

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

PRINTED: 11/20/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315369	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/04/2022
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NAME OF PROVIDER OR SUPPLIER CAREONE AT VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 OLD HOOK ROAD WESTWOOD, NJ 07675
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS Survey Date: 5/4/22 Census: 78 Sample: 5 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		6/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/19/2022
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	<p>Continued From page 1</p> <p>conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of</p>	F 880			

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F 880	<p>Continued From page 2 infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of records, it was determined that the facility failed to practice appropriate hand hygiene for 3 of 7 staff observed in accordance with the Centers for Disease Control and Prevention guidelines for infection control to mitigate the spread of COVID-19.</p> <p>This deficient practice was evidenced by the following:</p> <p>According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, updated 5/17/2020 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom." It further specified the procedure for hand hygiene which included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a clean towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times."</p>	F 880	<p>1. ID Prefix Tag FTag 880 SS=D</p> <p>2. How the Corrective Action will be Accomplished for those residents found to have been affected by the Practice. No residents were affected. An immediate inservice of CNA #1, CNA #2 and LPN/Unit Manager on handwashing, hand hygiene policy and procedure were provided, including observation for return demonstration competency.</p> <p>3. How the Facility will identify other residents having the potential to be affected by the same deficient practice. Residents have the potential to be affected by the practice.</p> <p>4. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur. The Facility conducted an in-depth Root Cause Analysis (RCA) on the event related to the handwashing concern and found that the staff knew the protocol and handwashing practices of facility as they were previously inserviced/educated on it. However, the staff shared that they were not used to being observed by State</p>		

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F 880	Continued From page 3 1.) On 5/3/22 at 11:52 AM, the surveyor observed the Licensed Practical Nurse/Unit Manager (LPN/UM) perform handwashing for 10 seconds. The LPN/UM did not wet her hands before applying soap. The surveyor also observed that the LPN/UM did not use a clean towel to turn off the faucet. 2.) On 5/3/22 at 11:57 AM, the surveyor observed Certified Nursing Assistant (CNA) #1, assigned in a non-COVID unit perform handwashing for 8 seconds. CNA #1 did not wet her hands before applying soap. CNA #1 was observed scrubbing her hands with soap for 3 seconds then continued to scrub her hands under the running water for 5 seconds. The surveyor also observed that the CNA #1 did not use a clean towel to turn off the faucet. 3.) On 5/3/22 at 12:50 PM, The surveyor observed CNA #2, who was assigned in the COVID unit perform handwashing. The surveyor observed CNA #2 scrub their hands with soap for 17 seconds. A review of the facility's Policy and Procedure titled, "Handwashing/Hand Hygiene" that was provided by the facility revealed under procedure "Washing Hands" 1. Wet hands first with water, apply soap and vigorously rub hands together creating friction to all surfaces for a minimum of 20 seconds (or longer). 2. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink. 3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel."	F 880	surveyors which resulted in them becoming nervous. An immediate inservice, reinforcement and competencies were conducted by the Facility Educator to CNA #1, CNA #2 and the LPN/Unit Manager. The three staff members demonstrated competency. The Facility Educator or designee re-educated staff regarding the Handwashing/Hand Hygiene policy including a return demonstration. The Facility or designee will utilize the handwashing/hand hygiene tool during audit and competency observation. 5. How the Facility will monitor its corrective actions to ensure that the deficient practice will not recur i.e. what quality assurance program will be put into place The Facility Educator or designee will conduct handwashing audit upto 10 staff weekly for four weeks, then 10 staff per twice monthly for two months. The Facility Educator or designee will continue random audits thereafter upto 10 per month. Results of the hand hygiene audits will be reported at the Quality Assurance Performance Improvement committee meetings on a monthly basis for three months for review and to determine the need for further educations or revisions to the plan. 6. Directed In-Servicing Training completion a. Module 1 - Infection Prevention and control program - training provided to		

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F 880	Continued From page 4 On 5/4/22 at 12:05 PM, the surveyors met with the Administrator, Regional Administrator, and Director of Nursing and were made aware of the above concerns. They all responded and specified that handwashing should be at least 20 seconds. NJAC 8:39-19.4 (a) (1) (n)	F 880	<p>topline staff and infection preventionist. https://www.train.org/main/course/1081350 (topline staff and infection preventionist)</p> <p>b. CDC Covid-19 Prevention messages for front line longterm care staff: Keep Covid 19 out! - training provided to front line staff. https://youtu.be/7srwrF9MGdw</p> <p>c. CDC Covid 19 Prevention Messages for front line longterm care staff: Clean Hands - training provided for front line staff. https://youtu.be/xmYMUly7qiE</p> <p>d. Module 7 - Hand Hygiene - provided for all staff including top line staff and infection preventionist. https://www.train.org/main/course/108106</p> <p>e. Module 6A - Principles of Standard Precautions - provided for all staff including top line staff and infection preventionist. https://www.train.org/main/course/1081804</p>		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315369	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 7/29/2022	Y3
NAME OF FACILITY CAREONE AT VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 OLD HOOK ROAD WESTWOOD, NJ 07675		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	06/15/2022	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 5/4/2022

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO