on 03/10/20 at 12:02 PM, the Licensed Clinical Social Worker (LCSW) stated she saw Resident #28 weekly and the resident had a history of [REDACTED]. The LCSW stated Resident #28 had post-traumatic stress disorder ([MEDICAL CONDITION]) related to their ex-spouse. The LCSW stated that Resident #4 would mistake Resident #28 for their spouse. During an in person interview with the surveyors on 03/12/20 at 11:35 AM, the LCSW stated she had met with Resident #28 who informed her that Resident #4 still wandered into his/her room at night while they were trying to sleep. The LCSW stated Resident #28 informed her that Resident #4 was targeting him/her for invasion and that he/she felt they should not have to change their room and that they had a right to be free of somebody unwanted from entering their room. The LCSW stated the staff was aware Resident #4's wandering into the room upsets Resident #28. The LCSW stated Resident #4 sees Resident #28 as his/her spouse and had a sense of entitlement to him/her and prior to that, Resident #28 had informed the facility about the concern. During an interview with the surveyor on 03/12/20 at 12:22 PM, Resident #67, the roommate of Resident #28, stated that Resident #4's wandering was terrible. Resident #67 stated Resident #4 was annoying and in and out of their room doorway and that the other night (he/she) came in and scared the hell out of (him/her). Resident #67 stated it was not acceptable for Resident #4 to wander in their room while they and Resident #28 were sleeping. Resident #67 stated Resident #4's wandering would cause Resident #28 to scream and the screaming would wake him/her up. resident #28 was present during the interview Resident #67 stated Resident #4 would refer to Resident #28 by their spouse's name. Resident #67 stated both roommates were present when the LCSW spoke to Resident #28 and that after the conversation, Resident #28 confided to Resident #67 that now they felt they cannot defend themselves. During the interview, Resident #28 interjected and stated Resident #4 came into the room and stated to Resident #28 (spouse's name), I want to talk to you. Resident #28 stated that the SW told him/her

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) again yesterday, But, I asked you if you want to change your room, and the resident said, again, she/he stated that he/she did not want to move and asked the surveyor, Why should I have to move? Review of resident #67's Admission Record revealed the resident had been admitted to the facility with [DIAGNOSES REDACTED]. Review of the Quarterly MDS dated [DATE], revealed Resident #67 had a BIMS of 15 which indicated intact cognition. During an interview with a surveyor on 03/05/20 at 11:59 AM, five alert and oriented residents selected by the facility, attended a group interview (Resident #13, #46, #51, #67 and #69). All five residents stated Resident #4 had wandered in and out of rooms through the facility all the time. Resident #46 stated the stop sign across the front of the doors was not keeping Resident #4 out of resident rooms and if they closed their door, their rooms would get too hot and uncomfortable. Resident #67 stated Resident #4 slept all day and was up wandering all night. On 03/06/20 at 8:49 AM, the surveyor observed Resident #4 sitting in bed and eating his/her breakfast. Review of Resident #4's Admission Record reflected that the resident had [DIAGNOSES REDACTED]. Review of the resident's most recent Annual MDS, dated [DATE], revealed the resident had a BIMS score of 03 out of 15 which indicated the resident had severely impaired cognition. A review of Section C1310 Signs and Symptoms of [MEDICAL CONDITION] reflected the resident had fluctuating behaviors in severity of inattention and disorganized thinking. A further review of the resident's MDS Section E Behaviors, revealed the resident had wandering behaviors which occurred one to three days from 02/25/20 to 03/02/20. These wandering behaviors placed the resident at significant risk of getting into a potentially dangerous place and significantly intruded on the privacy or activities of other residents. Review of the resident's annual Progress Note (PN) dated 03/02/20 and timed at 15:29 (3:29 PM) documented by the SW #1 indicated that the resident had behaviors reported by staff of wandering at times and could be combative. Further review of the PN indicated Resident #4 demonstrated intrusive wandering into other residents' rooms on 0[DATE] at 23:08 (11:08 PM), on 02/18/20 at 17:05 (5:05 PM), on 02/17/20 at 19:09 (7:09 PM), on 02/11/20 at 23:03 (11:03 PM), and on 02/11/20 at 19:18 (7:18 PM). Review of the Psychiatry Progress Note (PPN) dated 11/20/19 indicated that the resident had frequent episodes of Sundown (when a person with dementia confusion and agitation gets worse in the late afternoon and evening), which usually started around 4:00 PM and the resident was unable to be redirected. Review of the resident's January 2020 Medication Administration Record (MAR) behavior monitoring for intrusive wandering indicated that Resident #4 during the 7:00 AM to 3:00 PM shift had two incidences of intrusive wandering on 01/04/20, and one incident of intrusive wandering on 01/10/20, and 01/20/20. The January 2020 behavior monitoring for intrusive wandering indicated that Resident #4 during the 3:00 PM to 11:00 PM shift had two incidences of intrusive wandering on 01/01/20, 01/03/20, 01/29/20, and 01/30/20, one incident of intrusive wandering on 01/06/2020 and 01/10/20, and three incidences of intrusive wandering on 01/08/2020 and 01/20/20. The January 2020 behavior monitoring for intrusive wandering further indicated that Resident #4 during the 11:00 PM to 7:00 AM shift had zero episodes of intrusive wandering. Review of the resident's January 2020 Psychoactive Medication Monthly Note indicated the Resident #4 had ten episodes of wandering. This contradicted the January 2020 MAR which indicated Resident #4 had 16 episodes of intrusive wandering behavior. Review of the resident's February 2020 MAR behavior monitoring for intrusive wandering indicated that Resident #4 during the 7:00 AM to 3:00 PM shift had three episodes of intrusive wandering on 02/03/20 and 02/27/20, and two incidences of intrusive wandering on 02/25/20. The February 2020 MAR behavior monitoring for intrusive wandering indicated that Resident #4 during the 3:00 PM to 11:00 PM shift had four incidences of intrusive wandering on 02/11/20, one incident of intrusive wandering on 02/12/20, 02/25/20, and 02/29/20, two incidences of intrusive wandering on 02/14/20, 02/20/20, and 02/27/20, three incidences of wandering on 02/15/20 and 02/19/20, and 15 incidences of wandering on 02/18/20. The February 2020 behavior monitoring for intrusive wandering further indicated that Resident #4 during the 11:00 PM to 7:00 AM shift had four incidences of intrusive wandering on 2/11/2020, three incidences of intrusive wandering on 02/15/20, two incidences of intrusive wandering on 02/20/20 and 02/27/20, and one incident of intrusive wandering on 02/25/20. Review of the resident's February 2020 Psychoactive Medication Monthly Note indicated the Resident #4 had six episodes of wandering. This contradicted the February 2020 MAR which indicated Resident #4 had 53 episodes of intrusive wandering behavior. Review of the resident's March 2020 Medication Administration Record (MAR) behavior monitoring for intrusive wandering indicated that Resident #4 during the 7:00 AM to 3:00 PM shift had two incidences of intrusive wandering on 03/01/20, three incidences of intrusive wandering on 03/03/20, one incident of intrusive wandering on 03/04/20, one incident of intrusive wandering on 03/05/20, one incident of intrusive wandering on 03/06/20, and five incidences of intrusive wandering on 03/09/20. The March 2020 MAR behavior monitoring for intrusive wandering further indicated that the resident during the 3:00 PM to 11:00 PM shift had one incident of intrusive wandering on 03/05/20. This indicated a total of 16 episodes of intrusive wandering behavior to date from 03/01/20 to 03/09/20. Review of the corresponding PN from 03/01/20 to 03/09/20 did not reflect that the nurses were documenting on the resident's intrusive wandering, how the wandering affected other residents in the facility, or interventions for the resident related to his/her intrusive wandering. Review of the Resident #4's CP, initiated 03/11/19, reflected a focus area for wandering/pacing related to dementia and wandering into other resident's rooms. The goal of the care plan reflected that the resident would wander safely within boundaries. The interventions of the care plan included attempt to minimize excess stimulation, help in locating own room, and provide supervision during recreational activities. During an interview with the surveyor on 03/10/20 at 9:16 AM, LPN #2 stated that she was an agency nurse and it was her third time working at the facility. LPN #2 stated that the MAR reflected that Resident #4 demonstrated behaviors of intrusive wandering and she thought maybe the behaviors occurred more at night. LPN #2 further stated that she had received report from the previous shift nurse who told her that the resident wandered into other resident's rooms. During an interview with the surveyor on 03/10/20 at 9:31 AM, the UMRN stated Resident #4 had behaviors of wandering and had other behaviors in the past that she, Couldn't remember. The UMRN stated that the last time she spoke with the Resident #28 was a couple of weeks ago and she couldn't remember the whole conversation. The UMRN stated that she did see Resident #4 sit outside of the Resident #28's bedroom door, so Resident #28 would close his/her bedroom door. The UMRN stated that the staff were responsible for documenting on resident's behaviors. The UMRN printed out Resident #4's March 2020 MAR and PN's. The UMRN reviewed the March 2020 MAR and PN's in the presence of the surveyor. The UMRN told the surveyor that when the nurses documented in the MAR, the were not required to document in the resident's PN's. After reviewing the Resident #4's medical record the UMRN was able to speak more on the resident's behaviors. The UMRN stated that the resident would go towards rooms with older residents who Resident #4 thought was his/her spouse. The UMRN further stated that the resident had behaviors of yelling, cursing, and being combative with staff during care, but never had hit another resident. During an interview with the surveyor on 03/13/20 at 9:30 AM, the Director of Nursing (DON) stated Resident #4 was visually and cognitively impaired. The DON stated that Resident #4's spouse had gone out of state in November 2019 and returned in January 2020 and that Resident #4's behavior had changed while the spouse was gone. The DON did not speak to if Resident #4's room was changed or if a room change was offered to the resident for his/her episodes of wandering into other resident in the facility's rooms. During an interview with the surveyor on 03/13/20 at 9:35 AM, the Administrator stated most of Resident #4's wandering was harmless and that some of the more feisty residents do not like Resident #4 because they think he/she is creepy. The Administrator stated Resident #28 was upset over the loss of a loved one and their grief was causing their reactions. Review of the facility's, Grievance/Complaints, Filing Policy revised, 04/11/18 revealed, The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. A further review of the facility's, Grievance/Complaints, Filing Policy indicated, All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response. Upon receipt of the grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint. The Grievance Officer, Administrator and Staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated. Review of the facility's, Grievance/Complaints- Staff Responsibility Policy revised October 2017 indicated, Staff members are encouraged to guide residents about where and how to file grievances and/or complaint when the resident believes that his/her rights have been violated. A further review of the facility's, Grievance/Complaints- Staff Responsibility Policy indicated, Should a staff member overhear or be the recipient of a complaint voiced by a resident, a resident representative (sponsor), or another interested family member of a resident concerning the resident's medical care, treatment, food, clothing, or the behavior of other residents, ect., the staff member is encouraged to guide the resident, or person acting on the resident's behalf, as to how to file a written complaint with the facility. Staff members will inform the resident or the person acting on the resident's behalf that he or she may file a grievance or complaint with the Administrator or other government agencies as noted on the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **315468**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE ONE AT MORRIS	**100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) bulletin board, without fear of threat or any other form of reprisal. Review of the facility's, Behavioral Assessment, Intervention and Monitoring Policy revised February 2019 indicated regarding Assessment, The nursing staff will identify, document, and inform the physician about specific details regarding changes in the individual's mental status, behavior, and cognition including a. Onset, duration, intensity and frequency of behavior symptoms; b. Any recent precipitating or relevant factors or environmental triggers (e.g., medication changes, infection, recent transfer from hospital; and c. Appearance and alertness of the resident and related observations. 4. New onset of behaviors will be documented regardless of th
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.** Based on observation, interview and review of pertinent documents, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to ensure safe food temperatures are maintained, b.) store foods in a manner to ensure items are not used beyond safe use by dates, c.) monitor the temperature of a room used to store food to prevent potential food degradation, d.) wash hands in an appropriate manner and d.) maintain equipment in a manner to minimize microbial growth and cross contamination. This deficient practice was evidenced by the following: On 03/03/20 at 9:19 AM, the surveyor completed an initial tour of the kitchen with the Director of Culinary Services (DCS) and observed the following: Inside the walk-in refrigerator, located on an upper shelf, a loaf of Texas toast was stamped Use by 03/01/2020, one loaf of Texas toast was undated, and one loaf of wheat bread was stamped fresh through 02/17/20. The DCS stated he is throwing the items away. At 9:42 AM, the surveyor toured a separate storeroom with the DCS. The storeroom contained a battery of reach in freezers against a wall. The temperature in the room felt very warm and the DCS acknowledged there were no thermometers in the storeroom. The DCS stated the temperature of the storeroom should be 70 degrees Fahrenheit (F). At that time, the DCS took out his calibrated thermometer and took an ambient temperature of the room. The DCS thermometer read 79 degrees F. A pallet of items including various shelf stable food items, were wrapped tightly in plastic and labeled with a stop sign and emergency. A shelving unit was observed opposite of the battery of freezers against a wall. Food items were observed and identified as part of the emergency food supply by the DCS. On 03/04/20 at 1:28 PM, the surveyor observed the Activity Director (AD) inside the kitchen, at the sink washing her hands. The AD was not wearing a hairnet and stated she was helping a resident. On 03/10/20 at 1:17 PM, the surveyor toured the kitchen and observed a cook (Cook #1) remove two dirty dishes from the cook's area and placed the dishes by the dish machine. Cook #1 proceeded to wash his hands at the handwashing sink, placed soap on hands and rubbed hands for two seconds under running water, dried hands with a paper towel and donned gloves. Cook #1 then proceeded to remove turkey and cheese from the refrigerator and obtained a cutting board and bread. Cook #1 placed the items in the cook's area. Cook #1 removed his gloves and proceeded to apply soap on his hands, lathered for six seconds and placed his hands under the running water. The cook then donned gloves and proceeded to make a sandwich that was provided to the DCS. The surveyor interviewed Cook #1 at that time, who stated I am supposed to wash my hands for 3, 4,5 seconds. At 1:33 PM, Cook #1 approached the surveyor and stated, it was okay because he washed his hands often. The surveyor observed another cook (Cook #2) wash his hands appropriately. When finished, Cook #2 turned off the faucet with a paper towel and used the same paper towel to pick up a wet towel out of the sink. Cook #1 did not rewash his hands. At 1:38 PM, the DCS joined the surveyor. The DCS stated that staff should wash their hands for twenty seconds and it was not okay to wash for less. At that time, the surveyor observed the following: A reach in refrigerator inside of the storage area located near the handwashing sink. The temperature inside of the refrigeration unit felt warm and the thermometer revealed a temperature of 45 degrees F. The DCS stated the temperature should be 40 degrees F or below. The refrigerator contained a box of defrosted hot dogs, a box of partially frozen sausage patties and three undated, prepared sandwiches, one tuna, one egg salad and one peanut butter and jelly. The DCS stated the sandwiches and hot dogs were used for alternate food choices. The DCS and surveyor took the food temperatures of the egg salad sandwich which revealed: Surveyor, 58.3 degrees F and DCS, 55.7 degrees F. The DCS and surveyor took the food temperatures of two hot dogs and the temperatures were as follows: 1st: Surveyor, 60.2 degrees F, DCS, 58 degrees F; 2nd: Surveyor 60.8 degrees F, DCS, 59.8 degrees F. The DCS stated the sandwiches that were undated would be discarded and the refrigerator was not at a safe temperature so the other foods would also be discarded. A food temperature log was observed on the exterior of the refrigerator which revealed the AM internal temperature of 38 degrees. A plastic wrap dispenser located inside the storeroom was visibly soiled on the exterior and a second plastic wrap container that was not in a dispenser and located in the kitchen that was visibly soiled on the exterior of the container. A review of the Refrigerators and Freezers Policy, revised December 2014, revealed acceptable temperature ranges are 35 degrees F to 40 degrees F for refrigerators. All food shall be appropriately dated to ensure proper rotation by expiration dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be compiled with expiration dates on all prepared food in refrigerators. Expiration dated on unopened food will be observed and use by dates indicated once food is opened. A review of the Food Receiving and Storage Policy, revised October 2017, revealed refrigerated foods must be stored at or below 41 degrees F or as otherwise specified by food service standards. Non-refrigerated foods, disposable dishware and napkins will be stored in a designated dry storage unit which is temperature and humidity controlled The Sanitation Policy, Revised October 2008, revealed kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent and accumulation of grime. The Handwashing/Hand Hygiene Policy, Revised August 2015 revealed .apply soap and vigorously rub hands together creating friction to all surfaces for a minimum of 20 seconds . NJAC 8:39 17.2 (g)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to ensure: a.) transmission-based precautions were implemented and followed for a resident with a positive wound culture for a Multi-Drug Resistant Organism. This deficient practice was identified for one of two residents reviewed for infections (Resident #25) b.) the facility's tracking of infections included accurate and appropriate tracking/surveillance data and c.) effective cleaning and disinfections procedures for environmental surfaces and equipment, the equipment observed was five of five medications carts and one of one medication refrigerators. These deficient practices were evidenced by the following: On 03/04/20 at 11:01 AM, the surveyor observed Resident #25 seated on a wheelchair in his/her bathroom. The surveyor observed that the resident was clothed and trying to close his/her abdominal binder with the assistance of the Certified Nursing Aide (CNA). The surveyor further observed that the resident had a Jackson-Pratt (JP) drain (a closed-suction drain that is surgically inserted and collects bodily fluids), that was filled with a reddish yellow liquid and attached the resident's abdomen. The CNA was observed helping the resident position his/her clothing around the drain for comfort. Review Resident #25's Admission Record reflected that the resident had [DIAGNOSES REDACTED]. Review of the resident's most recent admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 1[DATE]19 reflected that the resident had Brief Interview of Mental Status (BIMS) score of 11 out of 15 which indicated the resident's cognition was moderately impaired. Review of Resident #25's Progress Notes (PN) dated 02/19/20 and timed at 00:14 (12:14 AM) revealed the nurse changed the resident's JP drainage site and noticed a, Small amount of yellow crusty drainage on the old dressing. The PN reflected that the area around the site was inflamed, warm, and tender. The PN further reflected that the CNA observed the resident, tugging at drain continually despite teaching. Review of the resident's PN dated 02/20/20 and timed at 12:57 PM reflected that the resident's JP drainage site was red and warm to touch. The PN reflected that the nurse called the resident's physician and received a physician's orders [REDACTED]. Further review of the resident's PN dated 02/22/20 and timed at 15:07 (3:07 PM), reflected the Resident #25's physician was made aware of the JP drainage culture results and prescribed an antibiotic to treat the infection. Review of a Lab Report wound culture dated 02/22/20 and timed at 12:16 PM reflected [MEDICAL CONDITION] growth. The Lab Report further indicated to initiate isolation and notify infection control. Review of the resident's Comprehensive Care Plan (CCP) dated 02/20/20 reflected a focus area that the resident had an infection of JP drainage which had resolved. The goal of the CCP reflected that the infection would be resolved without complications. The interventions of the CCP included to administer medications per physician orders [REDACTED]. Complete review of the resident's medical record did not indicate that the resident was placed on transmission-based precautions related to [MEDICAL CONDITION] infection.

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NAME OF PROVIDER OF SUPPLIER **CARE ONE AT MORRIS**	STREET ADDRESS, CITY, STATE, ZIP **100 MAZDABROOK ROAD** **PARSIPPANY TROY HILL, NJ 07054**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) Review of the facility's February 2020 Monthly Infection Surveillance Log indicated that Resident #25 had a [MEDICAL CONDITION] infection which was a Multi-Drug Resistant Organism (MDRO), and the resident remained on standard precautions. The surveyor interviewed Resident #25's regular CNA on 03/06/20 at 9:30 AM, who stated that the resident was never on transmission-based precautions and she was never required to apply Personal Protective Equipment (PPE) (gown, gloves, or mask) prior to entering the resident's room and providing care. The surveyor interviewed the resident's Licensed Practical Nurse (LPN) on 03/06/20 at 9:34 AM, who stated that the resident was alert and oriented with confusion. The LPN stated that the resident would touch the area around his/her JP drain. The LPN further stated he recalled the area around the resident's JP drainage site was red and looked infected, so the doctor came in and assessed the area and ordered an antibiotic for the infection. The LPN was unaware if the area around the JP drainage site was cultured. The LPN stated that the resident was never placed on transmission-based precautions related to the infection which required him to apply PPE prior to entering the resident's room. The surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) on 03/06/20 at 9:56 AM, who stated that the area around the resident's JP drain was infected and the resident's physician had ordered a wound culture to the area and started the resident on antibiotic treatment. The surveyor asked if the RN/UM if she recalled the results of the wound culture and asked if the resident was ever placed on a transmission-based precaution. The RN/UM stated that she couldn't remember. The surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) on 03/06/20 at 11:04 AM, who stated that the facility would place a resident on contact precautions if they had [MEDICAL CONDITION] infection. The ADON/IP stated that contact precautions meant staff who had direct contact with the resident had to apply PPE, like a gown, gloves, and mask. The ADON/IP stated that she kept track of the resident's in the facility that required antibiotic treatment for [REDACTED]. The ADON/IP stated that the nurses did not come in contact with the infection because they weren't coming in contact, With the wound bed. The ADON/IP stated that she had to look back for specifics on the resident before she could answer further questions from the surveyor. The ADON/IP further stated that the facility followed CDC recommendations for implementing infection control practices. The surveyor conducted a follow up interview with the ADON/IP in the presence of the Director of Nursing (DON) on 03/10/20 at 9:45 AM, who stated the resident's infection was isolated to the skin surrounding the JP drainage site and not in the JP drainage. The ADON/IP further stated that when the resident's wound culture came back positive [MEDICAL CONDITION], she did not think it was necessary to place the resident on contact precautions because the site was contained under a dressing. The surveyor interviewed the DON on 03/10/20 at 9:53 AM, who stated that if she had a question about infection control practices, she would consult with the ADON/IP. The DON agreed with the ADON/IP that the resident should not have been placed on contact precautions for the infection because the site was contained under a dressing. The DON stated, The care would have been the same. The surveyor interviewed the Advanced Practitioner Nurse (APN) who specialized in Infectious Disease on 03/12/20 at 9:22 AM. The APN stated that if a resident had active symptoms of an infection, was being treated with an antibiotic for the infection, and had a positive wound culture [MEDICAL CONDITION], the resident should have been placed on transmission-based precautions. The APN further stated that a [MEDICAL CONDITION] culture would indicate placing the resident on contact precautions for the infection. Review of the facility's, Isolation- Categories of Transmission-Based Precaution Policy revised October 2018 indicated, Transmission- based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet, and airborne. The facility's, Isolation- Categories of Transmission-Based Precaution Policy further indicated, Contact Precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Staff and visitors will wear gloves (clean, non-sterile) while entering the room. a. While caring for a resident, staff will change gloves after having contact with infectious material (for example, fecal material and wound drainage). b. Gloves will be removed and hand hygiene performed before leaving the room. Staff and visitors will wear disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. MEDICATION STORAGE On 03/04/20 at 10:16 AM, in the presence of the Director of Nursing (DON), the surveyor observed the small, medication refrigerator in the subacute medication storage room. The top shelf, located on the door of the refrigerator, was visibly soiled with a ring of a reddish colored, sticky substance next to a blue and clear bag with medication bottle inside of it. The second shelf, located on the door of the refrigerator, was visibly soiled with a blue and clear bag with a medication bottle on one side and a medication bottle directly on top of the substance on the other side. At that time, the surveyor interviewed the DON. The DON stated there was no schedule to clean the medication refrigerator and no log showing accountability that the medication refrigerator had been cleaned. The DON stated the nurses are just expected to clean it. The DON further stated for infection control purposes, it was not ok for the medication refrigerator to be soiled. On 03/04/20 at 10:07 AM, the surveyor inspected the subacute, medication cart #2, in the presence of the Licensed Practical Nurse #1 (LPN). The surveyor observed the top draw with visibly soiled red, sticky substance and over the counter (OTC) medication bottles that had been in the direct contact with the substance. The surveyor observed the third draw with visibly soiled, red crystallized substance where the blood pressure (BP) cuff had been stored. LPN #1 stated the medication cart should have been cleaned every night and was not sure when it had been cleaned last. LPN #1 stated it was important to keep the medication cart clean because of infect control; dirt could stick to the surfaces and transfer to other medications and supplies which could contaminate them. On 03/04/20 at 10:31 AM, the surveyor inspected the subacute, medication cart #1, in the presence of the LPN #2. The surveyor observed the third draw with a visibly soiled brown, sticky substance with a small piece of paper stuck to it in close proximity to three medication bottles; also a red, sticky substance in close proximity to a box of inhalation medications and a box with an inhaler in it. The surveyor observed the fourth draw with visibly soiled, red sticky substance and a pink crystallized substance in close proximity to seven bottles of medications; and red, sticky substance in close proximity to and dripped on a bottle of laxative medication. LPN #2 stated she should have cleaned her medication cart because there could be germs especially on the medication bottles. On 03/04/20 at 10:36 AM, the surveyor inspected the subacute, medication cart #3, in the presence of the LPN #3. The surveyor observed a brown, lumpy substance in the bottom draw. The surveyor was able to touch and remove some of the substance. LPN #3 stated the medication carts should be kept clean. On 03/04/20 at 10:41 AM, the surveyor inspected the long term care (LTC), medication cart #2, in the presence of LPN #4. The surveyor observed the third draw with a visibly soiled, red substance in close proximity to a medication bottle and a bottle used to dispose of medications. LPN #4 stated the medication cart should be kept clean for infection control purposes and the visibly soiled areas, Were not clean enough. On 03/04/20 at 10:45 AM, the surveyor inspected the LTC, medication cart #1, in the presence of LPN #5. The surveyor observed a red, crystallized substance in the third draw in close proximity to a box of inhalation medication. The surveyor observed the bottom draw with a visibly soiled substance in close proximity to six bottles of medication and one single medication pour cup. LPN #5 stated the medication carts were cleaned twice a week but the nurses should clean their own carts as well. LPN #5 stated it was important to keep the medication carts clean because substances in contact could dissolve packaging and contaminate medications. LPN #5 stated she did not have a chance to clean her medication cart yet that day and had completed her morning medication pass with the soiled medication cart. During an interview with the surveyor on 03/10/20 at 9:40 AM, the Administrator stated she would expect if the medication cart was visibly dirty, the nurses should clean them. The Administrator stated there was no specific policy, procedure or log for cleaning the medication carts or the medication refrigerator. During an interview with the surveyor on 03/11/20 at 12:36 PM, the Assistant Director of Nursing / Infection Preventionist (ADON/IP) stated every shift was responsible for cleaning the medication carts and refrigerator but that it was preferred for the 11:00 PM - 7:00 AM shift to do this the most. The ADON/IP stated that she checked the medication carts every day usually after the morning medication pass was completed. The ADON/IP stated there was no log to account for any staff cleaning the medication carts or refrigerator and that it was just a Verbal communication. The ADON/IP stated she had checked the medication refrigerator on 03/03/20 and it was Not acceptable but I don't remember what I did about it. The ADON/IP further stated that the visibly soiled medication carts and refrigerator could cause cross contamination. Review of the facility, Storage of Medications, policy dated 4/2019, revealed the nursing staff were responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Review of the facility, Job Description Staff Nurse, dated 12/2006, revealed under daily tasks #11, maintain facility policies, procedures and practices for Infection Control. Review of the facility, Medication Administration Observation and Medication Pass Audit, revealed tasks which included Medication cart clean and orderly; medication cart prepared with supplies, clean, organized, and Medication room clean, refrigerator clean. Further review

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) revealed that on 05/01/19, LPN #1 did not pass the medication cart clean and orderly task of her medication pass competency. NJAC 8:39-19.4 (a)(l); 31.4(a)(f)